Mentalization can be learned

Introduction to Mentalization Based Support (MBS)

Guidelines for all parents and caregivers supporting persons with a visual impairment and/or intellectual disability and also suffering from a problematic attachment, psychiatric disorders and/or behavioural problems

BARTIMEUS SERIES

Bartiméus aims to record and share knowledge and experience about the capabilities of people with visual impairment. The Bartiméus Series is an example of this.

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Prologue

Based on thorough research among individuals with severe intellectual and multiple disabilities, Francien Dekker-van der Sande and Paula Sterkenburg have converted their knowledge into a wealth of practical material. Their accomplishments include developing and delivering training courses for parents and caregivers; compiling video footage and digital material, and making this available to all with an interest in the subject matter. It is little surprise, therefore, that they also saw a need to expand their training courses by documenting their knowledge and expertise for anyone eager to improve mentalization within this population. This book is the crown on their generous and committed transfer of knowledge and this will undoubtedly not be the final product of this successful team. Bartiméus has given them an opportunity, and they have obviously used it to its full potential.

This is a printed guideline to help learn and adapt mentalization in stressful situations when others respond from the perspective of anticipated insecurity, thereby challenging your guidance. The book is divided into five topics, the final chapter containing an overview of potential interventions. Each chapter within the overall theme has a clear structure and ends with a summary and practical tips on the subjects discussed. Each chapter contains examples illustrating that failed or suboptimal mentalization can easily occur, each example closing with a proposal or suggestion for effective mentalization. Inclusion of the examples is both illuminating and relevant, as each example contains the same message from the perspective of a different situation. Each example illustrates how the reduction of tension and stress through mentalization is beneficial for the security of the relationship between the parties involved. But the book goes further than this, for the appendixes give you the opportunity to read frequently asked questions and answers, and to look up the definitions of the terms used in the book in the glossary.

In a nutshell, the book is a splendid guideline for interacting with children, young people and adults with a visual impairment and/or intellectual disability who are experiencing problematic attachment, other psychiatric disorders and/or behavioural problems. The power of the book lies in the concise, crisp chapters, each of which relates to a clearly distinguishable aspect of mentalization. It provides food for conversation and training material for learning how to mentalize and how to interact with others. The authors rightly argue that the only situation in which effective mentalization can be learned is during interaction with others. Mentalizing by yourself is like dancing alone. It might occasionally be fun to dance around without an audience, but a whole new experience is created when dancing with a partner. For my part, I would like to thank Francien and Paula for their high level of commitment and driven involvement in the development of this material, centering on the promotion of a secure attachment relationship. I still vividly recall the video images of the children from their research, illustrating this process so eloquently. This book will undoubtedly provide a welcome incentive for many people to learn about mentalization to help them avoid finding themselves in insecure attachment situations in the future.

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About the authors

Francien Dekker-van der Sande is a clinical psychologist/child and youth therapist who has been affiliated to the Bartiméus Psychotherapy department and has worked with the Bartiméus Centre of Expertise for Attachment and Social relationships since 2001. She has comprehensive experience in the diagnostics and treatment of children, young people and adults with a visual impairment and/or intellectual disability who have complex problems. In recent years she has specialised in the treatment of clients with disrupted attachment, complex traumas and personality disorders. She was actively involved in the compilation of the Guideline for Problematic Attachment in Youth Care (Richtlijn Problematische Gehechtheid voor de Jeugdzorg) (2014). These guidelines were presented both nationally and internationally.

Dr. Paula Sterkenburg is a healthcare psychologist/therapist at Bartiméus Psychotherapy department in Doorn and assistant professor at the The Faculty of Behavioural and Movement Sciences and the EMGO+ Institute for health and care research of the Vrije Universiteit of Amsterdam. The theme of her doctoral research was 'Integrative Therapy for Attachment and Behaviour'. In 2007 she was the recipient of the inaugural Disabled Care Award of the Dutch Association of Healthcare Providers for People with Disabilities VGN (VGN Gehandicaptenzorgprijs) for the way in which she has succeeded in building a bridge between research and practice. In 2012 the University of Groningen granted her the Han Nakken Award for most remarkable practical accomplishment with the workbook titled 'Developing Attachment' (Vertrouwensrelatie voor ontwikkeling). In 2013 she submitted a winning proposal for an APP with the following theme: 'Increasing one's own influence and control by and for people with profound intellectual and multiple disabilities' to the NutsOhra Fund in collaboration with the Vilans Centre of expertise for long-term care. Within a collaboration with Stichting Nieuwzorg the team won the expert jury prize 2015 from ONVZ Zorgverzekeraar for the best idea in caring interventions for their ideas for an app to facilitate the communication between clients and professionals called WhatsUpp.

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Inhoudsopgave

Practice

What you should know before starting MBS

The optimal basis for a healthy social and emotional development of any child is a secure bond with its parents. This also applies, of course, to children with a visual impairment and/or intellectual disability. If the child feels secure, it can develop freely in line with his own abilities and learn how to control his emotions. A child can bond securely with its parents if they are sensitive to their child's emotional signals. This parent knows and feels that his own behaviour and that of the other person is determined by thoughts, feelings, wishes and intentions. This is what we call mentalization.

Raising a child with a disability does not happen all by itself; parenting comes 'under pressure' (De Belie & Morisse, 2007). Effective mentalization is therefore vital for parents. That is what this book is about: how can we support you as a parent or caregiver in a manner that promotes mentalization, enabling you to respond even more sensitively to your child or client.

Below is a list of obstacles to parenting, which increase the likelihood of insecure attachment (Dekker-van der Sande & Janssen, 2010; Janssen et al, 2002; Sterkenburg & Schuengel, 2008):

- The parents find themselves in a coping process. Discovering that a child has a disability is a major loss experience and parents react to this with strong emotions. Key factors here are the psychological stability of the parents, their own history of attachment and the support from their social network. Feniger-Schaal (2012) states that parents who themselves are bonded securely and autonomously are better able to cope with the diagnosis while responding sensitively to their child.

- Infants and young children with a visual impairment and/or intellectual disability face stressful situations more frequently, impacting their feeling of basic security, such as premature birth, medical interventions, hospitalisations, and nutrition and sleeping problems.

- Disabilities in a child require significant parenting skills and adaptability. Parents are often unfamiliar with the development of a child with a visual impairment and/or intellectual disability and its perception of its environment. They cannot fall back on their trusted means of upbringing, which is working for the other children in the family.

- Vision is a very important sense in the development of attachment. Parents of a blind infant have to learn to use all the other senses of their infant and have to repeat things many times (Bakker & Roza, 2010). A blind infant expresses more feelings in the mobility of its hands and in its posture than in its facial expressions (Loots, et al, 2003).

- Children with an intellectual disability process information slower and their ability to cope with stress is impeded by their impaired cognitive skills. It is more complicated for the parents to gauge what they can expect of their child, because calendar age does not match developmental age.

- Multiple disabilities (visual and intellectual) may reinforce each other in children (Gunther, 2004). Blind infants, for example, use language to a greater level; while linguistic development is impeded by the intellectual disability.

- Children with a disability are institutionalised more frequently, where they have to cope with heterogeneous caregivers.

Children with a visual impairment and/or intellectual disability growing up in a family with complex problems, may have to contend with domestic violence, maltreatment, abuse, neglect or abandonment. The child's development is severely jeopardised in such situations. The child does not experience basic security. The child may develop disrupted attachment.
Children who are insecure attached and children with disrupted attachment find it difficult to control stress and emotions, which may lead to behavioural or psychological problems. They are not as good at thinking about themselves and acknowledging and expressing their feelings. The development of these children's personalities may be hampered by stress and lack of security, in other words: their mentalization abilities do not develop as well or do not develop at all. Caregivers providing support to these clients, some of whom have severe behavioural problems, quite often experience an inability to provide adequate support during their work.

The authors of this book have developed an approach for these children/clients and their parents, caregivers and teachers, designed to help them understand and cope with the client's stress. The method is called **Mentalization Based Support (MBS)**. These guidelines explain this concept and how to apply it. Many MBS workshops have been organised in recent years for teams of caregivers, teachers, (foster/adoption) parents, psychologists, (psycho)therapists and other personnel in the care sector for disabled persons. This book builds on that foundation. The authors have explored the method in greater depth using a study of the literature, personal training and supervision situations. They have also applied the method as therapists in supporting their clients over several years. The existing literature is particularly suitable for therapists and psychologists in a mental health care setting, e.g. for the treatment of clients with a borderline personality disorder. This book focuses more on practical situations and was written for the parents and caregivers of clients exhibiting problematic behaviour. If the reader wants additional theoretical background, he should consult the manuals available to (psycho) therapists and mental health care workers. (Please refer to the bibliography at the back of this book, e.g. Allen, 2008).

Do not do this alone!

One of the key conditions for working with MBS is: do not do this alone. If you are interested in using these guidelines, do so together with other parties involved with your client. Each party has its own role to play: putting into practice is the responsibility of the parents/caregivers, supported by a psychologist. Before embarking on this, have a licensed psychologist, (psycho) therapist or psychiatrist conduct a diagnostic assessment of problematic attachment, psychological disorders and behavioural problems.

When the book makes reference to 'your client', you may also read 'your child'. Clients may be children or young people, but also adults. When the book makes reference to 'he', you may also read 'she'. This book mainly uses the word 'caregiver'. This also refers to (foster and adoption) parent, father, mother, educator, caregiver, teacher or therapist.

The examples used in this book have been modified in such a way that they cannot be traced back to specific situations.

The book is intended as a set of guidelines that you can use in conjunction with training and peer-to-peer coaching in your everyday work. Do not be deterred by the theory, which is quite complicated. You will learn to recognise the process of mentalization in practical situations. The best way to achieve this is to discuss the problems you experience during peer-to-peer coaching sessions. The most important area for 'study' is the *relationship between parent/caregiver and child/client*. This means that we not only have to take account of how things are for the child, but also for the parent, caregiver, teacher or therapist who is interacting with the child. Disruptions in the interaction involve both the child and the parent/caregiver.

If while reading the texts you find yourself confronted by experiences from your own upbringing, discuss this with others. You could talk about it with a good friend, but you might also consider talking to a counsellor, education specialist or psychologist.

The application of MBS in care for persons with a visual impairment and/or intellectual disability is new and there is as yet no scientific research into the use of MBS in this population. More research and practical experience is needed in order to develop a clearly formulated methodology to encourage mentalization among our population. Došen (2014) indicates that "the concept of mentalization is still not being applied very frequently in practice for persons with an intellectual disability. Treatment based on this concept may without doubt also be very beneficial to this population." Clients with a visual impairment and/or intellectual disability are a very diverse group of people. Some clients with a visual impairment are capable of following formal secondary education, others have a very severe intellectual disability. This also means that the capacity of this population to learn how to mentalize is also very diverse. The promotion and maintenance of safe attachment in clients is the best precondition for developing their mentalization capacity. We hope that these MBS guidelines will support parents, caregivers, teachers and therapists in this process.

The book comprises two parts. Part 1 describes the theoretical principles of mentalization. We use practical examples during our explanations. Part 2 discusses interventions that may help to improve your own mentalization capacity and that of your client. You may use interventions during everyday support, although additional training is recommended for consolidation purposes.

THEORY

1 Mentalization, attachment and stress regulation

Introduction

We first explain the meaning of the term mentalization. We then describe the basic attitude needed for this. Mentalization helps you understand what is going on in your own mind, control your emotions, and articulate them to others. The theory of mentalization is based, among other things, on attachment theory. We will return to this later. This chapter examines the Circle of Security, the sensitive mirroring of emotions, and the failure to mirror them when there is insecure attachment. Susceptibility to disruption of the mentalization process as the result of stress or trauma is explained in the chapter on broadening the stress tolerance zone.

1) Mentalization entails thinking about feelings and feeling about thoughts

Mentalization is a term introduced by the Hungarian-born British psychoanalyst Peter Fonagy, and is derived from the word *mental*. It is a somewhat strange word. You are unlikely to find it in a dictionary or in your computer's spell-check routines. The term is used in psychotherapy. Mentalization means ... looking at yourself from your outside and looking at another person from his inside. Looking at yourself from your outside means: that you look at yourself as though you are watching a film in which you yourself have a role. Looking at another person from his/her inside means: that you are paying attention to the thoughts and feelings that the other person might be experiencing in that situation. If you think about your own behaviour and that of the other person, and you realise that behaviour is motivated by "something inside of you and the other person", we refer to that as a mental state. What is a mental state or the psychological situation of an individual? What verbs might be used to describe this?

… I feel
… I think
… I want
… I wish
… I hope

A mental state comprises feelings, thoughts, desires, convictions and intentions that you observe in yourself and another person and that you can use to assess and explain the behaviour of the other person and yourself. You cannot see a mental state, unlike behaviour such as crying or bullying. Mentalization entails thinking about feelings and feeling about thoughts. An example can clarify this: "I responded angrily to Sylvia. That is because Sylvia responded bluntly when I asked her a question. But when I think about it, I remember Sylvia had told me she was really busy. I thought she responded bluntly because I had done something wrong. But it might simply be because she's really busy. That can happen sometimes. Next time I'll start by saying that I understand she's really busy and ask whether it's convenient to ask a question." So you consider what you yourself are thinking, feeling and wishing, and then what the other person is doing and might feel, think and wish. Then you consider again how this might influence your thoughts, feelings and wishes and what consequences it might have for your behaviour or attitude to the other person.

Mentalization is a human ability that we use intuitively. It's an automatic process. If there is a misunderstanding in communication and you want to correct this, you have to think more consciously about how the conflict arose, such as in the above example involving Sylvia. How do you detect a misunderstanding between you and your client? You can see this by the way your client responds to you. A misunderstanding may have occurred if the client avoids contact, loses interest or withdraws. You can also recognise it by strong emotions, such as an angry response. Mentalization comes from the verb to mentalize. It is something that we do or fail to do.

Toddlers learn to mentalize during play

Children naturally learn to mentalize from the age of three or four. The child is in a process of development that is becoming increasingly complex. Children learn to mentalize within the secure attachment relationship with their parents and practice it during their play. A great deal of attention is paid to mentalization during their upbringing and education. Children enjoy playing with each other at school. It's often a spontaneous process; a skill we master automatically. But sometimes, when things don't go according to plan, it is necessary to stop and consciously consider the situation. For example, teaching children to think about why nobody enjoys being bullied or how to resolve arguments. Mentalization or the function of reflection is a basic concept in a child's upbringing and how people treat each other.

A visual impairment requires special attention

Children with a visual impairment can learn to mentalize effectively if special attention is paid to their sight loss during their upbringing and at school. The child's visual impairment may prevent him from perceiving the facial expressions and body language of the other person. This can be compensated for by the use of language. Another limitation is that the sensory impairment makes observation more difficult, which means much more effort is needed to process information, and this may be much more fatiguing. Consequently, learning and therefore also mentalization may develop in a lower pace.

