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Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy

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Background. Mentalization has recently been identified as a major process in the origins, maintenance, and recovery from various mental disorders.

Aims. Questions arise however, as to the degree to which deficits in mentalization can be trait or state-like: whether they manifest themselves across all types of human interaction, or are they relationship dependent, such that different types of relationship (e.g., affiliative vs. competitive) can facilitate or compromise mentalizing?

Findings. This paper suggests that mentalization has a complex evolutionary history, has various subtypes and functions, is highly regulated by the experience of threat or safeness within relationships, and can operate differently in different types of social relationship.

Implications. Awareness of this enables therapists to pay particular attention to the social roles and types of relationships in which mentalization occurs, its specific focus and functions for specific types of relationships. Therapists can be mindful of the kind of specific events in social roles that activate threat and loss of mentalizing (e.g., abandonment threats, feeling controlled by 'the other', status loss, non-reciprocation).

In the wake of the 200th anniversary of Darwin's birth, it is useful to reflect on how profoundly the publication of *On The Origin of Species* in 1859 transformed our thinking about the nature of our minds. We now know that human minds are products of evolution, designed to carry forward a range of motivations for achieving specific social goals and forming particular types of relationship, including care seeking-care giving (attachment), competition for resources and forming social ranks (dominance–submission), alliance building and cooperation, and sexual pair-bonding (Buss, 2003; Gilbert, 1989). Evolutionary thinking has also focused on the profoundly *human* psychological *competencies*, labelled in various ways, such as, theory of mind, meta-cognition, empathy, and mentalization, that stem from, and are deeply embedded within, recent human social evolution (Byrne, 1995; Choi-Kain & Gunderson, 2008; Hrdy, 2009;

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Whiten, 2000). In this paper, we use the wide-ranging term 'mentalization' to refer collectively to all the higher order competencies that enable humans to infer and think about the mental states of self and others. Although these do represent a family of different overlapping processes that require more fine grained definition and research, it is well known that helping people to stand back from their immediate reactions, to think about the intentions and processes in the minds of others, and in their own minds, is a very important focus for many therapies (Bateman & Fonagy, 2004; Choi-Kain & Gunderson, 2008; Dimaggio & Lysaker, 2010).

Different hypotheses have been advanced regarding the influence of different social motivational systems (e.g., for attachment, or competitive behaviour) both in the evolution of mentalization and in its exercise during individual development. One of these hypotheses suggests that the evolution of mammalian attachment is the main motivational system that underpinned the evolution of mentalization (Fonagy, Gergely, Jurist, & Target, 2002). However, quoting recent brain imaging studies, Fonagy and his collaborators acknowledged that the activation of brain areas mediating attachment behaviour actually *inhibit* brain areas mediating mentalization (Fonagy & Luyton, 2009; Fonagy & Target, 2009). As it will be argued in a later section of this paper, it is possible that the activation of the attachment system, in the face of threats, inhibits mentalizing abilities because the evolutionarily older threat-defence (fight–flight) system, that is also active in such circumstances, normally inhibits higher order cognitive processes (see below). In contrast, *feeling safe* because of the protective availability of an attachment figure, who is perceived as capable to protecting against the danger and signals low threat, may foster mentalization. These considerations suggest that attachment *per se* is not the only evolutionary underpinning of mentalization: rather, attachment processes may allow for the recovery of mentalization, in the presence of danger, through the contact with an attachment figure that is able to provide help and guidance and activates a renewed *sense of safeness and soothing*.

Whatever might be the role of the attachment system in the evolution of mentalizing abilities, it is possible that a range of social roles (e.g., alliance building) that create feelings of safeness, may have facilitated the evolution of mentalization. For example, Alexander (1989), Gergely and Unoka (2008), and Humphrey (1976), see a role for mentalization in successful competition for social rank. Chimpanzees, for example, have a degree of self-awareness and mentalizing ability enabling them to understand the impact of their social signals on others – and conceal them. Cheney, Seyfarth, and Smuts (1986) offer an interesting example:

> In a captive group of chimpanzees two adult males Nicki and Luit were engaged in a prolonged struggle for dominance. During one fight Nicki was driven into a tree. As Luit sat at the bottom of the tree, he nervously 'fear grinned'. He then turned away from Nicki, put a hand over his mouth and pressed his lips together to hide a sign of submission. Only after the third attempt when Luit succeeded in wiping the grin from his face did he once again turn to face Nicki. (p. 1364).

