Chapter 1

Integrating Systemic and Mentalizing Approaches

When Salim's mother, Mrs. G, telephoned the clinic to ask for help for her 6-year-old son, the therapist taking the call asked what the issues were that concerned her. She tearfully explained that her much loved son had been showing extensive behavioral problems that had been flagged by the school. This had not surprised her as she knew Salim had found it difficult to make friends and also had "many worrying behaviors" at home. She then explained that Salim had "a major eating problem" and that he could "never be alone by himself in a room," which meant she always had to be with him, including sleeping in Salim's bed every night. She went on to say that Salim took many hours each day to do his homework, that "he often cries like a baby," and that he was generally very demanding. Mrs. G said she and her husband felt absolutely exhausted and were concerned about Salim's future.

Systemic and mentalizing approaches have a lot in common: Above all, they view many emotional and behavioral problems as being essentially relational in nature. This book views systemic work through a mentalizing lens. It intends to inspire systemic practitioners to expand their work in ways similar to the ways in which mentalizing therapists have been inspired by systemic concepts and practices. The aim of mentalization-informed systemic therapy (MIST) is to enhance mentalizing in order to open a person to improved social communication and interaction, within the family as well as in other social settings, and

thus to increase openness to learning, epistemic trust (Fonagy, Luyten, Allison, & Campbell, 2019), and resilience. By epistemic trust we mean trust in the information about the social world that we receive from another person. The ability to take in what others communicate to us as having personal relevance greatly enhances our ability to adapt in the face of challenging situations. This is why we have suggested it is a potentially powerful protective factor in mental health and social functioning (more on this in the section below in this chapter, "Why Is Mentalizing Important?"). The therapeutic focus is on encouraging the natural process for solving social problems by genuinely considering each other's experiences and points of view. After all, it is the experience of feeling one's perspective of reality aligned with another's that generically improves confidence in the value of engaging with perspective taking as a whole. In addition, this experience potentially opens the mind of each family member to the possibility of learning and discovering something relevant to them, thus improving trust in social learning as a whole.

THE MENTALIZING LENS

Mentalizing is an imaginative activity that interprets human behaviors in terms of intentional mental states. It is important to emphasize the word *imaginative,* as it is imagination that underpins mentalizing: It enables us to intuit the thoughts, feelings, and intentions of those around us and so to make sense of their actions, just as we organize our own subjective experiences. Mental states refer to a person's needs, desires, feelings, beliefs, fantasies, goals, purposes, and reasons. Mentalizing is mostly preconscious, but it can also be a deliberate activity of reflection. It is crucial for representing, communicating, and regulating feelings and belief states linked to our wishes and desires, whether they are being met, threatened, or frustrated. The same psychological and neural mechanisms we use to understand ourselves are also used to understand others. In this way, the foundations are laid for our social interactions.

The acquisition of the ability to mentalize is evolutionarily protected and modulated by the environment in ways similar to those by which language is acquired and developed. The capacity to mentalize emerges as essentially a nonconscious, reflexive appreciation of others' intentions, emotions, and perspectives (Seyfarth & Cheney, 2013). The nature of our mentalizing skills is shaped by our social environment, just as the particular language we first learn as children depends on our mother tongue. The predominance of family as a basic social unit has made it the primary context for acquiring and shaping social understanding.

This and other reasons (some of which may be genetic) account for the fact that the ability, willingness, or appropriateness to adopt a mentalizing stance varies between individuals and families. Our wider cultural environment may also encourage a stronger focus on mentalizing the self over the other, depending on how strongly individualism is valued (Aival-Naveh, Rothschild-Yakar, & Kurman, 2019).

Mentalizing is a fundamentally bidirectional or transactional social process (Fonagy & Target, 1997). It develops in the context of early attachment relationships and interactions with others, and its quality is very much influenced by how well those around us are able to mentalize. This experience of being mentalized by others is internalized and enables us to enhance our own capacity for empathizing and engaging better in interactive social processes. The relationship between attachment and mentalizing is also thought to be bidirectional in that difficulties with reflecting on mental states are likely to adversely affect close relationships; a poor attachment relationship—the experience of not being responded to in a sensitive way—may undermine the natural development of the capacity to mentalize, which, after all, depends on having been understood oneself. We need to understand others to appreciate others as understanding us. Think of how we learn a language by being spoken to, and then, being brave, we engage in conversations with others. Mentalizing is just the same process. We learn it by doing it. The problem is that some of us, for one reason or another, do not do it terribly well. We misunderstand people; we make assumptions about why they do things; we act before thinking about what we are trying to achieve; we know precisely how we should not behave, yet find ourselves doing the very thing we abhor; we spend endless hours ruminating on what our friend meant by saying something, only to discover that he or she was not even aware of having said it; we feel overwhelmed by emotions for reasons we do not understand, or we feel nothing when something upsetting happens; and so on. Failure of mentalizing, or to put it more appropriately, ineffective mentalizing, is what most of us do quite a bit of the time, especially when we are upset. One insight that we have had as therapists working with individuals, couples, and families is that making ineffective mentalizing just a little bit more effective in most families improved their situation and sometimes removed difficulties they presented with altogether. This is how MIST was born. It is our contention that more effective mentalizing builds both individual and family resilience: A better understanding of the mental states of others and self leads to a freeing of more meaningful communication. And this is what MIST tries to promote.

