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MENTALIZATION IN CLINICAL PRACTICE – A PSYCHODYNAMIC PERSPECTIVE

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mentalization,
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Summary

The aim of the article is to try to integrate the clinical work, theoretical knowledge, and scientific research in the context of the latest mentalization theories. The theoretical and practical basis for considerations on mentalization is Otto Kernberg's concept of personality organization and the psychotherapy system for patients with personality pathology – Transference Focused Psychotherapy (TFP). In the article, the issue of diagnosis of patients' mentalization along with the level of personality organization is discussed. Possible mentalization disorders appearing in the patient-therapist relation (pseudomentalization, concrete mentalization and lack of mentalization) are also described. Moreover, the latest research on mentalization in the context of psychodynamic psychotherapy is presented, concerning two aspects of mentalization: as the function of the therapist and the patient. The last part of the article refers to the importance of mentalization as a therapeutic factor in TFP. Conclusions: Mentalizing can be seen as a certain independent attitude, a specific meta-theoretical basis of the therapy, followed by techniques resulting from a specific paradigm. Psychodynamic psychotherapy is intended to provide maximum comfort of mentalizing for both the patient and the therapist.

Introduction

This paper is inspired by the intention to integrate and give form to the triangle of clinical work–theoretical knowledge–research in the area of mentalization. Whereas research on mentalizing seems to have a well-established status in the Polish and international literature, there are still few studies – besides the mainstream publications by Fonagy, Allen, and their team – showing how to use this body of knowledge when working with patients. The theoretical and practical basis for reflections on mentalizing will be Otto Kernberg's concept of personality organization and his system of psychotherapy for patients with personality pathology – Transference-Focused Psychotherapy (TFP), which is one of the most popular types of psychodynamic psychotherapy in Poland, discussed in both research and clinical contexts [1].

The concept of mentalization has been defined and its meaning has been analyzed many times in the Polish literature. For the most comprehensive presentation, the reader is referred to the book edited by Cierpiałkowska and Górska [2]. For the purposes of the present paper, I will present only the key elements of the concept of mentalization. Mentalizing is a mostly unconscious representational mental process which consists in identifying and understanding one's own and other people's behaviors as stemming from intentional mental states. It involves

the basic ability to differentiate between internal and external reality and to generate representations of one's own and other people's mental states. It is, therefore, a process of transforming the non-mental into the mental, which makes it the opposite of acting-outs or somatization, the most "tangible" manifestations of nonmentalizing. One of the functions of mentalization is to explain and attribute meaning to behaviors. But apart from its important role in interpersonal functioning, authors emphasize its intrapsychic aspect associated with self-regulatory processes; mentalization is associated with the ability to regulate emotions and with the maintenance of a stable self-image. Mature, optimal mentalization presupposes the awareness of the symbolic and dynamic nature of mental states and a stable motivation to identify them, as well as the ability to use advanced regulatory strategies in response to difficult experiences. An important element of mentalization is the ability to decenter – that is, to describe other people's mental states independently of one's own perspective and engagement in the relationship with the person one is "mentalizing about." It is associated with the ability to keep one's distance from the egocentric perspective defined by the contents of one's inner experience. To sum up, it is possible to distinguish three main functions of mentalization: (1) navigation in the social world, (2) navigation in one's own inner world, (3) regulating the social world and the inner world as well as maintaining an appropriate connection between them. It seems obvious that mentalizing is of great significance for the process of psychotherapy, from both the therapist's and the patient's perspectives. What is important, mentalizing is an interactive process; in the context of psychotherapy, it manifests itself in two forms: as the therapist's function and as the patient's function.

Mentalizing is one of the psychotherapist's main tasks during the session. In the psychotherapist's office, we mentalize ourselves and the patient as well as "meta-mentalize" the mentalizing and nonmentalizing which we experience and which manifests itself in the therapeutic relationship. Mentalizing is an indispensable element of all professional actions that a therapist engages in. We engage in mentalization when we understand the patient's feelings connected with the history and experience he or she shares and when we help the patient gain an understanding of other people's behaviors, particularly by enhancing his or her ability to decenter. We mentalize when we diagnose problem areas and discuss them with the patient; we also mentalize when we monitor our own countertransference-based feelings and use them to help the patient. Mentalization works when we are able to stop and reflect on what is going on during the session, even when faced with one's own and/or the patient's strong emotional arousal.

