Manual of Mentalization-Based Art Therapy

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Doctor of Art Therapy

By

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Introduction

The purpose of this manual is to describe a mentalization-based art therapy intervention that incorporates essential aspects of both mentalization-based therapy and art therapy modalities. This manual is intended to be a guide that can be used by practitioners of either discipline to conduct mentalization-based art therapy sessions with their clients. The protocol described herein is quite specific, yet it allows for adaptation at every juncture, as the needs of different clients dictate.

Many other art therapy interventions might incorporate techniques outlined here, and are likely to foster increased mentalization in clients. This protocol, however, is intended to comprise a true integration of art therapy and mentalization-based therapy techniques, procedures, and mechanisms of change. It is hoped that the result will be a synergistic increase in effectiveness, especially with clients for whom traditional art therapy and/or mentalization-based therapy might be difficult due to artistic or verbal limitations, respectively. Case-based evidence has been presented to date as verification of increased effectiveness (Havsteen-Franklin & Altamirano, 2015); the hope is that this protocol will serve as a prototype that can be validated in the future, and refined through a continuing process of action research modification.

Who Can Use This Manual

This manual is intended to provide a working model of a therapeutic technique that incorporates principles of both art therapy and mentalization-based therapy. As such, the methods described herein should be practicable by art therapists as well as therapists whose practice is based on mentalization theory.

For the art therapist, these mentalization-based art directives should provide a new way of approaching personality disorders, as well as other pathologies for which mentalization-based therapy has been shown to be an effective intervention. In contrast to art therapy sessions that incorporate mentalization-oriented techniques in the discussion of client artwork, the mentalization-based art therapy method outlined here incorporates mentalization-based techniques into the art-making phase of the session. In the protocol described in this manual, the client and therapist collaborate to develop and clarify narrative artwork that depicts interpersonal interactions. As the session progresses, the client and therapist share opportunities to uncover and work through failures in mentalization, with the aim of increasing the client's reflective functioning. In other words, the goal is for the client to gain understanding of the minds of others and of their own.

Practitioners of mentalization-based therapy should be able to use the technique described in this manual to enhance their mentalization-based practice by adding a visual channel through which clients can express their narratives, which can be especially helpful for clients who have trouble describing their experiences verbally. Additionally, this technique involves recording the client's narrative on index cards that can be viewed and reviewed by the therapist and client simultaneously. Therefore, the entire narrative need not be held in the memory of either participant in the session. As a result, the influence of subjective remembering by both parties is reduced, which is helpful in clarification, with the caveat that the initial sequence of the client's memories is information that can be used by the therapist to identify lapses in the client's mentalization. Further, the use of graphic storyboards generated by clients to depict their

narratives can shed light on their ability to parse experience in terms of affective and cognitive shifts, possibly illuminating their perception of the mental states of others, and ultimately their own.

How to Use This Manual

This manual is intended to be a prototype, subject to amendment and improvement based on future learning. It is meant to be the starting point for a process that will advance practice and guide theory going forward. For now, my hope is that this manual will help art therapists to incorporate mentalization-based techniques into their practice fully, starting with art making and extending to discussion of the art made within art therapy sessions.

The reader will note that the manual presented here is not configured in a linear, proscriptive fashion, with the exception of the initial invitation to the client to make a storyboard of an interpersonal interaction. For the most part, overarching principles are described, along with interventions to be implemented contingent on certain occurrences within the session. Therefore, clinicians engaging in mentalization-based art therapy must keep all the concepts outlined in this manual in mind as they conduct sessions, and intervene accordingly as each situation dictates.

How This Manual Was Developed

Shortly after I began to work with adolescent psychiatric inpatients, an attending psychiatrist expressed concern that her patients were unable or unwilling to complete a verbal behavior chain analysis worksheet. The behavior chain analysis, an important component of dialectical behavioral therapy, is meant to help patients reflect on their situation, emotions, thoughts, and behaviors leading up to critical incidents such as self-

harm or a suicide attempt. The doctor approached me because she noticed that many of her patients were more inclined to make art than they were to put words to feelings, thoughts, and behaviors. I had also noticed this, so I set about making a graphic form of the behavior chain analysis worksheet. The product consisted of a series of blank boxes intended to invite drawing, along with blank spaces for words describing the patient's behavior, thoughts, emotions, and physical sensations. A hypothetical example of this is depicted in Figure 1. In this example, the client relates her experience leading up to her suicide attempt. Notably, the suicide attempt is omitted in the "action" box, and instead the client chooses to depict herself already in the hospital. This kind of omission seemed to me to be a possible defensive lapse in mentalization. At this point it struck me that it would be helpful to have the ability to insert frames into the storyboard. It seemed that with some discussion, and possibly the insertion of intervening narrative components, this client might have been able to mentalize the moment when she decided to act on her suicidal impulse.

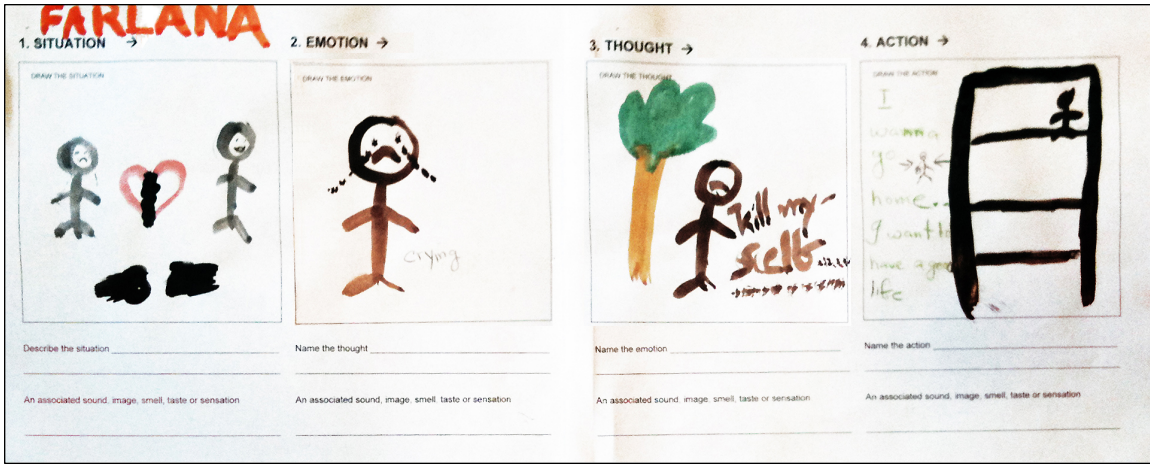


Figure 1. Hypothetical Pictorial Behavior Chain Analysis by a Suicidal Teenage Girl

Concurrently, I began working with The Animation Project (www.theanimationproject.org) where I helped adolescents on probation, who were under great socioeconomic stress and at risk of being remanded to police custody, construct narratives around themes that were relevant to them. As I worked with these young clients, I began to appreciate how they sensed, perceived, and interpreted their surroundings, as well as the interpersonal interactions that influenced the course of their lives. Sometimes, the teens would draw their own stories in the form of graffiti or a graphic novel. More often, I would draw what was dictated, always checking for confirmation that what I depicted was faithful to the clients' intention. At this point I realized that using cards afforded the ability to add, eliminate, and reorder experiences in a way that more closely emulated the recreation of those experiences in memory. It also became apparent that clients could work in collaboration with the art therapist to create a faithful representation of their experience. Thus it seemed to me that clients' narratives were clarified and new insights could be gained by the clients in collaboration with the therapist.

Clinical Vignette

In order to briefly illustrate the basic concepts of the mentalization-based art therapy (MBAT) protocol, the following hypothetical vignette, constructed from the author's experience, is presented. This example is meant to describe how an MBAT session might proceed, and it will be referred to at other points throughout the manual.

The hypothetical client is a 50-year-old Caucasian fire fighter, who we will call Frank, struggling with major depression. He has recently been discharged from an inpatient psychiatric hospital, where he was admitted after a serious suicide attempt by hanging. Since his discharge, he has been living by himself and he has not spoken with his wife and two adult daughters since he was hospitalized.

In this case Frank, the client, is reluctant to discuss his feelings regarding his family relationships. His inhibition is evident in the restricted style of his drawings. The therapist slows down Frank's account of his interaction with family members, validates his experience, then uses the sequenced drawings as a basis for pausing, rewinding, and elaborating the narrative. Throughout, the therapist takes a position of respectful curiosity, and near the end poses a direct question about Frank's perception of his daughters' mental process. The goal is for Frank to better understand the minds of his family and, ultimately, his own.

These aspects of MBAT, and others, will be discussed in greater detail later in this manual. The MBAT session begins with an invitation by the therapist to draw a storyboard:

Therapist: "I wonder if you'd be willing to draw a storyboard in today's session."

Frank: "A storyboard? You mean like a comic?"

Therapist: "Something like that. It's a way to tell the story of an interpersonal interaction that stands out in your mind for some reason."

Frank: "I really can't draw."

Therapist: "You can represent the story in any way you want."

Frank: "Even stick figures?"

Therapist: "Sure. Here are some index cards and markers, colored pencils, pastels, and watercolors. Just draw a scene on each card, the way you remember it happening."

