Commentary

The widening scope of mentalizing: A discussion

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The editors of this special issue have commissioned us to bring together some of the conceptual and empirical research presented in six intriguing papers that illustrate the widening scope of mentalization. Our discussion will look at each paper in turn, but bring ideas and findings from the other papers into focus when relevant.

The evolutionary and ontogenetic origins of mentalizing

Liotti and Gilbert’s (2011) paper is exceptionally thought provoking. As we understand it, Liotti and Gilbert link attachment processes to mentalization in an evolutionary rather than an ontogenetic sense: attachment processes are seen as an avenue provided by evolution for the recovery of mentalization against a background of potential threats that can be mitigated by a relational experience of safety. This perspective, in addition to more recent empirical findings from developmental psychology, has encouraged us to revise our views and consider alternatives. Liotti and Gilbert suggest that the activation of the attachment system does not necessarily facilitate mentalizing and the relationship between the two (what we have called loosely coupled systems; Fonagy & Target, 2000; Fonagy, Steele, Steele, & Holder, 1997) is moderated by the context and background against which activation takes place. They helpfully identify the intense activation of the attachment system in the face of threat as a cause of inhibition rather than facilitation of mentalizing. This is consistent with our theorizing based on neuroscientific observations that have also guided our clinical interventions (Bateman & Fonagy, 2004).

In contrast to our attachment theory perspective, Liotti and Gilbert suggest that a feeling of ‘social safeness’ could be a pre-requisite for successful mentalizing. For them, ‘social safeness’ encompasses a broader range of settings than those covered by the attachment construct. Social safeness may arise from being in a position of authority, for example, which would promote mentalizing according to Liotti and Gilbert’s model. (Anecdotally, our encounters with Chief Executives of National Health Service Trusts do not confirm this hypothesized association.) The issue they raise is

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complex and subtle. Interestingly, the paper by MacBeth, Gumley, Schwannauer, and Fisher (2011) also reports that attachment classifications relate to different aspects of patient experience other than mentalizing capacity (engagement with services and quality of life, respectively) suggesting the absence of isomorphism. We are in agreement with the model proposed by Liotti and Gilbert, suggesting that the background to the association between attachment and mentalizing is rooted in our evolutionary past. We have suggested that the availability of the caregiver to the infant was a signal of environmental stress (Hrdy, 2009) that empowers infants to make adaptive choices depending on the circumstances in which they find themselves. Where caregivers do not have the time or resources to devote individual attention to their infant, the infant’s subsequent priorities may call for physical assertion rather than the kind of social collaboration that mental state understanding of others prioritizes. In environments where resources are insufficient for the population, relative inattention in the context of primary attachments prepares the child’s mind and body for violent competition for resources (Fonagy & Bateman, 2008). Alternative, but incompatible, strategies for relating to others through intra-species collaboration, are sacrificed. This, in our view, is the evolutionary background that biases those with a secure attachment towards mental state understanding.

It is not our impression that Liotti and Gilbert would disagree with the view that there is an underlying relationship between attachment in infancy and precocious social understanding. After all, this was first reported by Bretherton, Bates, Benigni, Camaioni, and Volterra (1979) over 30 years ago. Nor would we disagree about the accumulating empirical support for an association between the quality of children’s primary attachment relationship and the passing of mentalizing tests (see de Rosnay, Harris, & Pons, 2008 for a critical review). We certainly agree with the general stance in their paper that exploration and safeness in the human context encompasses the exploration of minds. Epistemic safety (or epistemic trust) in this context refers to the ‘social mentality’ of the environment that individuals find themselves in. A secure attachment context then, where the caregiver shows interest in the infant’s mental state, can be expected to engender secure attachment and advance the development of mentalization (Sharp, Fonagy, & Goodyer, 2006; Slade, 2005). We concede that later in development it is not attachment per se but features of the social environment analogous to a secure parenting environment – particularly an adult mind taking an interest in a child’s mental state – that may be critical for the robust establishment of mentalization. Evidence shows that parenting characterized by authoritative rather than authoritarian practices and incorporating discussions involving affect, is associated with precocious understanding of mental states (e.g., Charman, Ruffman, & Clements, 2002; Pears & Moses, 2003). General characteristics of family functioning, rather than the quality of attachments per se, may be the primary vehicle whereby vulnerability to the loss of mentalization under stress is generated (Fonagy, Gergely, & Target, 2007).