The patient's mentalization is activated from the very first moments in the therapist's office, when the patient explains the reason for deciding to undergo therapy. The patient mentalizes when telling his or her story, including the relationships with significant others, when discussing these people's attitude to him or her and to the problem, and when identifying his or her own emotions and thoughts about the experiences being discussed. Finally, the patient activates mentalization when looking for links between his or her own and other people's symptoms, thoughts, emotions, and behaviors, and when he or she reflects on the therapeutic relationship and the therapist.

This brief outline does not cover all the situations in which mentalizing takes place in the patient–therapist relationship. It can easily be observed that this is not a new phenomenon in psychotherapy, which has been pointed out many times by Fonagy and Bateman [3]. As the

authors of Mentalization-Based Treatment (MBT) point out, mentalizing has always been an inseparable element of psychotherapy in every paradigm. With regard to psychodynamic psychotherapy, Barreto and Matos [4] name two main research centers investigating mentalization: one of them is the Canadian authors grouped around Marc-André Bouchard, associated with Freudian psychoanalysis and drawing on Bion's theory [5]; the other one is Peter Fonagy's British team, drawing on the developmental perspective, neuropsychology, and social cognition theory [3]. Even though it is the latter group that can be given the credit for the full bloom of the concept of mentalization worldwide in the last 20 years, it is hard to resist the impression that references to the assumptions of contemporary and classic psychoanalysis can more easily be found in the work of Bouchard's team. Kernberg's team, by contrast, has been on the sidelines, at the same time integrating the concept of mentalization with their assumptions on many points. In the two texts cited below, this author directly refers to mentalization and discusses its place in the contemporary object relations theory [6, 7].

Mentalization assessment in the context of individual psychodynamic psychotherapy

Mentalizing at different levels of personality organization

In the psychodynamic literature, disturbed mentalization is usually mentioned as one of the main symptoms of pathology in borderline patients [2, 3, 8]. Based on the available literature, it is also possible to formulate certain hypotheses concerning mentalization in psychotic and neurotic individuals, but they certainly require further empirical verification.

Psychotic personality organization (PPO)

Although in recent years PPO has practically disappeared from Kernberg's theory in favor of functional psychoses, I decided to describe the group of psychotic patients here as those who are distinguished by distorted reality testing. So far, the only study in which researchers have measured the level of mentalization[1] in individuals undergoing a psychotic crisis has been the study by McBeth et al. [9], with a sample of 34 patients hospitalized during the first phase of psychosis. The mean mentalization level in this group turned out to be low, but it was not the lowest possible level, which would have meant a total lack of mentalization. The severity of mentalization disturbances was associated with the patients' attachment style – subjects with an avoidant attachment style had the lowest levels of mentalization, including a total lack of it. This is a very interesting result, suggesting the heterogeneity of the group of patients diagnosed with psychotic disorders in the context of mentalization deficits. The question of how this observation should be understood in the context of personality organization levels remains open – it cannot be excluded that the subjects' personality organization levels varied. Despite the lack of studies on the mentalization level in the psychodynamic sense in psychotic patients, there is extensive literature on deficits in mentalization understood as a theory of the mind or as metacognitive skills (for a review of

[1]The study concerned mentalization in the psychodynamic sense, as understood also in this paper – measured, in this case, as a reflective function in the Adult Attachment Interview.