Intellectual disability impacts mentalization

Mentalization is a means of communication that you learn from the earliest age and which is linked to the development of all other domains, such as language, cognition, memory, motivation, attention, social-emotional development and motor skills, but is also linked to the level of support and stimulus you receive as a child. In the case of children with an intellectual disability, there may be specific limitations in all these aspects on account of a syndrome or for some other reason. For example, children with the same IQ may have completely different neuropsychological profiles with strong and weak aspects. Healthcare generally refers to persons with an intellectual disability by their 'developmental age', but more information has to be added for each individual. Studies (Van Nieuwenhuijzen, 2007) of the processing of social information among children with a mild intellectual disability have demonstrated that they observe more negative information and that their problem-solving skills are not as well developed as in normally intelligent children. Young people with a mild intellectual disability also find it difficult to remember and process information, such as separating main and subsidiary issues, planning and thinking about cause and effect. Their limited working memory means that their understanding and usage of language lags behind, and therefore their understanding of the spoken word is not as well developed as in normally intelligent children. This may hamper their ability to learn how to mentalize properly.

People can respond to their environment in two ways (Wijnroks, 2013). People primarily respond intuitively. The quality of the attachment relationship between parent and child, which

may be a secure or insecure one, determines whether the child experiences a social situation as secure or insecure. Even children with a low level of development and infants are good at responding intuitively. Their intellectual disability has little impact on this. People exhibit a secondary response in second instance. In doing so, they consciously think about things as new information or an unexpected event. An intellectual disability exerts a powerful negative influence on this way of thinking. The secondary system enables people to think about their emotions and regulate them. This is necessary for mentalization.

Research among young people with a mild intellectual disability (Van Nieuwenhuijzen, 2007) shows that they have a tendency to skip steps in information processing. They also experience stress from time pressure and negative learning experiences. The secondary system is at risk of becoming overloaded, making learning to mentalize more difficult.

Children with a moderate intellectual disability have just started to mentalize situations. This is linked with their developmental age, which roughly lies between the ages of four and seven. Individual differences must of course be taken into account (Došen, 2014). It is possible that clients with a mild intellectual disability cannot learn to mentalize situations as well as a normally intelligent adult because they continue to think in too concrete terms and they experience problems in processing large amounts of information simultaneously. What has yet to be investigated in greater detail is the influence of a secure attachment style on the development of the mentalization capacity of a client with a mild intellectual disability.

It is important during a child's upbringing that parents and caregivers understand the level at which the child can mentalize situations. That is why this book also pays a great deal of attention to the precursors of mentalization, and we give the reader suggestions on how to trigger and stimulate mentalization.

The opposite of mentalization is "mindblindness"

The opposite of mentalization is "mindblindness". This term originates from investigations among individuals with autism spectrum disorders. Persons with autism have, to some degree or other, a disorder in the reciprocity of contact, communication and imagination. Persons with autism are unable to mentalize situations. This is probably caused by neurobiological disorders that impede the development of social-emotional involvement. British researcher Baron-Cohen (1995) describes what you experience when you are unable to mentalize situations: "Imagine what your world would be like if you were aware of physical things but were blind to the existence of mental things. I mean, of course, blind to things like thoughts, beliefs, knowledge, desires, and intentions, which for most of us self-evidently underlie behaviour" (Allen, 2008).

Not only persons with autism, but also many persons with psychiatric disorders and behavioural problems find it difficult to mentalize situations, to some degree or other. This might include, for example, clients with problematic attachment, depression, post-traumatic stress disorder, anorexia nervosa and personality disorders, such as borderline or antisocial personality disorder. MBS endeavours to transform shortcomings in a person's mentalization capacity in their daily

life. Extra support in the form of therapy (Mentalization Based (Child) Therapy) may be necessary here.

Example 'Argument about a TV programme'

Ann and Peter, two clients with a visual and mild intellectual disability, get into an argument about a music programme on TV. Corry, their caregiver, did not observe exactly how the argument began. She attempts to mediate by asking Peter and Ann what the problem is. Peter says that Ann is sitting right in front of the TV and that he cannot see the screen. Ann says that she can only watch her favourite programme properly when she's very close to the screen because of her visual impairment. Peter thinks that Ann is in the way and Ann thinks that Peter shouldn't complain. Corry thinks about this for a moment. She understands that this is irritating to Peter but she's also aware that Ann's visual impairment is very serious and that this is the only way she can follow the programme. Peter didn't mind her wanting to watch the programme. And in turn, Ann was so engrossed in the TV programme that she was unaware it was annoying to Peter. By talking about it, they understand each other and eventually reach a solution. Ann is allowed to sit right in front of the TV when her favourite programme is on. When other programmes are on TV she promises to ask Peter whether this is annoying for him and Corry will talk to them both to see how they are getting on.

By helping to resolve the argument, Corry is mentalizing the situation in an everyday manner. Corry is pleased that she has helped to resolve the argument between Ann and Peter and feels competent about this. Corry remained calm 'on the inside' while resolving the argument, she clarified the feelings and thoughts of Ann and Peter in a positive neutral manner and without judging them, and she resolved the situation together with them. But what if Corry was herself stressed and had a headache, which prompted her to respond in an irritated or impatient manner? That would have made it more difficult to resolve the argument with an open attitude and the irritations might have even been compounded further. In a situation such as this, Corry must be aware of her own restlessness and calm down before she can guide Ann and Peter. Ann and Peter can mentalize the situation with Corry's help, because they are prepared to look at things from each other's perspective and are willing to resolve the argument.

What does this mean for caregivers?

Mentalization is being aware of the emotional significance of the client's behaviour. In doing so, you are aware of your own emotions and behaviour. At the same time, you are aware of how your behaviour and emotions can in turn invoke behaviour and emotions in the other person (the client) and you are aware of the impact of your behaviour on your relationship with the other person.

Practical suggestions

Try occasionally to make a point of mentalizing situations while you are at work: what is and what is not going well in the relationship between you and the client or between the clients themselves? This is particularly important if clients are restless or if there are behavioural problems. Make sure not to assume what the client is thinking or feeling. Check whether you know what is going on 'inside' your client and what the client's intentions are. Realise that you can never be sure, but that you are willing to investigate the matter, for example by asking questions. Once you become accustomed to this attitude, you can at the same time become aware of what you yourself are thinking and feeling in a particular situation.

In short

The key to mentalizing situations is that you become aware of your own behaviour, feelings and wishes, and of the behaviour, feelings and wishes of the other person and that you discover how it influences your relationship with the other person. That helps you to understand each other, to learn from each other and to work together.

How does this work for you in practice?

Can you empathise with the other person enough to discover what they want, feel, wish for and are thinking? Can you articulate for the client what he might be feeling, wishing for or thinking? Can you identify for yourself what you are thinking and feeling? Might it be a good idea to put this on the agenda of a team meeting?

2) The basic attitude of Mentalization Based Support can be learned

You can only help the client to (learn to) mentalize if you yourself are in a 'mentalizing state'. In stressful and emotional situations, everyone occasionally reverts to a non-mentalizing attitude. It is important that you recognise this in yourself and bring a stop to it by investigating your feelings and thoughts and to determine what has been affecting you. You can then redirect your attention openly to the client. In order to mentalize effectively, you have to be able to respond flexibly and tolerantly, even when there are conflicts in yourself or your client. The following basic attitude is appropriate here:

1. You yourself are calm 'inside' and have learned to check this with yourself.
2. You do not pass judgement on the other person, but maintain an open attitude.
3. You are curious and exhibit an interest in the other person.
4. You can't know for sure what the other person is thinking or feeling (your standpoint is that of someone who doesn't know), but you want to investigate it. You can say the following to children: "There are no tell-tale signs that let me know how you feel or what you are thinking."
5. You are being yourself and are honest.
6. You are flexible and prepared to reconsider your opinion.
7. You are transparent and therefore respond predictably for the other person.
8. You make sure that a difference of opinion with your client does not become too 'personal' by observing it from a certain distance.
9. You focus more on what your client is experiencing on the 'inside' (thinking, feeling, wanting, wishing) than on his behaviour. It's about understanding your own behaviour and that of the other person by looking for its significance.
10. The relationship you have with your client is the tool or instrument you use for your work. So there will be a strong focus on potential disturbances in your contact.
11. As a caregiver you are responsible for resolving misunderstandings in communication; you take ownership of that responsibility. Caregivers sometimes refer to this as the 'fool's method', because you say: "I didn't understand you correctly." This has the effect of reducing stress for your client.
12. You are stimulating skills and insights that promote mentalization, both in yourself and in your client.

What is the opposite?

The ability to mentalize situations is susceptible to disruptions, which can happen to us all. How do you recognise this? If you are angry or have become emotional by your client's behaviour or if you feel treated unfairly by others, this may provoke stress, fear, uncertainty, anger or disappointment. It may even develop into hostility and prejudice. It is impossible to mentalize at times like these and you will have lost your open attitude to the other person. Thinking in black and white about yourself or the other person or thinking too positively or too negatively, may be associated with a limited ability to mentalize the situation at that moment.

Example 'Clarity and predictability for Petula'
Petula is a young woman with a mild intellectual disability and a borderline personality disorder. She is unstable, which can be observed by her mood swings. Caregivers have the feeling that whatever they do is not good enough. Petula is constantly looking for her caregivers to make what she considers mistakes and then responds indignantly and hostile and is incapable of reconsidering her opinion. The caregivers endeavour to be as predictable as possible by making clear agreements. Because the caregivers remain calm and maintain a positive neutral attitude, Petula becomes calmer and learns to articulate more effectively when she feels as though she has not been understood.

What does this mean for caregivers?
Try to maintain the basic attitude that promotes mentalization and to remove barriers. Show an interest in your client and mirror his behaviour: "I can see what you are doing."

Practical suggestions

Check your own attitude and that of your client if a misunderstanding in communication occurs. Because you cannot be sure what the other person is thinking or feeling, you investigate this. Try rewinding the 'film' of the situation until you reach the moment just before the misunderstanding started. Ask your client what he was thinking or feeling at that moment. It often becomes clear that your client feels misunderstood. This may be due to your behaviour as well as that of your client. Try to resolve this. For example: your client tells you something at the very moment you find yourself yawning. Your client then thinks you are not interested in what he is saying, while you are feeling tired. By taking ownership of responsibility in that situation, by saying: "I yawned because I was tired, but I understand that you thought I was not interested," you can dispel your client's irritation.

In short

Effective mentalization requires a flexible, tolerant basic attitude in which you show an interest in what is going on inside the other person. You cannot be sure of this, which is why you investigate by asking questions. You reconsider your opinions as needed.

How does this work for you in practice?

Are you successful in maintaining the basic attitude that promotes mentalization in working with your client? Ask yourself questions about your client's 'inner world': what is he feeling, what is he thinking, what does he want? Do you have a respectful, open and tolerant basic attitude?

3) Controlling your own emotions helps you to continue mentalizing

Learning to mentalize is a key step for children in their development into independent individuals. Mentalization provides a feeling of continuity: you learn to understand that you are acting on wishes and needs, on the basis of self-awareness. If a child learns to mentalize, it will have the resilience to cope with difficult situations and deal with problems. We will discuss how children learn this from their parents during their upbringing later. A key condition for mentalization is to understand one's own emotions and to get them under control, by recognising them, articulating them and learning to restrain them if necessary. If a child can control its emotions, in other words can cool itself down if it is angry, the situation will not get out of hand and cursing and swearing or aggression can be avoided. Mentalization is only possible in situations of low-level or moderate stress.

When does mentalization not work?
Mentalization is impaired or impossible if you are stressed or are experiencing too many or too few emotions. If you are deeply in love, you are not as adept at reasoning realistically or mentalizing. There is a saying: 'love is blind'. Clients with behavioural problems often experience a great deal of stress, which may be reflected by impatient behaviour or the inability to cope with frustration. And if they are angry, it is impossible for them to be sensitive to what their behaviour means for the other person. Bullying, cursing and swearing, aggressive behaviour or an inability to cooperate with others are all examples of non-mentalizing behaviour. Of course, it happens to all of us on occasion. For example, when you're in a hurry and have to pick up your children from the nursery and you're stuck in a traffic jam, you become impatient and easily get irritated at a motorist driving very slowly. You are not mentalizing at times like these. When you become aware of this, you return to the 'Mentalization mode'.

Example 'Annie wants to maintain control of her emotions'
Annie is a young woman with a mild intellectual disability who works in a supermarket. During a meeting with her job coach she told him that she had been angry at a colleague, because that person had ordered her to clean something up. Her manager, to whom she always turns if something is wrong, was in a meeting at the time. Annie has to learn, for example, not to curse and swear on the shop floor when she is angry; that's not done with customers around. When Annie has calmed down, the job coach talks to her to find out what she can do if she unexpectedly becomes angry and how to deal with this. Annie is keen to keep her job and cooperates in seeking a solution. She wants to maintain control of her emotions, for example by counting to ten or walking off into the warehouse. Her job coach explains that it's impossible to think clearly when you're very angry.

What does this mean for caregivers?
You cannot think clearly when your emotions are running high. In order to keep yourself under control, it is important that you can calm yourself down when you're angry, comfort yourself when feeling sorrow, and reassure yourself when fearful. As a caregiver you need a time-out (a

cup of tea) on such moments to calm down and reflect on the situation. Once you are aware of this and can take care of yourself, you can also take care of your client. Your client will also have to calm down before being able to think clearly again. He will need your support for this. A few deep breaths may help both you and your client to calm down.

Practical suggestions
You must realise that you cannot think clearly in your contacts with your client if you are angry, fearful or sad. Your client is also unable to think clearly when his emotions are running high. Many clients need you as their caregiver to maintain control of their emotions.

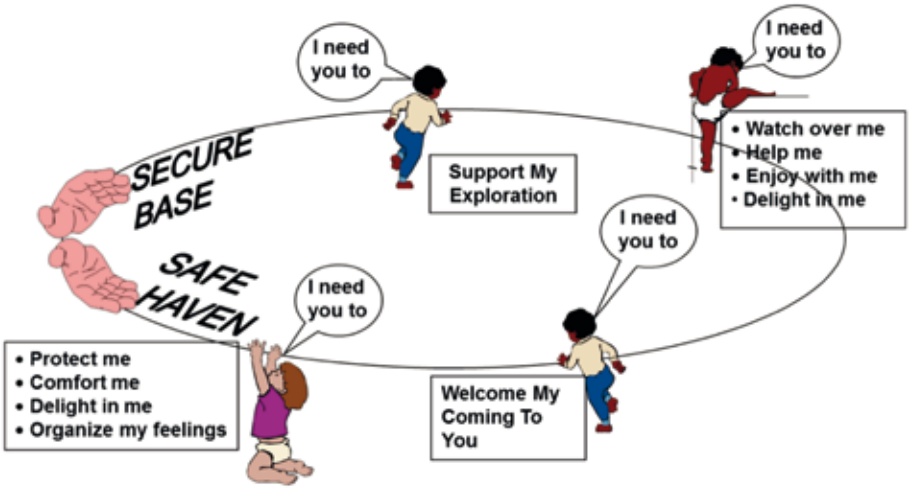
In short
Mentalization does not mix well with tension and stress. Likewise, mentalization does not mix well with very strong emotions either. You can only reflect on what might be wrong with yourself or the other person once you have calmed down again.

How does this work for you in practice?
You may encounter clients who are not keeping their emotions under control, which can be very intense for yourself. Do you ever have team discussions in which you look at situations in which you were no longer in control of your emotions and responded impulsively to the client's difficult behaviour? How do you calm yourself down and what can you do to help your client calm down? Try writing down one or two examples of such situations while carrying out your work in order to discuss them later.