Frank states that he will depict an interaction he recently had with his wife and two daughters, and uses a black marker to quickly draw two cards that look almost identical. They both show a solitary figure on the left, and three other figures grouped on the right (see Figures 2 and 3). As he finishes the second card, he says:

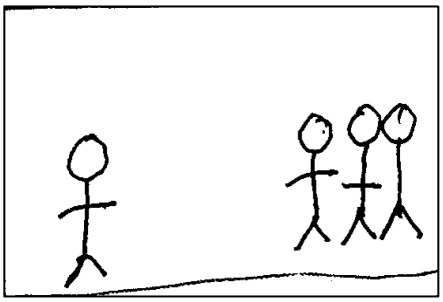


Figure 2. Frank's First Card

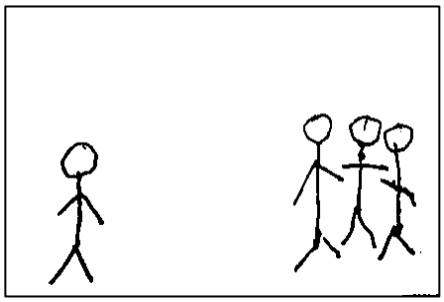


Figure 3. Frank's Second Card

Frank: "Okay, there. It's me talking to my wife and daughters about my depression for the first time. I can't draw, so that's all I can do."

Therapist: "It's a good start. That must have been a tough conversation. I'm curious about the positioning of the figures."

Frank: "Well, I haven't been close with my family lately."

Therapist: "I see. *(Points to the first card, Figure 2.)* Is this where you're talking to them?"

Frank: "Yeah."

Therapist: "If there was a card before this one, what would it show?"

Frank: "I guess me calling them to say I'm coming over."

Therapist: "Would you draw that?"

Frank: "Nah."

Therapist: "Okay, well, what was that like?"

Frank: "I needed some winter clothes, so I had to go to the house to pick them up."

Therapist: "Did you notice any particular thoughts or feelings at that time?"

Frank: "Nope."

Therapist: "I noticed that the two cards are almost the same."

Frank: "You want me to draw more?"

Therapist: "If there's something to add."

Frank: "Yeah, well… My daughter came over…"

Therapist: "Should we include a card showing that?"

At this point, Frank draws a third card depicting two of the figures hugging. He places it after the second original card (see Figure 4).

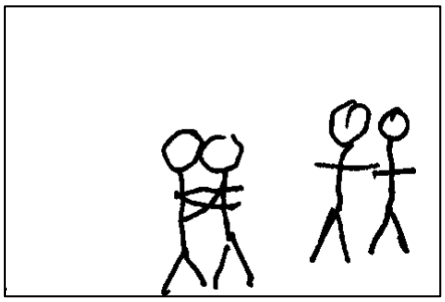


Figure 4. Frank's Third Card

Frank: "There. My daughter hugged me."

Therapist: "Hmm… I guess I'm wondering why you didn't include that initially."

Frank: "Because I knew you'd make a big deal of it."

Therapist: "Was it a big deal?"

Frank: "Well, yeah. We haven't hugged since she was little."

Therapist: "What were you thinking in that picture?"

Frank: "I was afraid I wasn't her father anymore. That she was taking care of me."

Both Frank and therapist pause to look at the cards for a few moments.

Frank: "It was embarrassing, but it felt good."

Therapist: "Did anything happen here, between the third and fourth card?"

Frank: "I was just talking about the depression. I apologized. And I cried. I've never cried in front of my kids before. Wait, you want me to draw THAT?"

Therapist: "That's up to you."

Frank: "Okay, fine."

Frank quickly draws a fourth and final card, showing himself as a stick figure with tears on his face. He places it between the second and third cards (see Figure 5).

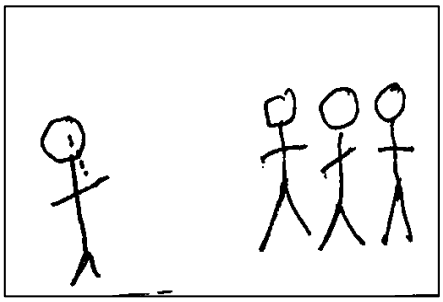


Figure 5. Frank's Fourth Card

Frank: "There."

Therapist: "Why do you think your daughter hugged you?"

Frank: "It's kind of obvious she felt sorry for me. She pitied me."

Therapist: "Maybe, but you said she was taking care of you. Why would she do that?"

Frank: "She's probably worried."

Therapist: "So she felt worried and also felt pity?"

Frank: "Probably mostly worried."

Therapist: "It's kind of interesting that the first thing you thought of was pity."

Frank: "It's pretty obvious. I mean, I am pretty pathetic."

Therapist: "Are you saying that's how you see yourself?"

Frank: "Yeah. Maybe."

Therapist: "Does that mean everyone else sees you that way?"

Frank: "I don't know. But it sure feels that way."

Therapist: "Do you want to keep your storyboard?"

Frank: "No! You keep it. I don't want to look at it anymore."

The therapist sets Frank's full storyboard aside (see Figure 6).

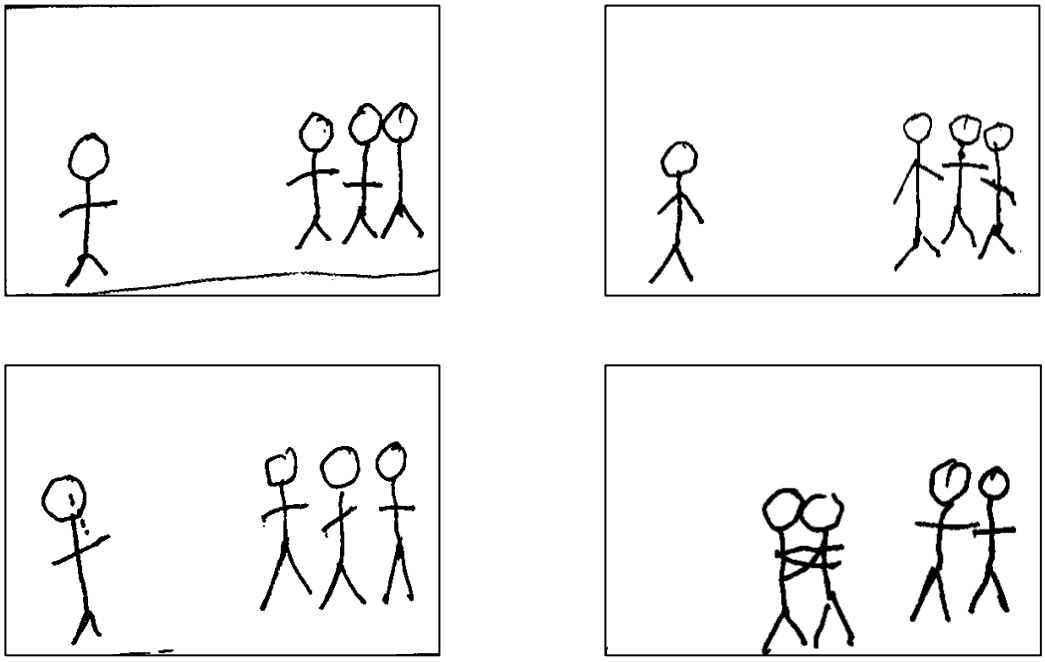


Figure 6. Frank's Complete Storyboard

In this hypothetical case vignette, Frank enters the session showing considerable inhibition. He seems reluctant to address the details of his interaction with his family for the first time after his hospitalization for suicidal depression. This is apparent in his first two drawings, which are static. The fact that he drew a second card identical to the first seems consistent with a sense of being stuck, or being held back from moving forward. Although this is a good theory of Frank's disposition, the therapist does not assume it is correct, and does not challenge it directly. Rather, the therapist maintains a "not knowing" stance (Bateman & Fonagy, 2012) and begins to explore the narrative by contextualizing it. This is done by inquiring about events, thoughts, and feelings that may have preceded the scene depicted in the first card. Although the therapist might suspect that Frank felt a fair amount of anxiety just prior to calling his family, Frank prefers to focus on a practical need for clothing and flatly denies having had any thoughts or feelings in response to the therapist's direct question. Frank's tendency to focus on

matters that are disconnected from his internal psychic process has been termed “pretend mode” by Choi-Kain and Gunderson (2008).

Such faulty mentalizing might initially be seen as purely harmful; however, it appears to be an important part of a Frank’s defensive system (Fonagy, Gergely, & Jurist, 2004). Therefore, a clinician seeking to bring a client’s attention to their deficiencies in mentalizing must take care not to abruptly strike down such patterns as pretend mode without providing an opportunity for the client to replace it with some other form of defense (preferably mentalizing.) In MBAT, the therapist is able to offer observations about the artwork, making it possible to avoid direct challenges to the client’s defensive non-mentalizing.

Recognizing that this is how Frank is retrospectively experiencing his narrative, the therapist moves from antecedent events to what might have transpired subsequent to Frank’s second and last card. Here, Frank shares that his daughter hugged him. However, he omits the expression of affect on his part that precipitated the tender gesture by his daughter. Frank’s omission of his own strong affect is likely defensive in nature (Fonagy et al., 2004); therefore, the therapist initially approaches the resulting gap in the narrative from a stance of curious not knowing. That is not to say that the therapist will not directly address Frank’s defensive non-mentalizing at a later time. In the present session, Frank is afforded the opportunity to defend against unbearable feelings by externalizing them in the form of a drawing, which he then asks the therapist to take away, never to be seen by him again.

When the therapist expresses curiosity about omissions, Frank comes close to expressing his reluctance to address his feelings about the interaction by saying he

doesn't want to make a "big deal of it." At this point, it becomes clear that Frank's thoughts and feelings in the session are as important as his mentalizing regarding the interaction itself. It seems likely that Frank's feelings and thoughts, secondary to his depression, are interfering with his mentalizing.

Finally, Frank draws an image showing himself crying in front of his family. Whereas many clients will start their session with a card depicting the most emotionally charged point in their narrative, others who may be actively suppressing mentalization of affective states are likely to address such details later. Frank expresses that he feels such expressions of emotion are inconsistent with his self-concept as a father. Here, Frank is operating from a "teleological stance," as described by Choi-Kain and Gunderson (2008), when he links his relationship with his family directly to a sense of paternal omnipotence. Frank seems to think that this episode of vulnerability indicates a complete disintegration of his identity as a father.