research, see: [10]). What emerges from these studies is a picture of a serious deficit in mentalizing capacity, but there are doubts regarding the permanent nature of these disturbances. Although there are studies suggesting their temporary character, dependent on the level of psychosis symptoms, the majority of reports show a permanent decrease in mentalizing capacity in psychotic patients, which manifests itself both during active psychosis and in the period of remission [10]. Based on the cited studies and the clinical experience of therapists working with psychotic patients, it can be said that the group of psychotic individuals is diverse in terms of the ability to mentalize. This conclusion is reflected in the evolving understanding of psychotic patients in Kernberg's theory [11]. Kernberg questions the existence of structural PPO criteria, which allows him to stress the heterogeneity of this group of patients, also in terms of the personality structure that accompanies psychosis, which may manifest itself at different levels of organization. It can be concluded that, on the one hand, a certain group of psychotic patients is observed to have a serious deficit in the ability to mentalize, while on the other hand, there is a diverse group of patients with symptoms of psychosis whose personality structure may be better integrated and, consequently, whose mentalization is less disturbed (e.g., borderline patients with temporary psychotic regression). Individuals belonging to the former group are patients who are incapable of reflection on the mind regardless of external factors: the circumstances or the person they mentalize about (namely, of whether the person is, for instance, a romantic partner or a stranger, such as a shop assistant). According to the deficit model, these people are characterized by a lack of certain functions responsible for mentalization because in the course of their development the processes responsible for its proper functioning were blocked. As a result, these people are unable to acknowledge the symbolic nature of mental states. In their experience, mental states are either perceived as real "things," with feelings and thoughts meaning as much, or as little, as their physical outcomes – or experienced as totally out of touch with reality. The low level of mentalization in these individuals can often be treated as a stable personality trait, not subject to change depending on the context. On the other hand, however, there is a large group of patients with symptoms of psychosis who will function similarly to individuals with borderline personality organization when it comes to mentalizing ability.

Borderline personality organization (BPO)

There are many studies on mentalization and related functions (social cognition, theory of mind) in individuals with personality disorders, but the majority of these studies concern borderline personality disorder, which obviously limits the possibilities of generalizing their findings to the entire BPO. Nevertheless, there are also studies devoted strictly to BPO as understood by Kernberg [2, 8, 12]. The most general finding of those studies is as follows: individuals with borderline personality organization exhibit different levels of mentalization depending on a number of factors (method of measurement, time and context of measurement, the subject's characteristics) [cf. 13]. On the one hand, the group of people with BPO is heterogeneous in terms of mentalization levels – there certainly is a need for further research in this area, in which an attempt will be made to define these differences using variables such as: type of attachment, type of symptoms and nosological diagnosis, specific experiences in life (e.g., a trauma or corrective relationship at some stage of life). On the other hand, based on

research and the available literature, it can be concluded that mentalization disturbances in individuals with BPO are conflict-based rather than deficit-based, which results in these people's mentalization level changing across contexts. In other words, mentalizing in borderline individuals is a dynamic and fluid function, which may manifest itself in different ways in the same person depending on various factors – the activation of internal mentalization-related structures may enhance, weaken, or even completely block it. To use the language of Kernberg's theory, depending on the activation or deactivation of a particular self–object dyad, associated with a particular kind of affect, the level of mentalizing capacity is expressed in a manner specific to a particular person in relation to this dyad. It is, therefore, possible to imagine a situation in which a BPO patient applies massive distortions in the case of his or her own or other people's mental states, but only for certain specific object relations, activated, for example, in the relationship with the therapist or with a romantic partner. In a different context, involving the lack of activation or the activation of a different dyad (e.g., one experienced by the patient as good and safe), these distortions may not occur at all, or they may take a different, less destructive form.

Neurotic personality organization (NPO)

A consolidated identity and a relative lack of primitive defense mechanisms result in NPO patients having a well-developed self-reflection ability and a well-developed understanding of the symbolic nature of thoughts and mental states, which makes their ability to mentalize relatively mature. According to Kernberg, mature mentalization is associated with the achievement of certain developmental steps, related precisely to identity consolidation and the ability to enter into relationships based on dependence and gratitude. So far, the issue of mentalization in neurotic patients has seldom been addressed in the literature. Preliminary studies of individuals with personality organization higher than borderline suggest that these individuals may exhibit certain temporary problems with mentalizing [14]. More studies in this area are definitely needed, but it can be assumed that individuals with NPO are characterized by a relatively high level of mentalizing capacity, which manifests itself in an accurate and valid inference of their own and other people's mental states in most situations. Nevertheless, certain difficulties in mentalizing may appear; they are not chronic and take a temporary form, usually induced by heavy stress or emotional arousal. They remain isolated to a given patient's specific area of difficulty, which means they occur exclusively in the area identified as marked by conflict (e.g., they may manifest themselves in the occupational context but not in an intimate relationship, or the other way around).