4) Mentalization and the Circle of Security

Children develop their mentalization capacity within the secure attachment relationship with their parents. You might say: if the parent is able to mentalize, the child will learn this too. The parents of securely attached children are often better capable of mentalizing than the parents of insecure attached children. Children who are securely attached learn to mentalize effectively because the parent strengthens the child's mentalization capacity. The key here is that the young child has experienced his parent mentalizing about him, i.e. that the parent investigates what is going on 'inside' the child.

Mentalization theory complements attachment theory. Parents who mentalize are able to put their own feelings, thoughts and wishes into words; by empathising with their child they can also articulate its feelings, thoughts and wishes and guide them. How does this work? If you observe the child's behaviour with the parent, you can see how an effectively mentalizing parent responds to this. We can explain this using the **Circle of Security**.



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The top of the circle represents the parent as a secure base, from where exploration and development is stimulated. For example: the parent realises that the child is enjoying an activity and encourages this. That's how children learn to do things independently. At the bottom of the circle the parent is the safe haven: the child goes to the parent for support, comfort and protection. For example: The parent sees that the child is sad and responds by talking to the child about this and comforting him. That's how children learn to recognise and articulate their feelings. Becoming aware of one's own feelings, thoughts and wishes is a key component of mentalization. So the child learns from the way in which the parent handles this. At the top, parents encourage children to explore; at the bottom, they offer comfort and protection. If one system is 'on' for the child, the other system is 'off'. This means: when the child is busy exploring, it cannot at the same time seek comfort. This is also true of adolescents and adults. Older children do not need the direct, physical presence of parents as a safe haven as much as younger children. Contact can also be more distant, for example by mobile phone.

Secure attachment in children with a visual and/or intellectual disability

Many children with an intellectual disability are securely attached, but the percentage of children with an insecure attachment is higher than in the normal population (Feniger-Schaal, 2012). There is a correlation between secure attachment in children with an intellectual disability and the secure attachment of the parent. A parent who as a child was itself securely attached to his parents (in adults we refer to this as autonomous), has usually also learned to mentalize in his youth and can respond sensitively. This parent is better capable of reading the child's often delayed attachment signals, understands the child's 'inner world' and is capable of accepting the diagnosis and adjusting to this, following a grieving period. The same is true of parents of a child with a visual impairment (Loots et al., 2003); they are often better capable of understanding the signals that are difficult to read from their child who is blind or who has a visual impairment. In our experience, parents who are securely attached themselves are better capable of working with counsellors and support can then be provided more effectively.

A parent influences the mentalization capacity of his child

If the parent is not as good at mentalization, or in other words, cannot empathise with the child, or articulate the child's feelings, thoughts and wishes, the child will not learn to mentalize effectively. One reason for this may be that the parent is too restless 'on the inside' and is exposed to high levels of stress over prolonged periods because there are many problems. There may also be problems with acceptance of a child with a disability. Similarly, there may be an obstruction on the side of the child, such as an autism spectrum disorder, a visual impairment and/or an intellectual disability. Signals of attachment behaviour are less easy to read in these children. This means that the parents can be less successful at guiding the child's feelings, thoughts and wishes. The child does not learn to recognise and articulate his feelings, wishes and thoughts adequately and will then experience problems in controlling its emotions. Securely attached parents exhibit behaviour that promotes mentalization and do not have any behaviour that undermines mentalization, such as hostile meddling behaviour, excessive unpredictable behaviour, overly insensitive response and neglect.

Example 'The Circle of Security in the playground'

A familiar example is that of a pre-schooler playing in a playground. Let's call him Daniel. Daniel wants to go down the slide and his father checks whether this is safe enough before helping Daniel to climb to the top. Daniel and his father laugh at the fun they're having and are proud that they have climbed to the top before Daniel goes down the slide. "That's fun" Daniel's father says. And Daniel immediately wants to do it again! This is represented by the top of the circle. And now the bottom: imagine that Daniel should suddenly fall, become tired, get hungry or has a fright, his father will comfort him and calm him down. This teaches Daniel to articulate his emotions, and he realises that you do not have to be overcome by them. As Daniel grows older, he learns to reassure himself by expressing the emotion, thought or wish and to devise a solution. Once the 'battery' has been recharged, i.e. his emotions have calmed down or Daniel has rested, his father encourages him to play again. These experiences that are repeated daily help Daniel's father teach him to recognise his emotions and learn that you do not have to be overcome by your emotions but that you can become calm, after which you can enjoy things again. This everyday form of gaining control of one's own emotions is a key step *en route* to learning to mentalize effectively. Daniel's father says to him: "We've got to leave the playground now because we have to collect your brother from school." Daniel becomes angry and does not want to go with his father. He lies on the ground, stamping his feet in anger. His father says: "I understand your disappointment, because playing here is great fun. But we can't keep your brother waiting, you have to come along now. You can go down the slide one last time, come on." He picks Daniel up and allows him to go down the slide again, and then says: "It's a pity, but we can come again tomorrow." And he puts him in the buggy. In the case of pre-schoolers it is also important that boundaries are set and the child learns to listen, for example if it wants something that is too dangerous or if something is impossible at a given moment. When the child is older, parent and child have to learn to negotiate with each other. If children are brought up within a secure relationship, the child's behaviour is sometimes not condoned, although the child as an individual is accepted unconditionally.

What does this mean for caregivers?

Clients need different types of support in order to feel secure as well as a stimulus to explore and learn something new. When supporting clients on a daily basis, it is important to verify whether you are offering sufficient comfort and support and whether you are challenging the client sufficiently. It is important to offer support and to share the enjoyment after a challenge. Describe the emotions that the client might be experiencing. If the client feels secure, that contributes to his learning to mentalize.

Practical suggestions
Understand that you are helping your client to put his emotions into words and come to terms with them as you consistently use both sides of the circle: you are a secure haven and a secure basis, because you offer the client a challenge. This allows the client to carry on with his activities. You are an example to the client; the client will copy this from you in order to use it later himself (the client will do this for himself later). It is very important to use both sides of the Circle of Security, also in the case of adult clients. Put up a poster of the Circle of Security on the wall of your office or at school.

In short
Parents who mentalize pass on this skill to their children by articulating the child's feelings, thoughts and wishes and by stimulating and supporting the child in (new) activities. The Circle of Security illustrates how parents do this.

How does this work for you in practice?
Can you recognise the Circle of Security in your work with your clients? Are you encouraging your client to push against his own boundaries, one small step after another? Do you talk to your client when he embarks on something new? Do you put his emotions into words? Do you also express your own emotions, such as 'I'm proud of you' or 'I think it's great for you'. Working this way, you are operating from an attitude that promotes mentalization.

5) Sensitive mirroring: a precondition for sound mentalization

A parent is a secure base and a safe haven if he is capable of mirroring and articulating the child's emotions in a correct or sensitive manner. You will have read about this in the previous chapter. This chapter focuses in greater detail on the concept of mirroring. This refers to the parent's sensitive mirroring of the child's emotion. You can also mirror in a non-verbal way, such as mimicking a movement or adopting a similar attitude. What does a parent do when he is mirroring sensitively? A sensitive parent is aware that his baby has its own 'inner world', which differs from that of the parent. The parent endeavours to understand this inner world of the child. So sensitive here means that the parent is sensitive to the child's signals and interprets them correctly. The parent is responsive if he responds correctly to the child's emotions. Being responsive means that the parent responds adequately at the right moment and that the response is tailored to the child's signal. So if the child cries, the parent responds by articulating in words what might be wrong and the child is reassured and calmed. In this way, children learn about themselves from the outside (i.e. through their parents) in (its own feelings, thoughts and wishes). Recognising and articulating emotions does not take place automatically during development, but the child discovers this through the responses of the parent to what is occurring within itself. Babies and young children are very alert to this mirroring response of the parent. If the parent is 'good enough' at mirroring the child's emotions, the child gradually learns to recognise its own emotions. The parent's mirroring responses also have a reassuring and regulatory effect on the child. And so the child learns that you need not be overcome by your emotions. As the child grows older, it will also learn to reassure itself. This teaches the child to endure minor frustrations, such as having to wait briefly. This gives the child resilience and flexibility.

Mirroring the child's emotions in a sensitive manner

Focus on the following key points:

- The parent mirrors and articulates the child's emotion and not his own emotion; this is what we call *marked* mirroring.

- The child's correct emotion is mirrored and articulated. So the parent does not articulate sadness if the child is angry. This is what we call *accurate* mirroring.

- The child is calmed down at the right moment and the parent shows he can cope with this, which is a support for the child. If the parent succeeds in calming down or controlling the child, the parent gains self-confidence in bringing up the child and feels competent. The child learns that you do not have to be overcome by emotion and on the basis of that security, it remains sufficiently curious to explore.

What should you be alert to when mirroring with a client with a visual and/or intellectual disability?

Mirroring emotions can be a problem with children with a visual and/or intellectual disability, for their emotions and behaviour are more difficult to read by their parent. If the child has a syndrome that forms the basis for the visual and/or intellectual disability, information about this may help to understand the strong and vulnerable sides of the child.

Parents of a blind baby have to learn to be alert to the language of its hands and body. The facial expressions of a blind baby are flatter than those of a seeing child. Parent and baby must learn to recognise each other's contact invitations (Loots, 2003). When the baby turns its face away, this does not signify rejection, but is an attempt to hear better. The child is pointing its ear at the parent. If the child responds to the parent in silence, this may be a sign that it is listening attentively. Children with a visual impairment are much less adept at picking up the other person's non-verbal signals and it helps them if the other person articulates them verbally. Blind children also have to learn which of their own facial expressions are associated with a particular emotion, such as understanding that smiling is not associated with sadness.

In the case of children with an intellectual disability, the developmental age must be taken into account. A great deal of repetition is necessary for the child to learn. Mirroring must take place simply and specifically. Some children with a (very) severe intellectual disability exhibit a delayed or lesser response when their parent seeks contact with them. The parent then has to learn to be alert to these delayed responses (Feniger-Schaal, 2012). In the case of children with multiple disabilities, it is essential to take their level of understanding into consideration on account of the combination of disabilities. In the case of children with an autism spectrum disorder, a knowledge of what autism is will help in understanding their way of thinking, feeling and information processing. Specialised counsellors can assist parents to learn to mirror the emotions of the young disabled child and to maintain contact.

What is less efficient mirroring?

Sometimes the parent is not as successful at mirroring. For example, if you have the same fears as your child. Imagine that you are frightened of thunderstorms, and your child cries because it is startled by thunder and lightning. You can imagine that mirroring is more difficult because you yourself are scared. You're not always calm enough for this. As a parent, you are often called upon to *multitask* in everyday situations: cooking, answering your phone, and watching the children, including a baby. In that case, you might not be at the very height of your sensitivity. It's not a disaster if you as a parent do not mirror correctly all the time. What is important, is to subsequently restore your relationship with the child. So to verify what the child needs and then offering support (the bottom of the circle) or stimulating the child to do something (top of the circle). You then return to mirroring and see how the child experiences this. You should tailor your mirroring to the child's needs. The goal is to mirror the child's emotion as correctly as possible. Of course, this is not entirely possible all the time. A baby can develop resilience by occasionally experiencing a mismatch, a misunderstanding in the

mirroring that can be restored. The most important thing is that the child sees that the relationship is being restored and thereby learns that it can cope with mild frustrations.

When does mirroring fail?
Some parents are themselves restless and experience a great deal of stress from unresolved traumas, psychiatric problems or problematic living conditions. Or the parent may not respond adequately to the child, for example because of depression or strain. In that case, the parent does not have sufficient rest and inner stability to clearly see the child and his own style of upbringing. The parent finds it difficult to effectively mirror the child's behaviour and emotions. The parent might, for example, quickly withdraw from the contact, respond unpredictably or be overly intrusive and interrupt the child's play continuously. This may lead to misunderstanding in the interpretation of the child's behaviour. In that case, problems arise in the interaction between parent and child early on in its development, such as restlessness in the child or a parent who cannot calm the child down. If the parent does not mirror the baby's emotions accurately, or does not do so at all, the feelings remain unarticulated and that is confusing for the child, the result being that emotions are not controlled effectively.

Example 'Mary is startled'
Nine-month-old Mary is startled by an unexpected loud noise and cries. How does her mother mirror this? She mirrors Mary's emotion: "Oh dear, haven't you had a fright," and exaggerates slightly (she was not startled herself). She mirrors the correct emotion, i.e. having been startled, so not anger or sadness. She calms Mary down at the right moment (when she is startled) and not an hour later. Her facial expressions are calm and she automatically adjusts her voice and pitch to calm Mary down, for example: "shhhh", singing or humming or rocking the child to and fro while holding it close. Mary is unable to calm herself down. She depends on her parents for this. Mary gradually becomes calmer and her mother directs her attention to play and enjoyment. Mary's mother recognises the different ways in which Mary cries, and usually knows what is wrong. Mary learns to recognise her 'inner world' through her mother's mirroring. This will contribute to her own capacity to mentalize. Mary has the experience that her stress and emotions can be calmed with the assistance of her mother. In this way, children slowly learn to recognise their emotions, express them and gradually exert control over them.

Example 'open hands'
Conrad is a five-months-old boy. He was born blind. His parents are of course sad about this. The coach visits them at home. Conrad lies on his back in the playpen. His mother says: "Look, Conrad wants contact; I can see it by his hands, they're open." It's good to see that his mother has succeeded in adjusting to what Conrad needs by being sensitive and seeking a means of compensation for his visual impairment.

What does this mean for caregivers?

Mirroring correctly is conducive to the mentalization capacity. Clients need support in their everyday lives and you provide that by mirroring their emotions. This means that you pick up the signals from the client, interpret them correctly and respond to them quickly and adequately. Make sure not to mirror the wrong emotion and try to check this with your client. In the case of behaviour that is difficult to read, do this in collaboration with the parents and your colleagues. Clients with a visual impairment miss the non-verbal signals of emotions from another individual sooner. In that case, repetition of the mirroring is important, in which you also articulate the non-verbal signals. Also in the case of clients with an intellectual disability, it is important to repeat things frequently and to check whether they have understood, because their learning process is slower and language mastery is limited and concrete.

Practical suggestions

Use the three key points by mirroring the client's emotion correctly, i.e. 1: you mirror the emotion of the client and not of yourself; 2: you mirror the correct emotion and 3: you calm the client down by your timely response and you show that you are capable of this. One tool for learning to mirror more effectively is to use video feedback. If you are not sure whether you are mirroring the correct emotion, check with your client. In the case of clients with a moderate or mild intellectual disability, you do this by asking. You are then mentalizing, because you are checking whether you understand your client correctly.

In short

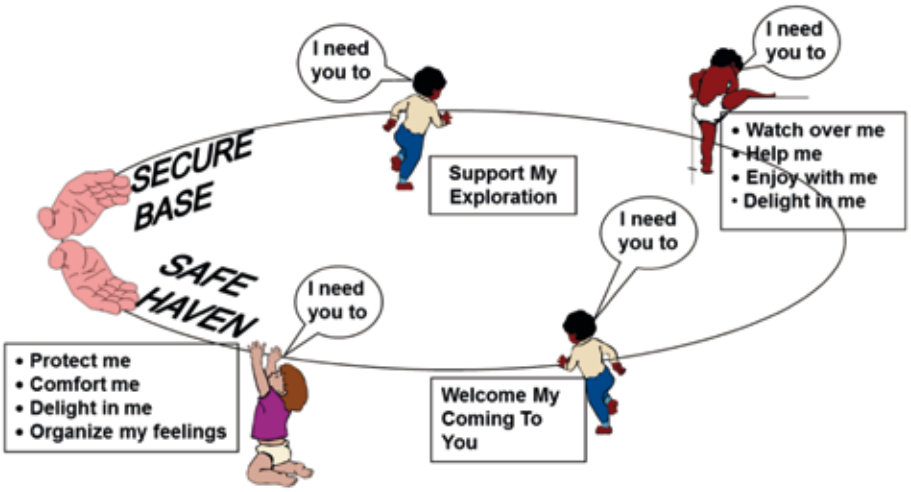
If you as a caregiver feel comfortable and calm, you are best capable of mirroring the client's emotions correctly. You do this from a mentalizing attitude. This means you are aware of your own feelings, thoughts and wishes and at the same time also consider what the feelings, thoughts and wishes of the client might be. The client will then feel understood because the correct emotion is mirrored at the right moment, which calms him down and restores positive contact.

