

Abstract

Mentalization-based therapies (MBTs) are rigorous, theoretically grounded, and evidence-based interventions. However, dissemination of this psychodynamically informed intervention lags behind that of more skills-based therapies because of a lack of concrete operationalization of its key components. In this proof-of-concept paper, we describe how the learning (mediational) components of an educational intervention, the Mediation Intervention for Sensitizing Caregivers (MISC), can operationalize key components of MBTs in behaviorally anchored ways. We suggest that the process of the recovery of mentalizing can be operationalized through five learning components: focusing, affecting, expanding, rewarding, and regulating. In operationalizing the process of rebuilding mentalizing using these observable, behaviorally anchored concepts focusing on creating epistemic trust, we hope to increase the accessibility of MBTs to a wider audience.

Keywords: mentalizing; mentalization-based therapy; mediational intervention; caregivers; psychotherapy

Learning to Mentalize: A Mediational Approach for Caregivers and Therapists

Mentalizing and Mentalization-based Therapies

Mentalizing refers to the capacity to reflect on one's own thoughts and feelings and those of others to predict and understand behavior (Bateman & Fonagy, 2016). The concept has its roots in psychoanalytic literature (Marty & De M'Uzan, 1963), and was incorporated into mainstream neuroscientific and developmental literature in the 1980s and 1990s and social neuroscience in the 2000s. Several clinical applications of the construct have emerged over the past two decades (see Bateman & Fonagy, 2016 for a review). Mentalizing is a transdiagnostic construct, and the enhancement of mentalizing is suggested to be a general characteristic of any good psychotherapy, regardless of the modality, and may be a common factor in positive treatment outcome for all psychotherapies (Fonagy & Allison, 2014).

While different MBTs each have unique features, they all share a definition of mentalizing as a form of imaginative mental activity whereby human behavior is implicitly and automatically perceived in terms of putative mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons) that may account for actions and are sometimes consciously and explicitly reflected on in mental-state terms (Fonagy, Gergely, Jurist, & Target, 2002). While often categorized as psychodynamic, MBTs are integrative, bringing together aspects of psychodynamic, cognitive-behavioral, systemic, and ecological approaches. MBTs are designed to stimulate mentalizing when it is ineffective or lost (Bateman & Fonagy, 2019). Mentalizing is ineffective and likely to be inaccurate when it is dominated by automatic, excessively self-focused, emotion-driven ideas or when it is excessively focused on others, overly cognitive, and reflective in a ruminative manner (Fonagy & Luyten, 2009). Treatment effects are achieved through restoring a balance between the different polarities of mentalizing (automatic versus controlled, self versus other, internal versus external, cognitive versus affective), by the therapist maintaining a "mentalizing stance". Through

the use of this stance, the therapist demonstrates his/her own interest in the mental states underpinning behavior, qualifying his/her own understanding and inferences (showing respect for the opaqueness of mental states) and showing how such information can help the client to make sense of his/her subjective experience. Thus, the MBT therapist will engage with, but is not primarily concerned with, content or narrative. Instead, through focusing on and engaging with mental states underpinning actions, the therapist helps the client to generate multiple perspectives to free the client from one or more non-mentalizing modes, including the teleological mode (physical action is seen as the only way to modify someone else's mental state), pretend mode (the mental world is experienced as decoupled from external reality) and psychic equivalence (a mind-state where the distinction between the contents of the mind and the external world is unclear). With improvement in mentalizing, the client is then able to experience an array of mental states (secondary or symbolic representations) and to recognize them as such (meta-representation).

MBTs have been successful in bringing psychodynamic thinking back into the mainstream, as evidenced by several randomized controlled trials (RCTs) and recognition of MBT as one of the major treatment approaches to BPD in adults and adolescents (Cristea et al., 2017). RCTs have also been conducted for eating disorders (Robinson et al., 2016), comorbid antisocial personality disorder and BPD (Bateman, O'Connell, Lorenzini, Gardner, & Fonagy, 2016) and parenting (e.g. Slade et al., 2019; Suchman et al., 2017). Despite the popularity of the construct of mentalizing and the status of MBT as an evidence-based treatment, acceptance of MBT has been slower than that of cognitive-behavioral approaches, especially true in the United States where there is a stronger emphasis on instructive, directive, and skills-based psychotherapies. The mentalizing construct has been described as “obscure” (Choi-Kain & Gunderson, 2008). Moreover, MBTs have been criticized for being too abstract and relying too heavily on expert supervisors who can translate dense psychodynamically based theory into practice (Hutsebaut, Bales, Busschbach, & Verheul,

2012). Hutsebaut et al. (2012) reported in their implementation study that MBT-trained therapists, after training, felt insufficiently prepared to apply their new knowledge and skills to deal with everyday changing situations in their setting. MBTs include some skills-based learning (e.g. “stop and rewind”, “contrary moves”), and general strategies, such as increasing mentalizing flexibility by shifting discourse across polarities. However, the core of MBT, like most psychodynamic therapies, is non-directive and non-instructional. It is a fundamental part of the theoretical model underpinning MBT that consciously instructing mentalizing will not lead not to sustainable change, but to what is termed “pretend mode”—the use of mental-state language where ideas form no bridge between inner and outer reality and the mental world appears decoupled from external reality (Fonagy et al., 2002). Such pseudomentalizing reflects the dominance of explicit mentalizing without the counterbalance of intuitive and non-focally conscious processes generating belief-desire reasoning (Fonagy & Luyten, 2009). Pretend mode, which often manifests as discourse in which groundless inferences are made about (and from) mental states, is experienced as meaningless, inconsequential, often lacking in affect, ruminative, and circular. For this reason, historically, MBTs eschewed explicit training or teaching of mentalizing, and adopted an implicit behavioral change model that has more to do with promoting “common factors” across psychotherapeutic modalities (Wampold, 2015) and places emphasis on a therapeutically generated hypothetical change in social communication patterns of increased trust across the spectrum of the client’s interpersonal experience (Fonagy & Allison, 2014). As a consequence of this lack of specificity, MBTs may be difficult for novice therapists to learn. Moreover, MBT manuals suggest openness, high cognitive flexibility, intellectual humility, low rigidity, adaptability, and high tolerance of uncertainty as key ingredients of the mentalizing stance, but granular-level, behaviorally anchored guidance is not provided on how to achieve these. Concrete protocols may be needed to reduce therapists’ uncertainty and anxiety.