Not everyone agrees with the view we present of how mentalizing comes about in the course of a child's development. There are those

who propose that mentalizing (theory of mind) is an innate module in the brain that requires little more than maturation (Leslie, Friedman, & German, 2004). Many cognitive psychologists believe that mentalizing emerges through a process of quasi-scientific deduction in which the child evolves in order to create a plausible account of the social reality (Gopnik & Wellman, 2012). Some have put forward convincing arguments that mentalizing is taught by adults more or less explicitly (Heyes & Frith, 2014). However, in this book we will take a social-developmental approach and suggest that mentalizing is a uniquely human-evolved capacity that emerges in each mind, a capacity that is triggered by the interpersonal environment and wider social system the person finds themselves in. Radically, we maintain that were it not for others around us making us focus on our subjective experiences, mentalizing would not emerge—any more than a child of 18 months would begin to speak easily unless spoken to.

THE FAMILY SYSTEMS LENS

The other lens through which we work with families is the systemic one. Viewing the family as a system is useful, for it permits describing families as, for example, having "homeostatic tendencies" and specific properties such as hierarchies, boundaries, subgroups, as well as overt and covert communication exchanges and coalitions. For therapists, it can be helpful to view family members as behaving according to a set of hypothesized explicit and implicit rules that have developed over time, and often over generations, governing the relationships and communications within "the system" (Watzlawick, Bavelas, & Jackson, 1967). If specific features of the system, thought to contribute to the presenting problem(s), can be discovered or uncovered during therapy, then the system can perhaps be changed by questioning those features, such as established rules and relationship patterns.

Since the 1950s, systemic practitioners have developed a range of conceptual frameworks and interventions aimed at treating different types of problems and presentations. Some of these are particularly relevant to a mentalizing approach. Salvador Minuchin's ideas (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) are especially helpful in elaborating a mentalization-inspired approach (Asen & Fonagy, 2012a, 2012b). Minuchin introduced a focus on "dysfunctional" interactions that can evolve spontaneously in the here and now of the session. If these interactions do not occur, he suggests making them come alive in the session by encouraging deliberate "enactments" of typical problematic patterns (Minuchin, 1974). Such enactments allow intense thoughts and

feelings to emerge in each of the participating family members so that they may be immediately utilized to promote change. The technique of "circular and reflexive questioning," originally developed by the Milan team (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), is an example of how long-established systemic tools powerfully promote the process of mentalizing. "Interventive questioning" (Tomm, 1988) tunes into the mental states of the individual family members. We have noticed that many systemic practitioners employing this approach tend *not* to inquire explicitly about the individuals' current feeling states. Instead, they are likely to focus more generally on how each person's actions and beliefs affect another's, and how family patterns and other contextual factors account for people's actions and interactions (Boscolo, Cecchin, Hoffman, & Penn, 1987). The mentalizing principle is "always focus on and work with current thoughts and feelings."

The classical systemic approaches tend to focus relatively little on the subjective states of family members when, for example, heated interactions take place. Traditionally, there was little interest in exploring how an individual's experience in such sessions may have altered their understanding of a relationship. The mentalizing approach, by contrast, retains the family members' focus on the specific episode and each person's experiences in the "here and now" of the session. It pays specific attention to how family members feel and think about acute social experiences. Mentalizing, the understanding of others' understandings, can change fundamental assumptions. It can change the mental states that appear to drive actions and the behaviors of other family members, and it can also alter how the family as a whole may think or feel about specific issues.

MENTALIZATION-INFORMED SYSTEMIC THERAPY

We refer to the approach put forward in this book as mentalization-informed systemic therapy (MIST). It not only harvests concepts and techniques from the systemic field, but is also enriched by mentalization so that all family members can see and experience themselves and others in new and nuanced ways that open up a multiverse of possibilities and experiences. The mounting evidence base for the effectiveness of mentalization-based therapies (see, e.g., Bateman & Fonagy, 2008, 2009, 2019; Blankers et al., 2019; Byrne et al., 2019; Fonagy et al., 2014; Keaveny et al., 2012; Rossouw & Fonagy, 2012; Smits et al., 2020) lends this approach increased legitimacy. MIST is not a new model of therapy—it is an integrated way of working with couples and families. The mentalization-informed therapist does *not* aim primarily

at helping families to find pragmatic solutions to problems, but rather to remove temporary—or not so temporary—blocks in family relations. Such blocks can, for example, include suddenly and unexpectedly refusing to answer a question, going "blank," or inadvertently or deliberately misunderstanding what another family member has said. The removal of blocks can, however, help a family to find its very own solution(s) to perceived problems.

Why Is Mentalizing So Important?