How does this work for you in practice?

How do you mirror emotions for your clients? Are you using the three key points? Are you expressing the emotions with an appropriate tone of voice in the way that Mary's mother would? Do you adjust your method of mirroring to your client's possibilities and limitations?

6) Limited mentalization by parent and child if mirroring fails

Let's go back to the Circle of Security.



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The two previous chapters explained what happens to mirroring when the circle is secure. However, there are also three insecure circles, in which mirroring is suboptimal or even fails completely. The consequence of this is that the child's mentalization development is limited and sometimes even undermined. This is not something you can see by looking at a child, although you do notice it as it interacts with others. While the various forms of insecure attachment are quite complicated to recognise in practice, we will set them out briefly below.

Anxious-avoidant insecure attachment: an insecure haven

There is a secure base: the child explores well and appears independent. However, the home haven is insecure. If the child turns to its parent for comfort or support, i.e. the safe haven, the parent is incapable of providing that sufficiently. The parent experiences painful feelings such as aversion, uncertainty or rejection. The child may then experience intense feelings of frustration mixed with fear. We refer to this form as avoidant insecure attachment. The parent *mirrors insufficiently and in a one-sided manner.* The child unlearns to express emotions and learns that this vulnerable attitude is seen by the parent as whining. Because the parent supports the exploration in a one-sided manner, children may start to feign their independence. Where learning to mentalize is concerned, this means that the child does not learn to recognise its own vulnerable emotion. When experiencing stress, it will have the tendency to focus attention on the environment or on toys or, for example, doing fun things, i.e. on the top of the circle. The child does not expect any comfort and it tries to avoid emotions, such as sadness. The child is sometimes overcome with intense emotion, such as a fit of temper.

Anxious-ambivalent insecure attachment: an insecure base

The circle is limited to the safe haven: the child seeks proximity and wants to remain close to the parent. The parents of these children respond in a changeable manner: sometimes adequately and sometimes insensitively. The parents themselves are, for example, fearful if the child leaves or they need the child for themselves. The child observes the attachment figure continuously and cannot lose himself in play. The parent's *mirroring* is not delineated, *marked out* sufficiently: the parent adopts the child's emotion and becomes fearful or angry himself, leading to escalation and exhaustion. The child does not learn to distinguish between its own emotions and those of the other person. It does not receive reassurance and it learns that: what I'm feeling is really bad. The child does not receive enough stimuli to explore the world.

Disorganised insecure attachment

The parent is unpredictable and unreliable for the child with regard to the safe haven and the secure basis. The child is facing a dilemma that cannot be resolved: the parent is a source of fear and comfort at the same time. The child is facing a situation of fear that cannot be resolved (*fright without solution)*. This leads to an extremely high level of stress in the child, resulting in confusion and the exhibition of conflicting behaviour. This stress also has a negative impact on neurobiological development. This attachment style often occurs in children who have been maltreated or neglected. Parents with unresolved traumas may also exhibit behaviour that may be frightening to children. This sometimes occurs in a subtle way by means of gestures or changes in the parent's voice. In young children, the fear of the attachment figure is visible immediately or may be inferred from bizarre or conflicting behaviours towards the attachment figure during stressful situations. The child simultaneously laughs and cries or walks towards the parent and away from him again without making eye contact. After a while, children generally start to develop strongly controlling behaviour as a kind of strategy. It appears as though the child wants to keep control of the situation in order to prevent new frightening situations. Role reversal sometimes occurs in the form of exaggerated considerate or punishing behaviour towards the parent or the child has a great deal of uncertainty regarding the emotional availability of others. The child finds it difficult to develop confidence in its own observational capacity. Learning to mentalize is undermined because the child cannot deal with the frightening information. Mirroring fails and there is no control of emotion.

The relationship between insecure attachment and limited mentalization capacity of parent and child is strong

There is a relationship of approximately 75% between (in)secure attachment in the child at one year of age and the attachment style of the mother as measured during pregnancy (Van IJzendoorn, 1995). The primary explanation for the transfer of attachment style appears to be the mentalization capacity of the mother (Slade, 2005). Parents who are not good enough at mentalizing are less capable of mirroring the child's emotion, which may lead to rigid patterns in insecure avoidant attachment and insecure ambivalent attachment. In the case of children who have disorganised attachment, the stress and restlessness is so high that the child's

mentalization capacity is undermined. This may lead to psychological disorders and behavioural problems. So there is a close correlation between a limited mentalization capacity and the parent's insecure attachment style and the transfer of this to the child.

Is it possible to transform an insecure attachment relationship into a secure attachment relationship?

By creating secure relationships in the here and now, and by stimulating mentalization, a client can gradually start to feel more secure (Zevalkink, 2007). This also means that the child can adjust its expectations of the other person and itself in a positive sense, for example from mistrust into greater confidence. Another term for that expectation of the other person and of oneself is the internal working model. Our own research (Sterkenburg, 2008) shows that children up to the age of 18 with a visual and severe intellectual disability were able to enter into another attachment relationship with a healthcare psychologist or were able to do so for the first time (see also database of acknowledged youth interventions of the Netherlands Youth Institute).

The opposite of failing mirroring is effective mirroring, which helps in learning mentalization
There is a full Circle of Security. The contact is secure for the child. Mirroring the emotions of the child is good enough. The child adequately experiences the parent as a buffer in the event of stress and emotions and starts exploring again once it has been reassured. The child is understood and mentalization starts to develop. The child learns to recognise, express and control its own emotions. This also enables it to start understanding the emotions, thoughts and wishes of the other person.

Example 'Limited mirroring'
Annette, the mother of Cathy, an 8-month-old baby, is depressed. Annette feels guilty that she is not playing enough with Cathy. She tries to overcome this by playing with Cathy so intensively that it becomes too much. Cathy cannot cope with all this stimulation and keeps withdrawing from the contact in order to regulate herself. Annette does not recognise the overstimulation that Cathy is experiencing and feels rejected by Cathy. Annette herself then withdraws and is disappointed and her mood becomes even more dispirited. In the meantime, Cathy has calmed down and again seeks positive contact with Annette. Unfortunately Annette fails to recognise the moment and Cathy in turn feels rejected. Because this occurs regularly, it has resulted in a negative pattern in the contact between Annette and Cathy. Mirroring goes wrong because Annette cannot recognise Cathy's emotions. Annette is preoccupied with her own emotion. Cathy feels rejected and insecure, just like Annette, her mother.

What does this mean for caregivers?
Clients who are insecure attached need positive, corrective experiences with social relationships and emotion control. What helps to reduce insecure attachment? First and foremost the client needs an emotionally available attachment figure in everyday life, who is capable of responding to the client in a sensitive manner. Might you be that person? Observe whether the client feels more at ease and more open in his contacts in evidence of a growing confidence in

you. When mirroring the client's emotion, check whether the client understands this and can cope with it.

Practical suggestions

If a child sees that his emotions, thoughts and intentions are mirrored correctly, he will feel better understood. This is very simple in the case of a young child, for example: "You want to pick up that toy, go ahead." And then: "You're happy that you succeeded, aren't you?" Feeling understood does not come automatically, the child has to learn this through experience. Also apply the three steps of successful mirroring with clients who have not yet learned this. Mirror as concretely as possible, including the physical signals of tension. For example: "You're clenching your jaws tightly; you're sitting in a corner with your head in your arms; you're stamping your feet; your voice is loud; you're whispering ..." By doing this you stimulate your client's mentalization capacity. If your client is experiencing tension, you can also seek out positive moments, humour and fun in your contact. This has the effect of reducing stress, for laughing is incompatible with stress.

In short

When the parent does not mirror effectively and does not tailor responses to the child's inner world, that is a risk factor in the development of children. Consequently, children do not learn to recognise their own emotions, which makes it difficult for them to control them. They exhibit rigid responses and feel either too little (I'm showing off) or too much (what I'm feeling is really bad) or they are confused and respond in a conflicting manner. In the case of insecure avoidant and ambivalent attachment, the child's mentalization capacity is underdeveloped. In the case of disorganised attachment, this capacity is even undermined.

How does this work for you in practice?

Have you ever wondered whether the client is experiencing insecure attachment? What did you do if you suspected this? Have you discussed it with the psychologist? Can you give a concrete example of insecure attachment behaviour in your client? What elements of your contact work well?

7) Expanding the stress tolerance zone

One person can tolerate more stress than the other. This may also vary depending on the situation or relationship. We refer to the amount of stress people can cope with as the individual 'bandwidth' or 'tolerance zone'. In the tolerance zone you can think about yourself and the other person and deal with difficult experiences, or: mentalize them. Just like other mammals, people have a stress response system that helps them survive in the event of danger. If this system is switched 'on', you cannot mentalize situations at the same time. You might say that your stress response is your 'rapid' system and mentalization is your 'slow' system. If you are in danger of being hit by a car in traffic, you don't stop and think first, but respond immediately. This response ensures survival. Mentalization is switched off or 'overruled' by your superfast instinctive survival response. If the situation is secure again and the danger has subsided, the slow, thinking brain can regulate the stress brain.

There are two types of stress response systems, which are closely associated with the control of emotion. The first is more active: in the event of increased tension and alertness (*hyperarousal*) the *fight* or *flight* reaction ensues. The third option is an alert, motionless posture in which you do not want to stand out and you observe the situation, but in which you are hypervigilant and ready to fight or flee (*active freeze*). If you have done something stupid that you are ashamed of, you might exhibit a flight response: 'I wanted the ground to open up and swallow me'. The second stress response system is of a more passive nature: responding by falling very quiet (*passive freeze*), in which tension and emotion are suppressed and there is little alertness (*hypoarousal*). This form may occur if you experience a threatening situation, such as sexual abuse.

Everyone has these two stress response systems, which are 'switched off' when we're feeling secure, which is when the brain is calm, and you can learn things by turning your attention to them, and reflect on things and mentalize them again.

This is represented by the following diagram:

Start diagram

WINDOW OF TOLERANCE

Increased tension: chaos, hyperarousal, hypervigilance
Behaviour is impulsive and rapid: fight/flight/hypervigilant (*active freeze*). You cannot think calmly. You are overcome by emotion. You may relive traumatic experiences.

Optimum condition: correct bandwidth, mentalization, integration
There is a normal level of concentration and alertness. Your thoughts, emotions and behaviour are calm. In this 'condition' you can mentalize, are socially involved, have the attention to learn things and can process and integrate information. There is good emotion control. You can say the following to a child: your 'window' for learning is just right. In this state a child or client can also investigate painful or conflicting feelings, for example during a therapy session or a discussion with the parent, teacher or caregiver.

Too little tension: hypoarousal, extreme inhibition and rigidity
You cannot think. Nothing happens. You feel no emotion. You feel flat and empty. This is what we call the '*passive freeze*'. Even pain reactions may be diminished. Dissociation may occur, which means that certain thoughts, emotions, observations or memories are placed outside of consciousness, are temporarily 'irretrievable' or exhibit less coherence.
(Pat Ogden, 2006; Arianne Struik, 2010)

End diagram

Secure attachment contributes to effective stress regulation

The speed at which you can return to your window of tolerance in the event of stress, shock or intense emotion, determines your resilience. Stress regulation is optimal in children who are securely attached, because the child regularly experiences comfort and reassurance, thereby allowing fear and tension to disappear. The child then has the attention it needs to learn and feels connected to the other person. In the case of young children, good stress regulation has a favourable effect on the development and growth of the brain, such as the memory function (Waal, 2006). This is a key condition for young children learning to mentalize.

What if the window of tolerance is too small?
In children growing up in a situation of severe insecurity and stress, in clients with a borderline personality disorder or a complex post-traumatic stress disorder (PTSD), the window of tolerance is too narrow. In clients with a visual and/or intellectual disability, there is assumedly a heightened vulnerability to trauma. Clients suffering from intensely debilitating psychological symptoms may be so unstable that they are continuously on the boundary between *hyperarousal* or *hypoarousal*. This means that the very slightest trigger may cause disorder, which has a very disruptive effect on communication, social relationships and attention to

learning. If your client has an unresolved trauma, it may be relived in the here and now, leading to stress and panic. One problem in this regard is that it is an automatic response that the client is not always aware of. In children with an attachment trauma, in which the relationship with the parent is the source of tension, the hypersensitivity to stress lies in the relationship between you as the (adoption/foster) parent/caregiver and the child. You could say that the 'adjustment' of their stress thermostat is still in the 'danger' zone or towards the top of the diagram: too much tension: mistrust, hostility, aggression, walking away, hypervigilance or not wanting to stand out. The thermostat can also go more towards the bottom of the diagram: feeling too little tension and emotion, inhibition. That was important in order to 'survive' in the stressful, dangerous situation in the past, but is no longer adequate because such a threat no longer exists today. It even has a counterproductive effect in a situation that is secure today, such as a good social relationship with your partner, caregiver or adoption/foster parent. In young children who experience a chronic threatening situation, the overly high level of stress disrupts the development of the higher brain functions (Waal, 2006). That is why the negative impact of disrupted attachment on the development of young children is so significant (Coppens & Kregten, 2012). The good news is that research shows that intensive treatment can help to improve the disordered neurochemistry of the brain and thereby help the child feel secure (Schuengel & Janssen, 2011; Cozolino, 2010). This is what we refer to as the neuroplasticity of the brain. For example, Integrative Therapy for Attachment and Behaviour (*Integratieve Therapie voor Gehechtheid en Gedrag*, Sterkenburg, 2008) in clients with (very) severe intellectual disability and disrupted attachment has shown a positive effect on entering into an attachment relationship. Communications improve, there are fewer behavioural problems and cortisol production is lower. Cortisol is a stress hormone that increases under tension. If the window of tolerance is too narrow, this may be broadened by reassuring and stabilising the client. This is very compatible with therapies designed to promote mentalization. Additionally, (psycho)therapy may help to reduce the psychological and stress-related symptoms that have a detrimental effect on mentalization, as in the case of fear, depression or trauma.

Example 'Sam feels easily threatened'

Sam is a ten-year-old boy with a moderate intellectual disability. He has been growing up in a family in which both parents have psychiatric problems. Sam has disorganised attachment and feels easily threatened. He says he constantly has a 'knife feeling' (fight) or a 'running away feeling' (flight). Sam has many behavioural problems and moves to live in a special grouphome for children with behavioural problems. It takes years before he can experience greater calmness 'inside' and broaden his window. During the therapy sessions he exhibits a repetition of traumatic, disorganised play for a long time, such as disasters and abductions, which can gradually be transformed into more neutral perceptions.