Different faces of pathological mentalizing observed in the patient–therapist relationship

Although mentalization disturbances can take very different and complex forms, the classification developed by Fonagy and colleagues makes it possible to usefully divide them into three large groups. These are: nonmentalizing (a reflection of the teleological mode), concrete mentalizing (a reflection of psychic equivalence), and pseudomentalizing (a reflection of the pretend mode) [Fig. 1]. They occur in individuals with pathological personality structure – namely, in psychotic and borderline individuals, as well as, temporarily, in neurotic

individuals. According to the developmental model, pathological mentalizing modes originally emerged in the early stages of the child's development and had an adaptive function in that period, but with time they should be replaced by mature mentalization [3]. In individuals with mentalization disturbances, they continue into adult life and are a source of difficulties observed in their intrapersonal and interpersonal functioning. In the literature, they are referred to as "modes" – ways of experiencing the inner world, which convey their global nature and the fact that they dominate the emotional and relational functioning of people with personality pathology.

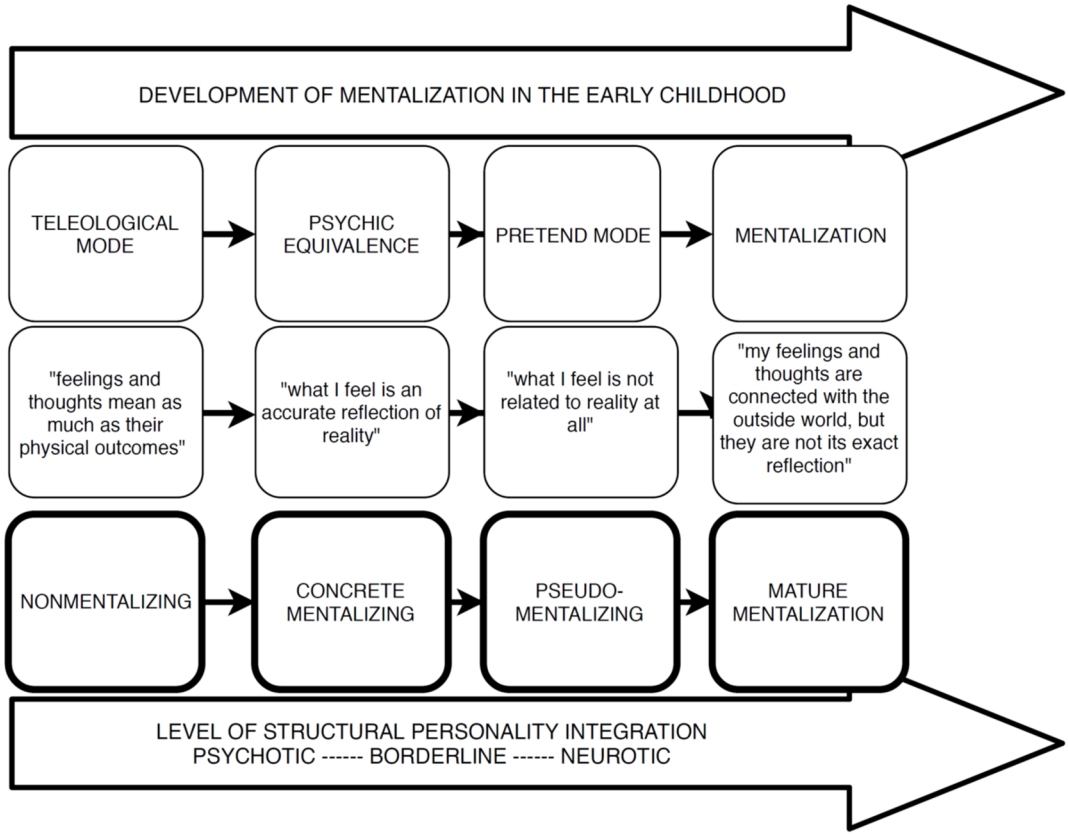

Figure 1 **Mentalization disturbances observed in psychotherapy**

Pseudomentalizing is difficult to diagnose during psychotherapy; this refers particularly to one of its types, which Fonagy calls *overactive mentalization*. In this situation, paradoxically, we may observe a high level of elaboration and expression of mental states by the patient; however, this stems from the reflection on mental states, and its only function is for the patient to maintain a defensive distance from his or her own experience. This type of pseudomentalizing can be diagnosed when, despite the patient's long and sometimes complex story about his or her inner experience, full of metaphors and digressions, the therapist is left with a sense of emptiness, disorientation, and confusion, often accompanied by the inability to empathize with the patient's experience. This manner of functioning during sessions is characteristic of some narcissistic and obsessive-compulsive patients, who can devote plenty

of time and effort, both in and out of session, to the analysis of their emotions and experiences; their analysis, however, is based on isolation mechanisms and does not lead to insight. Instead, it leads to an impasse in therapy and a sense of frustration in both the patient and the therapist. This kind of primitive mentalization is often aided by more mature defense mechanisms, such as intellectualization and rationalization.