This example shows how some forms of mentalization can be useful in conflictual and competitive situations and enable perceptions and displays of things like deception, bluffing, and awareness of intent. Other theorists focus on alliance building and cooperativeness (Moll & Tomasello, 2007) or abilities to relate to multiple caregivers (Hrdy, 2009) to account for the socio-motivational underpinnings of mentalization. So the evolution of mentalization in human phylogeny may be developed *through different types of social relating*, and in turn influence a range of social relationship

forming abilities. If this is the case, then how different social motivations and mentalities influence mentalization is an important issue for psychotherapists interested in assessing and fostering a patient's mentalizing capacity during clinical dialogues. In this paper, we will make three suggestions:

- First, while the potential mechanisms that enable mentalization are innate, the ontogenetic development of mentalizing involves explorative behaviour, which flourishes most in conditions of open attention and social safeness. In the normal course of events feeling safe and open to explore (that is conducive to mentalization) flourishes in conditions created by affiliative relationships inside *and outside* the attachment context.
- Second, while affiliative behaviour is usually associated with soothing and feeling safe with other people, for those from neglectful or abusive backgrounds these feelings can be threatening. If affiliative signals from others thus come to signal active threat, and threat processing closes down the open exploration of contents of one's own and other people minds, then for some people 'too much affiliation' can rupture mentalization abilities.
- Third, personality development creates individualized patterns of activity of different social motivational systems that may involve mentalization deficits when a given motivational system is active, but not when another motivational system comes to govern interpersonal behaviour.

Threat and safeness

The distinction between threat and safeness is fundamental to all living things (Gilbert, 1989, 2007). Pursuing any goal carries risks and threats as well as benefits. So, animals have to be able to process both the threat and potential value of pursuing the goal. The greater the value of the goal the more risks individuals may take to secure them. We know that the basic mammalian threat-detection and responses systems (giving rise to fight–flight–freeze–faint–submit) are located in phylogenetically old brain systems and can be triggered rapidly (LeDoux, 1998). Capabilities for more complex processing, choosing to re-evaluate or override the initial threat interpretation, or not act out a threat-defence, are linked to much younger evolved systems – primarily in the frontal cortex. In high threat contexts complex thinking is turned off in favour of rapid actions (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; LeDoux, 1998) and threat tends to generate heuristic and stereotypic styles of attention, thinking and behaviour (Gilbert, 1998). The neuro-imaging study by Rauch *et al.* (1996), for instance, showed that the priming of traumatic memories, that involves the operations of the defence (fight–flight) motivational system, is accompanied by reduced metabolic activity in the frontal cortex of the dominant hemisphere. The inhibition of higher order mental processes coincident with the activation of the threat-defence system makes evolutionary sense: mentalizing could be a hindrance to the rapid 'better safe than sorry' potentially life-saving actions that are necessary when facing serious threats.

The regulation of threats occurring to an individual, and the regulation of inner experiences of threat processing, has been significantly modified with the evolution of the mammals and their attachment reproductive strategies (MacLean, 1985). Species without an attachment system disperse rapidly after birth, parents can be threats to them, and very few will survive to adulthood to breed. The evolution of attachment – whereby infants are orientated to stay close to their parents, are not frightened of

them, and parents are orientated to care rather than attack or ignore their infants – has had a profound impact on the evolution of the mammalian brain (Depue & Morrone-Strupinsky, 2005; MacLean 1985). Attachment is linked to the evolved mechanisms that enabled relationships to regulate the *exposure* to threat (e.g., mother keeps the infant out of harm's way and protects against predators), and the *internal* responses to threat and stress (e.g., mother acts as a soothing agent (Bowlby, 1969, 1973). Porges's polyvagal theory (2003, 2007) details how the evolution of the myelinated vagus nerve has supported interpersonal approach behaviours by modifying threat responses in the sympathetic and parasympathetic nervous system and enables social affiliations, caring, and sharing. Attachment is mediated through specialist brain systems, associated with endorphins and oxytocin (Depue & Morrone-Strupinsky, 2005; Panksepp, 1998). Without the proper operating of the attachment motivational system, partly facilitated by oxytocin, closeness could be experienced as distressing instead of soothing, and such threat-distress would interfere with the more open-curious, attentional focus that allows exploration of the other's mind. Hence, one of the major relational sources of safeness, that enables an openness of attention and exploration, both of which are central to mentalization, is attachment (Bateman & Fonagy, 2004).