Finally, Frank exhibits a non-mentalizing stance of psychic equivalence. This breakdown in mentalizing, described by Bateman & Fonagy (2005) as mind-world isomorphism, leads Frank to assume that his family must pity him because he feels pathetic. Put another way, it does not initially occur to Frank that his internal state might differ from external reality. The therapist challenges this notion, and Frank is able to use reflective critical thinking to articulate that, although his subjective experience is that his family pities him, in reality they still see him as a father.

Background

Greenwood (2012) described mentalization succinctly as "the capacity to see ourselves from the outside and others from the inside" (p. 5). Most mentalization-based

sessions are conducted verbally and involve slowing the client down during the act of relating a narrative involving interactions with others. The aim is to afford opportunities for clients to enhance their reflections on the thoughts, feelings, motivations, and beliefs of others and, ultimately, their own psychic process. The therapist facilitates increased mentalization by asking the client to take a stepwise approach to the narrative, looking at each event along with thoughts, feelings, assumptions, and conclusions made at each point. This is usually done by the therapist carefully expressing curiosity or puzzlement about details of the client's narrative; however, the therapist might challenge a client directly in order to break a cycle of self-reinforcing non-mentalization, or simply to get the client's attention so they can reengage in dialogue. This must be done carefully, and often consists of the therapist bringing the conversation into the here-and-now, possibly by saying something uncharacteristically candid. This kind of intervention might take the form of the therapist calling attention to anomalous material in a curious, not-knowing way, or simply by clarifying how clients perceive their own process and the minds of others.

No aspect of a session is more important than the affect focus during a salient interaction between the client and therapist. In order to encourage clients to become curious about affective transactions occurring with the therapist, the therapist can invite clients to verbalize their emotional state in the moment, but rather than interrogate clients, the therapist should explore the affective quality of the intersubjective. That is to say, directly demanding of a client, "How do you feel?" usually results in increased anxiety, activation of the attachment system, and a subsequent decrease in mentalizing. With this in mind, the therapist must provide a safe environment where the client can

experience arousal and subsequent triggering of unconscious material. Once unconscious material is triggered it must incubate, unprobed, until it can be brought to the next phase of awareness (Bucci, 1997)

The result might be a realization, for example, that the client is feeling angry, the therapist is feeling confused, or both are feeling worried. From there, client and therapist can work together to understand how they each came to experience that particular affect, and how this may have affected the quality of their relationship. When client and therapist have begun to consider the affective quality of their relationship it is possible to expand the exploration of the therapeutic relationship in a larger sense and also provide a first-hand demonstration to the client of mentalizing patterns in the context of a significant relationship. In doing so, the therapist validates the client's experience and seeks to collaborate with the client in constructing a new, more accurate perception of their relationship within the changing moment. It is important that, in doing so, the therapist includes personal contributions to the transference/countertransference system, including distortions and affective bias. Although some might consider mentalization-based therapy to be purely manual-based, others, including Fonagy (2015) consider there to be a convergence between manual-based and psychodynamic therapies. For example, in order to accomplish mentalization of transference, therapists must constantly attempt to mentalize their own countertransference, whether it takes a form of concordant empathy or complimentary reaction to the client's mental state or behavior toward the therapist (Bateman & Fonagy, 2012). In order to accomplish this, therapists must keep in mind the fact that the therapeutic relationship is one between two people, rather than between a sick person and a healthy one (Racker, 2012).

Clinical Objectives of the MBAT Session

Generally, the clinical objectives of mentalization-based art therapy are the same as those for a verbal mentalization-based therapy (MBT) session: to move the client from implicit to explicit reflection, from emotional to cognitive processes, and from internal to external focus. In MBAT this is accomplished through use of the following elements, executed in roughly this order:

- Mentalizing and mirroring the client's mental state
- Taking a not-knowing stance
- Validating the client's experience
- Establishing the narrative using a stepwise process
- Expanding the narrative using a stepwise process
- Drawing attention to dysfluencies in the narrative
- Challenging non-mentalizing
- Mentalizing the transference

Often, the goal of the session is for the client to begin to consider the minds of others. However, a therapist might find that a particular client needs to move in the inverse direction. For example, a client who is preoccupied with the internal states of others might benefit from increased focus on the self. This is not to say that such clients should become preoccupied with their own internal state, rather, they should begin to mentalize their preoccupation with others (Bateman & Fonagy, 2012). The basic axes of client movement are outlined in Table 1.

Table 1. Client Movement Within the Mentalization-Based Session, as Outlined by Bateman and Fonagy (2012)

Position ⟶	**Goal**	**Process**
Implicit	Explicit	Clients move from unconsciously held beliefs, assumptions, and emotion-driven unconscious theorizing to more deliberate questioning and analysis.
Nonconscious	Conscious	Clients' internal processes should become increasingly subject to higher-order cognitive scrutiny.
Nonverbal or non-pictorial	Verbal or pictorial	Clients become more able to describe their experiences in words or pictures.
Procedural	Deliberate	Clients' internal processes become less automatic reactions to stimuli, and more goal directed.
Unreflective	Reflective	Clients pay more attention to mental states and processes in themselves and others.
Mirroring	Interpreting	Clients are not only able to mirror mental states in others, but are able to understand their underlying processes.

Moving From Implicit Toward Explicit

Clients move from implicit beliefs, assumptions, and emotion-driven unconscious theorizing to more deliberate questioning and analysis (Bateman & Fonagy, 2012).

Implicit functioning comes about as a reaction to stimuli, as in very early childhood. Explicit attention, reasoning, and behavior develops later and is associated with intentionality, future planning, and an ability to understand the minds of others as well as the self (Bevington, Fuggle, Fonagy, Target, & Asen, 2013).

Moving From Emotional Toward Cognitive Psychic Function

For many clients, their emotional state will exert a largely unconscious and inflated influence over cognition and behavior. An example might be the prototypical client with borderline personality disorder, whose traumatic past continues to have a present-day impact via affective storms, fluctuation between intense idealization and devaluation, impulsivity, and aggression. In these cases, a move appropriate to facilitation of mentalization would aim to increase clients' cognitive engagement in their psychic process. Increased cognitive involvement in clients' psychic function usually increases their reflective functioning and provides protection from painful interpersonal experience through greater attentional and behavioral control.

However, some clients may exhibit over-involvement of their cognitive faculties as they attempt to cope with impinging stressors. Such clients might overanalyze or over-intellectualize their life narrative. They might adopt external belief systems or become over-involved in irrelevant or self-serving topics. In the parlance of mentalization, this is termed "pretend mode." Clients in pretend mode might divert their narrative to irrelevant topics such as politics, social injustice, or sports, or they might refer frequently to beliefs they have formed as a result of reading psychology books or articles on the Internet. Clarifying a pattern of protective disengagement from affect while fostering curiosity about how to coherently make use of affective experience may be helpful to such clients.

Less commonly a client will exhibit a preoccupation with understanding the mental states of others, which, on the surface, appears to be an attempt to mentalize. Two traits distinguish this pattern from true mentalization. First, such a client might desperately want to sense the mental states of others, but seems to lack the ability to do so, and therefore repeatedly fails, resulting in great distress. Second, preoccupied non-mentalizing clients will likely fail to move from understanding the minds of others to understanding their own minds. The attachment systems of such clients are likely to be preoccupied, entangled, or ambivalent. They may be acutely attuned to mental states in others, but as a defensive measure resulting in an interpersonal hyper-reactivity that results in disruption, rather than facilitation of relationships (de Vito, 2012). Such clients implicitly consider others to be unpredictable, and will persist in reflexive, unconscious efforts to defend against abandonment or aggression they deem inevitable. An inverse of such hyper-attuned attachment could be considered defensive dissociation (Liotti & Gumley, 2008). This second move, from understanding the other to understanding the self, is a central clinical aim of all mentalization-based therapy, including MBAT.

It should be pointed out here that I have used the term "understanding the mind"; however, it is clear that no one can understand one's own mind or certainly that of another person completely. One hallmark of reflective functioning, or mentalizing, is appreciating the opaqueness of mental states. This lends a certain autonomy and flexibility to conclusions drawn about mental states in others. It is impossible to be completely certain about the contents of others' minds, or even the full extent of one's own complex mind (at the least in terms of those aspects which remain nonconscious). Therefore, mentalization must always be a process of approximation, relying on

inference. Paradoxically, pursuit of perfect mentalization might result in diminished mentalization, as exemplified by a lack of appreciation for the opaqueness of mental states and rigid certainty about one's inferences about other minds and how well others understand one's own mind. We must acknowledge that, inherent in effective mentalization, toleration and correction of misconceptions of the minds of others and self are key. With this in mind, we must consider that effective therapy will both improve clients' ability to mentalize and their ability to tolerate and remediate inaccurate mentalization whenever it becomes evident. Opaqueness of mental states does not mean that it is hopeless to draw conclusions about other minds—it merely means that tolerating inaccuracy in one's inferences becomes important in order to adapt to various relationships and interpersonal circumstances. Effective mentalizing entails sufficient certainty to autonomously construct a coherent interpersonal narrative, but not so much certainty as to preclude flexibility and curiosity about the mental states of one's self and others.

Interventions in the MBAT Session

After the usual greeting and/or introduction between client and therapist, the client is asked to recall an interpersonal interaction that stands out in the mind for any reason. This direct intervention is appropriate to a short-term acute care setting. In longer-term treatment, it may be possible, and even preferable, to let the narrative unfold more organically. In either case, the therapist invites the client to draw a series of cards to form a "storyboard" of the interaction, including written captions and dialogue. The client is encouraged to include thoughts, feelings, behaviors, sights, sounds, physical sensations, and anything else that seems pertinent, remembering that it is most interesting to know what material the client will spontaneously introduce into the narrative as opposed to what has been asked for.