Another type of pseudomentalizing is *destructively inaccurate mentalization.* It is relatively easy to diagnose due to its hostile and destructive nature. The patient does not attempt to identify the therapist's true mental states and freely replaces them with others, at the same time believing them to be true and feeling as though they were true (thus engaging in projective identification). This usually manifests itself in an attitude full of accusations, demands, and aggression. A somewhat less destructive type is *intrusive mentalization*, in which the patient is certain that he or she "knows" what the therapist feels and thinks, but this knowledge is based only on the patient's projections and is impervious to doubt or reflection on the validity of this experience.

Concrete mentalizing consists in equating internal and external reality in the patient's experience – his or her mental experience becomes an external fact. What the patient feels is true and justified because it is confirmed by the intensity and plausibility of his or her experience: "If I feel that my therapist is neglecting me, then this is the case indeed." Thoughts and feelings are not hypothetical or subject to modifications; they are unambiguous and certain. Concrete mentalizing usually manifests itself in the form of paranoid transference, when the therapist is constantly experienced as hostile and unsatisfying. The patient is unable to process and reflect on the overwhelming and acute sense of danger and experiences intense negative emotional states as if they were reality; everything the therapist does confirms the patient in this terrifying experience. Another manifestation of concrete mentalizing is narcissistic transference, with the expression of the patient's grandiose self, which – equally destructively – makes it impossible to really experience the therapeutic relationship.

The last type of mentalization disturbance described by Fonagy is *nonmentalizing*, which, in some sense, consists in negating the existence of one's own and other people's inner mental world. Actions are understood as their physical outcomes, while internal states do not play any role in the understanding and interpretation of behavior. Emotions and thoughts exist only when they are expressed in actions. The patient is unable to process his or her experience but is only able to get rid of it – for example, in the form of acting-outs (self-inflicted injuries, suicide attempts, outbursts of aggression). Likewise, the therapist is experienced in a way that that stems from his or her physical activities and their outcomes ("If you have no time for an additional appointment for me, it means you want to get rid of me"). This is the most primitive manifestation of mentalizing disturbances.

Assessment of the patient's mentalization level in the consultation process

An important starting point for the work on mentalizing is the assessment of the patient's mentalization level, which is yet another component of the comprehensive psychodynamic assessment performed in the course of consultation. Although Kernberg does not refer directly to the mentalization level in his personality organization level criteria, and

although mentalizing seems to pervade most of his structural criteria, the aspect of personality organization that relates the most directly to mentalizing is social reality testing. As in the case of mentalizing, in a healthy personality, reality testing is usually stable, whereas in neurotic individuals it may temporarily decrease in the areas of conflict, in borderline individuals it is sometimes seriously disturbed, particularly in certain types of close relationships, and in psychotic individuals both its social and non-relational aspects are disturbed [11]. Mentalization assessment during psychotherapy may take two kinds of course – it may be performed in a less structured way, with the patient's ability to mentalize being assessed *post factum*, based on the information about the patient's functioning acquired during the session as well as based on general impressions in contacts with the patient and his or her history, or it may be performed in an intentional and more formal way, with the therapist asking the patient questions aimed at assessing his or her mentalizing capacity. This kind of intentional assessment of mentalization can also be performed based on Kernberg's structured interview [15], since questions concerning the representation of object relations and identity yield very good material for the assessment of mentalizing – both about oneself and about others. Another method useful in the preliminary assessment of the patient's mentalization level can be the request to describe an example conflict situation between the patient and his or her significant other (this is a procedure used in research, but in can be useful also in the clinical context [cf. 8]). Assessing the patient's answers to this kind of open-ended questions, it is possible to establish whether and how the patient responds to mental states, whether the patient is able to recognize and tries to understand his or her own and other people's mental states, whether he or she has the ability to decenter, whether he or she is motivated to mentalize, and whether he or she uses the knowledge about mental states to regulate his or her own behavior and interpersonal relations. Is it possible to observe indicators of prementalizing modes of functioning, such as excessive certainty about other people's mental states or a tendency to give empty intellectualized accounts of one's own inner experience?