Example 'Lucy overcomes her nightmares'

Lucy is a thirty-year-old blind woman with PTSD problems. She was the victim of sexual abuse some years ago. She feels guilty for not having resisted the offender. She relates that she 'didn't feel anything'. Her therapist explains that during the abuse she was in a state of hypoarousal in order to survive. It is a normal, human response to an abnormal situation. Because Lucy is blind, she was unable to fight or flight, and instead she 'froze' (*passive freeze*). Her nightmares ended following EMDR trauma therapy. There is also a focus on increasing her resilience and she is learning to set boundaries.

What does this mean for caregivers?

It is important to be aware of the client's window of tolerance and to recognise too much or too little tension. This can be seen in the case of a child with attachment trauma by it feeling rejected too quickly or closing itself off from influences. This is because the child has a trauma in the relationship, causing excess tension too quickly (fight/flight response) or even too little tension (nothing happens). If this occurs, respond neutrally and with caution and try to reassure the child. Be alert to things that may trigger or provoke an old trauma. This may be a sound or an odour. If the child 'explodes' at the slightest provocation, you may suspect it could have something to do with a past trauma. It is important for adoption and foster parents to understand this and to recognise it in their child (Coppens & Kregten, 2012).

Practical suggestions

Offering reassurance, support and security help in developing an attitude that promotes mentalization. You do not pass judgement, but show empathy. The goal is for the client to feel at ease, which broadens the window of tolerance. Check whether the client exhibits physical tension or restlessness. Try to get the client breathing calmly and participate yourself, inhale and exhale: whhhh. Getting some exercise may also be helpful, for example going for a short run or hitting a punch ball. One suggestion from a caregiver to a client with a visual impairment and/or mild intellectual disability may be to look for a way to regulate increased stress, which will help to lower tension and reduce the risk of an explosion. Clients who understand this are already capable of mentalization.

In short

It is only possible to mentalize situations if you are inside your window of tolerance. Traumas, such as exposure to domestic violence, sexual abuse, maltreatment or neglect lead to disruption of the stress response system, undermining mentalization. In such cases, only a very small trigger is needed to cause the client to switch to a state of *hyperarousal* (fight, flight or not stand out) or *hypoarousal* (freezing). The frequent and long-term repetition of offering reassurance, support and security is necessary to correct this behaviour in a positive sense and to broaden the window of tolerance. A client may benefit from (psycho)therapy to cope with a trauma.

How does this work for you in practice?

Think of a client who is coping with increased stress. How are you offering reassurance, support and security? Are you observing any progress? Does the client feel secure? Is he less fearful or vigilant?

2 The stepwise development of mentalization

Children develop best when they feel secure and are at ease. Children who are securely attached have self-confidence and allow themselves to be influenced in a positive way during their upbringing at home and at school. The child has the attention to learn, both regarding feeling and thinking for themselves and with regard to the perspective of the other person. Children gradually learn to mentalize. This development is associated with the development of self-awareness. If the parent mirrors emotions correctly, the child becomes increasingly conscious of its own self. Besides being able to mirror correctly, a playful attitude of the caregiver is important for the development of mentalization.

Children develop their self-awareness in six consecutive phases which the child passes through between the ages of 0 and 6. The various phases gradually transition from one to the next and can also exist alongside each other. The child constantly practices the precursors of the following phases. Children like to play. Their play is a natural tool in experimenting with mentalization. The importance of play, and particularly pretend play, is substantial.

The development of self-awareness is connected with how the child thinks and experiences reality. That happens in four steps. Three of these four steps are precursors of mentalization. If the child is capable of simple mentalization at the age of 4, it has completed these four steps in experiencing and thinking and this can be seen in how the child plays.

Mentalization skills become more complex and refined in school children and adolescents. Besides the relationship with their parents, relationships with peers also become important.

In the case of children with a visual impairment and/or moderate to mild intellectual disability, the development of mentalization is slower and special attention is necessary in their upbringing and education to stimulate mentalization. In principle children with a visual impairment go through the same development phases as seeing children. There are several differences in children who are born blind, which are set out in the following chapters. In children with an intellectual disability the various phases take longer and the various domains (such as language, motor skills, memory) develop less harmoniously. Quite frequently, for example, social emotional development lags behind cognitive development (Došen, 2014).

We already established that a child does not learn to mentalize correctly if the mirroring of emotions by the parent fails. Mentalization stagnates in that case. This means that the growing child continues to function in a young non-mentalizing way of thinking, in whole or in part, even when it is an adult, which may lead to psychological disorders. The chapter titled ‘Reverting to a non-mentalizing way of thinking’ discusses this further.

1) Mentalization and the development of self-awareness. Learning social-cognitive skills

If the young child feels secure because the parent is available and mirrors emotions effectively, the child becomes increasingly aware of its 'own self' and this is associated with learning to mentalize. A securely attached child experiences itself as someone who matters, who has influence and who is valued. Children learn by imitating and by being receptive to what the adult wants to teach them. There are large individual differences in the tempo of development. The mentioned calendar age is intended as a general indication. There is, however, a fixed sequence of six phases in the development of 'self-awareness' (Allen et al, 2008), which are described using baby Elise as an example:

Phase 1: first few months: its own body as a source of action (physical)
The baby experiences that its own body is different from an object, for example by moving its arms and legs or moving a toy in the cot. While lying in the cot, 3-month-old baby Elise discovers that the baby gym moves if she moves one of her hands against it. This is the start of the physical self, i.e. the child learning that a physical action prompts a reaction.

Phase 2: first 6 months: the baby as a social being (social)
Baby Elise realises that she can have a social influence on the other person. By smiling, for example, the other person laughs back and her father or mother comes when she cries. This is the start of the 'social self'.

Phase 3: from approximately 9 months: targeted action (teleological)
The child learns to make actions even more targeted. This is still possible without language. The baby is focused primarily on the goal to be achieved and not yet on understanding cause and effect. The child develops the understanding that it can do things efficiently with a specific goal, for example crawling towards a ball. The goal is for the baby to take the shortest route. From the approximate age of 6 months, Elise learns that an action has an effect. For example, she pushes away the spoon while feeding, turning this into a game, and expects the spoon to return. The child is focused on the visible, audible, tangible action and this is still pre-verbal, non-lingual.

A major precursor to learning to see things from another person's perspective, is to learn *joint attention*. This means that if Elise's mother points to something, Elise understands that it's not about her mother's finger, but about what she is pointing at, for example a toy. If the child understands joint attention, this signifies the transition to the next phase, i.e. an understanding that the other person has an intention. Another key social cognitive skill that children now learn is that the young child pays a great deal of attention to the emotional response of the parent to what it is doing. The child also takes note of what the parent thinks of a certain toy. Does mummy approve or disapprove of the toy? Is a situation secure or dangerous? This skill is referred to as *social referencing.*

Phase 4: from the approximate age of 2 years: precursors of mentalization: the child discovers intention (intentional).
The child understands that an intention lies behind the action of the other person; the other person has a wish or a will. The child also discovers its own wishes and intentions. Elise says for example: "I want to play outside." The child starts to play with others and its fantasy develops. Linguistic development is a key skill in learning to mentalize. In this phase children learn the words to express their thoughts and feelings. Around its second year of life, the child recognises itself in a mirror and discovers that the mirror image is something different from its own face. This contributes to self-awareness.

Phase 5: from the age of 3 to 4 years: a thought or a feeling is something inside and something different from reality (representational)
Elise discovers that if you think about or feel something, it is not a fact, but a conviction. Elise can look at herself and the other person from a certain distance. This is the phase in which the child learns to mentalize in a simple manner. The child learns the difference between what you do (behaviour) and what you can think or feel 'inside' in the process.
Phase 6: from the approximate age of 6 years: *the child experiences itself as having been placed in time (autobiographical memory)*

Elise starts to recognise more cause and effect and can place her own memories in a coherent, autobiographical narrative with a past, present and future. At around the age of 7, Elise can recall that she still believed in Father Christmas when she was 5, but she no longer believes in him now she is older. Elise starts to better understand herself. Elise discovers that she herself or someone else does something on the basis of a particular intention, but also that people have certain character traits. From the age of about 7 onwards, Elise starts to understand what it means when someone has died, i.e. that the departure is final. This is important for the grieving process.

Development in clients with a visual impairment

In clients with a visual impairment, extra attention is needed in their upbringing in all steps in the development of self-awareness. Vision plays a significant role in learning to recognise the signals from the parent (*social referencing*, phase 3). It is necessary to compensate for the lack of vision by the other senses, such as hearing and language. Joint attention does not develop in blind children until they reach the age of 18 to 24 months (Moleman et al, 2009) instead of 9 months in a seeing child. It is more difficult for a blind child to focus its attention on an object and a person at the same time. Parents of a blind child have to learn to observe subtle signals of attention of the child when it responds to sounds, such as a minor movement of its head or body (Preisler, 1995).

Development in deaf-blind clients

Besides visual disabilities, hearing impairments also frequently occur. There is a small group that is deaf and blind. Sometimes an intellectual disability is also present. Specialist expertise is required for communicating with this group of deaf-blind individuals.

Deaf children develop faster than children who are blind (Preisler, 1995). Damen et al. (2014, 2015) describes various studies in deaf children, showing that joint attention of deaf children with deaf parents develops at 10 months while symbolic communication develops at 12 months. Deaf children with deaf parents develop faster than deaf children with hearing parents. The use of sign language is essential for deaf children. It is also important for the child to be able to see its parent at all times during their contact. No research is available on the development of social contact in deaf-blind children, although it is likely that their development proceeds slower than in a blind or deaf child. Deaf-blind children have a great deal of difficulty in understanding others and making themselves understood, as a result of which they may become isolated. There is a special intervention programme to stimulate communication and development in deaf-blind children, the key factor being that the child's social partner adapts to the child's specific possibilities and limitations (Damen et al., 2015).

Development in clients with an intellectual disability

In clients with an intellectual disability, the level of the intellectual disability, or developmental age, and not the calendar age is the ceiling of their development of self-awareness. The tempo of development is also slower and simpler and several problems often occur. For example, visual, auditory, motor disabilities and epilepsy frequently occur. If the child has an intellectual disability because of a syndrome, information may be available on development with the syndrome with specific strengths and weaknesses. For example, the development of joint attention is delayed in children with Down's syndrome, because the child focuses more on contact with its parent than on an object, such as a toy (Hauser-Cram et al, 2012). The level of self-development must be assessed for each client individually. If the developmental age is linked to the development phases listed in this chapter, the following image broadly emerges.

- Developmental age between 0 and 2/very severe intellectual disability: first 3 phases may be feasible
- Developmental age between 2 and 4/severe intellectual disability: phase 4 possible
- Developmental age between 4 and 7/moderate intellectual disability: phase 5 possible
- Developmental age between 7 and 12/mild intellectual disability: phase 6 possible

We note here that we are making an assessment on the basis of clinical experience, because the development of self in this population has yet to be researched. In the case of children with an autism spectrum disorder in addition to their intellectual disability, the development of self-awareness will be especially difficult, because they experience problems with observing and processing (social) information. Children with an autism spectrum disorder will have had

difficulty with imitation and joint attention when they were babies. Their imaginative play is also delayed (Warreyn et al, 2014).

Children who are unable to mentalize well

In primary school age children who are unable to mentalize effectively, we observe this among other things, by a poorly developed self-awareness. This may give them the idea that they are powerless to control their lives. Children who have experienced too much stress and insecurity during their first years of life, run a higher risk of suboptimal self-awareness. They do not understand they are gaining more and more control over their lives as they grow older. Their social cognitive development and associated mentalization capacity stagnates. This has serious consequences for their social emotional functioning: they are unable to cope with their experiences. This makes them vulnerable and may cause psychological problems. The mentalization theory in clients with a borderline personality disorder considers the disorder of self-awareness a key aspect.

Example 'Mindy thinks it's time that grandma came back'

Mindy is a 13-year-old girl with a visual impairment and a severe to moderate intellectual disability. As far as the development of her self-awareness is concerned, she is functioning on the border between fase 4 and 5, and not yet at fase 6: seeing herself placed in time. She is referred for therapy on account of depressive symptoms. A pupil in her class passed away 3 months ago. Mindy cannot help but cry about this time and again. Her grandma passed away a year ago. Mindy tells her mother: "It's been long enough now, it's time for grandma to come back." Her teacher moved to another job 6 months ago, which made Mindy sad. Mindy appears downcast at the death of her grandma and her classmate and the teacher's departure. The therapist sees that for Mindy the sadness at the departure of the teacher, but also of trainees, and the passing of people around her are intermingled in her perception. Her experiences are a chaotic mishmash. The therapist makes sketches, drawing a house for the people who have departed and a casket for those who have passed away. The therapist orders her drawings in which Mindy places photos of the people in question alongside the house or the casket. In this way, the therapist brings order to the chaos. Mindy becomes calmer and learns the difference between departure (those people who might still visit her) and passing away (those who cannot visit her any more).

What does this mean for caregivers?

Check whether you understand the six phases of the development of self and can recognise this in your client. It is important to align with the correct phase in the development of self-awareness and stimulate the following phase. Phase 5 is achievable for clients with a moderate intellectual disability: the start of learning to mentalize. You can stimulate self-awareness in this phase by teaching your client to express his wishes, feelings and thoughts. Or to learn social skills, such as taking your own wishes and those of others into consideration and negotiating about this. This is quite difficult for a client with a moderate intellectual disability, but it is also a challenge to learn in a simple, concrete manner not only to focus on oneself but also on the other person and to find a balance between the two.

Practical suggestions
Read these six phases and determine the phase you recognise in your client. The phase in which the client finds himself determines what is needed to stimulate his self-awareness. Support can then be geared to his self-awareness.

In short
The development of self-awareness keeps pace with that of the mentalization capacity. If self-awareness is well-developed, the client understands that he can have an influence on his environment. This is important for a positive self-image and a feeling of competence.

How does this work for you in practice?
How would you assess your client's self-awareness? In which stage does your client find himself? Has he completed all the phases? What does your client need? What form of support will match his self-awareness?

2) The importance of play for the development of mentalization

Young children practice mentalization in a natural manner during their play. There are many moments of play during contact between parent and baby: the child mimics the adult and vice versa. Parent and child enjoy their playful contact. The tempo and intensity of their play must be well-matched.

The first type of play involves manipulation, such as feeling a rattle or cuddly toy. The next type of play involves combination play in which the child plays with two or more objects, such as tapping two blocks of wood together. The child develops more functional play from the approximate age of one. The child mimics reality, such as holding a telephone to its ear or stirring a saucepan with a spoon. The object is always put to its correct use. The child increasingly exhibits more symbolic play from the age of 18 months, such as removing a doll from a bathtub and drying it with an imaginary towel. The most important thing here is the child's fantasy, although this is not connected to reality. The inner world is still disconnected from reality. The fantasy is experienced as something real, i.e. reality, and the child can rapidly be distracted from its imaginative play. The child's ability to hold on to its imaginative play gradually improves. For example, the child pretends that it can fly like Superman, and wears a cape.

During play, the child starts to express more emotion and experiences and increasingly will understand that fantasy and reality are not one and the same. From approximately 4 years of age, the child develops its pretend play, expressing experiences and emotions in its play and connecting the reality of its own experience and emotion with fantasy. We refer to this as the integrative method of play and thought, or in other words, the child starts to learn to mentalize. The child can understand that the inner world is unrelated to but at the same time connected with the outside world. Play also stimulates the ability to think flexibly and to approach and resolve a problem creatively. That is how a child learns to cope with conflicts; it is a 'game' after all (Groothoff, 2009). Aside from the development of fantasy, the ability to concentrate on play is also a key condition for playing well.