As the client and therapist view the cards in together, verbal MBT techniques are used to discuss the storyboard. Starting from a stance of not knowing anything about the client and the narrative, the therapist allows the client to initiate the narrative in the client's own voice. The therapist now shifts to a stance of genuine curiosity, gently drawing the client's attention to narrative dysfluencies. Based on conversation, the client can make changes if desired. Cards are added where there seems to be a gap and can be reordered to clarify sequence or cause-and-effect relationships. Individual cards can be elaborated or even redrawn if the client decides they are inaccurate.

Overview of the MBAT Technique

The MBAT technique follows that of the mentalization-based technique, as outlined by Bateman and Fonagy (2012). The principal difference is that MBAT incorporates art making and discussion, whereas MBT is conducted exclusively through

verbal interaction. The following steps are generally followed in order; however, the process is nonlinear, and each step may be revisited as needed throughout treatment:

1. Validation and empathy: The therapist communicates a sense of having heard and recognized the client's concerns and conveys a sense of genuine empathy. This step lays the groundwork for a productive alliance.
2. Stepwise clarification: The therapist asks the client to slow down in recounting the experience being described. Then, the client is asked to rewind to a time before the point where the narrative was begun. This is done from a stance of "not knowing," which is to say, without superimposing the therapist's preconceptions or interpretations.
3. Challenge: Still from a stance of "not knowing," the therapist draws attention to discrepancies or gaps in the client's narrative. The therapist expresses curiosity or puzzlement in response to elements in the client's narrative that don't make sense to the therapist. This takes the form of collaborative reconstruction of the client's experience.
4. Affect focus: Typically, the client will focus less on affective experience and more on thoughts, external events, and behaviors. The therapist invites the client to identify personal affect, as well as impressions of others. Thoughts and behaviors are framed as factors contributing to affective states. For clients in the midst of intolerable affect during the session, it may be necessary to restore mentalizing by reducing focus on affect in favor of cognitive function or even somatic intervention such as deep breathing.

5. Mentalizing the transference: A session may come to the point of addressing the emotional and cognitive intersubjective between therapist and client. Here the therapist should be honest about any personal contributions. This stage deals with non-mentalizing in the here and now, and is possibly less susceptible to distortions of memory. It is also possible that the client might stand a better chance of mentalizing the relationshionship with the therapist if attachment within the therapeutic frame has been managed well. Finally, if client and therapist succeed in mentalizing the transference, this can reinforce the alliance.

Details of the Intervention Process

The MBAT session will not always proceed in a predictable way; however, the therapist can use the following basic framework to shape the session.

Support, validation, and empathy. This is done verbally, for the most part. Unique to MBAT, the therapist must extend these expressions to the client's art production. This is especially important because many clients will experience considerable anxiety when they are asked to make art. In our initial vignette, the therapist validated the client's experience by saying, "that must have been a tough conversation," and supported his art making by encouraging the use of stick figures and referring to the client's initial art expression as "a good start."

Clarification. The therapist identifies aspects of the client's narrative that the therapist genuinely doesn't understand or possibly might not fully appreciate. Again, this must be done from a stance of "not knowing" and a genuine desire to accurately understand the client. This might, in fact, need to be stated explicitly by the therapist, as the client might become frustrated or feel blamed for being unclear. Conducting this

discussion as a collaborative exploration of the artwork can facilitate clarification. In the vignette described above, the therapist asked if a certain drawing showed the client talking to his family about depression.

Challenge. As the client's narrative becomes clearer, the therapist identifies breaks in mentalizing, usually in the form of pretend mode, psychic equivalence. or a teleological stance (see Glossary for definitions). When a break in mentalizing is identified, the therapist empathically helps the client to rewind the narrative and explore antecedent triggers, thoughts, feelings, and behaviors that may have led to diminished mentalizing. In an MBAT session, this can be accomplished verbally, but the art-based modality has an additional advantage of representing the client narrative in graphic form. Thus, the verbal "rewinding" can take place in the form of adding cards to the storyboard prior to the break in mentalizing.

In the vignette presented earlier, psychic equivalence interfered with the client's mentalizing. That is, Frank felt strongly that he was pathetic; therefore he assumed, possibly incorrectly, that his family members must pity him.

Affect focus. The client is asked to annotate each card in the narrative storyboard with thoughts, feelings, and physical sensations. From my experience on the inpatient psychiatric unit, emotions are the last items to be labeled, and require the most support from the therapist if the client is to identify and share any feelings. Almost universally, the first prompt to focus on affect results in the client restating thoughts rather than emotions. In MBAT, the art can serve to communicate affect on a level that the client might find more manageable. For example, the client might draw facial expressions on figures, or choose colors to represent affect at different points in the narrative. It should

be noted that the client's affective states in the session and in the context of the narrative might not be congruent. It is the client's affective state in the present that influences the client's ability to mentalize. For example, humiliation felt in a recalled narrative might become shame mixed with anger when it is recounted later in the session. However, it has been my experience that clients' remembered affects are heavily influenced by how they are feeling presently as a result of revisiting the narrative. In the vignette above, Frank may not have been able to articulate his feelings in the session, but he might have been feeling some of the shame he felt as a result of appearing vulnerable in front of his family.

Mentalizing the transference. If clients are able to observe their mental state in the context of the session, they might be able to mentalize the relationship between themselves and the therapist. To some extent, this stage resembles a microcosm of the session (or course of treatment) as a whole. Validation, exploration, clarification, and collaborative understanding are now employed to mentalize the therapeutic relationship. In addition, the therapist must recognize personal contributions to the intersubjective. Because attachment has a pronounced effect on mentalizing, the clients' reactions must be monitored especially closely, keeping in mind that clients' ability to mentalize their own reactions in the moment would be an indicator of clinical progress.

Mirroring in Service of Mentalizing

Psychotherapists are familiar with the concepts of active listening and reflecting back to clients. These technical skills are related to a process Bateman and Fonagy (2012) referred to as "mirroring." Mirroring in the context of mentalization refers to an interaction between an infant and their caregiver. Essentially, the caregiver perceives, or

mentalizes, the internal state of the infant and then communicates back to the infant that the infant's mental condition has been recognized, or mentalized (Bigelow, Power, Bulmer, & Gerrior, 2015).

In an MBT or MBAT session, the therapist strives to mentalize the internal state of the client in a process that is analogous to that between the infant and caregiver. In the case of therapist and client, the mentalization and mirroring by the therapist is intended to help clients do so for themselves, independent of the therapist (Bateman & Fonagy, 2012). Receiving effective mirroring from a caregiver is also thought to foster development of an agentive self (Kernberg, 2012).

Mirroring can be verbal, but it also extends to nonverbal cues such as tone of voice, eye contact, body language, and facial expression. Whether in the nursery or in a therapy session, in order for mirroring to be effective it must satisfy three basic criteria. First, the mirroring must be contingent, meaning it must correspond with expression of affect by the other. There should be a predictable quality so that the connection between the mirroring and expression of affect is evident.

Next, mirroring must be congruent, which is to say, it must be accurate in terms of content. An example of noncongruent mirroring would be someone who reacts to a family member by trying to cheer the person up. This common behavior is likely due to a disconnect in mentalizing, with the cheerful party unaware that such attempts to soothe another are motivated by a need to quell one's own over-activated attachment system.

Lastly, mirroring should be marked. Put another way, it must be obvious that the affect expressed in the mirroring communication is not the caregiver or therapist's own

mental state and is rather an acknowledgement of that of the child or client, as the case may be.

Validation and the Not Knowing Stance

Validation and the "not knowing" stance are two techniques that come into play at the beginning of each session and remain in the background throughout treatment. Validation conveys empathy on the part of the therapist by confirming the client's subjective experience has been witnessed and emotional content is considered valid, although the ways in which those emotions came about might come into question later in the session. For example, if a client says, "I was happy that my sister got that big promotion, but for some reason I cut myself that night," the therapist might be tempted to point out that there seem to have been some negative feelings as well as happiness. Instead, in order to convey empathy, the therapist would most likely confirm hearing the client's expression of happiness, and perhaps share in the client's puzzlement about the self-injurious behavior.

The not knowing stance is an important tool for clarifying the nature and degree of the client's mentalizing. "Not knowing" does not mean being disingenuous in that the therapist does not pretend ignorance or lack of understanding. Rather, emphasis is given completely to the client's interpretations, thoughts, feelings, reactions, and beliefs. For example, a client might say something like, "I told my family I got a big promotion, and my sister goes and cuts herself. Well, you know what that's about." Such a statement presents the therapist with an opportunity to clarify what the client thinks is going on. The therapist might have some theories about the two sisters, but at this point it is more important to find out how the client is mentalizing her sister's reaction as well as her own

role in the scenario. Later in the session, the therapist will suggest interpretations to the client, but will continue to do so tentatively, with deference to the client's viewpoint, always remembering that the most important material will come from the client. For example, the therapist at some point might say, "I wonder if your sister feels bad about herself," to which the client might reply, "She's fine. She just wants to be like me. I've always been the successful one, and she saw me cutting when I was her age." Contrary to, or perhaps on top of, the therapist's initial theory about sibling jealousy, the client's process has now taken on a somewhat narcissistic tone, but further clarification is needed, still from the not knowing stance.

The therapist proceeds from this point, elaborating and clarifying the client's process via respectful inquiry, always from the not knowing stance. Later the therapist might say, "I'm wondering why you drank so much that night—way more than you wanted to, by your account—after you've been doing so well in AA." Here, by moving down avenues opened up by the therapist, the client might come to realize she doesn't really think her sister is "fine," but said so initially as a non-mentalizing defense against deep feelings of guilt at having set a poor example for her younger sibling, and for having monopolized the family's attention when she and her sister were younger.