We have an evolutionarily unparalleled capacity to learn new information and pass it on to those who learn from us, particularly our children. We spend the first years of our lives learning how to do things, how to use an extraordinary number of words, how to use tools, how to learn the millions of rules that we have to follow, and so on. But we cannot learn everything by observation alone— life is simply too complicated. We have to be taught, and over millennia we have evolved extraordinarily efficient ways of passing on information to our young, so that they know exactly what they should absorb, pick up, and make their own. When children are addressed directly, when eye contact has been made, when they have been called by their first name, when they have been smiled at, or were just looked at with a raised eyebrow, or someone said a warm "hello" to them—all these little gestures are cues for children to know that whatever is coming next is important for them to remember. These cues, also referred to as *ostensive cues* (see Chapter 7), serve to make the child feel that they are being recognized as important, as respected social agents. They counteract the natural "epistemic vigilance" we all feel—the self-protective suspicion toward potentially damaging, deceptive, or inaccurate information (Sperber et al., 2010). Ostensive cues appear to make the child drop their guard and listen and absorb what they have heard. Being recognized in this way makes it more likely that we can trust what we hear—that is, we develop *epistemic trust,* a trust in knowledge. Adults also will respond to feeling recognized, just as little children do. The only difference is that, for an adult, a raised eyebrow or a smile may not be enough. In an adult, these ostensive cues tend to be more signals that indicate to the listener that the communicator "gets" them: recognizes their agency, the possible complexities of their state of mind, and shows validation and support in relation to these states. In essence, the communicator demonstrates through word or action that they are able to view the world from the other's perspective. In a systemic context, it is awareness of the idiosyncrasies of the family (e.g., particular family traditions, known demarcations and boundaries) that can serve as an ostensive cue to the system of the trustworthiness of an individual.

Mentalizing comes into this because understanding someone else's state of mind can in itself, if communicated appropriately, constitute a powerful ostensive cue. Mentalizing has the capacity to generate epistemic trust. If I mentalize someone, I recognize them as an agent. However, in order to establish epistemic trust via this route, I need to be able to mentalize the other well enough for that person to see themselves as accurately mentalized.

As human beings, we have evolved to be able to communicate and to employ dedicated mechanisms of communicative mind reading to enable us to collaborate effectively in productive social systems (Tomasello, 2019). The family is perhaps the most obvious example of the systems that benefit from this remarkable capacity. Of course, it is also the context where the malfunctioning of communicative mind reading becomes most obvious. What we try to do in MIST is to slightly retune this part of the social mind–brain. We do not try to replace bad thoughts with good ones or to generate good feelings in place of bad ones; we simply offer opportunities for communicative mind reading to be restored to its natural state; we try to remove blocks in the way of the spontaneous processes of thinking and feeling.

Getting Started: Mentalization-Guided Systemic Telephone Conversations

Let us return to Mrs. G and Salim.

The therapist asked how urgent Mrs. G felt the issues were and how soon she wanted to have an appointment. She replied, "As soon as possible . . . I could come to the clinic any time to explain more about Salim and his difficulties." The therapist inquired who, in her view, should attend the first appointment and asked her to consider the advantages and disadvantages of bringing her son, as well as the pros and cons of her husband accompanying her. The therapist also encouraged her to contemplate whether there was anyone else who might helpfully attend the first meeting. This was done via gently posing a number of questions:

- "Why do you think it might be more appropriate for you to come on your own?"
- "How might your husband feel if he is not present for the first appointment?"
- "What might be the disadvantages if Salim is there and hears about your worries directly?"
- "What might you not be able to talk about if Salim is in the room—and would this be a good thing or a bad thing?"

Mrs. G patiently answered all the questions put to her, frequently hesitating before replying and prefacing many of her answers with, "I'm not sure," or "I don't really know." The therapist continued, and asked Mrs. G about her preferences regarding where to have the first meeting: in the clinic, the family home, at the health center (as the referral had been made by the general practitioner [GP]), or somewhere else. Where would she feel most comfortable, and where might Salim and her husband like to meet? How might they decide? And would her husband agree with the referral and what Mrs. G had described as the problems—or would he have a different take on it? At the end of the telephone conversation, which lasted approximately 20 minutes, Mrs. G said she would like Salim to attend the first appointment together with both parents. The therapist validated her decision and added that, if after giving the matter further thought or discussing it with family members or friends, she wanted to change the appointment or who was going to attend, this would be fine.

Readers may query the wisdom of a therapist subjecting a potential client to a barrage of questions before the first therapy session. Mentalization-informed systemic work starts the moment a referral is received. In this way, the therapist signals from the outset what might be expected from the therapeutic encounter: the opening up of multiple possibilities and perspectives. In this first encounter the referring person, be that a parent or a professional, is encouraged to mentalize themselves as well as other members of the system, be that the family, the care system around the child, the school, or the child and adolescent mental health service.

But what does that mean in practice?

The questions the therapist put to Salim's mother during the telephone conversation could be described as *interventive* in the sense that the questions aim to help her—and the therapist—to look at issues from more than one perspective. Similar phone conversations can take place with a social worker, teacher, GP, or other professional (though bear in mind that regardless of the source of referral, the preference in mentalization-informed systemic family work is to talk to a family member first before having conversations about the family with professionals).