In partial response to this need, MBTs have begun to incorporate directive elements of psychoeducation to more explicitly teach mentalizing (Bateman et al., 2016; Karterud, 2015) or create a mentalizing culture to instill implicit mentalizing (Karterud, 2015). While useful, the MBT approach remains challenged by the need to provide a formal programmatic framework that is readily and replicable executed by therapists with varying levels of experience. Such a protocol needs to be able to generate genuine mentalizing rather than a pretense of explicit mentalizing, which is voluntarily superficially evidenced by the client in compliance with the therapist's instructions. MBTs must be able to engender a robust strategy for implicitly incorporating mental states spontaneously and effectively in a variety of social actions. In line with this tenet, we grapple with the question of how to teach people to mentalize without *explicitly* teaching them, and without relying heavily on expert supervisors who can translate dense psychodynamically based theory into practice—therefore, learning to “mentalize from the inside out”. Consistent with the ethos of implicit learning, the current paper suggests that effective mentalizing can be taught implicitly without instruction by operationalizing the process, adopting an innovative set of strategies based on concepts of social learning rooted in the work of Lev Vygotsky (1978). We propose a framework based on theory and practice from an intervention developed in educational psychology: the Mediation Intervention for Sensitizing Caregivers (MISC; Klein, 1996). MISC was originally designed to improve children's outcomes by enhancing flexibility of mind and the capacity to learn. As such, MISC is grounded in Feuerstein's (1979) theory of cognitive modifiability and is delivered by operationalizing the components known to open up the capacity to learn. As we will suggest, when the MISC learning (mediational) components are applied in social interaction, the end result is a mentalizing stance that in essence fortuitously ensures the integration of these two independently elaborated approaches. In short, we will advance the argument that this imbrication enables MISC mediational (learning) components to provide granular-level, behaviorally anchored, observable

actions that promote balanced mentalizing, minimizing the risk of pseudomentalizing. We view learning as a common factor of change. However, learning is not typically operationalized in any sophisticated way in psychotherapy. By demonstrating how MISC components can be used to operationalize key elements serving the therapeutic goal of enhancing mentalizing in MBTs, we hope to offer a more practical, yet implicit (as opposed to psychoeducational) approach to teaching mentalizing in a variety of contexts, including mentalization-based therapist training, caregiver interventions, and psychotherapy with clients. We suggest that the MISC paradigm engenders implicit changes in ways of thinking that in turn empowers the capacity to learn in social situations. MISC and MBT share an orientation to increasing receptivity to learning and facilitating cultural transmission (Tennie, Call, & Tomasello, 2009).

We begin by discussing the theoretical and conceptual overlap between MBTs and MISC, both of which are grounded in attachment theory, but both move beyond it into the domain of learning and education. As we will elaborate, social learning is a functional consequence of relationship building; while arguably rooted in attachment the mechanisms involved take the process significantly beyond Bowlby's notion of protection (Bowlby, 1969).

Learning to Mentalize: An Attachment-Based Formulation

Attachment and Parental Mentalizing

Fonagy and colleagues' attachment-based theory of mentalization (Fonagy et al., 2002) offers a coherent framework for understanding the mechanisms by which sensitive caregiving results in positive socioemotional outcomes; or conversely, how suboptimal early caregiving results in negative outcomes. According to mentalizing theory, to achieve positive outcomes, caregivers engage in mentalizing. Thus, in the same way that the MBT therapist mentalizes a client in order to repair mentalization capacity in the client, the parent makes use of mentalizing to instill mentalizing capacity and affect regulation in the child. Parental mentalizing or reflective functioning (RF)

(Fonagy et al., 2002; Slade, 2005) inherently implies an acknowledgment of the child's autonomy at the very instance when it is challenged.

Consider, for instance, an everyday example between a caregiver and child around homework. A mother, arriving tired at home after work, finds her 8-year daughter had not completed her homework as previously agreed upon. The mother puts down her bag, sighs, and looks at her daughter, who is sitting in front of the television watching a favorite show. "What?" says her daughter. Mom responds by saying "You know what." Her daughter appears baffled. Mom sighs again and reminds her daughter in a somewhat exasperated tone that they agreed at school drop-off that the daughter would complete her homework at after-school care. Her daughter explains that she forgot and mom says "Well, that's not good enough. Go sit down now and do your homework while I start dinner. No buts! Now! Go sit down." The daughter becomes distressed and says that she wants to finish her show. Mom becomes more exasperated and says "I don't want to be saddled with your homework after dinner. Do it now! Or no more television for you for the rest of the week." By now, the daughter is crying and runs off to her room.

This example demonstrates a caregiver's challenge in mentalizing her child when her own internal resources are low. When internal resources and assets are limited, it is common for caregivers to take shortcuts, which potentially disregard the child's agentic self (autonomy). In the example, the mother is tired and perhaps emotionally hypersensitive to this issue, and this combination explains why through imbalanced mentalizing (seeing her own but not the child's position), she shows limited reflection and adopts a solution based purely on outcome (teleological mode): the fastest way in which the mother sees the homework problem being solved is by making her daughter sit down to do it. The mother's desire to get the homework done usually comes from a noble source—that is, most mothers have good intentions. She wants her daughter to do well at school because she knows that a good education will facilitate a bright future. Perhaps the mother

did not have similar opportunities growing up. But the intense emotion triggered gives rise to dysregulated catastrophizing automatic thoughts experienced in psychic equivalence mode. The result of the shortcut, however, is a shut-down of mentalizing in teleological mode where only outcomes matter, action replaces thought in mother and daughter alike. This mutual shut-down in turn results in goals not being accomplished (the homework is still not done), the daughter feeling upset and crying, and the mother feeling even more emotionally depleted.

The mentalizing stance provides the mother with an alternative to the shortcut. Balanced, more conscious reflection would enable her to slow down the interaction (Fonagy & Luyten, 2016) and move herself and the daughter to a place where more alternatives are available. In other words, by discerning difficulties with automatic responding, the mother reflects deliberately, to identify where the child is mentally at that moment. This helps the mother to slow down the interaction and treat the child as a conscious agent with thoughts, feelings, needs, and desires different from her own (Sharp & Fonagy, 2008). We believe that through this kind of parental mentalizing that mentalizing capacity, autonomy, and self-regulation are fostered in the child because the child's mind is "minded" (Fonagy et al., 2002). To operationalize mentalizing-in-the-moment, Fonagy and colleagues describe the process of slowing down the interaction through "affect focus", contingent communication/interaction, and the use of ostensive cuing. This is referred to as "affect mirroring." Meaning that the caregiver's ability to respond with contingent, marked, and ostensive affective displays of their own experience in response to their child's subjective experience facilitates the child's development of coherent second-order representations of their subjective experience (Fonagy & Luyten, 2016; Kim, 2015). Caregivers' communications are *marked* when they demonstrate that they understands the child's internal state, while concurrently signaling that their expression concerns the child, not themselves. This is achieved by the caregiver modifying (e.g.,

exaggerating, slowing down) their display of the child's affect, rendering it perceptually distinguishable from her expression of their own affect.

Marking affect also has a communicative function of drawing the child's attention to the caregiver's intent to communicate. In general, this attitude is demonstrated with a type of social cues termed ostensive communicative cues (Csibra & Gergely, 2011), which include making direct eye contact with the child, slightly tilting the head toward the child, speaking with a "motherese" intonation, and calling the child by name. These ostensive cues are understood to manifest the caregiver's pedagogical intention, signaling to the child that the caregiver's expression concerns the child and what is unfolding within him/her (Kim, 2015). In other words, through affect mirroring the caregiver is understood as signaling to the child that she is about to 'teach' him/her something, to communicate information that is relevant and potentially useful in contexts beyond the current one. Over time, through contingently matched affect mirroring that is gradually internalized, the child first develops an awareness of his/her subjective internal state, which sets the stage for increasing self-awareness, increasing control of internal states, and, ultimately, self-regulation. Empirical research across developmental stages, outcomes, and settings supports the importance of parental mentalizing for child socioemotional development (Sharp & Fonagy, 2008).