As the session begins, the client will usually describe an interpersonal situation or experience, the entry point to which is often the part of the narrative that carries the greatest emotional weight. The interaction initially described by the client may not appear to be charged with emotion. This is not a problem, as every interaction can be mentalized to some extent. If the patient starts with a 10-second interaction experienced with a bus driver rather than a lifetime relationship with a parent, this might represent a need to

initially deal with less weighty material, apropos of the client's stage of recovery. Mentalizing the interaction with the bus driver can be very productive, as doing so constitutes practicing the process of mentalization—a skill that might ultimately be transferred to relationships that are more central to the client's life.

The therapist must recognize that the client is describing a personal sense of reality as it presently exists. Errors in mentalizing might immediately be evident to the therapist; however, this is an opportunity for the therapist to validate the client's experience, clarify initial interpretations, and strengthen the alliance. Challenging the client's narrative at this point would not accomplish these objectives. Further, by focusing on what and how the client initially communicates, rather than the client's internal thoughts, the therapist allows for a period of unbiased collaboration. This is not to say the therapist should be a blank slate. The therapist can certainly summarize, rephrase, and make observations. If a client recounts an experience using affectively restricted language but appears extremely angry while talking, the therapist might observe, "It seems like that made you angry."

That said, the therapist must try to validate clients' emotional experiences without colluding with their potentially non-mentalizing interpretation of their narratives. In a session with an adult psychiatric inpatient, such an interaction might take this form:

Client: "I asked the nurse for toilet paper, and she acted like she was better than me."

Therapist: "I see in your drawing that the nurse is walking away from you."

Client: "Yeah. See, she didn't even turn around."

At this point, the therapist is likely considering the possibility that the nurse might not have heard the patient's request, and that the patient had possibly been feeling humiliated before the interaction due to having to ask for toilet paper and the stigma of inpatient psychiatric treatment. It might even occur to the therapist that the client has incorporated his own poor male self-image as he imagines the female nurse's perception of him. However, instead offering these interpretations, the therapist simply seeks to clarify the client's lived experience:

Therapist: "What was that like for you?"

Client: "It was humiliating. A grown man just goes out and buys toilet paper."

Experienced therapists will likely have some ideas about their clients' feelings and flaws in their own, as well as their clients', mentalization. However, a mentalizing therapist must put these thoughts aside and instead take a stance of "not knowing." This does not mean abandoning professional acumen, experience, or common sense. Rather, it means that the narrative of the client's experience must initially be considered valid, just as it is described.

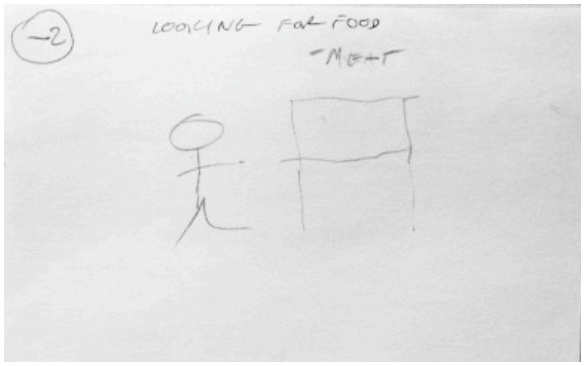
At this stage of the session it might be helpful for therapists to see themselves as genuinely curious observers with no obligation to make corrections or even be "helpful" beyond witnessing and clarifying the client's experience, as the client sees it. Clinicians might experience feelings of inadequacy, helplessness, or being "de-skilled" as they attempt to maintain a not-knowing stance. Professionals in clinical practice (especially in acute care) are conditioned to feel that they should quickly figure out their clients' problems and soon thereafter come up with a concrete plan to address those problems. The MBAT session, on the other hand, starts with a mutual understanding of the client's

narrative; then, if all goes well, moves toward a mutual discovery of flaws in mentalization. The ultimate goal is a collaborative process of discovery and solution-focused thinking, rather than a didactic lecture or Socratic questioning of the content of the client's mental process. The results of this collaboration are not the objective either. Rather, it is the mentalizing process, as a new client experience enabled by well-managed attachment, that constitutes the therapeutic material of the session. In brief, mentalization, and by extension the MBAT protocol, are not about correcting what clients think about their relationships. Rather, the objective is to improve how clients think and feel about their relationships, and how they handle activation of their attachment systems (Bateman & Fonagy, 2012).

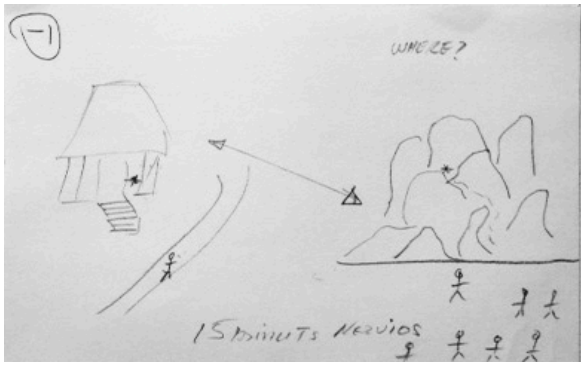
Attachment Within the Session

Whether as a result of having a caring person pay close attention or by mere exposure to the therapist, a client's attachment system will be activated within the context of therapy (Allen & Fonagy, 2006). Activation of clients' attachment systems is likely to have an effect on their reflective functioning and therefore their ability to mentalize (Morel & Papouchis, 2015). The exact nature of the activation, and the resulting effect on mentalizing capability, will vary from client to client depending on each one's particular attachment style. For example, clients with borderline personality traits are particularly sensitive to attachment and rejection, and therefore are likely to experience reduced mentalizing capacity when their attachment systems are activated (Bateman & Fonagy, 2012). Conversely, some might experience hyper-mentalizing as a result of attachment system activation (Bateman & Fonagy, 2006), expressed as pretend mode or faulty abstraction (Ripoll, Snyder, Steele, & Siever, 2013).

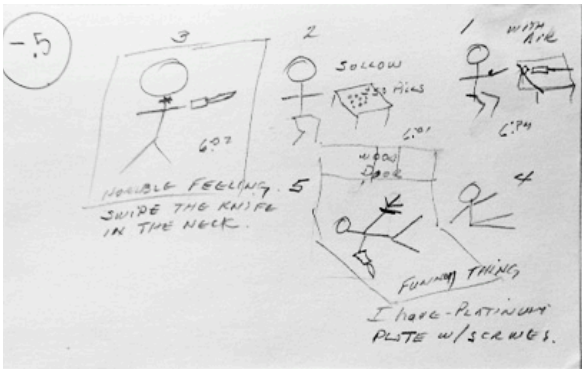
An example of an MBAT session where the client operated primarily in pretend mode is provided in Figure 7 below. In this session, a hypothetical client we shall call John draws a storyboard depicting his suicide attempt.



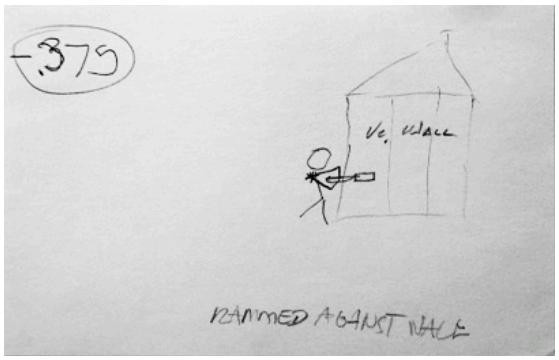
In John's sixth drawing (having worked backwards from depicting his suicide attempt), he represents his experience arriving in New York City and looking for a restaurant where he can eat a steak.



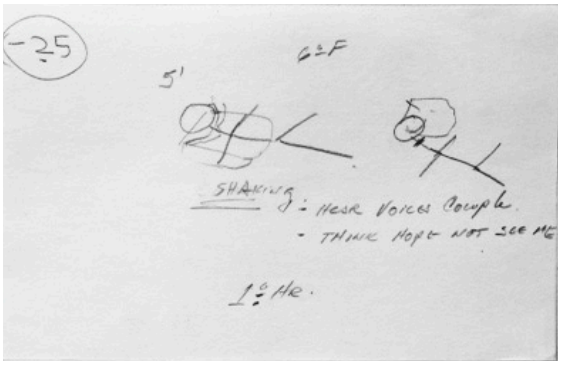
In John's fifth drawing, he depicts himself searching for a place to kill himself. He chooses a gazebo in Central Park, and calculates the likelihood of being discovered by bystanders. The gazebo seems isolated, but there are others around.



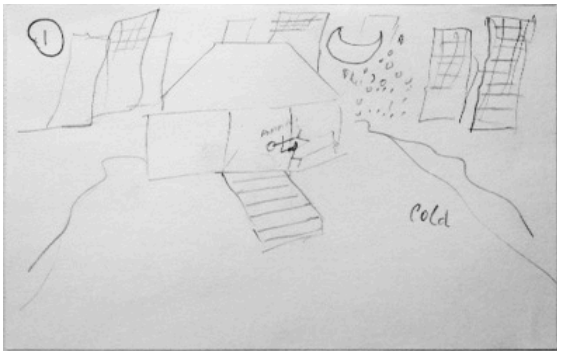
Drawn fourth, here John depicts himself stabbing himself, injecting air into his veins, and taking pills. The suicide attempt is elaborate, and done in a semi-public place.



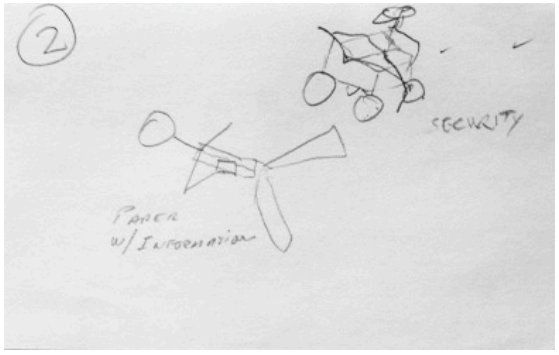
Drawn third, here John shows himself running into a pillar, with a knife to his chest.