Systemic therapists tend to consider the context(s) in which the request for help arises. It is helpful to think of doing this at different levels of the system: the level of the individual client, of the referrer, of significant others, as well as the level of the neighborhood and friendship network, their faith-based connections, the schools and work settings family members relate to, the culture or subculture the family belongs to, and the overall sociopolitical context. Bronfenbrenner's (1986) ecological

approach is relevant here. Such multilevel *context reading* allows therapists to consider multilevel interventions. Should they just work with the family? Do they need to include other professionals or the family's own network? How can the family's faith-based or other cultural connections become involved to help with the presenting issues or problems? Does a child or a parent need to be seen individually? When viewed from a systemic perspective, clinicians have plenty of choices, as there are many possible contexts within which the work can be carried out. Mentalizing is not just the product of the dyadic mother–child or the triadic mother–father–child relationship. Rather, it is the product of a social group, a culture that the child experiences as focused more or less on their concerns, fears, and pleasures (Asen, Campbell, & Fonagy, 2019; Fonagy et al., 2019). The global aim of MIST is to enhance mentalizing within the entire wider system. Problems, we claim, arise because mentalizing stops or gets sidetracked, if not derailed, in the family's ecology.

Co-Constructing Therapeutic Contexts

After *context reading* comes *context making*: How can one make relevant therapeutic contexts that provide a response to the request for help? The question for therapists is, "What are the contexts that I need to use—or make—to address the presenting problems and issues?" Context matters! When answering this basic question pragmatically, it is helpful to consider four types of context: person, place, time, and activity (Asen, 2004).

The Person Context

The question of *who* should be concretely present in a meeting or session opens up many possibilities—from children, parents, and members of the wider family to significant others, be they friends, religious figures, or other professionals. In this way, the therapeutic system remains open for new persons to join or others to leave in future sessions. Mentalizing is an intensely interpersonal business. We have to remind ourselves that mentalizing occurs in the space *between* people, where we imagine the reasons for others' actions (or indeed our own) or imagine who we are in someone else's mind. So the person context determines the mentalizing context; feelings and thoughts will alter with the change in context.

The Place Context

There are a number of options for *where* the work is carried out: the clinic, home, school, hospital ward, supermarket, court, mosque, com-

munity center, town hall, and corridors of the court, to name a few. Working with a child and family in a naturalistic setting, a setting where the problem manifests itself concretely, can be more effective than confining all clinical work to sterile offices or other agency-based interview rooms. Instead of sitting-down talking therapy, *walking therapy* may loosen the minds of the clients and therapist. Just as with the who, the where determines the content and shape of the work. Mental states and family dynamics arise in the spaces between places as well as between people. The child's problems at school may be about conflict between the school and the home, so place matters. Feelings and thoughts can be buried in locations. Visiting these locations or choosing not to can both be wise options. But probably the wisest option is to question why certain places are immediately ruled out.

The Time Context

The *when* can be defined in terms of length, frequency, duration, and actual time of the session(s). Therapists of different persuasions tend to create discrete time slots lasting between 45 and 90 minutes, with a set number of sessions (6 or 12) that often take place over a period of 3 months to 1 year. Are there optimal therapy session minutes? Sigmund Freud probably invented the 50-minute hour more for his own convenience of note taking than in order to determine the optimal consultation period. Similarly, the 90-minute session systemic therapists tend to allocate for families may be born out of habit rather than need.

Context can often inform, if not dictate, the duration of sessions. In a pressurized clinical service, it may be realistic to offer 30 minutes per family. Family sessions lasting 10 or 15 minutes may be the appropriate time frame for carrying out family work in a family doctor's office, as this fits the very specific primary care context (Asen, Tomson, Young, & Tomson, 2004). At the other end of the spectrum, we may want to offer more time for multiproblem families when difficulties are chronic. Families are not likely to make the necessary changes if they receive 60-minute sessions at two-week intervals. Here we may have to consider longer interventions. These tend to be undertaken in multifamily settings (Asen, 2002), as it is more economically viable to work with six to eight families over such a time span rather than just with one.

The contextual parameters of timing should be guided by pragmatism. But pragmatism in the interest of what? Here MIST offers what we hope is a clarifying perspective. The pragmatic aim is to optimize the system's capacity to generate mental state understanding, that is, to increasingly see behavior as the expression of underlying beliefs, wishes, needs, desires, and intentions.

The Activity Context

What is actually taking place during the course of therapeutic work? The activities families are involved in can vary a great deal. This context includes, of course, therapeutic conversations or discussions that tend to be word-focused. In our view, manuals often overspecify and try to dictate what is talked about, which can limit mentalizing. MIST uses many playful activities, some of which are nonverbal or paraverbal, such as role plays, sculpting, collages, and exercises. The therapeutic activities are fitted to the presenting issues and may change from session to session.

Why is MIST more playful than many other therapies? It is not out of disrespect for our clients, and it is certainly not to sidestep the severe pain they sometimes bring to our door. MIST brings play into the therapeutic encounter to empower imagination for a deliberate reason: Mentalizing and in particular flexible mentalizing require an imaginative openness. Mentalizing involves imagining the internal states of another human as well as oneself. Some degree of self-awareness is required for this. We have to imagine how we might feel in order to attribute meaning to someone else's actions. So MIST is about shamelessly encouraging imagination, and we could happily call our approach MSTI: Making Systemic Therapy Imaginative.