These general questions can be supplemented with more concrete ones, focused on more precisely determining the ability to recognize mental states (what does the patient think/feel and what do the people he or she speaks about think/feel?), the ability to link emotions and thoughts with behavior (why does he/she feel/think something? is there a cause-and-effect perspective in the story?), and the general level of inner experience integration (is it possible to understand the patient's inner experience and empathize with him/her? does the patient build a consistent narrative, referring to the contradictions and dynamic nature of mental states?). The final stage is the assessment of how the patient copes with difficult experiences and of whether he or she uses primitive regulation strategies, such as acting-outs and avoidance, or more advanced strategies, such as the use of knowledge about other people's mental states to regulate the intrapersonal and interpersonal context [cf. 16]. This kind of comprehensive assessment of the patient's mentalization in the initial stage of therapy may have considerable diagnostic value, enabling differential diagnosis of the personality organization level, particularly in those cases in which it is difficult to make classification decisions. It also helps to adjust therapeutic interventions to the patient's level of mentalizing, which can contribute to their better adjustment and, consequently, to their greater effectiveness in the process of treatment.

The application of mentalization theory in individual psychotherapy in the context of transference and countertransference

Research on mentalizing in the patient–therapist relationship

In the literature on object relations theory, mentalization as a function of the therapist and psychotherapy has been addressed much more often than mentalization defined as the patient's ability. Studies reveal a significant relationship between therapists' high mentalizing capacity and better outcomes of psychodynamic psychotherapy [17], as well as the usefulness of brief mentalization training for inexperienced therapists for a better coping ability in their work with difficult borderline patients [18]. Interestingly, according to the preliminary study by Diamond et al. [19], the therapist's mentalization level differs depending on the patient – which means that mentalization during therapy is an outcome of interaction, dynamic and specific to a given therapeutic relationship rather than merely to a given therapist.

As early as in the 1990s, a Canadian team of researchers [20] distinguished three levels of therapists' mentalizing, defined as ways of coping with mental states during the session. The first two of them are triggered as defense strategies against the anxiety associated with the activated transference. The first one is the objective-rational style, in which the therapist becomes a distanced observer of the relationship with the patient and remains emotionally disengaged, focusing on theoretical categories and relying on general psychotherapeutic knowledge, thus remaining, in a way, out of contact with and out of relation to a specific patient. The maintenance of this kind of defensive intellectual dialog leads to an impasse in therapy and should be spotted in time in the process of supervision. The second non-optimal way of the therapist's mentalizing is the reactive style, in which the therapist is an unconscious participant in a game of transference and countertransference and becomes incapable of understanding the mechanisms enacted in the relationship, yielding to projective identification and enacting the primitive states activated in countertransference; he or she may feel anger at or irritation with the patient as well as adopt an attitude full of criticism [20]. The main aim is to get rid of difficult emotional states rather than to acknowledge and analyze them. The therapist in this case is "too close," while in the objective-rational style he or she is "too far" from the patient's experience.

The opposite of these two defensive styles is the reflective style, which is mentalization in the strict sense. The therapist is both a committed participant in the therapeutic relationship and its careful observer, capable of containing and processing the patient's difficult experience. The therapist's basic activity is experiencing, reflecting on, transforming, and giving meaning to inner experience [4][2]. Interestingly, research shows that it is the less experienced therapists who use the reflective style more often compared to more experienced ones [21]. The classification proposed by Bouchard's team was confirmed in the research conducted by Rizq and Target [22]. Another interesting classification of therapists' mentalization levels was developed by Barreto and Matos [4], who described five ways of

[2] Two other mentalization styles were later distinguished within the reactive style (mature and primitive defense mechanisms), and a concrete style of mentalizing was described in which there is no awareness of one's own mind [5].

understanding the psychotherapeutic process, manifesting themselves in the therapists' ways of speaking about the session when it is over.