However, if social safeness (with attention more relaxed and open) is a key condition for the emergence of successful mentalization then we should note that social safeness has sources other than the attachment system. In the face of potentially threatening environments, a degree of safeness that allows for the exercise of mentalizing abilities can be provided by different types of social relationships, each related to specific motivational systems. For instance, in socially ranked relationships dominant individuals can feel safe because their subordinates offer signals of submission and deference (Keltner, Gruenfeld, & Anderson, 2003; Scott, 1990) which has neurophysiological effects (Gilbert & McGuire, 1998). In competitive contexts mentalizing can offer an advantage by understanding the intentions, fears, and concerns of potential competitors (Alexander, 1989). In egalitarian relationships between allies (cooperative and affiliation systems) trust and sharing can provide the degree of safeness that is a prerequisite for engaging in mentalization. Here, for cooperation, mentalizing ensures smooth interactions so that each individual understands 'the other(s)' and does not violate other people's values or concerns – which could rupture the relationships. So mentalization could facilitate sharing across a complex of activities such as playing in an orchestra or working as a team. Indeed, oxytocin, that has been linked to attachment (Carter, 1998), also influences a range of affiliative behaviours such as trust (Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005), pleasure in social relating (Carter, 1998) and mediates the effect of social support on stress reduction (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2003). There are oxytocin receptors in the amygdala which reduce threat sensitivity to threatening social stimuli (Kirsch *et al.*, 2005) and increase attention and memory for positive social stimuli (Guastella, Mitchell, & Mathews, 2008). Hence, one of the major relational sources of safeness, that enables an openness of attention and exploration, both of which are central to mentalization, is affiliative interactions in range of social relationships, in which oxytocin may play a key role.

Exploration and safeness

One of the fundamental effects of access to a soothing (safeness-creating) individual is that it facilitates confidence and the ability to explore the environment (Bowlby, 1969). A soothing individual is experienced as a safe base for exploration. A safe base is not somewhere to be passive, inactive, and static, but a base to explore *out from* – returning

if threats become too intense (Bowlby, 1969). In addition many primates including humans show a fascination with, and exploration of, the physical bodies of others (e.g., parent–infant and peer grooming (Field, 2000). In our view, once humans became aware of 'the minds of others' and develop 'self-awareness' capable of separating a physical from a mental world, there would be high adaptive advantages for our explorative drive to engage these 'interior' domains for investigation and discovery – both of our own minds and those of others. Thus, the motivation for (social) exploration can prime mentalization. In this endeavour to explore and predict others, we can run internal simulations of interactions in our minds. For example, I can run through a scenario of, 'If I say that to Sally how was she respond?' The working out of '*how* she will respond' is clearly an explorative and 'curiosity' activity. We can extend this explorative process to other minds, so that we can work out what she is likely to say to Harry about what I'd tell her, and then what will Harry think? I can then think of how I will respond according to how she responds to me, and using 'my knowledge' of her (feelings, values, and intentions), which goes beyond this specific encounter. If we lose or fail to mature a generalized motivation to take an interest in and explore the contents of the minds of others, then our mentalization competencies and development of requisite skills can be compromised.

The relationship between exploratory motivation and mentalization is at the very core of psychotherapy. Indeed, psychotherapy is often regarded as a way of exploring one's thoughts, feelings, motivations, and memories in the dialogue with an empathic interlocutor. Without such an exploratory motivation in the patient, and without the support provided to him/her by an empathic therapist, fostering a patient's mentalization capacity could hardly proceed within the therapeutic dialogues. Moreover, the therapists' empathy also depends on both exploratory motives and mentalization capacity. Empathy uses (explorative) imagination 'to walk in the shoes of others', to be sensitive to what 'the patient' may be feeling, and *not* just what the *self is feeling*. This kind of explorative behaviour requires therapists to inhibit impulses to jump to conclusions, or act impulsively – in order to observe, consider and learn – to become 'mindful' (Katzow & Safran, 2007). The safeness created by therapists' empathy, and ability to understand and repair ruptures can enable openness of attention and explorative behaviour in patients, allowing for an optimal exercise of their mentalization abilities both in regard to their own and other's minds.

Although necessary, the activation of explorative motives within the therapeutic dialogues is not sufficient to yield an optimal exercise and development of mentalization. This is because there is a range of complex levels of the meta-representations of 'self-in-relationships-to-others' that constitute mentalization (Choi-Kain & Gunderson, 2008; Dimaggio & Lysaker, 2010). A level that can have a major impact on mental health concerns the judgements and evaluations one makes in terms of 'what is going on in the minds of others' – especially in regard to 'feelings about oneself' and 'intention towards oneself'. This links to the importance of understanding shame and key interpersonal process (Gilbert, in press). Indeed, perceiving threatening intentions, and believing that 'others look down on the self' (linked to the concepts of feeling shamed in the eyes of others (Gilbert, 1998), has been found in a range of disorders, such as social anxiety, eating disorders, depression and personality disorders (Gilbert & Irons, 2005). Thus, if the patient is mainly motivated to explore, and mentalize about, other people's judgmental, rejecting or hostile mental contents, then therapeutic dialogues may foster a pathogenic type of mentalization rather than a healthy one. One gets caught up in projection and repetitions of threat based evaluations rather than open exploration and curiosity.