Children with a visual impairment and/or intellectual disability progress through the same stages as seeing children, but the development of play is slower. It is important to stimulate play and fantasy in blind (and also visually impaired) children. A special course has been developed to that end, "Spel bij blinde kinderen voor begeleiders" (*Play in blind children for caregivers*) (Moleman et al, 2009). Blind children find it more difficult to mimic others. Imaginative play is delayed. Children with a moderate or mild intellectual disability process information slower and a great deal of repetition is needed during play. Play is a good means of expression for children with a moderate or mild intellectual disability, as it is less of a challenge for their verbal capacity.

What problems occur during the development of play?
Some children with problematic attachment are unable to play well. It may appear as though they are 'playing' outdoors when, for example, they are cycling, running and climbing. But if you study this play carefully, you note that fantasy and playing together are missing. If fantasy falters or if an older child entirely loses itself in its fantasy, these are potential signals of stagnation in social and emotional development and in learning to mentalize. If children pay too little attention to play, this may be a signal of restlessness or stress. It is important at all times to look at the entirety of the child's functions. Delayed play development might be caused by tiredness associated with illness.

Example 'Playing school'
Elise is 7 years of age and in primary school. She plays school with her 9-year-old brother, where one child is the teacher and the other the pupil, although the roles may change. This enables Elise to process her impressions and emotions in a natural manner. Play is not threatening because of its pretend nature.

Example 'Karen is fearful of her thoughts'
Karen is a 7-year-old blind girl. Play therapy is teaching her how to play. Because of her visual impairment, Karen finds it difficult to understand the world around her and soon becomes afraid. When she hears somebody's voice over the lift's intercom, she is startled and thinks someone else is in the lift. She believes that her thoughts are reality. If she's talking about a wasp, for example, she thinks there is a wasp in the playroom. By stimulating her to engage in imaginative play, she begins to learn that her thoughts are inside her head and need not necessarily be true. She starts to enjoy experimenting with her fantasy. She says that there is a film inside her head that is a kind of story. She does not understand that the therapist cannot know what is happening in the film and is therefore incapable of playing the story together. A few play sessions are needed before she understands this and can tell the story of her film.

What does this mean for caregivers?
Mentalization is connected with imagination; with being able to imagine what another person is thinking and feeling. So it is important to stimulate the development of play. You achieve this by adopting a playful attitude as an caregiver. Make sure you set aside enough time to play attentively with the child, and in doing so mainly follow the child's own play. Attempt to consolidate the play by articulating what the child is doing while playing and making appropriate noises, such as "vroom" when a car is moving. You can make suggestions for play, but take care not to allow your own fantasy to dominate the play. Many adult clients with a moderate or mild intellectual disability are still eager to play and it is important to maintain and stimulate this. This can take the form of role play or making a story together so that it is age-appropriate and not too childish. If children lose themselves in their fantasy too far, make a connection with reality. In that case you might say: "It's not real. It's just pretend. It can't be like this in real life."

Practical suggestions

It is important to stimulate play and fantasy for the development of children. You can help the child by displaying an interest and taking part in its activities. Feel free to sit next to the child at the table or on the floor. Try to extend the play or raise it to a higher level. Combined play involving children starts by them sitting alongside each other. You can try to raise their consciousness of each other by saying: "Carol enjoys doing that too." Children's social skills are stimulated when they play together.

You can securely assume that children with a visual impairment and/or intellectual disability will always need help and support in their play. Stimulate their curiosity and enjoyment in playing. Some children are easily distracted and cannot play by themselves for very long without support. Other children, for example those who are disorganised attached, may become disinhibited in their play, as a result of which things may become chaotic, aggressive or focused only on disasters. Caregivers must set limits to this kind of play. You have to maintain supervision, also in the interest of the other children. Try to exert an influence and encourage 'safer' play, such as 'boy's game with shooting'. Such children may benefit from play therapy in order to learn safer games and come to terms with their traumas.

In short

Play helps in the integration of reality and fantasy and in the learning of ever better mentalization skills. The ability to mentalize is the 'tool' you need for learning to cope with life's difficult situations, such as disappointments, frustrations and significant events. A child who plays in a concentrated manner in its youth, learns to mentalize in a natural way.

How does this work for you in practice?

How do the children play in your grouphome or at school? Do they play imaginatively? If young children do not play, this may indicate development that is stagnating. Verify whether the child is paying sufficient attention to the game. How might you provide support for (imaginative) play in adult clients with a moderate intellectual disability?

3) Step 1 Goal- and action-oriented way of thinking

A 9- to 15-month-old baby focuses on a goal and achieves it through an action. This is still possible without language, i.e. without words. For example, the child crawls in a very direct way (the action) to the location of the ball (the goal). A baby of this age still experiences very intensely the visible, sensory side of an action or deed: a kiss from his mother means that she loves him. In this phase the baby learns object permanence, i.e. that objects continue to exist for the child, even if they are not in his field of view. Children practice this by throwing toys away and retrieving them again. The social version of this is personal permanence, i.e. the child learns that the adult will return, even if the child cannot see or hear that person. Children practice this by playing peekaboo. This is also possible for blind children, using sound: a special audio version of peekaboo. Personal permanence is important for the development of attachment. In this phase, playing and thinking are still without language and are not symbolic. If this goal- and action-oriented way of thinking often occurs in older children, this may suggest a stagnating social and emotional development and limited mentalization. We will discuss this in greater detail in the chapter on a non-mentalizing way of thinking.

What is the opposite?
The child is good at integrating fantasy and reality. The child can place itself in the perspective of the other person and can observe and assess its own behaviour and that of the other person and assess situations on the basis of wishes, thoughts and feelings, or in other words: mentalize.

Example 'Corey hears himself'
Corey, a 10-month-old blind baby, stamps his feet on the wooden floor and listens to the sound they make. Corey's play does not involve any words. He acts by stamping his feet with the goal: hearing the sound. Because he is blind, this is his way of exploring the world around him. This is normal behaviour for his age.

Example 'Ian finds it difficult to finish his story'
Ian is an 11-year-old blind boy with a mild intellectual disability. He is suspected of having autism spectrum disorder. He responds in a very childish way when his therapist asks him to finish the story he was telling, which was part of an educational game. The playing pieces have wooden feet and Ian is focusing only on those. He doesn't get round to finishing the story and is only interested in stamping the wooden feet on the floor. He says he'd also like a pair of wooden shoes to make a noise with them. Ian has yet to develop imaginative play. Ian is good at talking and should, in line with his mild intellectual disability, be able to make up a short story. But he seems unable to do so. He doesn't get round to it, and focuses only on making a noise with the wooden shoes. Ian has no idea of the purpose of the play test. The fact that he is focused on sounds is in keeping with how blind children act, but the fact that he is fixated on the sounds and cannot detach himself from them would suggest an autism spectrum disorder. Ian has not progressed beyond the action-oriented way of thinking of very young children, in which there is a visible, tangible or audible goal. He is unable to curb his impulse of becoming fixated on sounds, and therefore pays no attention to the world around him. He needs

structure imposed from the outside in order to focus his attention on other things. He is unable to learn this by himself.

What does this mean for caregivers

This action- and goal-oriented way of thinking is still in its infancy. Such a way of experiencing things occurs frequently in clients with a very severe intellectual disability, corresponding with their own individual capacities. In children whose development is slow, it is important to stimulate the next stage. In that way, you can help the child to progress from manipulatory play to combination play. For example, by comparing the noises made by two toys on the table.

Practical suggestions

Try to understand that the client assesses you based on what you do, the visible facts. You can set an example in the way you act. You, for example, might have a rule that says you mustn't spread your peanut butter too thickly on your bread. Check whether your client mainly mimics you or whether he can apply the verbal explanation in practice.

In short

In very young children and clients with a very severe intellectual disability, a focus on a visible goal by taking a particular action is a normal phase in their development. In normally intelligent children from the age of about 4, who do not progress further than this or who constantly revert to this, this may suggest a disorder or delayed development.

How does this work for you in practice?
Do you recognise this mode of reaction in your clients or your grouphome? Are you bearing in mind that children who function in an action-oriented way are still unable to use language but they do understand the tone in which you say something?

4) Step 2 Thinking in reality

Children of about 1½ to 2 years of age continue to equate their inner world of thoughts and fantasy - the things 'going on in their head' - with the outside world; they are still unable to distinguish between fantasy and reality. So a child can be afraid of its own fantasy, because it does not understand that they are its own thoughts. If the child thinks that there is a monster in the cupboard, then there is actually a monster in that cupboard. Thinking is still in concrete terms. The child is not yet able to think in terms of alternatives and also thinks that the other person is thinking the same thoughts as himself. If it thinks about anger or fear, it is actually angry or fearful. The child is too realistic in this phase. Dreams also appear to take place in reality. If a young person or adult dreams, the things they experience during the dream appear to be real. But when they wake up, they realise that it isn't real or true. Very young children are unable to do this yet.

If something is so good that it's hard to believe, adults sometimes say, "I had to pinch myself to see whether it was real." And if the pinch hurts, then this 'dream' is true. A kind of reality check. Very young infants cannot do this yet.

What is the next step in development?
The thing that the child has to develop in the next phase is imagination, which is detached from reality, and subsequently integrate fantasy and reality in step 4. The child is then able to mentalize.

Example 'Cliff gets very angry'
Cliff gets very angry if he engages in sword fighting role play with the therapist or boxes wearing the boxing gloves. Cliff cannot yet play as-if, it's too much like reality. The therapist articulates this: "Cliff, this is pretend fighting, it's not real," to help him distinguish play from reality and to stimulate his fantasy: it's only a game.

Example 'Reexperiences are reality for Eric'
During therapy, Eric, a 9-year-old boy with a visual impairment and mild intellectual disability, plays in the doll's house and decorates everything because someone has moved house. Suddenly, entirely unexpectedly, everything is dismantled without noticeable reason. All the furniture flies through the house and chaos ensues. In the beginning this is pretend play, but the play approaches reality too closely because of his traumatic history. He is overcome with the re-experience invoked by his play. He cannot control it. He is still unable to think: it's just pretend. He needs the therapist's help for this. Eric is rapidly overcome with restlessness which suddenly comes over him. This makes him very impulsive. The same occurs in his everyday life. He can have a sudden fit of temper. Eric has a trauma on account of maltreatment at home when he was younger. It is possible that his play triggers the re-experience of his trauma. Re-experiences are reality for him (*actual mode*). Eric is unable to think about this yet, he is overcome by it. The therapist tries to help him get to grips with this by stopping his play and saying: "Let's rewind the film. The furniture was being installed neatly and calmly, so what suddenly happened?" Eric replies: "It was bad weather, a storm …" Therapist: "They were

startled …, what can they do …" Eric: "Shut the doors and windows." The therapist says: "So shut the doors and windows, just pretend." That is how Eric learns to take control of his impulses and to articulate them.

Example 'A lion in the playroom'
Elsa, a 10-year-old blind girl plays about a lion that is about to attack ... This is imaginative play. But she suddenly becomes afraid, perhaps there is a lion in the playroom? Elsa's blindness means that she cannot make a visual check to see whether there really is a lion in the playroom. The step towards imaginative play is more difficult for blind children because their imagination can be threatening when it becomes too real. Children with sight scan the room with their eyes and reassure themselves. But young, seeing children can also be afraid of their imagination and then have to be reassured by reality. The parent mirrors the child in that case: "I can see that you've had a shock," and can then walk with the child to its bedroom, for example, to reassure the child that no lion is hiding under the bed.

Example 'Rows of cars'
Peter is 7 years of age and visually impaired. He arranges his toy cars in rows; places the animals in a zoo, arranges playing pieces in groups that belong together, but his play does not progress any further. Peter does not give in to his fantasy. The play is too static for his age. The caregiver can stimulate Peter's fantasy by joining in the play, for example by moving a car down an imaginary road and making the appropriate noises: vroom, vroom. This way, he can coax the child into playing … And where is this car off to? He can make the car go fast, or even go off the road …

What does this mean for caregivers?
The step from reality to imagination is a big one for a blind child. The child may be afraid of its own imagination. However, children must first develop imaginative play in order to learn to mentalize. You stimulate the child's development by offering imaginative play in a playful manner. If the child still only thinks in terms of reality, it is unable to empathise. The child experiences what it is thinking or feeling as an established fact. As a caregiver you have to be attuned to this and follow the child.

Practical suggestions

Play along with children so that you can stimulate their fantasy. Do not hesitate to sit on the floor with them, or at a table, and encourage them to turn their attention to play. If the child is afraid of its own imagination or has an unpleasant dream, you might say: "It's not real, it's only a game, it's just pretend."

In short

Children and clients whose thoughts represent reality for them, experience their thoughts and feelings as facts. They are unable to think about them correctly. They can be overcome by their emotions. They are also susceptible to misunderstandings in communication, because they assess everything on the basis of the other person's behaviour and not the intention behind it.

How does this work for you in practice?

Do you observe that your client is thinking in terms of reality? Does your client already have fantasy? Your client is not only thinking in terms of actions any more, but is using language to tell what is going on. Can you use words to explain to your client what is going on?

5) Step 3 Pretend thinking

Imaginative play develops further during the pretend-thinking phase (from about 2 years of age). The child first mixes reality and fantasy (step 2), after which it experiences fantasy and reality separately (step 3). Imaginative play in this phase is detached from reality. The inner world is divorced from the external reality; reality is suspended for a while, it briefly disappears during imaginative play. The child plays a game, for example, in which a row of chairs represents a train. It is pretending, but does not yet clearly understand what pretending means. In blind children, it is important that imaginative play is stimulated and that the child learns to use it.

What is thinking in imaginative terms not?
It is not yet the ability to mentalize, not yet being in the integrative mode. In step 2, the phase where one thinks in terms of reality, there is no difference between fantasy and reality; imagination may be threatening. Imaginative play is a normal step in the development of the young child. If older children continue to function in this pretend fashion, their imagination may 'run riot' as a kind of escape from reality. So imaginative thought cannot yet be considered as mentalization, as it excludes reality. Children find it more difficult to process frustrations and disappointments because they are unwilling to address them; they escape into fantasy, into a pretend mode that they pretend is real for them. They often respond in clichés, such as: "because", or "I don't know" or have delusions of grandeur through idealisation.

Example 'Marion strongly identifies with her idol'
Marion, a 19-year-old woman with a moderate intellectual disability, frequently focuses on Robbie Williams, her favourite pop singer. She wishes to be addressed only as Robbie Williams and no longer responds to Marion, her own name. She fails to respond when the caregiver asks, "Marion, it's lunch time, will you come to the table please." She only responds when asked: "Robbie Williams, your lunch is ready." Then she comes to the table. Marion is functioning in *pretend mode* (fantasy) and is unable to integrate the reality of her being Marion with her fantasy that she is Robbie Williams. What started as a joke is now impossible for Marion to forget. Young children often have imaginary play friends, but this fades away in time. In clients with a moderate intellectual disability, such an obsession may remain with them for years if the intellectual disability makes it impossible for them to achieve the next step in their development. Marion has an intellectual age of 4, which means she is functioning on the boundary of step 4, learning to mentalize.