The contextualizing questions Who? Where? When? and What? need to be asked not only at the beginning of taking on new work, but throughout the whole process of treating a family. By regularly involving individuals and families in this questioning process, it becomes possible to co-construct ever-changing relevant contexts for change, opening up new ways of seeing and experiencing. There are therapists who argue that too much flexibility—too much making and changing of contexts—is confusing to families. Other therapists maintain that too much predictability and routine are antitherapeutic and can kill natural curiosity and spontaneity. From a mentalizing perspective, it is important that therapists, together with their clients, try to think and rethink continuously whether the established *who, when, where,* and *what* contexts are still helpful.

Of course, being reflective is preferable to its opposite. But that is not central here. What is central is the shared or joint attention to a problem or issue that is considered important by all participants. It is the jointness of the process of continuous questioning and shared reevaluation that contributes to healing. It allows for the process of shared collaborative reflection, which is MIST's primary focus. Of course, flexibility also allows for the therapeutic system to remain open, so much so that the composition of who attends sessions can change, as well as

where, when, and for how long sessions take place. Yet it is not flexibility that heals, but the curiosity and surprise that it can bring that actually does the heavy lifting.

Generating a Focus and Considering Therapeutic Interventions

When the G family attended their first session, the primary aim was to create a jointly negotiated and agreed-upon focus for the work. In this case, the therapist opted for a problem-oriented approach, encouraging the family members to list all the worries they had and to specify what they wanted help with.

Session 1

Salim's mother quickly started listing the many different worries she had about her son, while Salim and his father busied themselves with a computer game. She repeated what she had said on the telephone and provided a long list of concerns: Salim's eating issues and anxiety states, his often very demanding behaviors, the lack of friends, hyperactivity, babyish and clinging behavior, temper tantrums, and many other worries. She talked for 10 minutes without any remarks from her husband or child. The therapist noted this process but did not comment on it.

Once Mrs. G had finished, the therapist thanked her and asked the father whether he wanted to add anything else. He said his wife had explained things well, much better than he could, and he added that he was also worried about Salim but less so than the mother. When Salim was asked whether he knew why his parents had brought him to the clinic and whether there was anything that he himself wanted help with, he shrugged his shoulders and then resumed his play. The therapist turned to both parents and asked them which of the issues the mother had mentioned they felt should be tackled first. Salim's father pointed at his wife and said, "Let her decide, she is the boss." The therapist encouraged the parents to discuss together which particular problem to tackle first. The mother replied that the most urgent issue was Salim's "eating problem . . . it takes him 3 hours to eat his lunch and 1½ hours to eat his breakfast. . . . It's driving me mad." The father added, "It would drive me mad, too, but I am out at work all day. I manage a restaurant and that means long hours. My wife has to help Salim eat most of the time." The parents were asked when they wanted to come for an appointment to address the issue. The mother said, "As soon as possible, how about next week!" and the father agreed. The therapist suggested that the next session should take place at lunchtime, with food being supplied by the parents, and that it should last some 3 hours so that the "eating

problem" could be fully studied. After some discussion, the parents decided that only Salim and the mother should attend, as it was almost exclusively she who was engaged in the daily struggles over eating.

During this first session, the therapist immediately noticed specific relationship patterns, such as how the mother played a dominant role and how the father seemed to feel he had to agree with his wife, and observed that Salim was oblivious to the parents' repeated requests to stop playing the computer game. However, the therapist refrained from commenting on these interactions. Instead, he decided to leave open the possibility to return to his observations at a later stage. Why did he not challenge Mrs. G or Mr. G? There is an important technical issue here for MIST. Following the principles of the intervention, the therapist endeavored to place himself in the shoes of all the family members. He considered, if he were Mrs. G, whether any intervention that questioned her behavior would be likely to enhance her capacity for interpersonal understanding. Then he did the same for Mr. G and Salim. In doing so, he became aware of the shame and embarrassment that any or all of them may have felt by attention being drawn to a specific interaction he had observed. It seemed the therapist knew little, and even polite questioning could generate shame or embarrassment, or a feeling of being misread or misunderstood. MIST recognizes that feeling misunderstood or misread is an experience that generates pain. Thus, the stance that is gently curious and is experienced as being open and inquisitive rather than knowing is far more likely to be productive in enhancing reflection.