This consideration brings us to focus on the types of social motivation and social mentality that can direct the exercise of mentalizing abilities towards specific kinds of mental contents, both in self and others.

Social mentality theory

Gilbert (1989, 2005) suggested that the desire to form attachments, sexual liaisons, friendships, and gain status can be seen as pursuing different types of biosocial goal – where a biosocial goal is forming reciprocal role relationships (e.g., the dominant entices the subordinate to submit; the mother answers the distress call of her infant; allies share with each other). Animals have a range of biosocial goals that they will pursue over their lifetime, and indeed, from day-to-day and hour to hour. To switch between these different goals involves switching motives, attention, various processing systems and, of course, behavioural output systems. In humans, it may also involve switching *types of mentalization*.

A social mentality is a loose description of how specific motivations (to form certain types of social relationship) direct attention appropriately, recruit relevant cognitive processing and guide emotions and behavioural outputs. Suppose we are motivated to seek status and compete with others. Then our competitive mentality orientates our attention to relevant information about competitors, compares what they have to what we have, judges whether competing with them would be helpful to us, chooses the manner by which we will compete, works out how to influence encounters in our favour, and monitors the success or failure of our efforts. Seeing others do badly and ourselves doing well may be associated with positive affect and we may have little interest in caring for those who fall behind. Our compassion for our competitors, is turned off – especially if they're seen as enemies or very threatening. In contrast, when we are in a caring mentality our motives are to relieve distress and attention is orientated to the other's distress. We focus our thoughts on working out why they are distressed and what we can do to help. Our emotions of sympathy and concern are aroused, whilst aggression is turned off. Seeing them do badly is now aversive. So, competing and caring mentalities, as well as other mentalities (care-seeking, mating, cooperative), are organising patterns that coordinate motivational, emotional, and various other psychological competencies in the pursuit of that goal. The question now is how mentalization operates within different social mentalities. To illustrate this point, let us briefly consider the mentalities related to care-giving, competition, and cooperation.

Care-giving mentality

A study by Koren-Karie, Oppenheim, Dolev, Sher, and Etzion-Carasso (2002) illustrates the operations of mentalization in care-giving. The study explored three types of maternal interaction: positively insightful, one-sided, and disengaged. Positively insightful mothers try to see their child's experiences through the child's eyes, whilst accounting for them being a child. The mother makes an effort to understand the child's feeling and motives and explores them (that is, they have concerned empathy; Eisenberg, 2002). The one-sided mother, (we might see her as using projection), is keen to care for her child but has pre-set ideas of what a child needs and a 'unidimensional' view of the child. Koren-Karie *et al.* (2002) think this could lead to inconsistent care. All is well when the child conforms to expectations, but not when the child does not conform, and new things need to be understood. These mothers impose care rather than empathically working

out feelings with the child. Disengaged mothers are they characterized by a lack of emotional involvement. Even thinking about what might be going on in their child's mind is novel to them and not something they find pleasant. As one might expect, and in accordance with widely replicated findings by Fonagy, Steele, and Steele (1991), the positively insightful mothers had the most securely attached children. These mothers appear to *feel safe* and less threatened by their children. They do not see their children as threatening their authority or sense of competency, nor are they threatened by feelings in themselves that their children may have stimulated. Safeness in the mother is conveyed to the child, which in turn helps the child feel safe and creates an openness to (explore) the relationship that is conducive to developing mentalization.

Competition mentality

There is good evidence that human competition is designed not only to outsmart the antagonist in a struggle for social power, but also to stimulate positive affect (e.g., admiration) in the mind of others, such that others will be positively disposed towards the self – typically referred to as impression management (Leary, 1995). Barkow (1989), Gilbert (1989, 1992, 1997), and others have noted that humans have become a species deeply reliant on the support and cooperation of in-group others, so much so that most human competition now is to create good impressions in the minds of others about the self. Concerns with our social standing, what people think of us, together with efforts to work out and manipulate how we exist for others, can be traced back to Plato and beyond. As many writers and researchers have pointed out, the desire to be attractive to others, both physically but also in terms of being seen as talented, gifted, and able, is right at the heart of many creative and relational efforts. Recently, it was labelled as 'prestige seeking' by Barkow (1989) and 'positive social attention holding' by Gilbert (1989, 1992, 1997). Indeed, these motives show up early when children seek to demonstrate their abilities by 'showing off' to parents and others with the anticipation of generating admiration in the mind of the audience. Early childhood may regulate this type of seeking for what Kohut (1977) called 'mirroring', but for others the (competitive) desires for approval and mirroring – in order to feel accepted and safe in relationships – can be intensified. Some individuals can become highly competitive with desires to 'be (seen as) the best', 'win the competition', 'be selected and chosen' – by working out how to create positive impressions and feelings in the minds of others, often with demonstrations of talent, ability, and other personality attributes.