Epistemic Trust

In a recent extension of this description, Fonagy and colleagues have introduced the construct of epistemic trust (Fonagy & Allison, 2014; Fonagy & Luyten, 2016). This extension is highly relevant to the thesis we propose in this paper, because epistemic trust is understood to foster the child's ability to discern the safety of the social context for learning. Grounded in 30 years of developmental research (e.g. Csibra & Gergely, 2009, 2011; Gergely & Csibra, 2003; Sperber et al., 2010), the mentalizing stance is suggested to facilitate epistemic trust in others. Trust is defined as "an individual's willingness to consider communication conveying the knowledge from someone as

trustworthy, generalizable and relevant to the self' (Fonagy & Luyten, 2016, p. 766). Epistemic trust catalyzes learning. It is a biological signal that conveys that knowledge about to be passed on is reliable since it comes from a trusted source. In an attachment context of background security, an individual will be more likely to learn from their caregiver (Harris & Corriveau, 2011). Epistemic trust contributes to resilience in a child, enabling adaptation to changing environments and protecting the child from the development of psychopathology as he/she matures.

The interdependent processes of attachment, sensitive caregiving, parental mentalizing (affect mirroring), and epistemic trust ensure effective social functioning and openness to social learning. The disruption of these systems is assumed to cascade, with adverse childhood experience undermining both the opportunity to develop mentalizing and the ability to remain flexible in terms of social adaptation, generating vulnerability to automatic thinking and an apparent rigidity in terms of behavior. Thus, limitations of mentalizing capacity create the potential vulnerability for a variety of psychological disorders, in particular those that involve pathology of the self and interpersonal relatedness (for reviews see Sharp, Fonagy, & Goodyer, 2008; Sharp & Venta, 2012). Of these, and in the context of the original development of MBT, BPD is seen as the paradigmatic disorder. Indeed, over a decade of empirical research demonstrates mentalizing impairment in BPD (Fonagy & Luyten, 2009, 2016; Jeung & Herpertz, 2014; Sharp, 2014; Luyten, Campbell, Allison, & Fonagy, in press). Mentalization-based theory and empirical work suggest that attachment trauma, whether real or perceived, obliterates epistemic trust, closing off the most important channel for receiving self-relevant information about the world. It stifles learning about the mind, depriving the individual of the "felt security of knowing" about the self, others, and the world. The result is an impoverished agentive self and a personality structure that is unstable and vulnerable to external events. In the absence of a solid center that can flexibly respond to the environment, the individual with BPD rigidly holds on to the same response, irrespective of a changing context. Rigid

inflexibility in responding and adapting alternative positions in response to a changing context has been identified by most theories of personality and personality pathology as central to the definition of personality disorder (Beck, Freeman, & Davis, 2004; Kernberg, 1984; Luyten & Blatt, 2011; Rogers, 1961), and can be seen as a failure to appropriately and flexibly respond to new information (Fonagy et al., 2015), akin to Bayesian updating. In life, there are few things as unpredictable as our interpersonal interactions, which rely on a myriad of stochastic variables acting together. For the individual with BPD, updating of information does not take place as new information flows into the system, because “epistemic freezing” (Kruglanski & Webster, 1996) or “epistemic petrification” (Fonagy et al., 2015) has occurred. The individual does not know who to trust and closes him/herself to socioemotional learning, leading to feelings of intense abandonment and aloneness.

Clearly, there is much to be gained from mentalizing and instilling epistemic trust. The extension of MBT theory to include epistemic trust not only makes BPD (and other attachment-related disorders) partly a disorder of impaired social learning, but it puts learning front and center in understanding mentalizing. In this proof-of-concept paper, we capitalize on this new development to introduce an approach to learning (a mediational approach) that extends these concepts by describing the learning environment that has been empirically shown to increase the potential for learning in vulnerable populations. This extension of MBT theory and practice achieves two important outcomes: (1) it demonstrates the value of the mentalizing-based theory conceptualization of learning by showing its ability to explain the effectiveness of an important intervention program; (2) through creating this bridge, an integrated framework is created for applying these principles of learning not only to the clinical practice of MBT, but also to the training of MBT therapists. In particular, as we will show, MISC elaborates ostensive cuing, epistemic trust, and mentalized affectivity (Jurist, 2005), by operationalizing, refining, and defining the components of interactions that facilitate learning.

Before introducing MISC, we wish to point out again that the attachment origins of mentalizing and the therapeutic process of MBT are inextricably linked, making MBT at its core developmental (Fonagy & Luyten, 2009). Just as the caregiver mentalizes the child to promote mentalizing and build epistemic trust and resilience, so does the MBT therapist with the client, and so does the MBT supervisor with a trainee. We highlight this point to suggest that the MISC model can be used to promote mentalizing across various agents engaged in mentalizing.

Learning to Mentalize: A Mediational Approach

Earlier, we pointed out the challenges in helping caregivers and therapists effortfully develop a mentalizing stance. Like most attachment-based interventions or other psychodynamic approaches, the affective/emotional components of MBT are well articulated. However, while such approaches are assumed to instil epistemic trust and open up to social learning, the putative learning processes and strategies are not articulated in a detailed way, at least not as espoused by any theory of learning. Moreover, while the goal of a mentalizing stance has been described, progress toward it is less comprehensively operationalized, which makes it hard for parents, therapists and trainers to know “how to learn mentalize”. Central to our current argument, the mechanism of action of MBT can be explicated only in very general terms and the mechanisms whereby therapeutic gain is achieved remain, as is often the case (Kazdin, 2007), unexplored. Indeed, tools to assess mentalizing such as the Reflective Functioning Scale (Fonagy et al., 1998), and parental mentalizing tools such as the Parent Development Interview (Aber, Slade, Berger, Bresgi, & Kaplan, 1985) tap into *representations* of relationships with attachment figures, and not behaviorally anchored interactive processes of mentalizing in the here-and-now. Behavioral measures such as maternal mind-mindedness (Meins, Fernyhough, Fradley, & Tuckey, 2001), while well operationalized, cover only selected aspects of a mentalizing stance (frequency of mental-state language and synchrony). Other gold-standard measures of mentalizing capacity such as the Movie

for the Assessment of Social Cognition (MASC; Dziobek et al., 2006) may be ecologically valid, but are not self-relevant and assess mentalizing capacity more globally.