However, before conceding the possibility of a direct link between attachment and mentalizing, we would challenge Liotti and Gilbert to provide a more detailed and coherent account of recently emerging biological data, to which they allude, firmly linking the biological systems underpinning attachment to interpersonal understanding in terms of mental states. Oxytocin, which they briefly mention, appears to perform a mediating function between mentalization and attachment (Heinrichs & Domes, 2008). A rapidly accumulating body of empirical findings has suggested that oxytocin specifically improves performance in mentalizing tasks (e.g., Domes et al., 2008; Guastella, Mitchell,
Intranasally administered oxytocin also appears to improve trust, generosity, and emotional attunement to observed suffering (Barraza & Zak, 2009; Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005). We also know from both rodent and human studies that oxytocin plays a major role in attachment and pro-social behaviour in both animals and people (Insel, 2003; Insel & Fernald, 2004). Oxytocin is present at significantly elevated levels in women around childbirth and during breastfeeding (Macdonald & Macdonald, 2010). More specifically, work from our lab suggests that mothers coded as securely attached on the Adult Attachment Interview prior to the birth of the child manifest higher levels of oxytocin when in the presence of their child (Strathearn, Fonagy, Amico, & Montague, 2009). Similar associations were reported in experimental studies exploring the impact of oxytocin on the experience of attachment security (Buchheim et al., 2009). Our own study monitored maternal brain activity in response to distressed as well as happy affect expression on the part of their infants and revealed that expression of sadness on the part of the infant appeared to generate less brain activity associated with attachment in insecure mothers, and more activity consistent with a subjective experience of sadness. It is possible that oxytocin permits the individual to distance him/herself more from the affect they observe, and become aware of the mental state revealed by the other’s expression, as opposed to simply resonating with that state. In other words, it enables the caregiver to offer marked, contingent mirroring, showing the infant through her facial expression that she is aware of his state of distress but that she is coping with it rather than feeling it. By contrast, trauma and maltreatment appear to reduce oxytocin levels (Fries, Ziegler, Kurian, Jacoris, & Pollak, 2005; Heim et al., 2008) and is known to be associated with impaired mentalizing (de Rosnay et al., 2008).

Thus, we would suggest that the social mentalities model advanced by Liotti and Gilbert could be expanded further to incorporate the impact of neuroactive hormones such as oxytocin that impact on brain areas associated with emotions and social behaviour and no doubt they would have done so if space permitted. We suggest that increased oxytocin in secure parental attachment while in the presence of the infant, will ensure a more mentalizing parental stance, characterized by marked and contingent responses to the infant when the latter is in a state of high emotional arousal. This in turn increases the likelihood of robust symbolic representations of self-states being created in the child’s mind. Second-order representations of constitutional self-states ensure better affect regulation in interpersonal interactions. This will contribute to creating a social mentality around the child that facilitates the development of mentalizing. Ultimately the child will show increased resilience to stressful social experience.