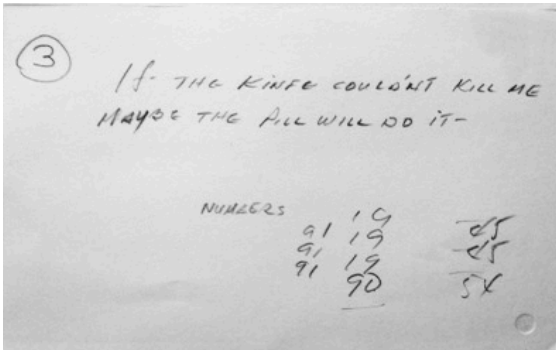
In his second drawing, John shows himself lying in the snow, bleeding. He is shaking from the cold. He hears a couple approaching.



In this, the first drawing made by John, it is cold, nighttime. He is looking for a place to "do it." This is the point at which John enters his narrative.



In the last narrative card he draws, John shows a security officer coming upon him in the snow.



Finally, John resorts to compulsive numbering as a way to comfort himself.

Figure 7. Hypothetical Storyboard by a 55-Year-Old Male Depicting His Experiences Before, During, and After a Suicide Attempt

Activation of a client's attachment system can manifest itself in various ways. For example, the client might attempt to elicit increasingly sympathetic reactions from the therapist. The client might even become seductive, or seek special favors in the form of bent or broken boundaries. Conversely, the client might become withholding, angry, or devaluing of the therapist. The client might move away from the therapist by arriving late or missing sessions, and the use of immature defenses such as splitting, projective identification, or acting out is likely to become more pronounced. All of these phenomena are considered by the therapist to be manifestations of clients' difficulty understanding their own and others' minds. The ultimate goal is to restore and ideally expand the client's repertoire for effective mentalizing and genuine, flexible, and autonomous curiosity about mental states, without sacrificing the therapeutic alliance.

Because each client will have a unique attachment profile, the therapist must be ready to make adjustments as informed by constant monitoring of the client's attachment-related behavior. Such adjustments may be counterintuitive to the therapist and may seem anathema to human nature. For example, as a client emotionally discloses mistreatment by a romantic partner, the therapist might be tempted to soothe the client sympathetically

with supportive statements. At this point, the therapist should question whether the client is able to better self-regulate with the additional support. It is also possible that the client could become increasingly dysregulated as the therapist attempts to offer comfort, thereby inadvertently increasing attachment activation. If this is indeed the case, the therapist might decide to pull back, recognizing that emotional mirroring would only serve to increase the intensity of this client's dysregulated activation. This does not mean the therapist should attempt to become a "blank slate" devoid of any affective reflection, remembering that mirroring, if it is to be effective in fostering mentalizing, should be distinctly marked. That is to say, the caregiver must effectively indicate having witnessed the client's affective state without taking on that state personally.

Another example of over-activated attachment interfering with mentalization is seen in clients who distance themselves from the therapist after they begin to feel attached. In this instance, the therapist must consider judiciously moving toward the client in order to try to avoid disintegration of the therapeutic relationship, but not to the point of becoming threatening or intrusive. With an adolescent client in her third session, such a conversation might go something like this:

Client: "I'm quitting therapy. This is pointless."

Therapist: "So, you feel what we're doing is pointless?"

Client: "Yeah, that's what I said. Duh."

Therapist: "Well, it's up to you. It's your decision."

Client: "Yup, that's my decision."

Therapist: "Okay. Well, we still have about 45 minutes in this session. How about doing one last storyboard?"

Client: "Fine. Whatever. She [mom] paid for it."

The client draws a 3-panel storyboard of her interaction with the therapist during the first 10 minutes of the session. They are done in an off-hand manner with stick figures and minimal detail. The therapist and client discuss the storyboard:

Client: "This is our last session, so this is my gift to you *(sarcastically)*. Ha."

Therapist: "Thanks. Um, what's going on here?"

Client: "This is you saying hi. Then, this is me saying this is pointless. And in this one, you're telling me to draw."

Therapist: "What am I thinking in this one?" *(Pointing to the first drawing.)*

Client: "How should I know? It's pointless."

Therapist: "I'm thinking it's pointless?"

Client: "Well, yeah. It's obvious."

Therapist: "And what am I thinking in this drawing?" *(Pointing to the third drawing.)*

Client: "Ugh. You just want me to leave. You looked at your watch as soon as I came in. Look—I drew you with no face because you're fake. Ha. How's that for an analysis?"

Therapist: "You seem convinced that I'm a fake."

Client: "You get paid either way. You probably want me to leave."

Therapist: "Really? I remember you telling me you want to leave, but is that what I'm thinking?"

Client: "Just stop pretending to care. You get paid to pretend."

Therapist: "It's true I get paid when I work with you. How about quitting next week so I can get paid for one more session?"

Client: "Ha! Fine. Whatever. *(Hands the therapist her drawings.)* Here's my brilliant art."

In this vignette, we see an adolescent client exhibiting signs of ambivalent resistant attachment (Ainsworth, Blehar, Waters, & Wall, 1978). The behaviors characteristic of this attachment style are prominently expressed in the third session, when the client's attachment system has been activated by a developing bond with the therapist. In a baby, this attachment style might come to light in the form of lack of exploration in strange situations complemented by minimal comfort-seeking behavior and increased hostility or resentment upon the return of the caregiver. In an adolescent, there is likely to be a tendency to question the validity of relationships with attachment objects. These behaviors might be associated with normative individuation, and many adolescents are able to incorporate them into functional relationships with caregivers.

In the vignette described above, the client's rejection of the therapist is accompanied by covert attempts to cement the same relationship. She announces she is ending the therapeutic relationship, apparently starting the conversation at the end of a previous faulty mentalization sequence. Recognizing that the client is possibly having difficulty mentalizing in the context of increasing attachment, the therapist redirects attention to the art making, in the hope that focus on the third object provided by artwork might reduce the intensity of the attachment activation. The therapist chooses not to directly engage the splitting suggested by the client's disdainful reference to her mother as "she," in an attempt to maintain focus on the therapeutic relationship.

The client obliges and makes some art. She does so as a "favor" for the therapist, demonstrating a sense of agency she has likely not felt at home. By this point, the therapist in this scenario has likely realized that the client is ambivalent about their relationship. By discussing the art, the therapist slows down the rapid back-and-forth banter that has previously been fuelled by raw emotion. In fact, the therapist has been trying to do this by way of demeanor since the beginning of the session. As a result, a significant deficit in mentalizing comes to light when the client expresses her thought that the therapist actually wants her to leave. Rather than contradict this belief, the therapist asks for clarification of the statement. The client cites her observation that the therapist looked at a watch as evidence that the therapist is fake and does not care about her. Again, the therapist does not directly refute this belief, but takes the somewhat risky step of asking the client to return so that the therapist can get paid for another session. By using the client's frame of reference, the therapist has asked her to stay on her own terms, including her defensive sarcastic humor. More importantly, the therapist has mentalized the client's ambivalent attachment and therefore recognizes her underlying desire to stay in therapy.

Finally, the client gives the art to the therapist as a gift. By reiterating that she does not care about the art, and then giving it to the therapist, the client has distanced herself from the affective quality of her attachment, while at the same time enacting the attachment in a way that feels safe to her.

Establishing the Narrative

As the client provides the first draft of a narrative, the therapist uses common therapeutic techniques such as active listening, looking, and reflection. The therapist does

not intervene at this point except to invite and encourage the client to bring the narrative into the shared space of the session. The goal at this point is to establish the narrative in the client's own voice, so the therapist must pay particular attention to maintaining a stance of not knowing. Early in the session the therapist might communicate a sense of genuine curiosity but does not pose questions or express puzzlement, as might be appropriate later on.

Exploring, Expanding, and Editing the Narrative

At this point in the session a graphic representation of the client's narrative, done on a series of cards, is laid out on the table. As the therapist and client view the cards together, the therapist begins to take a more active role in guiding the conversation. Interventions continue to be aimed at clarification, and are done from a stance of genuine interest. The therapist continues to adhere to a not-knowing stance in terms of conveying a genuine curiosity about the client's experience of any clarifications and other therapeutic interventions, and a willingness to edit such formulations as the client provides contrary evidence.

As the client describes the experience depicted in the cards, the therapist seeks to slow down the pace of the narration and to encourage a stepwise approach to the narration. This has already been accomplished to some extent by having the client make a graphic depiction of an experience, because most people simply draw more slowly than they talk. The purpose of slowing down the narrative is to allow time for reflective functioning to take place, with the idea that emotionality usually shifts faster than cognition unless the whole process can be slowed down. The making of a storyboard also

helps parse the narrative into visual clumps that correspond to the way the client initially remembers an experience.

It may be helpful for the therapist to literally ask clients to pause on occasion as they tell their stories. When asked to pause, clients might feel frustrated or anxious as they resist the impulse to proceed immediately to the next emotionally charged image. Pauses in discussion might allow space for increased mentalizing in the client (as well as the therapist), as the emotional spikes that accompany each new thought are able to cool down slightly before moving on. If this is the case, the triangular dynamic set up by having art on the table for both therapist and client to look at can help to dissipate the anxiety that often arises during silent pauses.