In several studies, researchers have also examined changes in the patient's level of mentalizing capacity in the course of transference-based psychotherapy. The results show that TFP causes a significant increase in this level, as opposed to other therapies examined in the study [19, 23, 24]. What is important, improvement in mentalization was associated with the increasing level of personality integration.

The studies outlined in this section show, on the one hand, that working with transference results in a special way in an improvement of patients' mentalizing capacity, and on the other hand – that it gives a special role to mentalizing as a function of a good therapist and therefore constitutes an important mechanism involved in effective treatment.

Mentalization as a healing factor in Transference-Based Psychotherapy

Kernberg [7] understands work on mentalization as developing one of the specific mechanisms of change in psychodynamic psychotherapy – namely, building a realistic picture of the self and others as well as integrating self and object representations. What happens in the course of therapy is the reconstruction of mentalization disturbances specific to a given patient in a situation that involves the activation of specific self–object–affect representations. Next, the disturbances are diagnosed and discussed as part of the transference–countertransference relationship. This is a necessary introduction to further interventions aimed at changing the internalized self–object representations. In a different study, Kernberg [6] refers to this advancing interpretive process simply as "phases of mentalization development." The focus on mentalization is an important element here, leading to in-depth interpretation but not replacing it and not taking over its function. Moreover, in the course of therapy, thanks to mentalizing, through an empathic and patient attitude in explaining the patient's mental states, his or her experience is constantly clarified, which "facilitates the cognitive framing of the patient's own affective experience" [7, p. 63] and results in the regulation of violent and intensive experiences in his or her relationship with the therapist. Mentalization "training" is the first step towards the acknowledgment that the therapist and the patient have distinct and different minds, and that the experience of these differences does not have to mean the end of the relationship. Apart from performing the function of catalyzing and enabling the process of interpretation, better mentalizing capacity becomes a valuable acquisition for the patient as an element indispensable in regulating his or her own internal and interpersonal world. The patient gradually acquires and enhances mentalizing capacity when he or she is able to retrieve contrary emotional states of the self in moments of strong emotional arousal during the session [7], i.e. when interpretation leads to a decrease in the level of splitting. According to Kernberg, proper mentalizing is the capacity for self-reflection even in conditions of intense negative emotional states. A patient who has this ability is already a patient with an integrated personality structure.

To sum up the place of mentalization in TFP, it is possible to distinguish at least three areas in which it manifests itself: (1) the therapist's mentalization as a precondition of the containment of the patient's states during the session; (2) mentalizing in the patient–therapist relationship as an introduction to interpretation; (3) the patient's increasing mentalization as an

instrument of integrating and regulating his or her own experience. These refer, respectively, to mentalization as the psychotherapist's function, to mentalization as the interaction between the patient and the therapist, and to mentalization as the patient's important autonomous ability[3].

Conclusion

Mentalizing can be treated as an independent attitude and a kind of meta-principle of therapy, to be applied with techniques stemming from a specific therapy paradigm. As has been stressed many times by Fonagy, it is a process that therapists of all orientations have always been using but did not necessarily call mentalizing [3]. A therapist who supports his or her patients' mentalizing is consistently focused on mental states and encourages them to explore their own and other people's (the therapist's, significant others') mental states. He or she devotes a considerable amount of time to the exploration of different points of view, while recognizing the value of the patient's individual perspective. A mentalizing therapist calmly accepts the fact that he or she is not an expert in the patient's mind but a kind of companion in the complicated exploration of their own and other people's inner world. It is important for the therapist to adopt an attitude of curiosity and uncertainty, conducive to the enhancement of the patients' understanding of their own experience. What is also stressed is the value of the therapist's reliance on common sense and genuine exchange with the patient in order to maintain a close and engaged dialog with him or her. Psychodynamic psychotherapy is supposed to ensure maximum comfort of mentalizing to both participants of the interaction; the therapist becomes free from the pressure to react directly and focuses on his or her own observations and emotional responses, monitoring countertransference from a "third-party" point of view [7]. What is important is the focus on the present, on the "here and now," and the stable direction from explanation – clarification and confrontation – to interpretation. There is no doubt that mentalizing is one of many variables significant for therapy. We can choose how to call this process and where to place emphasis when analyzing the complex mechanisms that make up the process of effective psychotherapy.

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