By contrast, insecure parental attachment, linked to reduced oxytocin levels in the parent, may lead to non-mentalizing (unmarked, non-contingent) parental responses to distress expressed by the infant. We see such responses as undermining the natural process of maturation for mentalizing by violating the infant’s and young child’s expectation of basic principles of reciprocity, fairness, and rational action. The infant’s failure to internalize self-states through interactions with the parent, creates a potential vulnerability. Mentalizing can more readily go awry for these individuals, particularly under conditions of high arousal and threats to attachment. Mental states will then be ‘enacted’ rather than experienced. Such actions will have a destructive effect on the child’s social environment. The individual’s actions can disrupt and distort social interactions, potentially undermining future opportunities for the development of mentalizing and ultimately creating environments in which the social mentality does
not encourage mentalizing. This may be a source of concern in situations where the child’s mentalizing resources are particularly called upon when caregivers and others are behaving in ways that violate ‘healthy’ expectations. The child needs extra resources if she or he needs to understand the motivations, thoughts and feelings of those who expose him or her to interpersonal adversity, that is, attachment trauma (Allen, 2004).

**Mentalization as a trans-diagnostic concept**

Two papers in the special issue link mentalization deficit to schizophrenia (Lysaker et al., 2011; MacBeth et al., 2011), one to borderline personality disorder (BPD) (Lecours & Bouchard, 2011), one to obsessive–compulsive personality disorder (OCPD) (Dimaggio et al., 2011) and one to psychosomatic conditions (Vanheule, Verhaeghe, & Desmet, 2011). Other mental disorders could have been included, such as eating disorders (Skarderud, 2007), panic disorder (Rudden, Milrod, Aronson, & Target, 2008) or depression (Luyten, Fonagy, Lemma, & Target, in press). In a unique empirical study, MacBeth et al. (2011) demonstrated that first episode psychosis (FEP) was not as strongly linked with insecure attachment as has been observed in samples of chronically mentally ill patients (MacBeth et al., 2011). Mentalizing in the FEP group was unsurprisingly below what may be expected from normally developing individuals. Importantly, mentalizing was negatively correlated with quality of life. The latter association is interpreted by the authors as linking social functioning and mentalization supported by other studies indicating difficulties in understanding mental states and impaired social and neurocognitive performance (Brune, Abdel-Hamid, Lehmkamper, & Sonntag, 2007; Lysaker, Dimaggio, Buck, Carcione, & Nicolo, 2007).

Lysaker et al. (2011) have made an exceptionally clinically helpful contribution by presenting a clinically readily accessible assessment scale for metacognition (metacognition assessment scale or MAS). The MAS may serve as a useful guideline for therapeutic interventions, which will help psychotherapists to avoid the iatrogenic potential of demanding a level of mentalizing competence from a patient, which the patient feels unable to reach (Fonagy & Bateman, 2006). At low levels of MAS, where patients may not recognize their thoughts as their own or may be unable to distinguish and differentiate cognitive operations, it should suffice to intervene with reflections on the fact that patients have specific thoughts that belong to them, that they have intentions related to these thoughts, and to reinforce the clients thinking about their own minds. At higher levels of MAS, therapists may create a safe yet provocative environment, conducive to a therapeutic dynamic, which assumes that patients are capable of recognizing and reflecting on different cognitive operations. Where patients attain even higher levels of MAS, therapists are advised to encourage patients to recognize and distinguish different emotions. Only at high levels of MAS should cognitive therapists support patients in challenging their own thinking and trying to distinguish it from reality.