Session 2: MIST in Action

One week later, Salim and his mother attended for the second session, as agreed. Mrs. G had brought lunch for both Salim and herself. They sat down at a table in a large consulting room. The therapist came in and out of the room at 5- to 10-minute intervals, observing the family briefly and commenting occasionally. He observed that Salim had hardly begun to eat and was chatting with his mother, pleading with her to feed him or stating repeatedly that he was not hungry. The mother responded by telling him that he was a "big boy . . . you can eat yourself . . . you said you were hungry . . . " and repeating these phrases endlessly. Salim continued to behave in ways much younger than his biological age. The mother frequently made encouraging noises and accompanying actions, more befitting a 1-year-old infant than a 6-year-old child. There was a lot of "gootchie gootchie" and small talk, and the mother paid a lot of attention to Salim's not eating. The

therapist eventually asked the mother how, in her opinion, the eating was progressing. She pointed at the full plates and commented that it was "not going very well." She said this was "typical of how it is at home—it takes ages for him to eat anything." The therapist asked the mother whether she felt that Salim was too thin. She replied, "No, he has a normal weight, but he wouldn't if I didn't work so hard to get food into him." When asked to speculate on why Salim was so slow at eating, she was at a loss. The therapist said to the mother: "Maybe you should leave the room and come back when he has eaten his food." The mother looked shocked but left the room together with the therapist. Salim seemed even more shocked; he said: "What?! No!!" and began to scream louder and louder and then banged on the door through which his mother had left. This went on for 2 minutes, with Salim repeatedly screaming, "I'm dying!" Meanwhile, Mrs. G, in an adjoining room, became extremely agitated and began to hyperventilate. She said her son could not bear to be in a room alone and that he would be in a panic.

The therapist went back into the room where Salim was continuing to scream for his mother and said to him: "Your mom will be back when you have eaten some more food." Salim was beside himself and speechless. He made an attempt to swallow some food. The therapist encouraged him to eat a bit more. Salim complied, and as he was eating, he was unable to scream, but he still produced tears. The therapist called the mother to return to the room. She looked emotionally drained, and she immediately went up to Salim to dry his tears, which interrupted his eating. He dropped the spoon and leaned back. His mother continued to fuss over him, wiping his face and taking the spoon out of his hand.

The therapist asked the mother to sit down, away from her son, and watch his eating. Salim started again to put some food in his mouth. The therapist knelt next to him and put his ear playfully on his belly, pretending to listen to the food entering his stomach and exclaiming, in a somewhat silly voice: "Hurrah hurrah, says your tummy, I am happy to have some food down here . . . thank you, thank you." Salim laughed, his mother laughed. The therapist was serious when he turned to the mother: "You know I somehow knew that Salim could cope with being in the room by himself and could eat by himself, with me and even without me. I think he would have been able to eat the whole lunch—and pretty quickly . . . but I was worried about you . . . I was worried that you might crack up next door—I was worried that you might not be able to cope with being out of sight of your little boy, but he is quite a big boy . . . and see how well built he is, these muscles, he is much bigger than perhaps you think he is."

The mother had by this stage calmed down a bit, and, after listening to what the therapist had said, she had a smile on her face. The therapist,

now standing close to Salim, asked the mother to imagine what Salim was feeling and thinking then and there, making a physical gesture of imaginary thought bubbles coming out of the child's head: "If there were thought bubbles coming out of Salim's head, what might be written in there?" She smiled and said: "He is thinking, 'I am not coming back here.'" The therapist checked with Salim whether his mother got it right. He hesitated, then looked at his mother, and he nodded. Therapist: "So will your mummy have to drag you back here?" Salim smiled and shook his head.

The therapist asked again to listen to his "tummy," and Salim clearly enjoyed it when the therapist exclaimed, again in a rather silly voice: "I want more, come on feed me, I am still really really hungry." Salim proceeded to eat at a good pace, with a big smile on his face. When the therapist left the room to attend to another family with "eating problems," Salim turned to his mother and said: "Feed me mommy, if you love me." The mother responded: "Do you think I don't love you? Why do you say that? Why do you say I don't love you?" Salim: "Because you are not feeding me." This went on for a time, with the mother pleading again with Salim to eat. When the therapist reentered the room, he said: "I think—but I may well be wrong—that Salim thinks he needs to behave like a baby to be loved by you. I know he is a clever boy and I bet that he can eat all the food in 10 minutes or less—but as long as you don't think he can, he won't. He probably needs to know that you know he is 6 and not 1 year old." The therapist left the room again and when he returned 10 minutes later, Salim had finished all the food. The mother reported that all she had done was to tell Salim repeatedly that he was 6 years old and not 1. The therapist commented: "You can probably behave older than 6—the way you ate all that food and so quickly, that was so impressive—only older children can do that."

He turned to the mother and said: "Well, we had scheduled 3 hours for this, so there is another 1 hour and 40 minutes left . . . is there something else you'd like to use this time for?" The mother said: "Yes, it's to do with his homework—it always takes him 1 hour or more, and the school says he should do it in 10 minutes . . . but he won't. I need to sit next to him and help . . . and then we end up arguing and I have to do it basically because Salim says it's too difficult to do on his own." Therapist: "Well, why don't you both have a go now, and I'll be back in 1 hour or so." Ten minutes later, Salim came out from the room in search of the therapist. When he found him, Salim said proudly, "I'm finished—and my mom didn't even help me." The therapist asked Salim what he thought she might be feeling. "Proud," he replied. The mother confirmed that Salim was right, and she was then encouraged to speculate about what thoughts and feelings might have been going on in Salim at different stages over the last 2 hours.