The artwork created in MBAT could be considered analogous to Ogden's (1994) "analytic third"—essentially an experience of the intersubjective through the subjectivity of client and therapist. Thus, the artwork can serve as a subjectivity co-created by client and therapist that they each experience in their own way. Importantly, in MBAT the client and therapist have set about constructing this third object in an explicit and deliberate way, resulting in a concrete representation of a shared experience. By viewing and by mutual agreement altering the artwork, client and therapist approach a congruent subjective experience. As the process of mutually refining the pictorial narrative proceeds, it is possible that subjective differences in experiencing the third object might come to light, providing glimpses of non-mentalizing on the part of the client as well as the therapist.

It is at this point that the therapist intervenes by asking the client to rewind or fast-forward to consider what may have happened before or after the initial depiction of the

interaction. Antecedent and residual emotions, thoughts, behaviors, physical sensations, beliefs, and motivations should all be addressed, if the client is able and willing.

This is also the point at which the therapist attempts to facilitate teasing out the narrative. By noticing dysfluencies such as jumps in time, space, or logic, the therapist can help the client focus on unconscious omissions or inconsistencies in the narrative. Such interventions consist of simple statements such as, "I wonder why your daughter suddenly decided to hug you."

For the remainder of the session the therapist attempts to help the client think about any feelings involved and understand the effect those feelings have on thoughts. Clients are also encouraged to focus on what they think and feel about others and themselves at various points in the narrative. Working backwards from the client's initial observations, it may be possible to construct a well-mentalized model of emotional, cognitive, and behavioral cause and effect at work in the social scenario under consideration. As treatment progresses, and depending on the client's ability, the client might be able to mentalize several steps in the sequence of reactions and interactions, or even interwoven layers of feelings, thoughts, and behavior. It is even possible that clients might come to understand the reasons for their initial mentalizing deficit. In the case of Frank, he might eventually be able to say, "I guess I omitted my crying because it felt like I was losing my identity as a father, and that's basically all I had besides the fire department."

The stance of curious "not knowing" is especially important here, as the clinical objective is to help the client to develop mentalizing skills, over and above improved mentalization of a particular incident. Whenever possible, the therapist should set the

stage for clients to exercise their mentalizing abilities. Early in treatment, the therapist should avoid mentalizing for the client unless the session calls for modeling of mentalization, in which case the therapist might offer a personal example of mentalization of a specific interaction between therapist and client within the session. Such an interaction might go this way:

Therapist: "Did you notice I made a joke just after you came in?"

Client: "Yeah, it wasn't very funny."

Therapist: "Probably not. I guess I noticed you had a certain expression on your face that led me to think you were anxious."

Client: "So?"

Therapist: "Well, I think I got a little anxious myself because I sort of feel responsible, and I want you to feel better. And frankly anxiety is a bit contagious. Anyway, joking around is one of the ways I tend to deal with anxiety, so that's probably why I did that."

As the treatment progresses, the objective is for clients to develop a familiarity with the process of reflecting on their own mental process and that of others. When a client demonstrates this ability, the therapist is able to offer mentalizing options for the purpose of catalyzing open, honest discussion of any client/therapist interaction, as well as scenarios occurring outside the session as described by the client. Such an exchange might go this way:

Client: "I was with my whole family for the first time in a long while. My daughters looked so grown up. I don't know why, but I just started to cry. It was humiliating."

Therapist: "You started to cry when you saw your daughters all grown up? Do you think there might be a connection?"

Client: "Well, of course I knew they were grown up. One of them is married, but it never hit me like that."

Therapist: "I've known you for a while now, and it seems to me that being a father is an important part of your identity. You've been your daughters' protector—the guy who will take care of everything. Is that right?"

Client: "Yeah. That's being a dad, right?"

Therapist: "Sure, but your relationship with your daughters might have changed as they've grown up. I wonder how that affected you as you walked into the room that day."

Client: "It hit me all at once, and I wasn't in a good place. I felt weak."

Therapist: "Not a good feeling. Maybe that's why you left the card out?"

Client: "Well of course I left it out. Who wants to be humiliated like that?"

Therapist: "Of course, that's understandable. We've talked a lot about your depression, and how it affects your thinking. Do you suppose your depression is distorting how you see your relationship with your family?"

Client: "Yeah. I'm proud of them but all I can think about is how they don't need me anymore."

As the session draws to a close, the client and therapist might explore alternative scenarios involving improved mentalizing. This is a way of concretizing any gains made in the session, especially if the client can depict the new scenarios in the form of art. The client might be able to imagine changes to the narrative, incorporating better mentalizing,

that would result in more favorable outcomes. This can start with exploration of possible alternative or desired outcomes. Once goals are established, it might be possible to discover how improved mentalization could enable the client to attain those goals. If the fire fighter from our initial vignette identified increased closeness with his family as a goal, he might be able to see a better understanding of his daughters' thoughts and feelings as a way to achieve that goal.

Demand Questions and Permit Questions

Verbal interventions made by the therapist will generally be open-ended. However, certain direct questions can be used as a way to elicit mentalizing in the client. The reflective functioning index has been established as a measure of mentalizing, and such questions are termed "demand questions" in the parlance of reflective functioning. Therapeutically, such direct questioning might not directly support increased spontaneous mentalizing ability in the client, but it could be a step in that direction if the question stimulates mentalizing cognition. Table 2 shows demand questions contained in the Reflective Functioning Manual (Fonagy, Target, Steele, & Steele, 1998). Note that many of these questions implicitly motivate curiosity about the effect of mental states on other mental states (within one person or between persons), change in mental states over time, and flexible, inferential linking of mental states as causes for behavior.

Drawing Attention to Inconsistencies

Narrative inconsistencies can be used as markers for breaks in mentalizing. Temporal, spatial, syntactic, and logical jumps can indicate that the client has omitted or misinterpreted some aspect of the narrative. Initially, the therapist notices these

inconsistencies and expresses curiosity about them. Later in the session, a direct inquiry or demand question might be required.

Table 2. Examples of Demand Questions From the Reflective Functioning Manual (Fonagy et al., 1998)

Category	Demand Question
1. Closeness	To which parent did you feel closest as a child?
2. Rejection	Did you ever feel rejected by your parents, even though they might not have meant it or been aware of it?
3. Overall experience	How do you think the experiences with your parents have affected your adult personality?
4. Setback	Are there any experiences that you feel were a setback in your development?
5. Parents' behavior	Why do you think your parents behaved as they did during your childhood?
6. Loss	Did you experience the loss of an important person during your childhood?
7. Changes	Have there been many changes in your relationship with your parents since childhood?
8. Current relationship	What is your relationship to your parents like for you now as an adult?

Contextualizing the Narrative

The therapist should invite the client to explore what happened before the client's storyboard started. Not only does this afford an opportunity to illuminate how the client's prior mental state affects mentalization going forward, but it also might help identify a

source of emotional distress that predates the narrative described by the client in the session. A client might be inclined to recall childhood experiences, which can be helpful, but the client might also bring an experience of a few minutes or even seconds prior to the narrative into the session. In the first vignette, John was unable to identify affect throughout his narrative, including in the moments leading up to his suicide attempt. In the second vignette, Frank avoided addressing his feelings preceding the interaction with his family, but it became clear that he felt humiliated and disoriented because his role as a father seemed to have changed.

By inquiring what happens after the client's narrative ends, the therapist can invite the client to mentalize the processing of residual feelings from the interaction. The client might also envision alternative outcomes, informed by improved mentalization.

Contrary Moves

When a client exhibits a great deal of certainty about a particular fact, the therapist should gently wonder if the fact is indeed true. It is important that the therapist not contradict the beliefs of the client. Instead, the therapist should notice and remark on the certainty of the client's belief and then wonder if there might be a plausible alternate belief.

When clients exclusively reflects on themselves or, conversely, reflect solely on others, the therapist should encourage the inverse reflective focus. When clients appear emotionally distant, the therapist should encourage them to experience their emotions fully. However, if clients seem to be unduly influenced by emotional states, they should be encouraged to engage in reflective function and cognitive control over those emotional states.

Clients might express certainty about some aspect of their attachment narratives, with a statement such as, “I know my daughter pities me.” In a situation where a client seems absolutely certain, the therapist should make a contrary yet gentle move, such as, “You mentioned you feel pathetic, but is that necessarily how everyone sees you?” Again, the therapist should not contradict the belief outright, but should become curious about how the client’s absolute belief came to be. Such an intervention might simply be: “How can you tell she pities you?” Notice the wording does not contradict the client’s assumption, but questions the perceptions that led to the client’s belief.

Managing Attachment in the Session

The client–therapist attachment must be cooled off or reinforced as necessary. Experienced therapists know that some clients will pull away and others will seek ever-closer bonding with their therapist. Still other clients will be ambivalent or avoidant in their attachment approach. It can be anticipated that any client’s attachment style will be brought into high relief in the context of the therapeutic frame.

With boundaries firmly in place, the therapist and client can explore feelings, thoughts, and behaviors in the moment. Often, clients will choose to address interpersonal interactions that are temporally or socially proximal. That is to say, they will bring up an interaction that happened recently, or one that is more intimate and therefore emotionally weighted. The latter type will often yield important opportunities for increased mentalization, but the former can provide a starting point for clients who are not ready to mentalize the major relationships in their lives.

Identifying and Exploring Positive Mentalizing

The therapist should offer positive feedback when the client moves toward mentalizing. Such feedback can be given in the form of judicious praise. Such praise must refer specifically to mentalizing functions when they are achieved by the client, such as understanding thoughts, feelings, behaviors, motivations, and beliefs pertaining to an interaction with another person. After making note of a client's successful mentalizing, the therapist might explore how the client thinks others felt when the mentalizing occurred, and the resulting effect on the client's own emotional state. In order to consolidate progress, the therapist should ask clients to turn their attention to how mentalizing an emotional situation made them feel (Bateman & Fonagy, 2005).