Mentalizing can therefore be used to service different social goals such as 'getting along versus getting ahead'. (Wolfe, Lennox, & Cutler, 1986). However, such concerns can become excessive as people try to impress others to avoid rejection or put down (Gilbert *et al.*, 2007, 2009). If fear dominates the 'drive to impress' then individuals may simply use projection. For example, submissive individuals may use mentalization for appeasing goals – a not uncommon goal in some religions (Bering, 2002). Trying to work out what will placate another or how to make others 'like one', may not always be helpful in building sharing and caring relations. For example' if a parent constantly seeks to placate their young child, then there might be a failure to understand the child's needs. In contrast if people are only interested in winning (e.g., an argument) and seeking dominance over others, or more extremely, how to find their weak points or humiliate them – then this also is not conducive to affiliative, safe relationship building. Therapists too should be cautions of not being caught in the submissive/appeasing or dominating wings of the social rank mentality.

It is unclear how people who are highly shame prone engage in defensive manoeuvres with minimal mentalization and greater projection compared to low shame people. Shame can certainly be one of the main sources for people to 'not reveal' or share, and withdraw from social contact. In that sense shame can have a major impact on mentalization because it invites withdrawal, rather than exploration and sharing with others.

Cooperation mentality

Simple forms of cooperation, where individuals act as a team, coordinating their actions according to a shared goal and what others are doing around them, can be found in many species – most notably in hunting, in making alliances against a competitor or a predator, and in cooperative caring of infants. Human cooperation, however, is of a completely different order and depends upon our capacity for sharing and coordinating complex information that go much beyond the relatively simple ones required by hunting, alliance building and cooperative caring. For example, playing in an orchestra requires a shared goal, a commitment to practice, an ability to learn complex skills from others, and an ability to play in the context of others – to know one's place and part in the overall plan. Cooperative acts can be simpler than that, but do require a shared agenda and a shared understanding. Out of these, of course, grow complex networks of cooperators who then go on to build 'cultural and social institutions', institutions that then facilitate and enable cooperative behaviour.

Moll and Tomasello (2007) suggest that the unique aspects of human cognition – the cognitive and metacognitive skills needed to create cultural institutions and systems of symbols – were driven by, or even constituted by, social cooperation. Tomasello (1999, 2008) argued, on the basis of detailed across species comparisons of socio-cognitive abilities in humans and other primates, that our species' increased ability to *deliberately* share attention and cooperate towards a jointly chosen goal is a classical Darwinian adaptation. Pointing towards an object in order to invite others to share attention to it is a type of communicative behaviour typical of *Homo sapiens*. It appears spontaneously, in every culture, in infants about 9 months old – suggesting that it is an evolved specie-specific ability. Language and culture, according to Tomasello's Vigotskian model, stem from this adaptation that greatly expands the tendency towards cooperation already existing in other mammal species. Cultural evolution in turn reflects itself in increasing capacities for metacognitive processes that should be linked evolutionarily more to cooperative motives than to competition/ranking or attachment ones. Studies of the development of language in children (Tomasello, 1999) and comparisons of the capacities for cooperation in chimpanzees and human children (Warneken, Chen, & Tomasello, 2006) support this model. Cooperative motives, as attachment ones, involve feelings of safeness: individuals must feel safe enough to come into proximity long enough and to share and also not be cheated or exploited. Indeed sharing, working out what others want and giving it to them, then being appreciated in return, is a common source of pleasure and relationship building (Gilbert, 1989).

Recently, Hrdy (2009) has suggested that both attachment and cooperative motives underpin the evolution of mentalization in the human species. Humans are the only primate to share child care (alloparenting) in any significant way. For most primates, the mother stays in close contact with her infant until weaning and does not allow much in the way of physical contact from other relatives. Humans, however, are noted for allowing and encouraging other humans (especially relatives) to hold and care for the infant even within the first hours of birth. Different individuals who take care of the same

infant must interact in a cooperative mentality. Hrdy (2009) argues that the cooperative, shared caring of infants put an evolutionary pressure for the development of attention and evaluations to new and different individuals. Infants needed to be good at detecting who was likely to be more safe and soothing and who was less so. On the basis of these premises, Hrdy (2009) suggests that it wasn't attachment to a single individual that was key to the evolution of mentalizing, but rather the importance of detecting certain qualities in multiple other individuals (e.g., warmth and caring) and being able to create feelings within them such that individuals with those qualities would provide for the infant.