In general, these measures of mentalizing fail to capture the working mechanisms of therapies and cannot establish that a mediator is indeed a causal factor in the recovery process. The measures are unable to show a temporal and/or a dose–response relationship between mentalizing and an outcome and evidence a strong theoretical framework (Cuijpers, Reijnders, & Huibers, 2019). In this regard, there has been a recent interest in developing tools for assessing RF as it occurs in real time (Horz-Sagstetter, Mertens, Isphording, Buchheim, & Taubner, 2015; Josephs, Anderson, Bernard, Fitzer, & Streich, 2004; Karlsson & Kermott, 2006; Moller, Karlgren, Sandell, Falkenstrom, & Philips, 2017; Talia, Miller-Bottomo, & Daniel, 2017; Karterud, 2015, Karterud et al., 2013; Ensink et al., 2013; Suchman, Rosenberger, & DeCoste, 2010; Oppenheim, Koren-Karie, & Sagi, 2001). While these tools attempt to operationalize mentalizing in interactional contexts in global terms, they fall short of stepping outside the narrative frame and fail to provide a granular breakdown charting the process steps toward (re-) establishing mentalizing. We propose here that adopting the framework empirically elaborated in MISC (Klein, 1996) will provide a significant step in delineating the MBT therapeutic process with greater precision. MISC and its associated assessment tool, which offers a frame-by-frame coding system of behavioral interactions, provide exactly the granular level of assessment and intervention guidance that has been absent from MBT, and allow the elaboration of a behaviorally anchored and clearly defined set of mechanisms motivating the intervention as they occur in the here-and-now interaction between two people.

Background to MISC

The MISC manual was first published about 20 years ago by Klein (1996) as a semi-structured, video-feedback educational intervention specifically geared toward low-resource

environments. Figure 1 provides a visual representation of MISC's conceptual framework and may be helpful in interpreting the discussion of MISC that follows below.

Figure 1

The acronym MISC stands for both the process and the objective of the intervention. The objective of the intervention is to help children become More Intelligent and Sensitive (Socially Competent) Children (MISC). Klein's definition of sensitivity is auspiciously aligned with a conceptualization of mentalizing as the ability to understand one's own and others' emotions and respond in a way that will promote one's own well-being and that of others. The process through which this objective is achieved is also represented by the same acronym MISC – that is, caregivers mediating the subjective experience of children. MISC was designed to clarify the process that generates immediate learning experiences for the child. MISC elaborates at a granular level the characteristics that result in the “literacy of interaction”.

The starting point for the development of MISC was Klein's observation that, notwithstanding considerable differences between cultures regarding what is perceived as the “ideal child” or the “good parent”, flexibility of mind and capacity to learn from experience are relevant to and evident in all contexts. Klein identified the caregiver as pivotal in creating a predisposition for learning (Klein, 1996; Klein, 2001; Klein & Rye, 2004; Klein, Wieder, & Greenspan, 1987). The caregiver has the role of the “mediator” who is responsible for the transmission of cultural knowledge. Klein, Shohet, and Givon (2017) argue that while this provides a relatively robust basis for social learning, as the role can be taken on seamlessly by many in caregiving roles, there are settings where lives have been disrupted by economic and social conditions that dramatically impact on this fundamental aspect of childrearing practice, e.g. urbanization, mothers joining the workforce, thereby increasing their workload and stress, globalization, the breakdown of extended family structures, family mobility, war, poverty, natural disasters, the growing rate of divorce and

single-parent households, and acculturative stress associated with migration. While the parent–child affectionate bond may be unaffected by such social changes, they may deplete the internal assets of parents and catapult them into taking shortcuts, as described earlier. Parents almost invariably want the best for their children, but Klein points out that the wish motivated mostly by love is not enough; or, even more parsimoniously, “attachment is not enough”. As Klein (1996, p. 5) cogently put it: “In a way, one can say that the affectionate bond between a child and her caregiver opens the gate to the child’s mental development, but does not, in itself, determine what will pass through the gate.”

Klein acknowledged that attachment-based caregiving behavior, such as attentiveness, warmth, responsivity, and non-restrictiveness, are important, and that certain parenting behaviors (i.e., patterns of facial expressions and affect mirroring as discussed earlier) during face-to-face interaction may be critical in supporting children’s social development. But she pointed out that none of these characteristics define the necessary and sufficient conditions inherent in an adult–child interaction for that interaction, regardless of its content, to be considered a mediated learning experience (MLE) for the child. For this to be defined, Klein used Feuerstein’s theory of cognitive modifiability and MLE (Feuerstein, 1979, 1981). Mediated learning, to be distinguished from direct learning through the senses, occurs when the environment is interpreted for the child by an adult who understands the child’s needs, interests, and capacities and is able to intentionally and proactively align for the child components of that environment along with past and future experiences (Klein & Rye, 2004, p. 345). Klein et al. (1987) described an MLE as a universal phenomenon, which developmentally begins with interactions on a preverbal level and is not restricted to any modality, language, or content. As a child matures, MLE becomes increasingly verbal, and enables a child to benefit from experiences that he or she has not perceived directly, but can only perceive because an adult mediates them. The transmission of the past is made possible

this way, and the awareness of the past and mediated anticipation of the future enables the child to expand his or her understanding of time and space. A child who receives MLE acquires a need for more mediation, that is, a need for events or objects to be meaningfully related to other events and contexts, a need to search for connections beyond the information provided by the senses at any given moment. Klein suggests that MLE prepares the individual to be changed through future direct exposure to stimuli and supports the acquisition of basic structures that will optimize opportunities for future learning.

So how is an MLE specified in behavioral terms? An adult–child interaction is an MLE if it is intentional and reciprocal, if it transcends the satisfaction of an immediate need, and if it is focused on conveying meaning. In contrast, Feuerstein’s (1979, 1981) describes limitations to modifiability (learning) as manifested in a series of restrictions on processing information, including a lack of systematic ways of obtaining accurate information through the senses, sweeping exploration (with no appropriate focus on stimuli resulting in a blurred perception), lack of recognition of a need for precision, inappropriate use of temporal and spatial dimensions, lack of perception and projection of sequences, lack of spontaneous comparative behavior, and lack of recognition of a need for logical evidence. As opposed to “stimulating” a child, in MISC, parental objectives of mediating the world to the child are achieved through the process of matching what they intend to mediate to the child with the child’s response. In other words, it is the child’s response that regulates the caregiver response, and vice versa. To this end, the caregiver must read the child’s intentions, needs, and preferences. The caregiver is then able, through mediation, to organize the complex world for the child so the world has meaning, importance, and relevance to past and future experiences. As outlined here, the process of adequate mediation entails the process of effective mentalizing.

MISC Learning (Mediational) Components: Operationalizing Mentalizing in the Here-and-Now

The overlap with the concept of mentalizing is clear. MISC, however, extends prior conceptualizations of mentalizing by describing concrete, behaviorally operationalized learning (mediational) components within adult–child interactions that helps the caregiver to “read” the child. The basic observational measure used in the MISC model is Observing Mediational Interaction (OMI; Klein, 2014). The OMI makes use of real-life video recordings of the caregiver–child interactions that are the focus of the intervention, and codes blow-by-blow events and utterances as they occur, thereby allowing a profile of positive, sensitive, and responsive interactions, as well negative and unresponsive interactions, to be summarized quantitatively and visually through graphs. The original validation study of the OMI was conducted by Klein et al. (1987) in a sample of mother–child dyads across varying age ranges (50% boys), and demonstrated good interrater reliability and criterion validity through cross-sectional and prospective relations with child outcomes. In addition, caregiver behavior rated using the MISC components was found to be relatively stable over a 4-year follow-up.