Positive mentalizing is identified and explored in order to reinforce and consolidate the client's beneficial new skill. When mentalizing is achieved, the therapist may give judicious praise, but this must be done with the attributes of effective mirroring in mind (Choi-Kain & Gunderson, 2008). That is, the praise must be congruent with the situation and linked to real mentalizing. Praise must also be marked in the sense that it must be clear that the therapist is not simply expressing personal satisfaction. Finally, praise must be contingent, in that it must be given when mentalizing is achieved.

Once again using the middle-aged Caucasian male firefighter with depression as an example, we can see how judicious support of mentalizing function operates. In this case, the client drew four cards depicting a recent interaction with his adult daughters and wife, with whom he hadn't spoken in months. Two initial cards showed the client separated from his daughters, and were virtually identical. In the course of the session, the client added two cards with more detail. The session started in this way:

Therapist: "I noticed there's not much difference between your two cards."

Client: "Here *(pointing to the second card)* I told my daughters I feel stuck. But I don't want them to see me like this."

Therapist: "It wasn't easy, but you were able to tell them what was going on with you. Are there any other details you might add?"

Client: "No, I'm not really good with words."

Therapist: "What if you were to add another card? What happens next?"

Client: "My daughter hugged me."

The client adds a card depicting his daughter hugging him.

Therapist: "Why do you think she did that?"

Client: "Because I told them I'm stuck. I guess she wants to take care of me."

After some discussion, the client adds tears to his face on a fourth card.

Therapist: "What was that like for you?"

Client: "I felt like I wasn't their dad anymore, like I can't take care of them. But it felt good. It's been so long…"

In the above example, the therapist made note of the fact that the client had identified his feelings and thoughts, and the influence they had on his behavior. He was able to express this insight to his daughters, and was able to mentalize their process and his own reaction.

Conclusion

This manual is intended for use by practitioners of art therapy and mentalization disciplines to conduct mentalization-based art therapy sessions with their clients. The protocol described herein allows for adaptation as the needs of different clients dictate. The technique is nonlinear so as to provide the flexibility to respond to the dynamics of each session.

Many other art therapy interventions might incorporate techniques outlined here, and are likely to foster increased mentalization in clients. This protocol, however, is intended to comprise a true integration of art therapy and mentalization-based therapy techniques, procedures, and mechanisms of change. It is intended that the result will be a synergistic increase in effectiveness, especially with clients for whom, for instance, traditional art therapy and/or mentalization-based therapy might be difficult due to artistic or verbal limitations, respectively. Although no data have been presented to date as evidence of increased effectiveness, the hope is that this protocol will serve as a prototype that can be validated in the future and refined through a continuing process of action research modification.

Suggested Reading

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide.* Oxford, England: Oxford University Press.

Bateman, A., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Arlington, VA: American Psychiatric Publishing.

Hass-Cohen, N., & Findlay, J. C. (2015). *Art therapy and the neuroscience of relationships, creativity, and resiliency: Skills and practices*. New York, NY: W. W. Norton.

Havsteen-Franklin, D. (2016). Mentalization-based art psychotherapy. In J. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 144–164). New York, NY: Routledge.

Verfaille, M. (2016). *Mentalizing in arts therapies*. London, England: Karnac Books.

Glossary

Acting out. An immature defense involving physical or social action directed at another or the self.

Active listening. Indicating attentiveness and receptiveness using verbal and nonverbal cues while listening to another speak.

Affect. Expressed emotion.

Ambivalence. Possessing two or more incompatible thoughts or emotions simultaneously.

Art therapy. Psychotherapy conducted using visual art.

Attachment object. A person or item with whom another person has an emotional bond.

Attachment system. The process by which a person forms, reacts to, and enacts attachments.

Behavior chain analysis. An exercise used in dialectical behavioral therapy in which clients are asked to record the sequence of their triggers, thoughts, feelings, behaviors, and consequences associated with a critical experience.

Borderline personality trait. A trait associated with borderline personality disorder, including use of immature defenses, poor affect tolerance, hypersensitivity to social stimuli, and disrupted attachment.

Collaborative understanding. The act of seeking greater understanding in concert with another supportive person, such as a therapist.

Concretizing. The representation of feelings or thoughts in a solid, tangible form such as writing or artwork.

Congruent mirroring. One person accurately sensing the mental state of another, then communicating an awareness to that person.

Contingent mirroring. One person sensing the mental state of another in a timely manner, then communicating an awareness to that person.

Countertransference. The process by which a therapist superimposes previous relationship patterns onto a new relationship with a client.

Defensive system. The way in which a person avoids or seeks to soothe negative feelings.

Demand question. A question asked by a therapist that explicitly demands mentalizing on the part of the client.

Dysregulation. A state where a person's emotions are unregulated by cognition and have disproportionate influence over thoughts and behavior.

Explicit. A clear, complete, unambiguous, and direct communication.

Implicit. An unclear, hidden, ambiguous, or indirect communication.

Intersubjective. Involving or occurring between two conscious minds.

Marked mirroring. One person sensing the mental state of another, then communicating an awareness to that person in a way that makes it clear that the person has not taken on an identical mental state.

Mentalization. The ability to understand the minds of others and the self in terms of mental states, beliefs, behaviors, and motivations.

Not-knowing stance. The initial stance of a mentalization-based therapist, characterized by genuine respectful curiosity, that presumes no knowledge of the client except what is self-reported.

Permit question. An open-ended question posed by a therapist that creates an opportunity for the client to mentalize.

Pretend mode. The tendency to focus attention on matters that are either irrelevant to

one's mental state, or simply false.

Procedural. Patterns of behavior, thought, or emotion that take place automatically, without conscious involvement.

Projective identification. A primitive defense mechanism involving the induction of one's own mental state in the minds of others, usually through behavior.

Psychic equivalence. A failure in mentalizing involving a sense that one's internal mental world is identical to one's external reality.

Reflective functioning. The ability to discern the effect of mental states on other mental states (within one person or between persons), changes in mental states over time, and flexible, inferential linking of mental states as causes for behavior.

Splitting. A primitive defense mechanism involving dividing others, or elements of the self into all-good and all-bad categories.

Storyboard. A series of annotated drawings that represent a sequence of events.

Teleological stance. A failure to mentalize due to preoccupation with tangible objects or transactions as evidence of a relationship.

Therapeutic alliance. A relationship between client and therapist, where treatment goals are shared and pursued together in an atmosphere of cooperation and trust.

Therapeutic intervention. An action or words introduced by the therapist in an effort to move towards the client's clinical goal.

Transference. The process by which a client superimposes previous relationship patterns onto new relationships.

Unreflective. The inability to discern mental states in self or others, changes in mental states over time, and inferential linking of mental states as causes for behavior.

Validation. Recognition and acknowledgement of a client's lived experience.

References

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological analysis of the strange situation*. Hillsdale, NJ: Earlbaum.

Allen, J. G., & Fonagy, P. (Eds.). (2006). *The handbook of mentalization-based treatment*. Cichester, England: John Wiley & Sons.

Bateman, A., & Fonagy, P. (2005). *Psychotherapy for borderline personality disorder*. New York: Oxford University Press.

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide.* Oxford, England: Oxford University Press.

Bateman, A., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Arlington, VA: American Psychiatric Publishing.

Bevington, D., Fuggle, P., Fonagy, P., Target, M., & Asen, E. (2013). Innovations in practice: Adolescent mentalization-based integrative therapy (AMBIT)—A new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. *Child and Adolescent Mental Health, 18*(1), 46–51.

Bigelow, A. E., Power, M., Bulmer, M., & Gerrior, K. (2015). The relation between mothers' mirroring of infants' behavior and maternal mind-mindedness. *Infancy, 20*(3), 263–282.

Bucci, W. (1997). *Psychoanalysis and cognitive science: A multiple code theory*. New York, NY: Guilford Press.

Choi-Kain, L. W., & Gunderson, J. G. (2008). Mentalization: Ontogeny, assessment, and application in the treatment of borderline personality disorder. *American Journal of Psychiatry, 165*(9), 1127–1135.

de Vito, E. (2012). Ambivalent/preoccupied attachment and emotional vulnerability in adolescence. *Adolescent Psychiatry, 2*(1), 19–27.

Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: An update. *World Psychiatry, 14*(2), 137–150.

Fonagy, P., Gergely, G., & Jurist, E. L. (Eds.). (2004). *Affect regulation, mentalization and the development of the self*. London, England: Karnac Books.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to adult attachment interviews.* London, England: University College London.

Greenwood, H. (2012). What aspects of an art therapy group aid recovery for people diagnosed with psychosis? *Art Therapy Online, 3*(1). Retrieved from http://ojs.gold.ac.uk/index.php/atol/article/view/297

Havsteen-Franklin, D., & Altamirano, J. C. (2015). Containing the uncontainable: Responsive art making in art therapy as a method to facilitate mentalization. *International Journal of Art Therapy, 20*(2), 54–65.

Kernberg, O. F. (2012). *The inseparable nature of love and aggression: Clinical and theoretical perspectives*. Arlington, VA: American Psychiatric Publishing.

Liotti, G., & Gumley, A. (2011). An attachment perspective on schizophrenia: The role of disorganized attachment, dissociation and mentalization. In A. Moskowitz, I. Schafer, & M. Dorahy, (Eds.). *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology*, 117–133. New York: John Wiley & Sons.

Morel, K., & Papouchis, N. (2015). The role of attachment and reflective functioning in emotion regulation. *Journal of the American Psychoanalytic Association, 63*(4), 15–20.

Ogden, T. H. (1994). The analytical third: Working with intersubjective clinical facts. *International Journal of Psycho-Analysis, 75*(1), 3–20.

Racker, H. (2012). *Transference and countertransference*. London, England: Karnac Books.

Ripoll, L. H., Snyder, R., Steele, H., & Siever, L. J. (2013). The neurobiology of empathy in borderline personality disorder. *Current Psychiatry Reports*, *15*(3), 1–11.