Individual patterns of social mentalities and mentalization

It is not unreasonable to assume that individuals who display a high mentalizing capacity when they are in a given social mentality may be less proficient when mentalization is involved in another social mentality. For instance, a woman who is well able to read the mind of her child when she is in a care-giving mentality may be painfully unassertive and show mentalizing deficits when she is involved in competitive interpersonal contexts or dealing people in authority. Wispe (1986) pointed out that non-empathic torturers would put a gun to your head but empathic ones to your child's. Working out the intentions, fears, and feelings of others, and how to stimulate feelings in the mind of others, can have benevolent or malevolent intent – and that depends on the social motivation and mentality involved. Mentalizing abilities for hostile ends need not imply abilities to mentalize for benevolent ones. A skilful competitor may be poor at mentalizing in a care-giving way (care-giving social mentality) or in a (say) parental context. In the complex course of personality development, negative memories and expectations may come to be linked to a given social mentality, hindering the operations of the motivational system, while more positive and encouraging memories/expectations may support the mental operations – both motivational and metacognitive – of another mentality.

The possibility of mentalizing deficits associated with the activation of a *specific* motivational system and mentality is illustrated by a longitudinal study on children of mothers with postnatal depression at risk of developing conduct disorders (Hill, Murray, Leidecker, & Sharp, 2008). In a high threat scenario, 5-year-old children rated as secure in their infant attachments were better able than insecure children to interpret, in terms of mental states, the behaviour of a character in a story. However, in low threat scenarios no difference in this ability could be detected between secure and insecure children. High threat scenarios are likely to also activate the attachment motivational system, whilst low threat scenarios do not. Therefore, the findings of Hill *et al.*'s (2008) study may be interpreted in terms of shifting social mentalities: only when an attachment mentality is operative do mentalization deficits show up in insecurely attached children. Thus, mentalization may vary not only as a function of relatively stable personal features, such as attachment security, but also in the much more changeable interpersonal and emotional contexts where the attachment system is activated.

The possible role of the individualized patterns of shifting social mentalities in influencing mentalization capacities is in keeping with observations by clinicians who focus on mentalization in their psychotherapeutic work (Allen, Fonagy, & Bateman, 2008; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007). A patient's mentalization deficits do not show up in equal degree in the succession of clinical dialogues. These deficits, for instance, may show up at the highest degree when a patient is engaged in

dealing with (threat linked) traumatic memories, and may disappear altogether when she or he deals, in the clinical dialogues, with mental contents unrelated to traumatic interpersonal experiences.

Sparse empirical evidence could also be used to illustrate the context-dependent features of the exercise of mentalizing abilities in psychotherapy. For instance, a pilot study by Prunetti *et al.* (2008) found that the metacognitive capacity displayed by borderline patients in a single session at the beginning of psychotherapy changed from moment to moment in response to two general types of therapists' comments or interventions. Therapists' interventions that showed emotional closeness to what the patients just said (empathic comments, or interventions validating the patient's emotions) seemingly hindered, in this very early phase of treatment, the patient's capacity for organizing coherent thought and discourse (a key aspect of metacognition). The difference of metacognition scores between patients' responses to 'empathic' comments, and their responses to more emotionally neutral therapists' interventions, was statistically significant. A plausible explanation is that emotional closeness evokes memories of unresolved (threat linked) attachment traumas that interfere with the patients' metacognitive processes. There are many reasons why a patient can find closeness and 'being understood' a threat, e.g., 'If you get close and get to know me you wont like me', or, 'It makes me too sad and overwhelmed' (Gilbert, 2005). Indeed, there is now evidence that while some people are physiologically calmed by imagining kindness being directed at them, other people, especially those who are high in self-criticism, show a physiological threat response to the experience of kindness (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008).

Another study that is relevant to the understanding of shifting mentalization capacity during psychotherapy dialogues, is the one by Minzenberg, Fisher-Irving, Poole, and Vinogradov (2006). They found that a deficit in a component of mentalization, the ability to identify the source of a memory, whether coming from one's imagination and dreams or from a perceived outside reality (self-referential source memory), could be assessed in borderline patients only in interpersonal contexts eliciting hostility and suspiciousness. In other interpersonal and emotional contexts, the patients' ability to identify the internal or external source of mental contents was normal. Both Minzenberg *et al.*'s (2006) and Prunetti *et al.*'s (2008) findings can be interpreted in terms of 'threat versus safeness' processing, that in turn is linked to the activation of specific social mentalities in interpersonal contexts. All these studies attest to the importance of safe versus threat in facilitating mentalizing and how these are affected by types of social relationship the individuals are co-constructing.