EXPLAINING THE SESSION

This session—which was being video recorded—could not be described as a typical example of either purely systemic therapy or purely mentalization-based therapy, as described by Bateman and Fonagy (2016). A range of different techniques were employed, some from behavioral, structural, mentalizing, and other approaches. The therapist's position was central, and he was rather interventive, generating stress in both parent and child. This is why we call the approach MIST: It is essentially a systemic approach with a mentalizing focus.

From a mentalizing perspective, what happened could be described as follows: The therapist observed nonmentalizing interactions between mother and son; he blocked these interactions dramatically by asking the mother to leave the room; this immediately increased the levels of arousal in both mother and child, and their capacity for mentalizing completely shut down; they both were in a state of panic. Once the mother had returned, the therapist tried to help both to regain the capacity to mentalize by engaging Salim in a playful way, using pretend techniques and involving the mother in these interactions. This decreased the arousal of both mother and son, and they gradually regained their ability to think and be aware of feelings. This evident increase in mentalizing capacity then led the therapist to get the mother to speculate about the child's state of mind then and there, trying to explore his actual experience rather than her imagined picture of his mind. He did this because he became acutely aware that the anxiety between mother and son was unbounded, that the anxiety of each resonated with the anxiety of the other and rapidly became uncontrollable for both. As they had said accurately in the first session, they had the capacity to drive each other mad. Meanwhile, the therapist communicated his belief in Salim, including that he was older than he had chosen to act. Salim felt recognized by the therapist and was able to come unstuck, which assisted the mother to view him differently. This led to developmentally more appropriate interactions and communications between them.

Session 3

When Salim and his parents returned 2 weeks later for the third session, they reported that Salim now ate properly and that he was also keeping up with his homework. The mother then explained that she and her husband wanted help "for another big problem—he cannot be in a room on his own, not a minute, not a second." The therapist asked the parents' permission to see Salim on his own. They gave it, and Salim had no difficulty separating from them and following the therapist to another room. The therapist

spoke with Salim about his fears of being on his own and then suggested they play a little game; the therapist would leave Salim in the room for fractions of a second to see how long he could tolerate being alone in a room. Salim suggested 5 seconds. The therapist left the room for precisely 5 seconds and returned. He asked Salim whether 10 seconds was doable and Salim agreed. This was followed by a 15-second absence, and over time it went up to 2 minutes. The therapist then pretended to be a TV reporter and interviewed Salim about what he had thought and felt during each of those absences. Salim spoke directly into the running camera, explaining that he was worried before, but doing it was okay and almost fun. The therapist then handed the camera and microphone to Salim and suggested that he should leave the room for increasingly longer times and then interview the therapist about what he thought and felt in Salim's absence. Salim managed the task well, and both therapist and Salim went back to the room where the parents had been waiting. Salim explained what he had been doing with the therapist over the past 30 minutes, and both parents seemed not to believe him, prompting Salim to say: "You all go out of the room and I will show you." The parents and therapist left the room. In the corridor, the therapist asked each parent to put themselves into Salim's shoes and imagine what he was thinking and feeling while he was alone in the room. When they were reunited with Salim, the therapist asked him what he thought the parents would be thinking and feeling in their absence. Salim was spot on when he imagined that his mother had been full of worries about him, including that he might hurt himself badly in the consulting room or go too close to the window and risk falling out; he thought his father would "not be so worried," and, as to the therapist, Salim said: "Oh, he was not worried, he knows I can do it." The therapist got the family to remember the previous session. As the father had not been present, some of it was shown on a laptop. All three family members watched intently, and when it came to the point when the mother left the room and Salim had screamed that he was dying, he burst out laughing and said, "It's so silly." The mother, with tears in her eyes, was visibly moved. Salim went to her to reassure her and put his arms around her, seemingly in an effort to comfort his mother. The therapist drew attention to this interaction and asked the father: "What do you think is going on in your wife? And what might your son be thinking and feeling right now?" After listening to the father's speculations, he asked the mother to look at the segment of the previous session and reflect on her own feeling state and that of her son.

The behavioral technique of "exposure *in vivo*" is rarely part of a systemic approach, but it is perfectly compatible with a mentalizing one when done for the purpose of enhancing the range of thoughts and

feelings that can be brought to an issue. Here it was employed to provide Salim with a novel experience in a playful manner, with a subsequent use of a prop (video camera and microphone) to focus on the mental states of self and others. Once he had metabolized this experience, Salim also used his newly gained confidence in a playful interaction with his parents. At that point, they started seeing him through different lenses, and correspondingly he came to be aware that they also experienced him as being different. Naturally, this rapidly translated into new ways of seeing himself too. The use of video material from a previous session allowed Salim to look at himself and his parents to look at him from an external perspective: Seemingly unable to mentalize himself and his mother at the time she had left the room 2 weeks earlier, he was now thinking it quite funny. However, the mother's stressful experience was revived even when she had experienced her son's newly gained confidence only minutes before.

The focus of the first session was, by parental consent, the eating problem. The intervention tried to concretely address this issue in order to remove one of the barriers inhibiting mentalizing: the mother's sense of her son being a little baby who needed to be fed by her. During the course of the intervention, the mother gradually saw and experienced both Salim and herself differently. Of equal importance, Salim felt temporarily recognized by the therapist as an agent, a 6-year old boy with a mind of his own, rather than as a helpless baby. Removing this barrier temporarily kick-started effective mentalizing, and it allowed mother and child to move away from an intensive over-preoccupation with feeding.