The OMI codes two types of components known to enhance learning: emotional components and learning (mediational) components. Emotional components (akin to affective mentalizing and evident in most attachment-based or psychodynamic therapy approaches) include eye contact, smiles, vocalization, touch, physical closeness, turn-taking, sharing of joy, expression of positive affect, synchrony, length of communication chains, and excitement expressed toward things, people and experiences in the environment. The basic messages communicated through the emotional components are “I love you,” “I’m with you,” and “It’s worthwhile to act,” in addition to “I have time for you,” “I enjoy being with you,” and “I am proud of you.”

However, as mentioned earlier, the emotional components are necessary but not sufficient for learning (love/attachment is not enough). For learning to take place, the learning (mediational) components are necessary. These are (Klein, 1996): (1) *Focusing (Intentionality and reciprocity)*: Any adult act or sequence of acts that is directed toward achieving a change in the child's perception, or response (e.g., "Look! Do you see the large butterfly?!"). Through focusing, the caregiver is communicating intention to teach. (2) *Affecting/Exciting (Providing meaning)*: Through provision of meaning, the adult names, describes, and gives meaning (without interpretation) to the child's experience. In its simplest form, this means that the adult just describes the experience of the child ("This is an apple"). However, in order to create an experience of mediated sharing, the use of affect is key. The adult can use affect through nonverbal expressions of meaning (e.g., facial expressions of delight), and/or verbal expressions of meaning ("Wow! This is a beautiful butterfly!"). The adult must excite the child about the learning experience that lies ahead. (3) *Expanding (Transcendence)*: An adult's behavior directed toward broadening of the child's cognitive awareness beyond that which is necessary to satisfy the immediate need that triggered the interaction. The adult extends the child's understanding of what is in front of him/her by explaining, clarifying, comparing, or adding new experiences that go beyond the immediate interaction. This MISC component is crucial to learning because it is in going beyond the immediate. This is the metacognitive component of MISC and is referred to as "stretching" the child. It includes clarifying ("Look at the dark clouds, they are heavy with water, it will rain soon"), connecting experiences in the present with those experienced in the past ("Yesterday when we visited Julie, we saw a similar dog"), or the future ("Save the seeds; we can use them to feed the birds tomorrow when we go the farm"), comparing objects ("These two are the same size, but this one is heavier because it is metal and metal is heavy"), and general rules ("This flower blooms in the spring only"). (4) *Rewarding (Mediated feelings of competence)*: Any verbal or nonverbal behavior of an adult that expresses

satisfaction with a child's behavior or identifies specific components of the child's behavior that the adult considers successful, without explanation ("Good") or with explanation ("Very good; you put all the blocks in the box"). Through the process of rewarding, children learn to reflect on how to how to achieve success and, in time, will generalize this autonomously to new problems. (5)

Regulating behavior (Helping the child to plan before acting). The caregiver brings to the child's awareness the possibility of "thinking" before doing, of planning steps of behavior toward attaining a goal. By modelling, demonstrating, or scheduling objects or events in time and space, the adult introduces a pattern (plan) of activities for the child, thereby regulating the pace and reducing the child's impulsiveness in perception, elaboration, and expression (e.g. "It is hot; let it cool first before you put it in your mouth").

Let us now "MISC" the earlier "homework" example presented earlier: A mother, arriving tired at home after a full day of work, finds that her 8-year-old daughter had not completed her homework as previously agreed upon. She finds her daughter sitting on the couch watching a favorite TV show. She quietly sits down next to her daughter, takes the remote control, and says: "Sarah, can I pause your show for a moment, as I have something important to talk you about?" (*Focusing*). Her daughter says "Yes" and turns to her mom. Her mom, making eye contact, says "I can see you are busy watching your favorite show, but I realize that your homework is still not done and I've been looking forward to reviewing it with you (*Focusing/Affecting*). What about we look at it together to see what still needs to be done and then we can decide how to fit it all in around dinner?" (*Regulating*). Sarah agrees (partly because her show has not been completely switched off and she is agreeing to come up with a plan to get the homework done and not necessarily having to do the homework right now). "Ah!" says her mom (*Affecting*). "Look at this!" (*Focusing*). Your teacher has asked you to do more exercises in fractions (*Affecting—providing meaning*). What do you think about that?" Sarah then says that it's easy to do that. Her mom says "You want to show

me how you do it?” (*Focusing*). By now, Sarah is excited about showing her mom how fractions work, and she begins to work on her homework. After the first problem is completed, her mom says “Excellent work—I like how you first think through the problem and then write down your answer” (*Reward with explanation*). Sarah smiles and starts on the next problem. Her mom then says: “It’s close to dinner time; do you want to continue on with the fractions while I make dinner and then watch your show after dinner? Or do you want to wait until after dinner to do your homework?” (*Regulating*). Because Sarah is excited by the positive feedback and the thought of completing her homework, she elects to carry on with her homework while her mom cooks dinner.

It is clear that the five MISC components capture the spirit of the mentalizing stance. But MISC also extends and elaborates the mentalizing stance in a very practical way. First, it operationalizes the use of affect in MBT (mentalized affectivity; Jurist, 2005) by defining the emotional components that underlie the learning (mediational) components. Then, by behaviorally describing the mediational components of focusing, affecting, expanding, rewarding, and regulating, it is possible to operationalize the process (actions) of integrating cognition and affect, and instilling epistemic trust. We see the steps by which the caregiver *slows down* the interaction. Focusing, in particular, helps the caregiver recover her mentalizing through modulating his/her own emotions, because in order to focus the child, the caregiver has to also focus him/herself. We see the expression of the caregiver’s benevolent intent in communicating the intention to teach. We see mentalized affectivity in matching this intent with the child’s response in a continued attempt to create meaning in experience for the child. By creating meaning through mediation, rewarding learning, and helping to regulate behavior, provided that there is moment-by-moment matching, the caregiver is by default treating the child as a psychological agent. The caregiver is acknowledging the child’s agentive self as a fully contributing partner in the interaction. The caregiver is mentalizing.

Earlier, we emphasized that this paper concerns mentalizing not only by the caregiver of the child, but also by the therapist of the client, and the MBT supervisor to the trainee. For illustrative purposes, we now provide an example of how MISC's learning (mediational) components can be utilized in the context of an MBT psychotherapy session with a client with BPD who is expressing fears of abandonment.

Client: I'm just so frustrated! I'm not sure how to deal with this anymore. It is driving me nuts and I'm about to just give up! It's always the same. I can't take it anymore. I'm just...

Therapist: Hang on there, Sara. Can you slow down for a moment? I can see this is really important for you, but I have trouble keeping up. (*Focusing*)

Client: OK. Sorry. I was going too fast. Let me walk you through it again. As I said, Jack phoned me yesterday. I've told him a million times not to do that to me. Like that time last week...

Therapist: Hang on a second (*Focusing*). Let me get a clear picture in my mind. You were home and Jack called? (*Request for meaning*).

Client: Yes, he called.

Therapist: And something he said made you feel frustrated? (*Request for meaning*)

Client: Yes, he said he can't see me on Saturday. We've planned this for weeks and now I'm so angry because he always does this to me and I'm sick of it.

Therapist: Let's just stay for a moment with the phone call—I'm still trying to get a clear picture in my mind—is that alright? (*Focusing*). Sounds like you planned something important for Saturday night and Jack cancelled on you? (*Request for meaning*).