Both of these papers on psychosis raise questions about the trans-diagnostic character of mentalizing. It seems that shortcomings in mentalizing characterize a range of disorders and bearing the patient’s capacity for mentalization in mind may be just as helpful in psychotherapy for psychosis as for BPD (Bateman & Fonagy, 2010). Of course, psychotherapy and mentalizing capacity are closely interlinked, and given the presence of a mentalizing deficit, a therapeutic intervention based on symbolic communication that fails to take such limitations into account, is likely to be of limited value. Yet seeing
mentalizing deficit as trans-diagnostic does indicate the need to consider its respective role in generating symptoms that are characteristic of a wide range of disorders. In a Freudian model, anxiety has trans-diagnostic aspects as it is seen as a generic response of the patient’s ego to internal threat arising out of conflict (Freud, 1926). We can conceive of mentalizing problems as being a generic indication of mental disorder, regardless of the nature of the symptoms. Vanheule et al. (2011) begin their fascinating paper with the observation: ‘A substantial number of psychiatric patients find it difficult to understand what is going on in their own mind and body’ (p. 84). This statement may indeed be challenged. Is it not the case that all patients with mental disorder present specifically because they find it difficult to understand what is happening in their mind or because those around them draw their attention to their difficulty in understanding social requirements that involve taking the mental states of others into account (e.g., in antisocial personality disorder (ASPD) Bateman & Fonagy, 2008)? Dysfunctional mentalizing leading to disorders of self-experience occurs in all severe conditions that lead to referral for psychological therapy. In Mentalising in Clinical Practice (Allen, Fonagy, & Bateman, 2008), we boldly invited clinicians to consider mentalizing as a foundation of psychotherapeutic treatments, arguing that this apparent audacity was justified since mentalizing addresses the fundamental human capacity to apprehend our own and others’ minds as minds. Patient’s hope that therapy will enable them to recover a ‘calibration of their self perception through understanding others’ views of them. A generic aspect of mental disorder is the mind’s sense of lost capacity for coordination and processing in relation to the experiences it is generating both in terms of behaviour and phenomenological experience. All the papers in this issue speak to this phenomenon in different ways. The phenomenon is obvious in relation to FEP and the patient’s surprise and sometimes terror at their inability to attain a metacognitive understanding of the experiences generated by their own minds (Lysaker et al., 2005). Perhaps the phenomenon is least obvious in the case of alexythymia (Dimaggio et al., 2011; Vanheule et al., 2011), where patients fail to develop appropriate emotional experiences in response to events in their lives and therapy generates a circumstance where they become conscious of and motivated to address this manifestation of their ‘loss of calibration of subjectivity’.

If we accept that mentalization is a core facet of psychological treatment, then it follows that we need to take patients’ experience of their own mental states into consideration, and with this we must also take on board their experiences of the thoughts and feelings of others around them. Finding one’s own mind in the mind of one’s therapist will invariably play a part in any mental health intervention. No patient is likely to undergo therapy without harbouring certain expectations in relation to the intentions of their treater. Maintaining a sense of this process matters, regardless of therapist’s orientation or treatment approach. Psychotherapists across modalities necessarily use this capacity, whether or not they conceptualize this explicitly in their theories, and good outcomes may be conceptualized in terms of improvements in mentalizing ability. Without attention to the patient’s need to see themselves through our eyes as mental health professionals, we risk harming the individuals who we have committed ourselves to protect.

Mentalizing as a therapeutic technique

The focus on mentalizing being a core principle of psychological therapies is in no sense coterminous with identifying a common set of techniques to assist in the recovery of this
The widening scope of mentalizing capacity. In fact, it follows from the approach we have taken to mentalizing that there can be no emergent set of techniques that limit the approach. In this issue, Dimaggio et al. (2011) outline an exciting new approach to treating Cluster C personality disorder (PD) patients, a group generally regarded as difficult to access. Metacognitive interpersonal therapy (MIT) shares many commonalities with mentalization based treatment (MBT) (Bateman & Fonagy, 2006); but, whereas MIT is designed specifically for clients with poor emotional awareness (Dimaggio & Lysaker, 2010), MBT is tailored for patients whose affect dysregulation represents problems. Yet both approaches highlight a constant attentiveness to facilitating a cooperative alliance, creating a collaborative relationship and retaining a focus on moment-to-moment changes in the nature of self–other understanding. The approaches also overlap in looking to the therapeutic relationship as the most likely source of difficulty if the patient’s problems have not been adequately addressed. Just as in MBT, a structured, step-by-step procedure is provided for the therapist to follow. Eliciting detailed autobiographical episodes, elaborating and clarifying these and gradually digging deeper in search of feelings and ideas as motivations for actions within the episode, suggests a very similar technique to that routinely used with borderline patients in MBT.