It should be remarked that the patient samples in the above quoted studies comprise individuals with borderline personality disorder, most of them likely to come from a history of infant attachment disorganization (Levy, 2005; Liotti, 2004a,b; Lyons-Ruth & Jacobvitz, 2008). Attachment disorganization is the outcome of the simultaneous activation in the infant of the attachment system and the threat system, both directed towards the attachment figure. Hence they represent sources of both help/comfort and threat (Lyons-Ruth & Jacobvitz, 2008) producing a classic approach–avoidance conflict. Approach–avoidance conflicts, where the same stimulus is associated with both threat and reward has long been known to be highly stressful and to seriously disrupt information processing and problems solving – sometimes referred to as experimental neurosis (Gray, 1979). Thus, the inhibition of mentalization linked to the activation of the threat-defence (fight–flight) system adds to the inhibition of mentalization linked to the activation of the attachment system. A particularly serious hindrance to mentalizing

abilities is therefore the consequence of attachment disorganization. Individuals with an history of early attachment disorganization preserve, in their internal working model (IWM), the memory of interactions where the wish to be soothed by an attachment figure is also linked to the activation of the fight–flight system. When such an IWM of attachment becomes active, a subjective feeling of threat and impending danger is also likely to surface, together with a state-dependent hindrance to mentalizing. This individual pattern of activation of both the attachment and the defence system directed towards the same individual, may explain those situations in the therapeutic relationship where the patient shows increased anxiety in the context of therapeutic dialogues that are otherwise experienced as positive and helpful (Liotti, 2004a).

Mentalizing and social mentalities in psychotherapy

Allen *et al.* (2008, pp. 105–108), among others, have remarked that the exercise of mentalizing abilities is influenced by other mental processes. We have argued that motivational systems and the related social mentalities could be particularly important among the mental processes that come to influence mentalization. From our suggestions, it follows that clinicians, when paying heed to their patients mentalizing capacity during psychotherapeutic exchanges, may get a better understanding of the cause, nature and extent of deficits if they notice carefully the type of social mentality where defective mentalization is more likely to appear. It also follows that consideration of the therapist's role in priming one or another social mentality during the therapeutic exchanges cannot be overestimated. There is a risk that, without such careful consideration, therapists could regard their patients' mentalization deficit as a sort of stable mental trait, when in fact it is context-dependent and appears as an aspect of a social mentality that is influenced by threat – and related to traumatic memories. Moreover, this social mentality may have been engaged in the therapeutic relationship with the contribution (deliberate or otherwise) of the therapist's interpersonal attitudes.

A clinical example of the important consequences of inadequate attention to the interpersonal context of the therapeutic dialogue is provided by Liotti, Mollon, and Miti (2005, p. 211). A clinical psychologist asked for supervision during the treatment of a patient who, at the moment she asked for treatment, seemed to be only mildly depressed, but later on proved to be suffering from a dissociative disorder. At the beginning of treatment, no particularly serious mentalization deficit was apparent. Such a deficit, however, became quite evident when a 'child' ego-state began to emerge and to report traumatic memories. The therapist was deeply moved at the narratives of severe childhood abuse, and also felt that she must work extra hard for such a damaged and deserving patient. However, this excessively solicitous attitude seemed to result in an even stronger activation of the patient's attachment mentality, to which the mentalization deficit was mainly linked through the mediation of an IWM of disorganized attachment. The patient became both increasingly demanding and progressively less able to reflect on her own and the therapist's mental states. As the therapist attempted to limit her therapeutic involvement, the patient became increasingly agitated, alternating between threatening and pleading modes. The therapist experienced rage, fear, and bewilderment. She also felt guilty about her wish to withdraw, resulting in attempts to compensate by trying even harder to meet the patient's attachment needs, thus alternating between being overly gratifying and rejecting. Steadily, the psychologist became more and more exhausted, and her judgment increasingly impaired. As the

attachment/care-giving mentality came to be activated and shared by both members of the therapeutic dyad, mentalization capacities (that had been more efficiently used when, at the beginning of treatment, they had shared a cooperative social mentality during their dialogue) became progressively defective both in the patient and in the therapist.

While engaged in the challenging task of paying equal heed to their patients' mentalizing deficits, to the social mentalities involved in the narratives where such deficits appear, and to the ongoing activation of motivational systems within the therapeutic relationship, psychotherapists are assisted by two fundamental principles.