In this example the client is quite dysregulated and the therapist cannot get beyond *Focusing* and *Provision of meaning*. For the sake of illustration, we can jump to later in the session, once the client is a bit more regulated, to demonstrate other MISC mediational components:

Therapist: So if I get his right, you planned a party to introduce Jack to your friends. This is the fourth time you've tried to do this and he keeps cancelling on you (*Provision of meaning*).

Client: Yes!

Therapist: I can totally see how this might be frustrating (*Rewarding and Provision of meaning*). I would be frustrated too (*Expansion*). But I'm also thinking if I were in your situation, I might have felt a bit hurt? (*Request for expansion*).

Client: I do actually.

Therapist: And what do you think that might be about? (*Request for expansion*)

Client: It's like he doesn't want to acknowledge me in public as his girlfriend.

Therapist: Do you think that is what he might be thinking? (*Request for expansion*)

Client: Yes...

Therapist: Is that something he said in the past? (*Request for expansion*)

Client: No, he has not said that in so many words... but I know it's true!

Therapist: Can you tell me more about that... you sound very certain of it? (*Request for expansion*).

We can also imagine statements later on in the session, where the therapist might be saying "Wow, Sara, you worked hard today in making sense of all this" (*Rewarding*) or "So let me get this straight—what sometimes happen is that you think Jack is thinking some things, but that you don't always know for sure, and that those are the times you need to slow down and investigate first... is that right?" (*Regulating*).

While this excerpt is from an MBT session, we hope to convey that the OMI can identify granular-level actions taken by the therapist to facilitate mentalizing. In MBT terms we may have described the therapist as elaborating affect, validating affect, and so on. While the OMI has to be formally validated in this regard, we are suggesting that MISC enables the achievement of MBT

goals by focusing, affecting/meaning, expanding, regulating, and rewarding. Therefore, in MBT training it becomes possible to describe to a trainee the tacit behaviors that facilitate the elaboration of affect and so forth. It is also possible to describe the tacit behaviors that slow down the interaction. Anecdotally, we have found in our MISC work with uneducated lay caregivers of orphans in community-based organizations in South Africa that they can keep these five components in mind when they interact with children. In contrast, we have found that novice therapists struggle to keep in mind more abstract goals, such as “stay with the affect,” “elaborate the affect,” “mentalize the client,” “move the client to view the situation from a different perspective,” and so on.

As part of achieving integration between MISC and MBT we could consider tentatively linking specific OMI codes to specific facets of MBTs. (1) Focusing (Intentionality and reciprocity) serves to activate agency in the patient experiencing uniquely external causation of their internal states. (2) Affecting/Exciting (Providing meaning) reinforces mentalized affectivity and thus engages with and counteracts pretend mode potentially engendering curiosity about mental states. (3) Expanding (Transcendence) directly challenges and potentially can overcome psychic equivalence. (4) Rewarding (Mediated feelings of competence) has been described in MBTs as judicious praise and entails taking the perspective of the patient (validation) which in MBT must precede clarification. (5) Regulating behavior (planning/reflecting before acting) is denoting the process of presenting alternative perspectives. Clearly, systematic study of videotaped therapeutic interactions will be required to establish a reliable and valid coding system.

MISC Intervention: Teaching to Mentalize

MISC Evidence Base

Correlational evidence for MISC. Empirical data (Klein, 1984, 1991; Klein & Alony, 1993; Klein, Nir-Gal, & Darom, 2000; Klein et al., 1987) suggest that specific characteristics of

adult interactions with children constitute mediational behavior and may affect children's predisposition to learn from new experiences. Based on this research, the mediational (learning/teaching behaviors) components of learning that form the foundation of MISC (focusing, providing meaning, expanding, regulating, and reward) were empirically defined (Klein, 1996; Klein & Alony, 1993; Tzuriel, 1999) and are considered as basic determinants of quality mediation to young children. Support for these components was derived in a study that demonstrated that the factors of quality mediation in infancy predicted cognitive outcome measures at 4 years of age better than the children's own cognitive test scores or other presage variables related to pregnancy and birth histories and to mothers; education (Klein et al., 1987). Similar findings were reported for low socioeconomic status (SES) American (Klein et al., 1987) and Israeli (Klein, 1984) mother–infant samples. A more recent study on social mediation (Shuper Engelhard, Klein, & Yablon, 2013) found that providing children with a reason or an explanation regarding behavior in social situations (“regulation of behavior”) was significantly related to prosocial behavior at home and in daycare. This study also found that when mothers or caregivers expressed negative and critical attitudes toward the children's social behavior, or when they frequently commanded their children to do something without explaining why, higher frequencies of aggressive behavior were noted in the interactions of these children with other adults or children. In addition, more encouragement of positive social relations resulted in more prosocial adaptive behavior and less violent behavior.

Studies that address the causal effects of MISC. Five RCTs support the effectiveness of MISC. The first was conducted in 68 mother–infant dyads of a low-SES, urban, high-crime-rate community in Israel. Results after study completion and up to 6 years later showed increased and sustained maternal mediation, in addition to positive child outcomes—specifically cognitive outcomes as assessed through standard cognitive assessment tools. Similar results were demonstrated in an RCT with 120 rural Ugandan child–caregiver dyads with HIV/AIDS (Boivin et

al., 2013a); and an RCT of 119 uninfected HIV-exposed children and their caregivers (Boivin et al., 2013b). These results were then replicated in larger RCTs of HIV-exposed but uninfected (Boivin et al., 2017) and HIV/AIDS-affected (Bass et al., 2017) children in Uganda. Recently, a quasi-experimental trial to evaluate the effect of MISC in children orphaned by HIV/AIDS in South Africa has been completed (Sharp et al., in prep). Similar to previous RCTs, increases in mediational behaviors as well as improvements in child outcomes were found.

Structure of the Intervention

Consistent with psychodynamic orientations' implicit behavioral change model, MISC does not begin by "teaching" emotional or mediational components in any explicit way to a caregiver. Work with the caregiver (referred to as "training") is carried out in three basic modes. These modes are complementary, each scaffolding the effects of the others by providing three modes of experiential learning. The first mode is through individual video guidance, during which the MISC trainer and caregiver reflect on the thoughts and feelings that the caregiver experienced during the interaction. The MISC trainer emphasizes two or three mediational behaviors and conceptualizes them in terms of the MISC components to which they relate. For example: "I want to show you something nice you did with the child... You see, here you looked at the child and smiled. What do you think made the child smile?" Here, we suggest that when using the MISC components for training, the MISC trainer is in essence helping the caregiver to mentalize the child and connecting the caregiver's actions with the best interests of the child. In subsequent sessions, the trainer continues to work with the same video until the footage has been completely analyzed. The trainer continues to invite the caregiver to comment and reflect on his/her behavior.

Once trust (and specifically epistemic trust) has been established in the trainer-caregiver relationship, the trainer presents the caregiver with two or three behaviors that are identified as a potential for scaffolding and which the trainer would like to enhance. These teaching behaviors are

defined by the MISC components and are explained to the caregiver in terms of the positive effect of the desirable behaviors on child development. For example, “I would like to share with you some parts of the video that I have observed and that I have questions about. We will observe them together and will share our thoughts regarding certain behaviors.” After the identified part of the video has been shown: “Can you see this little boy’s behavior? What do you think he was trying to signal? Did you pay attention to it while you were interacting with him/or the group?” Or, “Here you said to the child... Do you think that you could expand on it? What else could you say?”