There is a difference in aiming to elicit episodes as material to generate hypotheses about underlying interpersonal patterns. It is not that MBT would not attempt to identify common patterns, perhaps driven by common relationship schemas, but MBT would not consider the generation of relation hypotheses as appropriate ends in themselves, but rather as vehicles for ‘rehabilitating’ the patient’s capacity for mentalizing. MIT proposes that a change-promoting macro step of the therapy involves encouraging patients to take a critical distance from their schemas and find different ways to think about their problems (Dimaggio & Lysaker, 2010). The aim, as with MBT, is the creation of more nuanced and varied self-with-other representations or, to put it another way, the enrichment of internal working models of relationships with more mental state contents. At first sight, this aspect of the work in MIT appears to hold the danger of precipitating pretend mode in the patient. This is something we have cautioned against in BPD and it is also likely to be unhelpful in OCD. So it is important to note that Dimaggio and colleagues state that the aim of the stage setting procedure, is to develop episodes ‘until previously unnoticed aspects of subjective experience appear’. The general stance outlined by Dimaggio et al. (2011) describes well the attitude that should be adopted by a therapist aiming to encourage the person they are with, to abandon rigid, schematic, two-dimensional ways of seeing themselves and others, and to achieve a more complex internal set of intra-psychic experiences.

It is exciting to read Dimaggio’s paper alongside the paper by Vanheule et al. (2011). The roots of the Ghent approach are Freud and Lacan creatively integrated with modern attachment theory (Verhaeghe, 2004). They identify a three-step logic that is on the surface almost identical to the one proposed by the Rome cognitive therapy group. They suggest putting into words the chain of events that makes up the difficult situation, making the patient’s appraisal of the difficult situation explicit, and addressing effective responses and discussing the patient’s way of handling the challenging situation. Asking open questions, summarizing the patient’s utterances, creating an ‘elementary narrative’ are almost identical to the technical recommendations that MBT considers acceptable to borderline patients. Only in the third step of this therapeutic progression are bodily experiences, conflicts, and self-reflection related to the conflict systematically addressed. The beautiful clinical work included in the paper illustrates the tentative way with which the therapist approached Emma’s experience of distress and exploring alternative ways.
to fleeing troubling events. The reported approach to these patients also overlaps with ideas about the use of a mentalizing approach for patients with eating disorders.

In patients with eating disorders, mental states are unable to achieve representation as ideas or feelings and therefore come to be represented in the bodily domain: 'Physical attributes such as weight come to reflect states such as internal well-being, control, sense of self-worth, and so on, far beyond the normal tendency for this to happen in adolescence' (Fonagy, Gergely, Jurist, & Target, 2002, p. 405). Mentalizing treatment suggests an initial focus on the body, to stimulate the patient to investigate his/her experiences with body and food and gradually connect them with emotional, cognitive, and relational experience, with the aim to translate them into a language that reflects upon them both as physical reality and as metaphor for mind (Skarderud, 2007). In our psychotherapeutic work with eating disorders, we explore triggers for bodily feelings with greater attention than with most other patient groups, identify small changes in mental states that can unsettle the patient physically as well as psychologically highlight patient’s and therapist’s differences in perceptions of the same physical events and bring awareness to the intricacies of the relationship between action and meaning. This process has the potential to generate changes in bodily experiences and place affect relating to these into a causal chain of concurrent mental experience.