Example 'Fantasy forms a distraction for Giselle'
Giselle is a 9-year-old girl with a moderate intellectual disability and is wheelchair-bound. Her eyes have deteriorated over the past year, and she has become blind. She likes fairy tales, and she listens to her audiobooks. She particularly likes 'The Wonderful Adventures of Nils', the story about a boy who has all kinds of adventures while flying around on a goose. This is the only thing she wants to talk about at school and in the group. Her parents and caregivers indicate that she is suffering from depressive complaints, probably because of the powerlessness she feels in the face of her impaired vision and motor skills. She refuses to talk

about this and distracts herself by using her fantasy. Giselle uses *pretend mode*, her fantasy as a distraction from her sorrow and powerlessness over her blindness. In order to accept and cope with her disability, she will have to face up to reality and learn to express her sorrow and powerlessness. If she fails to do this during therapy and her everyday life, her means of coping with her disability will stagnate. She will not progress beyond 'fantasy or *pretend mode'*.

Example 'Olivia's cup of imaginary tea'
Olivia is a 10-year-old blind girl with normal intelligence and autism spectrum disorder. In the playroom she recalls that she was playing with her 3-year-old cousin during the weekend. She says that there was 'something' to do with imagination. The therapist says: "Why not act it out." Olivia pretends to pour the tea into the doll's tea set and hands a cup to the therapist. "We have to drink it now, there's nothing in the cups, it's a fantasy." The therapist continues the play. "Would you like something to eat, Olivia?" And pretends to serve some chips. Play training teaches Olivia that there is something called 'fantasy'.

What does this mean for caregivers?
It is very important to stimulate children's fantasy. As a caregiver you can do this in an everyday, playful manner. When dealing with blind children, you can act out an imaginative play together, so that the child feels secure with its fantasy. In children with a moderate or mild intellectual disability, you can also stimulate the fantasy by thinking up a story together and by introducing more fantasy into play. Do this attentively and calmly.

Practical suggestions
It is important that children develop their fantasy. You can stimulate this by playing with them. Puppet shows are very suitable for teaching children to play different roles and consequently to inhabit different worlds. Another good means of stimulating their fantasy is to read to them. In adult clients with a (moderate) intellectual disability, you can devise a short stage play involving dressing up clothes to stimulate the fantasy.

In short
Development of the fantasy and experimenting with this during play is a key condition for learning to mentalize. Fantasy helps to observe things from a distance and to detach oneself from reality. The child can practice various roles during imaginative play and thereby learn to discover different perspectives. This is an important precursor to learning to mentalize. Children with a severe intellectual disability can start to learn imaginative play.

How does this work for you in practice?
If you work with young children: how do you stimulate imaginative play? And how do you do this for older children and adults? Do you ever switch roles during play so that your client experiences things from a different angle? Are you able to help your client out of his familiar pattern or role?

6) Step 4 Mentalization: integration of thinking into reality and fantasy

In this phase the child learns the difference between reality and fantasy. Imagination is no longer threatening for the child because the child understands that it is fantasy and not reality. For example: the child is playing a game about a monster but knows that the game is not real and so he does not become afraid. The child understands that the game is pretend and can at the same time play out its emotions and use them during the game. It can integrate the experiences and emotions from reality into its fantasy (from approximately 4 years of age). That is how the child starts to learn to mentalize. The child understands that the inner world is unrelated to but at the same time connected with external reality.

When does mentalization not happen?
Development is not progressing well if a normally intelligent child between the ages of 6 and 12 does not proceed beyond the first three phases and the integration of reality and fantasy has not yet commenced. This occurs quite frequently in children with a severe form of problematic attachment, as they are unable to develop in a calm and peaceful manner because of continuously high levels of stress and a lack of safety. This development may be slower in children with a visual impairment and/or a moderate/mild intellectual disability, and there is a higher risk of disrupted development. Step 4 is not achievable for clients with a severe intellectual disability. Their cognitive level lies between the ages of 2 and 4.

Example 'John learns to empathise'
John is a 13-year-old boy with a mild intellectual disability. He became blind several years ago. John has been referred for play therapy, asking for help in controlling his emotions; he rapidly becomes aggressive to other people. John plays a recurring game involving knights: they destroy each other, kill each other. In his everyday life he can soon become aggressive if he is startled or frustrated, which may cause him to 'explode' and threaten other people. When challenged about this, he is unable to mentalize the situation, i.e. he cannot empathise: he was threatened, so that entitles him to threaten other people, he thinks. If this is not possible, he wants to run away. John is incapable of realising what his behaviour does to the other person. While at play during the therapy session and in his everyday life with his caregivers, he can be receptive to suggestions in a neutral situation to calm down or resolve things differently. In the event of stressors such as shock, he adopts a stress response too quickly: he wants to fight or flee. Attempts are being made during therapy to further integrate his imaginative play (*pretend mode*) with reality, including his feelings about his blindness. The therapist makes a suggestion while they are playing with John's favourite dinosaurs: "Imagine that the dinosaurs are blind and have to find their way or accidentally bump up against each other, what might happen then?" This is a good intervention for John. John discovers and starts to realise that the other person is also unable to see him and practices this new reality during his play. John also starts talking about how he is sometimes startled because of his blindness. If someone is in his path on his normal route, he is afraid of losing his way. Because John can cope with the dramatic experience of losing his sight, he starts to understand his own startle response. People supporting him can also help him by offering frequent reassurance. John gradually finds more

peace; he is startled less frequently and does not get as angry as before. His window of tolerance becomes wider. He begins to enjoy his activities and learns about new opportunities, such as a specially adapted email programme for blind clients.

Example 'A memory corner for Kim's mother'
Kim is an 8-year-old girl whose mother has passed away. She reveals more about this in her play. She makes a kind of memory corner in the sandbox. The therapist says carefully: "I'm just thinking, does this have something to do with your mummy?" Kim nods in the affirmative and sighs. Therapist: "Is there anything else that you would like for this corner?" Kim remains silent, but decorates the corner with pretty stones. Kim integrates the experience of loss into the imagination of her play. She makes it clear to the other person that this is her intention. Kim is capable of integrating fantasy and reality and can mentalize this. That is favourable for the gradual coping with such a difficult experience.

What does this mean for caregivers?
How is the child thinking? Is it thinking very concretely, focusing only on the facts? Is the child mainly engaged with its fantasy, separate from reality? Once the child understands that someone else can think differently from himself, and once it understands the intention behind a certain behaviour, he is capable of mentalization. This is also achievable for clients with a moderate or mild intellectual disability. Do you recognise your client's way of thinking? This is important for understanding the client and making contact with him. Discuss this with your colleagues and the psychologist.

Practical suggestions

Give your client a helping hand in learning how to mentalize. This requires extra repetition and practice in clients with a visual impairment and/or moderate/mild intellectual disability. In clients who are blind or visually disabled, it is very important to use words to describe the facial expressions of the other person whom they cannot see.

In short

Children develop in their thinking. They initially focus on goal-oriented actions and mainly observe concrete facts. Then their fantasy develops. Normally intelligent children can mentalize situations in a simple manner, as a result of the process of development which preceded this, from about 4 years of age. Development is slower in blind and visually disabled children and children with an intellectual disability. Additional attention is also needed during their upbringing to stimulate these developmental steps.

How does this work for you in practice?

How do the children play in your grouphome or at school? Do they repeat their play or are you observing a development in which they act out their experiences and process them? Do they enjoy their play?

3 Four different dimensions of mentalization

Children start to mentalize in a simple way when they are about four years of age. This skill becomes increasingly complex and refined as the years progress. You can compare this to linguistic development, which progresses from saying simple words to sentences and then to abstract usage. A qualitative change in thinking occurs during adolescence, resulting in the young person becoming more conscious of himself and capable of more self-reflection. Adolescents learn to think more strategically by taking account of more than one facet of a situation. This is important in social communication, but also for decision-making (Blakemore, 2007). Mentalization capacity develops further during adulthood under the influence of new experiences, such as parenthood. Good mentalization also requires an active attitude to communication and social relationships of adults in order for them to understand themselves and the other person. Adults who can mentalize effectively are able to switch flexibly between the following four dimensions:

1. Automatic (implicit) – conscious (explicit)

2. Inwardly oriented – outwardly oriented

3. Oriented at oneself – oriented at another person

4. Thinking (cognitive process) – feeling (affective process)

A great deal of research is currently ongoing into the problems experienced by people who are unable to switch flexibly between the various dimensions. This may lead to problems in relationships and symptoms in the person himself. Researchers assume that many people with psychological disorders have a rigid, one-sided pattern of not being able to mentalize or only being able to do so to a limited degree. People with a visual disability may also fail to register information or not understand it correctly on account of their disability, potentially causing rigidity or one-sidedness. Mentalization in a broad sense in clients with a mild intellectual disability is presumably too complex and as a caregiver you have to be careful not to ask too much of them and avoid strain. It is important to point out the alternatives to this group in a simple manner. In that way, they may learn to look at themselves and the other person in different way. We will now discuss each dimension in greater detail. You will see that the dimensions are also interconnected.

1) Switching between automatic (implicit) and more conscious (explicit) mentalization

Mentalization is usually automatic and rapid. This is intuitive or implicit mentalization. It is achieved easiest in relationships in which both persons feel secure, as in a secure attachment relationship between parent and child, between partners or between a client and a trusted caregiver. Your initial response is often the best one. Only when there is a misunderstanding you will consciously discuss what has taken place. This is termed conscious or controlled (explicit) mentalization. Conscious mentalization is slower and requires greater effort than automatic mentalization during a conversation, because it demands attention and reflection. An example of conscious mentalization is the articulation of feelings when irritated or asking yourself 'how could I have done this' or 'what would my client think of this?'

In our day-to-day relations, it is fine that mentalization is intuitive or implicit, almost automatic, which makes social relationships smooth. For example, if you respond with understanding (intuitively) to what your client or colleague tells you, it is automatic. You empathise with the other person's experience, making him feel understood. But you can also make mistakes with implicit understanding, as you may draw the wrong conclusions. In that case, you need to make a smooth switch to conscious (explicit) mentalization in order to restore the misunderstanding. Conscious mentalization is much more difficult in emotionally charged situations. Explicit mentalization is difficult, for example, during a conflict in the workplace, during a domestic argument or in the face of your client's aggression. It is important to mentalize consciously (explicitly), but the capacity to mentalize comes under pressure because of intense emotions. It is beneficial first to establish the intention of the other person. Understand that you cannot be sure what the other person is thinking or feeling.

When there is no switch
Only mentalizing consciously (explicitly) bogs down social relationships, as explicit mentalization will always delay the conversation, making it less spontaneous. In extreme forms, we call this hypermentalization. If you only mentalize automatically (implicitly), you cannot identify your misunderstandings and preconceptions, as a result of which you may respond inflexibly.

Example 'Eating together'
You respond quickly to each other in an everyday family situation, such as during an evening meal. And if you reflect on every interaction, you are engaged in 'hypermentalization', which impedes social relationships. If one of the children is quieter than usual, it's a good thing to consciously ask them about this. Something bad might have happened at school or the child might not be feeling very well. If an argument ensues following a question to find out if anything is wrong, stress increases and it becomes much more difficult to mentalize explicitly. In that case, it is much more difficult or impossible to identify or discuss preconceptions. You can only discuss and reflect on what might be wrong once everyone is calm again. It might have

something to do with you, if you did not pay sufficient attention to the child, making him quieter.

What does this mean for caregivers?
Clients with a moderate or mild intellectual disability think about themselves and the other person slower and in more concrete terms. Do you detect a balance in your clients between automatic (implicit) and conscious (explicit) mentalization? If your client is *too* cautious and inhibited, this may be a reason to stimulate automatic (implicit) mentalization, i.e. learning to respond spontaneously during a conversation. If your client responds rapidly in his social relationships, but fails to detect misunderstandings correctly, conscious (explicit) mentalization will be a point of attention. This is too demanding for some clients and you have to keep things very simple, brief and concrete and observe whether they are not being overloaded. State that your client cannot know for sure what the other person is thinking or feeling, but that he can ask the other person about this.

Is there a balance in your own method of mentalization? Are you capable of switching flexibly between automatic and more conscious mentalization? Take note of how you think about your client when writing your daily report. Sentences like: … 'the client goes out of his way to get attention' or 'exhibits manipulative behaviour' may indicate a preconception.

Practical tips

Observe your client consciously; after a meal, record three examples of automatic mentalization and three examples of conscious mentalization. This will help you become more conscious of the way in which your client mentalizes. If you notice an imbalance between automatic and conscious mentalization, it is important to think about how you might stimulate your client to mentalize more automatically or more consciously.

In short

Mentalization is an important skill for understanding yourself and the other person and for interacting with each other. Rapid interaction in which you mentalize intuitively is pleasant. If there is a misunderstanding or if you do not understand something about the other person or yourself correctly, it is important to think about this consciously. By mentalizing both intuitively and consciously, you remain flexible and are able to prevent or resolve conflicts and arguments. This applies both to you as a caregiver and to your client.

How does this work for you in practice?

Take as an example a client who you suspect is unable to switch well between automatic and conscious mentalization. Do you recognise how he mentalizes automatically? Do you recognise how he mentalizes consciously? What might you say to this client to help him mentalize more intuitively or more consciously? Examples for prompting your client to think about things more carefully are: “Does the other person know that you think this? Have you told the other person this? What does your mother think about this? How do you feel about how your housemate responded? What would you think if someone behaved like that to you?” Be careful how you report on your client. What statements can you make about your client’s behaviour and about your own response?

2) Interpreting your own behaviour and that of the other person 'correctly' (external-looking versus internal-looking)

Becoming aware of the significance of the other person's behaviour starts by 'seeing' that behaviour. This involves observing the facial expressions and non-verbal signals such as a yawn, frown, laugh. The next step is to assign the correct meaning to this behaviour and to learn that there may be several meanings. For example: when someone frowns, he is uncertain or angry, or if the other person laughs, he is happy or shy. Children learn to assign the correct meaning to behaviour because the parent mirrors and articulates the child's (internal) emotions in combination with the behaviour and facial expressions (external). The young child learns that emotions and thoughts (internal) and behaviour (external) are interconnected and form a whole. When it is somewhat older, the child also learns to recognise the behaviour and emotion of the other person.

Clients who are blind or visually impaired miss a great deal of non-verbal information in interactions, and they must be made aware of this during their upbringing. This deficiency can be compensated for to some extent by listening attentively to silent moments, tempo, tone of voice, volume, breathing during a conversation. By using words to identify the non-verbal facial expressions of the other person and yourself as a caregiver, clients with a visual impairment are assisted in linking behaviour and emotion.

Clients with a moderate or mild intellectual disability may find it difficult to assess and maintain an overview of the social situation, for example because they do not understand some words or information. Caregivers must be alert to this.

When there is no balance

By failing to mirror the correct emotion to the child during the process of upbringing, the child does not learn to link emotion and behaviour in itself and the other person. This may give rise to misunderstandings and the stress may become so intense that it may result in differences of opinion, arguments or behavioural problems. There are two patterns that indicate a problem in the link between internal and external aspects in older children and adults. The first is that 'internal' (thoughts, feelings, wishes, intentions) is equated to 'external' (behaviour). This is referred to as 'overly concrete thinking' (*actual* or *equivalent mode*). The second variant is that internal and external are disconnected, we refer to this as thinking in the pretend mode. We will return to this later in this book.