Through this iterative process of shared reflection on the interactions between caregiver and MISC trainer, the caregiver’s own reflective capacity begins to increase. The caregiver starts to “stop to think and reflect” on his/her behavior, thereby increasing his/her mentalizing capacity in the context of the relationship with the child without having been explicitly instructed to do so. At the end of a session, the session is summarized by the MISC trainer asking the caregiver whether it was a learning experience for him/her, and, if so, what he/she learned. The caregiver is reminded of the main ideas and/or concepts that were presented during the session. Learning therefore stays front and central in MISC. The MISC trainer is using MISC principles to create an MLE for the caregiver, just as the caregiver uses MISC principles to create MLEs for the child. Similarly, in supervising the MISC trainer, the MISC supervisor creates an MLE for the MISC trainer through shared reflection.

The second mode of teaching MISC to caregivers is through “in-service training”, which takes place during everyday interactions between the caregiver and the child, in real time. The MISC trainer, who is present during the interaction, identifies teachable moments where the trainer can help the caregiver implement in the “here and now” concepts and ideas that were discussed during video guidance, and so enhance the quality of the interaction.

The third and final mode of training consists of group meetings to establish a professional learning group of caregivers, during which caregivers have the opportunity for sharing and elaborating on issues related to everyday typical experiences, and especially on the MISC model. This mode of training consolidates the caregivers' learning by expanding their individual experiences with their peers; experience; this helps them realize that there are individual differences among children and caregivers, to which the MISC components should be adjusted.

The overlap between MISC training and psychodynamically informed psychotherapy and psychotherapy training is clear. Both adhere to the notion that sustained change is likely when a trainee (or client) implicitly discovers needed change. As opposed to more instructional skills-based approaches, implicit change involves facilitating reflective capacity so that the client may discover a solution or answer independently. In MISC, as in MBT, the trainee (client) learns to mentalize by being mentalized themselves. More broadly, an underpinning assumption for much psychotherapeutic work with both adults and children is the importance of being able to see things from the client's perspective, and to convey that the client's point of view and ambitions are being recognized in this way (Horvath, Del Re, Flückiger, & Symonds, 2011; Wampold & Imel, 2015). While we wholeheartedly agree with this view, from a mechanistic perspective such assertions lack both robust empirical evidence and a strong theoretical framework (Cuijpers et al., 2019), which we believe MISC can provide.

MISC as a 'Royal Road' to Epistemic Trust in MBT

Why do we recommend MISC as an additional component to a therapy that already has a reasonable evidence base? We suggest that MISC, with its emphasis on the learning experiences it generates—which reaches back to Vygotsky's (1978) theory of mediation—offers MBT a critical set of specific methods to optimize communication between the therapist and client in the interest of establishing the therapeutic situation as a learning experience that requires the generation of

epistemic trust. MISC is implicitly focused on establishing the communicator (caregiver) as reputable and obliges the communicator to regard the interaction partner as a similarly valid, competent, and interesting agent, which opens a collaborative teaching–learning relationship between the two parties. In this section, we will seek to explain how MISC works to establish epistemic trust in a particularly salutogenic way (Antonovsky, 1987). We will briefly attempt to explain here why the learning conditions that Klein (1996) describes may be of such significance for the stimulation of epistemic trust by reference to recent theoretical and experimental developments in the domain of child development.

The starting point for our thinking is the idea that children are highly primed to learn from their elders, *in certain conditions*, as articulated in Csibra and Gergely's (2009) theory of natural pedagogy. Experimentally, humans' sensitivity to cues that signal a safe context for social learning, so-called *ostensive cues*, have been shown to be present even in preverbal infants (Csibra, 2010; Tauzin & Gergely, 2019; Vouloumanos & Waxman, 2014). However, while juveniles are evolutionarily disposed to learn in this way, elders do not necessarily have *carte blanche* when it comes to their accounts about the world and how it works: juveniles are also primed to be vigilant about whether or not it is advisable to learn from these elders. This capacity to discriminate (on the basis of the quality of ostensive cuing) about the reliability of communicators is an adaptive response to the very human reality that while people can be highly cooperative and supportive, they can also be unreliable, unhelpful, or actively ill-intentioned (Sperber et al., 2010). In a similar vein, it has been argued that reason is primarily social, that the function of logic and reason is to enable individuals to cooperate, negotiate, and agree social terms with others. Recent developmental research has started to reveal that even very young children are far more discerning than traditionally appreciated, in terms of evaluating the reliability of informants (Fusaro, Corriveau, & Harris, 2011) and the related issue of how children perceive they are evaluated as agentive

collaborators (Botto & Rochat, 2019). There is further significant evidence for the nature of social learning based on joint intentionality and mentalizing in humans, and that the quality of the relationship of a child to a communicator determines in large part the extent to which the child will acquire and generalize information from that communicator (Lane & Harris, 2015; Mascaro & Sperber, 2009; Shafto, Eaves, Navarro, & Perfors, 2012). This emphasis on the significance of reputation within interpersonal processes is in keeping with recent work exploring the inherently social nature and socially driven nature of higher order cognitive processes. We have suggested that the importance of mentalizing in achieving therapeutic goals may rest in enhancing therapeutic communication and generating epistemic trust in the therapist which could generalise to other social contexts reversing the experience of “epistemic petrification.”

MISC offers an interactive social language (the “literacy of interaction”) to establish reliability in this communicative process of knowledge exchange through generating joint attention (Liszkowski, Carpenter, Henning, Striano, & Tomasello, 2004). It achieves this through supporting *focusing*; by judicious use of *encouragement* addressing the child’s reputational concerns arising from evaluative audience perception (Botto & Rochat, 2019); through *expanding* a child’s cognitive awareness, taking it beyond the child’s immediate perspective (Tomasello, 2018); through *affecting/exciting*, creating shared positive emotion around shared objects of interest (Bennett, Larkin, Pincham, Carman, & Fearon, 2018); and, paradigmatically, through *regulating behavior* by providing effective demonstration (Király, Csibra, & Gergely, 2013). Botto and Rochat (2019, p.182) have recently proposed that “both the early attunement to others’ emotional reaction represented in social referencing, joint attention, and prosocial behavior, and the development of an explicit self-awareness would underlie children’s emerging perception of others as evaluators of the self”.

The close relationship between the development of mentalizing and reputational awareness (both in terms of individual development and in evolutionary terms), we argue, is suggestive of why MISC, a form of intervention that uses the stimulation of epistemic trust both as an outcome and a mechanism for further change, is indicated. The stimulation of epistemic trust—and the rich mentalizing this is dependent on, and which it supports in the child—creates an openness to other minds that is in itself a valuable developmental achievement. But, critically, it also makes possible a virtuous circle of social learning, communication, and cooperation with other minds that is highly protective in regulating the social imagination. The MISC program of work is of such interest to us because the mediational processes it outlines can be understood as powerfully cuing to the child an interest in his/her mind, establishing a “royal road” to the formation of epistemic trust. The mediational processes indicated in MISC necessarily involve recognition of the child’s subjectivity and agency, and signal an interest in collaboration and cooperation. They serve to enrich mentalizing by demonstrating a strong interest in the child’s mind, while giving generous access to the parent/teacher’s mind—marking the availability of the adult’s mind for the child’s learning, as well as the investment and interest of the adult’s mind in the child’s. We presume that in therapy, the very same methods focused on the person’s experiential understanding of their life events and circumstances, will serve to gradually enhance their mentalistic understanding and correspondingly transform the level of trust they experience in relation to the communication with their therapist. MISC is the best model we have to date how mentalizing achieves this generic therapeutic goal.