The therapeutic approaches included in this issue, including our own, represent a minor subset of the unlimited number of strategies that therapists could adopt in the face of a non-mentalizing patient. In some ways, this is the strength of mentalization-based therapies. The approach is pluralistic and the methods described in this set of papers illustrate this. Varied as they are, they all focus on the detailed subjective experience of the patient and do so in a measured way that is in keeping with the patient’s own mentalizing capacity. Just comparing the three approaches presented here, we find a number of shared features that may well be necessary aspects of successful mentalization-enhancing strategies for severe mental disorders:

1. A structured, graded approach that holds the therapist in check and prevents them from making unwarranted assumptions about the patient’s processing capacities measured against their own mentalizing ability.
2. A focus on episodic memory as the most productive material to use in elaborating the patient’s self-understanding and understanding of others.
3. An encouragement that the therapist makes few assumptions about the patient’s constructions, asks questions, encourages the patient to create a picture of interpersonal interactions, and checks his or her understanding of the patient’s constructions by paraphrasing and putting into words a description of the patient’s experience.
4. Therapists create alternative perspectives on mental experience, whether by addressing their relationship with the patient or by working with the patient to recover from misunderstandings or ruptures of the therapeutic alliance.
5. There is a particular concern by therapists to generating a safe and sensitive interpersonal environment that may relate to the social mentality of the developmental phase of acquisition of mentalization (Liotti & Gilbert, 2011).
6. Using the patient’s emotional response as a guide for focusing interventions on increasingly more difficult situations.
7. Using normative understanding of behaviour rather than a theory-driven understanding of behaviour as the reference point for interventions.
The therapist offers assistance with the patient's regulation of affect in many ways, but mostly by implication through contingent marked responding to the patient's affect and by creating a safe and sensitive interpersonal environment (Gergely, 2007).

Some characteristics of individual interventions may run across modalities. Such characteristics include: (a) simple and easy to understand, (b) affect focused, (c) actively engage the patient, (d) focus on the patient's mind rather than on their behaviour, (e) relate to current events or activities - whatever is the patient's currently felt mental reality (in working memory), (f) make use of the therapist's mind as a model (by therapists).

Therapists flexibly adjust the complexity and emotional intensity of their interventions in response to the intensity of the patient's emotional arousal (withdrawing when arousal and attachment are strongly activated).

The assessment of mentalizing

A feature of all the mentalization-based approaches presented in this issue, was the tailoring of the therapeutic intervention to the individual patient's mentalizing abilities, at each moment and at each stage of treatment as described in earlier literature (Bateman & Fonagy, 2006; Dimaggio et al., 2011; Lysaker et al., 2011). Two of the papers, in this issue, dealt with how to measure mentalization. MacBeth et al. (2011), as we have seen, used the Adult Attachment Interview (Hesse, 2008) in combination with the reflective function coding (Fonagy & Target, 1997; Fonagy, Target, Steele, & Steele, 1998). In this respect, it is essential to realize that mentalization is not a static and unitary skill or trait, and the adult attachment interview (AAI) will only yield an indication of a potential for mentalization, which may or may not be fulfilled depending on the context (or social mentality Liotti & Gilbert, 2011) in which the individual finds himself. Clearly, mentalization is a dynamic capacity that is influenced by contextual factors such as stress and arousal, particularly in the context of specific attachment relationships (Allen et al., 2008).