First, fostering some degree of safeness in the therapeutic relationship, that enables some degree of open exploration, is a prerequisite for the development of the patients' mentalizing capacity. As the above example illustrates, fostering safeness may sometimes require that therapists moderate their tendency to enter in an unrestrained caring mentality before patients have been trained in self-soothing abilities as, for instance, those aimed at in compassionate focused therapy (Gilbert, 2009, 2010). A carefully titrated balance between empathy, related to their cooperative social mentality, and sympathy, linked to their caring mentality, provides clinicians with other ways of dealing with patients whose traumatic attachments inhibit mentalization when they feel emotionally too close to their psychotherapists. As noted above the re-creation of safeness in the therapeutic relationship can reactivate attachment, which in turn reactivates complex of memories that may stimulate a fear of dependency, vulnerability, or – in cases of particularly severe histories of attachment disorganization and traumas suffered at the hand of the attachment figure – the expectation of being harmed by any potential caregiver. As one patient said, 'I don't like to feel safe (or cared for) because then I let my guard down – that's dangerous'. This catch 22, is especially noted in borderline patients by therapists. Other possibilities are suggested by studies on the psychotherapy process such as those performed by the San Francisco Psychotherapy Research Group (Weiss, 1993). These studies show that safeness achieved in the therapeutic relationship, that's sometimes achieved through fortunate therapist's enactments rather than through interventions, (such as sophisticated interpretations that require high mentalizing capacities in the patient), is predictably followed by patient's insight (mentalization).

The second principle that may assist therapists, who are trying to deal both with their patient's mentalization deficits and with the distorted interpersonal motivational processes characterizing psychopathology, is recognition that these aspects of mental disorders are inextricably intertwined. For example, if a therapist witnesses any deficit in a patient's mentalizing processes, the social mentality regulating the patient's narratives, and/or the therapeutic exchanges at the moment of the observation is likely to be haunted by traumatic memories and/or by negative expectations about the outcome of the corresponding type of interpersonal interactions. Reciprocally, if therapists notice a severely distorted interpersonal cycle in the patients' narratives or within the therapeutic relationship (Dimaggio *et al.*, 2007), mentalization deficits (perhaps not noticed until that moment) are likely to hinder the patients' ability to reflect on their own and others minds while the corresponding social mentality is active. In addition, the therapist needs to aid the patient in 'bearing' the pain, confusion, and distress of the emotional material that comes to light – a process that can be helped by teaching a compassionate and mindful orientation. Thus, therapists when encountering mentalizing deficits or problematic social mentalities, can make some basic clinical

choices. They may choose (1) to try to provide the patient with a corrective relational experience (sometimes by deliberate enactments: see Bromberg, 2008; Stern, 2008), they may (2) try to straightforwardly foster the patient's mentalizing capacity – e.g., by psycho-education, by other mentalizing interventions summarized by Allen *et al.* (2008) and by the imagery techniques involved in compassionate mind training and mindfulness (Gilbert, 2009, 2010) – or they may (3) try to do both things in an integrated way.

Conclusion

There is no doubt that metalizing is a fundamental human competency that underpins our extraordinary abilities for social relating, social sharing, and understanding our own minds and those of others. However, it has a complex multifaceted evolutionary history and is a member of a complex family of such competencies (Choi-Kain & Gunderson, 2008). It can also be used in a variety of different types of social role. Insofar as it is linked to relaxed and open attention with an explorative motive (one has to be *interested* in working out what's going on in the mind of others) it is significantly influenced by feelings of threat or safeness. Threats are major disrupters of mentalizing, in whatever role is being enacted (Fonagy & Luyton, 2009). When threatened individuals may fall back on 'better safe than sorry' rapidly activated protective strategies, some of which will involve simple projections and repetitions (e.g., those based on classical conditioning) (Gilbert, 1998). Therapists can help clients recognize these automatic responses, and to then slow down and stand back from their reactions, refocus, reflect, and ask questions of themselves and their processing. These 'cognitive' and 'mindful' techniques are not just to explore for 'alternative evidence' but to become more aware of metalizing processes themselves. The therapeutic relationship is of course one arena for these to be enacted safely. Equally therapists themselves need to be in tune with their own metalizing processes and notice when empathic links have being (defensively) broken by being (say) overly submissive–appeasing, dominating–controlling, detached–withdrawn, or 'technique focused' (Katzow & Safran, 2007).

We also outlined how mentalization can be influenced by the social role one is in. So, for example, in cooperative roles individuals may feel safe and capable of mentalizing for that role, but when engaged in (say) care seeking, recognising one wishes to be cared or closeness – this inner desire may activate the threat system and close down mentalizing. So in general the therapeutic task is the fostering of safeness within particular social mentalities to enable our exploration of those social roles, and work through (desensitization of), threat-based material that gives rise to projection and defensive behaviours and a loss of mentalizing.

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