Once the eating issue had been resolved (temporarily) in the session, the therapist invited the mother to consider working with the next layer—and Salim's difficulty with doing his homework was nominated. This was followed in session 3 by addressing another problem layer—Salim's seeming inability to be in a room by himself. This way of working could be termed the "onion layer" model of working. Preparing an onion for cooking, slicing into and then chopping it, is usually a rather tearful enterprise, so much so that one's vision can become blurred. Similarly, when working with families, getting too quickly into the core—or the "nodal point" (Selvini Palazzoli et al., 1978)—may be theoretically desirable but is usually unwise as an opening gambit: It can generate high levels of arousal among family members. The aim is for the family to be able to return to manageable levels of arousal and resume mentalizing in the stressful context that normal family life can come to represent. Furthermore, parents often say that "we have not come here because we have relationship problems, but because our child has serious problems. It's him and not us you should focus on." It is wise to go with what the

parents believe the most difficult problem is and start there, collaborating *with* them as it were. Only peel the next layer if or when invited by the parents or other significant family members. This way of proceeding is often more acceptable to clients and needs to be done at a pace the family can tolerate in harmony with their increasing capacity for mentalizing. At the opening stages of family work, the therapist carefully monitors the capacity of the family to absorb content that requires mentalizing. Even later on in therapy, during moments of high arousal, the therapist will stop short of explicitly offering accounts of interactions that require mentalizing when it is likely that these cannot be absorbed.

Another session took place some 6 weeks later; only the parents arrived this time. They reported that Salim was functioning "pretty well" now, both in school and at home. On top of this he had made a good friend, and the friend had come to visit him at home; it was a first. The father then said that his wife had always been anxious about Salim—he was a precious child—even before he was born. Three miscarriages had preceded his arrival, and he was gravely ill when born and was in and out of hospital during the first year of his life. "I think my wife still thinks of him as a baby who needs to be watched all the time. . . ." Two parental couple sessions followed.

This is an example of how, step by step, session by session, therapeutic work can get closer and closer to the "nodal point"—with the onion being peeled layer by layer until family members—in this case the mother—are willing and able to address difficult issues that are at the heart of the matter.

CONCLUDING REFLECTIONS

This brief introduction to Salim's family illustrates both the simplicity and the complexity of the MIST approach. Mentalizing is of a moment. It is the current understanding of each agent's mental state. It is therefore rapidly changeable, even ephemeral. Yet it can become rigidly held and is apparently impervious to external influence. Salim's mother's belief that he was a baby in need of being fed by her was exactly such a robust, yet ephemeral, construction—ephemeral in the sense that Mrs. G did not truly believe that Salim was a baby, yet her actions could only be understood as reasonable in the context of that evidently mistaken assumption.

What makes such ephemeral attitudes so tenacious? The nature of mentalizing makes change difficult if there is heightened emotional

arousal. Salim's capacity to generate anxiety in his mother undermined the potential for mature thinking and, from the perspective of her experience, made the fleeting impression feel like an incontrovertible truth. Naturally, being treated like a 1-year-old was not easy for Salim, though he accommodated it rather well. But in so doing, he made himself in all respects dependent on the ministrations of an all-attentive caregiver and resonated powerfully with her feelings of anxiety—as indeed almost all 1-year-olds would be expected to do. The same emotion-driven process that can make ephemeral beliefs concrete was also at work for him—his status as a baby was made quite real for him by his anxiety. The system where poor mentalizing in Salim triggered anxiety and poor mentalizing in his mother, which in turn generated anxiety and even more inadequate mentalizing in Salim, became a system that can only be described as rigid. It certainly did not feel in the least ephemeral to anyone.

Yet, breaking such an ineffective mentalizing cycle is relatively simple. In most average family contexts, resolutions are found every day, spontaneously without professional intervention. Why revealing beliefs to be ephemeral rather than totally compelling can require external intervention in some families and not others is indeed a complex question that we will try to address in this book.

But the complexity of that question should not be mistaken for the sophistication required to address problems of inadequate mentalizing in any particular instance. Attributing even complex family problems to suboptimal mentalizing can liberate the therapist to identify easy, playful, and relatively painless processes that encourage a rapid return to more acceptable patterns of family interaction. The reader might wonder why the simple intervention of listening to Salim's tummy appeared to have been such an appropriate and effective way of tackling this family's problems in relation to Salim's chronic eating difficulties. From a MIST perspective, the answer is that by adopting a playful, slightly humorous stance, the therapist mentalized Salim's tummy (not a part of the body normally regarded as capable of having thoughts and feelings). Yet, creating a mentalizing tummy could encourage Salim to mentalize his mother's excessive anxiety and let her reflect on the realistic concerns she might have in relation to Salim's physical well-being.

Throughout this book, we will consider simple interventions that have tremendous influence merely by reigniting the natural processes constantly available to all of us to modulate affect and stabilize interpersonal interaction.