Even more crucial to an adequate theoretical model is the recognition of that mentalization is a multi-faceted capacity. A most sophisticated demonstration of the complexity of the construct was introduced by Lecours and Bouchard (2011). The ingenious model they presented enables the clinician to obtain an indication of explicit mentalization in terms of verbal elaboration of discrete affects and implicit mentalization in terms of the proportion that these affects may manifest in verbal expression. The paper demonstrated an impressive association between the extent of verbal elaboration of a specific affect (sadness) and the endorsement of BPD symptoms by the patient. The proportion of hostility directed against others as part of the narrative appeared to be an implicit mentalizing indicator of BPD symptoms. It is of course striking that the two affect domains to yield significant associations with BPD symptoms, are indeed those that are most commonly suggested to be core to this type of personality disorder: aggression/hostility (Kernberg, Goldstein, & Carr, 1981) and affective disorder/sadness(Zanarini, Gunderson, & Frankenburg, 1989). Although the theoretical framework from which the measurement approach derives is independent and was quite separately developed from ours (Bouchard et al., 2008), we see much in common between the respective consideration of emotion organization. For example, the notion of non-mentalized affect as un symbolized and more closely linked to the bodily core...
(Marty, 1991) links to our assumptions concerning the embodied origin of cognitions (Fonagy & Target, 2007). What we are particularly indebted to these authors for, is their presentation of the possibility that a patient might insufficiently mentalize one specific emotional sphere, while doing well in another (e.g., the patient may mentalize well in relation to shame but not in relation to anger). This kind of affect related specificity is not open to global methods of measurement such as AAI-based measures, but is obviously linked to the domain and context specific theoretical model advanced by Liotti and Gilbert in this issue. Like all measurement systems, Bouchard and Lecour's (Lecours & Bouchard, 1997; Lecours, Sanlian, & Bouchard, 2007) approach has limitations in that the quality of verbalization can only be judged on affect that is brought into discourse and thus it remains unknown whether affect that is not present in the discourse would have been verbally elaborated well or poorly, had it been mentioned. This does not detract, however, from the richness offered by the approach in this reports' elegant identification of core features associated with BPD regardless of more trait like measures such as alexithymia and demographic variables such as age having been controlled for.

Mentalization is clearly a complex capacity with multiple components that, in our view, are organized into balanced pairs of oppositions or polarities that underlie the quality of mentalizing at any one time. Patients may show impairments in some of these polarities, but not necessarily in others (Fonagy & Luyten, 2009; Luyten et al., 2010) as a function of situational considerations, especially the social context they find themselves in. Hence, impairments in mentalization come in many variants, which necessitate partly different measurement and treatment approaches and affect and domain foci. A detailed knowledge of the specific types of impairments in mentalization - and particularly the specific attachment contexts in which these impairments are manifested - may not only inform the focus of treatment, but may also inform the assessor and therapist of the type of relationship and associated mentalizing difficulties that are likely to develop, and thus may serve as an important ‘transference tracer’ later in treatment (Bateman & Fonagy, 2006; Luyten, Fonagy, Lowyck, & Vermote, in press).

In our view, mentalization is underpinned by four functional polarities, each of which is related to relatively distinct neural systems. These polarities are (a) automatic–controlled, (b) internally focused–externally focused, (c) self-oriented–other-oriented, and (d) cognitive–affective, with Luyten et al. (2010). These polarities offer a framework for understanding the way mentalization relates to overlapping constructs such as theory of mind, empathy, mindfulness, alexithymia, emotional intelligence, psychological mindedness, and insight. For example, while empathy is largely other-focused, and builds on affect more than cognition, mindfulness tends to be self-focused and has more cognitive components. These oppositions represent balanced systems where a dysfunction at one pole may manifest as the unwarranted dominance of the opposite polarity. For example, a dysfunction at the cognitively focused pole of mentalization may manifest as excessively emotion focused mental representations. Thus, in terms of manifest distorted representational content, inappropriate representations of emotional mental states may reflect normal affective mentalizing that is not balanced by appropriate cognitive considerations. Therefore, an evaluation of an individuals’ mentalizing capacity, depends on detailing their mentalizing profile - that is their functioning with respect to each of the complimentary pairs of components of mentalizing, particularly since there may be dissociations between these polarities (e.g., impairments in one polarity, but not along other polarities) (Luyten et al., 2010).
Conclusion

This discussion and the papers in this issue point towards an almost endless research agenda. Our knowledge about the extent of human mentalizing remains rudimentary. The enthusiastic researcher can expand our understanding of the core polarities of mentalizing itself, or increase our knowledge about its attachment and socially related development, neurobiology, and application to a range of disorders, either for the purpose of furthering our general understanding or for treatment itself. An easily applied measure of mentalizing capacity is urgently needed. Finally it seems our bold claim that mentalizing is not only a basic human psychological process, but also a core feature of talking therapies, is supported by the papers in this issue.

References


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