Summary and Future Directions

In this proof-of-concept paper we have attempted to advance the argument that MBT is constrained by its representational conceptualization, as well as its over-focus on attachment (affect-based) components with no explicit reference to learning (mediational) components, despite the recent focus on deepening of epistemic trust as a driver of change, which lends itself to considering

learning more explicitly. MISC, which is also attachment-based but grew out of learning theory, adds learning (mediational) components that allow a granular-level behavioral operationalization of the facilitations mentalizing, which until now has been assessed and operationalized mostly through representations. We suggest that the MISC model, its associated assessment tool (the OMI), and the three modes of MISC training described above may provide: (1) an integrated conceptual framework for describing, operationalizing, and behaviorally anchoring learning components of mentalizing that have been implied in theory, but not articulated or operationalized; (2) an assessment framework for coding the components of mentalizing during real-life interaction at a granular (and not global) level, such that each event or utterance of the interaction is coded; and (3) a training framework by which the mentalizing stance can be taught to clinicians and parents/caregivers wishing to learn the mentalizing stance.

If this paper convinces readers of the value of MISC as suggested here, there are two important ways this agenda should be taken forward. First, the exact way in which MISC is incorporated into existing MBTs and training approaches of MBT will have to be worked out. The easiest integration is perhaps with regard to mentalization-based caregiver interventions. Attachment-based (e.g. Dozier & Lindhiem, 2006; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008; Moss et al., 2011) and mentalization-based (e.g. Slade et al., 2019; Suchman, DeCoste, et al., 2010) caregiver interventions typically make use of video feedback with a focus on mental states. Adding empirically defined and theoretically grounded mediational components to these reflections seems to be a relatively straightforward adaptation of these interventions.

Incorporating MISC into MBT workshop and training initiatives may be similarly feasible. Careful consideration would have to be given to not duplicate aspects that are already present in MBTs, but to streamline the training experience to show the unique features of MISC. The MISC model could also be integrated into supervision. While MBT supervision already makes use of

video-based feedback on therapy sessions, incorporating the mediational components in talking about therapist behaviors may demystify and anchor process variables more clearly for trainees. These goals are also the focus of recent training approaches, for example, the notion of deliberate practice (e.g., Rousmaniere, 2017).

Finally, the mediational components of MISC could be incorporated into direct client work. Sharing and reflecting on videos of sessions with clients is certainly an option too, but would require further thought and systematic planning and piloting. At the very least, keeping in mind the steps (mediational components) that promote slowing down of the reciprocal sequence of interaction between therapist and client will assist therapists in maintaining their mentalizing stance. However, additional aspects of work with adults will need to be considered, such as the fact that MBT is most widely known in the context of work with individuals with BPD who enter therapy with especially low levels of epistemic trust and impaired mentalizing capacity. The exact way in which MISC could be incorporated into this kind of work is beyond the scope of the current paper, and deserves thoughtful consideration.

Beyond working out the exact ways in which MISC could be incorporated into existing MBTs, a second important avenue for future work would be the validation of the OMI in the context of MBTs and, conversely, the assessment of mentalizing in MISC interventions. MISC has demonstrated enhanced sensitization of caregiving when using the OMI emotional and mediational components as outcomes. Such findings suggest that caregivers' mentalizing is enhanced by MISC; however, this should be demonstrated using measures and tools derived from mentalization-based frameworks, such as the various measures of RF discussed earlier.

In closing, we wish to reiterate that the theoretical and conceptual overlaps between MISC and mentalization-based approaches are clear; however, through its grounding in learning principles, MISC articulates the components by which learning to mentalize may take place, thereby

potentially providing a pragmatic framework for making mentalization-based training and intervention accessible to learners—whether these learners are therapists wishing to learn to mentalize their clients, or individuals wishing to learn to mentalize their family members. This paper represents a first step in bringing MISC and MBTs together, and our hope is that it will spawn further efforts.

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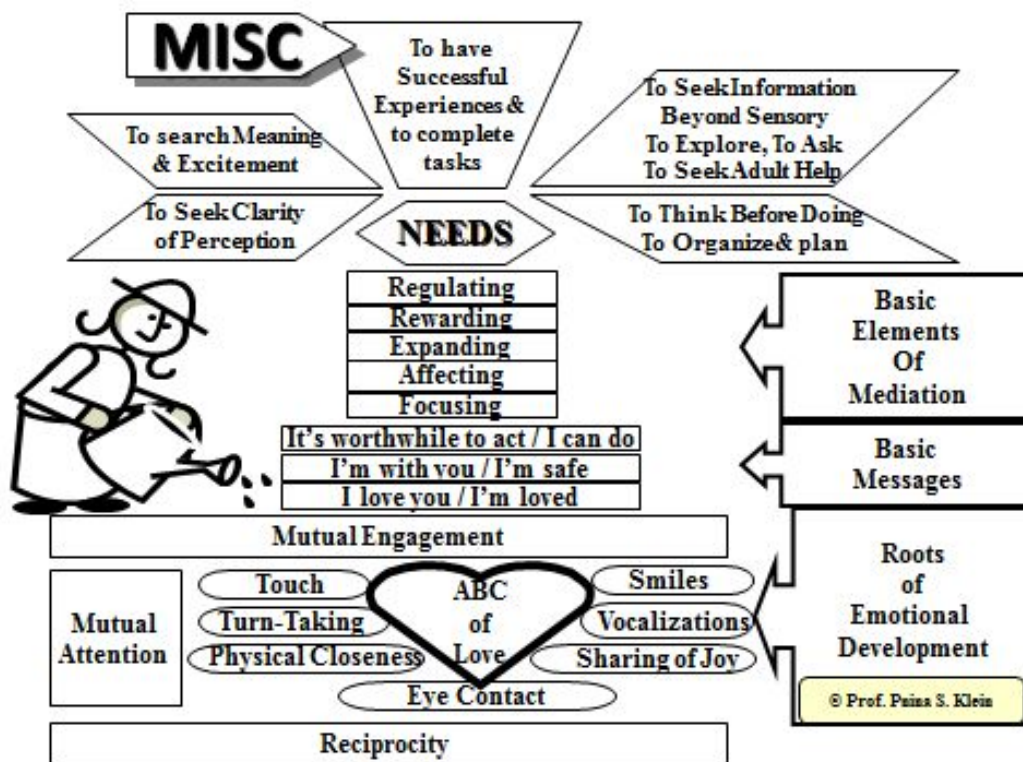


Figure 1. The conceptual model guiding the Mediated Intervention for Sensitizing Caregivers (MISC)