Example 'Theresa's mother'
Theresa is a blind 16-year-old adolescent. She has just had an accident, and this has shocked her deeply. She tells her mother about this together with her caregiver. Her mother is quiet and only says that it is horrible for her. Theresa later tells her caregiver that she did not think that her mother was very understanding. Because Theresa is blind, she does not see the non-verbal facial expressions and therefore sometimes fails to detect the other person's intentions. Theresa's caregiver tells her: "I saw tears in your mother's eyes and she's truly shocked." When Theresa asked her mother about this later, her mother said that she was very shocked and really felt for Theresa. Theresa's mother has to learn to put her facial expressions into words and Theresa has to learn that she must ask for this.

Example 'Yawning'
Imagine that you as a caregiver cannot stifle a yawn while talking to your client (behaviour); your client might interpret this as 'Sylvia thinks I'm dull and boring'. The client only assesses your behaviour on the basis of what he observes 'on the outside' (yawning), while you as a caregiver might have another reason for this (on the inside). You might be tired, because you have been working hard. Your client does not see any other reasons for your behaviour.

Example 'I want you to look inside yourself'
Andrea, a 20-year-old woman with a mild intellectual disability, feels very strongly about what she exhibits of herself (behaviour) to other people (external focus). For example, if she is angry or wants attention, she stands under the stairs in her house. She assumes that the caregivers understand her behaviour and will interpret it correctly. During a therapy session she discovers that this assumption is incorrect and leads to misunderstandings. Andrea starts to investigate the difference between her behaviour (what other people observe on the outside) and her feelings/thoughts and wishes (the meaning she gives to her behaviour). She discovers that she cannot assume that her caregivers will interpret the intention of her behaviour correctly. She sighs: "I wish I had a little hatch in my head so that you could look inside and understand me."

What does attention to the inside and outside world mean for caregivers?
Clients who are blind or visually impaired can miss information in the relationship between facial expressions and behaviour (external) and the thoughts and feelings of the other person (internal). It is helpful if you both understand this and use more words and intonation to support your behaviour, feelings, thoughts and wishes. Clients with a moderate or mild intellectual disability think slower and in more concrete terms. So learning to link 'internal' and 'external' is a point of attention for caregivers during the upbringing.

Practical suggestions

In clients with behaviour which is difficult to understand, such as aggression, we have a tendency to focus too much on the behaviour (the aggression) and less on the significance of the behaviour, in other words what is happening on the 'inside' (feelings and thoughts). By assigning several meanings to the behaviour, we can start to better understand the client. Articulating several of the meanings makes the client conscious of the difference between what the other person can observe (behaviour) and cannot observe (feelings, thoughts, wishes). You can also practice this by means of a game in which each person alternately says something. You start every sentence with: "I think that you think that …"

In short

In order to mentalize correctly, it is important that you link the correct meaning, from 'inside' (feelings, thoughts, wishes, intentions), to 'outside' (behaviour, facial expressions, posture). By presenting the client with alternatives, the client starts to learn that several meanings can be given to behaviour. This challenges him to be clearer about what he is trying to express by his behaviour.

How does this work for you in practice?

Think of a difficult situation or a misunderstanding between you and the client. Is your client conscious of the behaviour that he is displaying to the other person? Are you as a caregiver conscious of the significance that you are assigning the behaviour? Might it be possible that the client assigns a different meaning to his behaviour than you? Do you ask your client about the meaning of his behaviour? For example: "I can see you frowning. Are you uncertain or angry? Can you tell me what's wrong?" How does the client experience your desire to learn to understand him?

3) Switching between orientation on yourself and on the other person

If you can mentalize effectively, you can alternately focus on yourself and then on the other person. You then know there is a difference between your own thoughts, feelings and wishes and those of the other person. Pre-schoolers still assume that the other person's thoughts, feelings and wishes are the same as theirs, and this is normal for their age. The child gradually learns that what he is thinking, feeling or wishing is different from what the other person is thinking, feeling or wishing.

When is there no switch

There are various psychiatric disorders in which people find it difficult to observe the thoughts, wishes and feelings of the other person and of themselves. In some young adults with an antisocial personality disorder you see that they are capable of reading the thoughts, wishes and feelings of the other person, but that they have no understanding of their own inner world. Then they say: "That doesn't interest me." You sometimes see the opposite in clients with a borderline personality disorder: being extraordinarily engaged with their own inner world and having no interest in the thoughts, wishes and feelings of the other person or inability to assess either.

Example 'Being impacted by someone else's depression'

Michelle is a young woman with a mild intellectual disability and a borderline personality disorder. She tells her caregiver that she experiences a great deal of stress. She gives an example. Together with her boyfriend, she rings the front door bell of his parents' house. Her boyfriend's mother is depressed. The moment Michelle sees her 'mother-in-law', it's almost as though she is infected with her depression. This does not affect her boyfriend. During the therapy session, Michelle uses a drawing to describe this event at the front door. She draws the absence of a 'wall' between herself and the other person, as though she constantly adapts to the other person like a chameleon. Michelle finds it difficult to define the boundary between her own emotions and thoughts and those of the other person. This makes it difficult for her to mentalize because she is confused about which feelings are her own and which feelings belong to her mother-in-law.

Example 'Which crisps?'

Anthony is a 12-year-old boy with a mild intellectual disability and who is insecure attached. He finds it difficult to think positive thoughts about other people. The therapist asks: "Do you know what flavour crisps your housemates might enjoy this evening?" Anthony thinks this is a strange question and replies "I don't know." At the end of the session, his caregiver goes shopping with him and together they buy something tasty for the group. Anthony receives positive reactions in the evening. This is a new experience for him: learning to see something from someone else's perspective. He does not think of this himself.

What does this mean for caregivers?
Some clients think that the caregivers can tell what is going on inside them. As a caregiver, you can in turn help them by listing various interpretations and indicating that you cannot know for sure what the other person is thinking. There are no tell-tale signs that reveal this, they have to tell you. In clients with a moderate or mild intellectual disability it is important to teach them this by repeating it frequently. It is necessary for some clients to invite them in a playful and challenging manner to be curious about the other person: about what the other person is thinking, wishing and feeling.

Practical suggestions
Regularly ask your client what he is thinking, wishing and feeling. Ask whether the client has also told the other person this. Also ask him how the other person feels about that. Try to allow the client as much as possible to discover things for himself. Ask the client to ask the other person what he is thinking, wishing and feeling.

In short
It is important that there is a balance between attention for yourself and for the other person. You are engaged alternately in investigating what the other person is thinking, wishing and feeling and what you yourself think, feel or wish.

How does this work for you in practice?
Do you have a client that appears to assume that you are aware what is going on inside of him? Are you successful in making it clear to your client that you cannot know what is going on inside of him? Do you invite your clients to verify what the other person is thinking, wishing

and feeling? Are you able to turn this into a game during a relaxed moment? For example: Peter's favourite dish is … and yours is…

4) Balance and integration of feeling and thinking

In order to mentalize effectively, there has to be balance and integration between thinking (cognition) and feeling (emotion). If you think too much, you feel too little. If you are overcome by emotion, you think too little. You must first calm down when you're angry. Only then can you sort everything out, reflect on things and resolve problems. If you can mentalize effectively, you interpret your own thoughts and feelings and those of the other person correctly, and you can view your own problems or those of the other person in different ways.

When is there no balance
If you have recurring negative thoughts, i.e. if you worry too much, this may result in your no longer being able to consider any other perspectives. That happens when someone is depressed. He is no longer able to qualify the depressed thoughts as a 'thought', but experiences it as a fact. The same may happen with feelings: if you are no longer able to put your anger in perspective or stop it, it is not an assistive emotion but a disruptive one.

Children who have insecure attachment miss the balance between feeling and thinking. They express too few, too many or contradictory emotions and mainly experience a great deal of fear and stress. Their thinking is also rigid in nature or too chaotic because of restlessness.

Example 'Peter learns to cope with suspicion'
Peter, a 13-year-old boy with a visual and mild intellectual disability, tells his caregiver that he had a fit of anger while at home at the weekend. This was because he was nervous about a school assignment. The caregiver asks: "Does your teacher know this?" Peter says: "He's not interested." The caregiver says: "You can't be sure of that" and asks "Shall I go to school with you and discuss it with you and the teacher?" The teacher says the following during the discussion: "I didn't know that you're so nervous about the assignment. Now that you've told me, I can help you with it." This is a new experience for Peter: that he can forget his suspicion and can competently ask for help from the person who can provide it. This was hampered by rigid, negative thoughts and expectations about the other person. Because Peter quickly gets very angry under tension, i.e. he is overcome with anger, he is no longer able to think calmly or ask the teacher for help.

What does this mean for caregivers?
How is it with the thoughts and emotions of your clients in the grouphome? Are there clients who worry too much? Are there clients who do not express enough of what they feel or who are overcome by their feelings? How might you help? An open, interested attitude works best in this situation.

Practical suggestions
Try discussing helpful and interfering emotions and thoughts with your client. Helpful thoughts and feelings make it possible to acknowledge and recognise difficult experiences and to order and express thoughts and feelings. Try discussing a situation with the aid of the following: what was the event, which thought was associated with it, what feeling did this provoke, what behaviour did the client exhibit as a result and what were the consequences?

In short
If thinking and feeling are well balanced, this helps to mentalize effectively. You can then devise various perspectives, and at the same time there is an opportunity to order and express the emotions. If you are capable of mentalizing effectively, you are able to pay attention to feelings, thoughts, wishes, intentions of yourself and the other person, doing so in an investigative manner.

How does this work for you in practice?
How are your own thoughts and feelings? Are you successful in striking a balance between devising solutions and expressing your feelings?

4 Key characteristics of effective mentalization

A *precondition* for effective mentalization is that you feel *safe and connected* with your parents, caregiver, teacher or partner. In the previous chapters we named the four dimensions to which you can turn your attention flexibly in order to mentalize effectively. The following three chapters focus on this in greater detail. You can use the key points as a checklist to assess how effective you or your client can mentalize. Remember that you cannot mentalize effectively when stressed or in a state of high emotion such as anger, fear or sadness. We will elaborate on effective mentalization in three chapters:

1. Observing the other person's thoughts and feelings.
2. How do you look 'inside' yourself?
3. The didactic attitude, or how do you learn about yourself and the other person?

A person who mentalizes effectively:

- Understands that it is difficult to see wishes, feelings and thoughts.
- Has a sincere interest.
- Is relaxed and flexible.
- Can be playful, with humour.
- Can solve problems through give and take.
- Is empathic to other people.
- Articulates both his own experiences and intentions as well as those of other people.
- Takes responsibility for his own behaviour, is not the victim of circumstance.
- Is curious about the viewpoints of other people and expects that others are capable of expanding on their viewpoints.
- Understands that mentalization frequently fails and endeavours to correct this.

1) Observing the other person's thoughts and feelings

Checklist for effective mentalization about the other person:

- You cannot know for sure what the other person is thinking or feeling. This is what we call the 'impenetrability' of the other person's thinking. Some clients do not understand this and it helps them to discover that you 'cannot look inside their head' to know what is going on. That is why it is important that they tell you what they think, feel and want. Very young children do not understand this yet.
- Do not be suspicious.
- Investigate a conflict or misunderstanding and do not respond in a hostile manner.
- Be sure to adopt an open attitude.
- You are sincerely interested in the other person and are curious.
- You can adopt various perspectives: you understand that there can sometimes be opposing ideas or interests about certain things.
- In the event of a conflict or misunderstanding, you can understand the other person.
- Because you understand why some people respond in a certain way, you experience the world to be predictable.

What is the opposite?
Preconceptions, wrong interpretations, incorrect convictions, rigidity, hostility and suspicion impede the mentalization process.

Example 'Mother is all-powerful'
Pre-schooler Tina believes that her mother is 'all-powerful' and knows everything about her. When Tina knocks her head against the table, she responds angrily to her mother for not having prevented this. When Tina is 4 years of age, she learns that her mother is unable to prevent this kind of thing and she herself must be careful not to knock her head.

Example 'Angry'
Petula, a 20-year-old woman with a mild intellectual disability and a borderline personality disorder finds it very difficult to maintain control of her anger. Something makes her angry almost every day. She often feels as though she is not understood. Irma, her caregiver, teaches her to straightforwardly say what is wrong. Petula often assumes that this is clear for the other person, but Irma tells her that this is not the case. Caregivers cannot understand what is wrong if you do not use words to tell them. Irma understands that Petula cannot mentalize when she is angry and will therefore quickly feel as though she has not been understood, frequently causing misunderstandings. It is important for Irma to continue to mentalize herself by maintaining an open attitude and being curious about what Petula has to say. Irma is also inclined to be forgiving. She starts again with a clean slate after every conflict with Petula. Irma makes clear agreements with Petula in order to be as predictable as possible.

Example 'The holiday of compromises'
Every member of the Peters family has his or her own idea about what makes a good holiday. Father wants to go camping in the countryside; mother wants to stay in a hotel in a bustling seaside resort; the son prefers to stay at home near his friends and the daughter wants to visit an exotic destination. A great deal of negotiation and open conversation is needed to ensure that everyone is happy and can agree to a compromise. It is also helpful when every member of the family can understand without judgement what the other members would like and does not force through his or her own wishes.

Example 'Fred does not want to bother his mother'
Fred is a 40-year-old man with a moderate intellectual disability. He finds it difficult to make friends. He himself thinks that this is due to a disappointing experience with a friend. He wants to talk to his brothers about this, but not to his 80-year-old mother. He does not want to bother her with this at her age. He says that his mother would be concerned about it and that he does not want her to have to cope with that. Fred is able to empathise with his mother while at the same time he realises what he himself feels and wants. This then drives his behaviour to his mother. These are important mentalization skills.

What does this mean for caregivers?
Some clients are difficult to understand or withdraw from the discussion when they are angry. In that case, it is important to maintain the attitude of mentalization. Try not to judge, but investigate why your client is so angry. It may be that your client does not understand that you cannot know what he is thinking or feeling (the impenetrability of thought).

Practical suggestions
Check the list for ‘effective mentalization about the other person’: what do you recognise in yourself and what do you recognise in your client? View a misunderstanding as something that is interesting. You are prepared to investigate without judgement what your client is thinking and feeling.

In short
An open attitude is needed to mentalize effectively about the thoughts and feelings of the other person, in which you understand that you cannot be sure what the other person is thinking or feeling. This also makes you more cautious and lenient when assessing the other person’s behaviour. If your client is inclined to be forgiving, that would indicate a mentalizing attitude.

How does this work for you in practice?
Are you flexible and capable of switching your attention between your client and yourself? What are the reasons for any misunderstandings that might occur? Are you aware that your client is unable to mentalize when he is taking a hostile attitude? And nor can you if you are angry yourself.

2) How do you look at your own ‘inner world’?

Checklist for mentalizing effectively about yourself:

- You understand that you can change, you are not rigid, but flexible.
- You understand that you are constantly developing and are learning from experience.
- You acknowledge that feelings may be confusing, but this does not mean there is chaos.
- Sometimes you don’t know what the solution is, especially in the case of conflict.
- There may be incompatible ideas and feelings.
- You are interested in differences.
- You can investigate yourself.
- You understand that when you are very emotional, rational assessment of yourself and the other person diminishes. When you are angry or have a great deal of stress, you cannot think calmly at the same time. You first have to calm down. Only then can you see things clearly again.

What is the opposite?

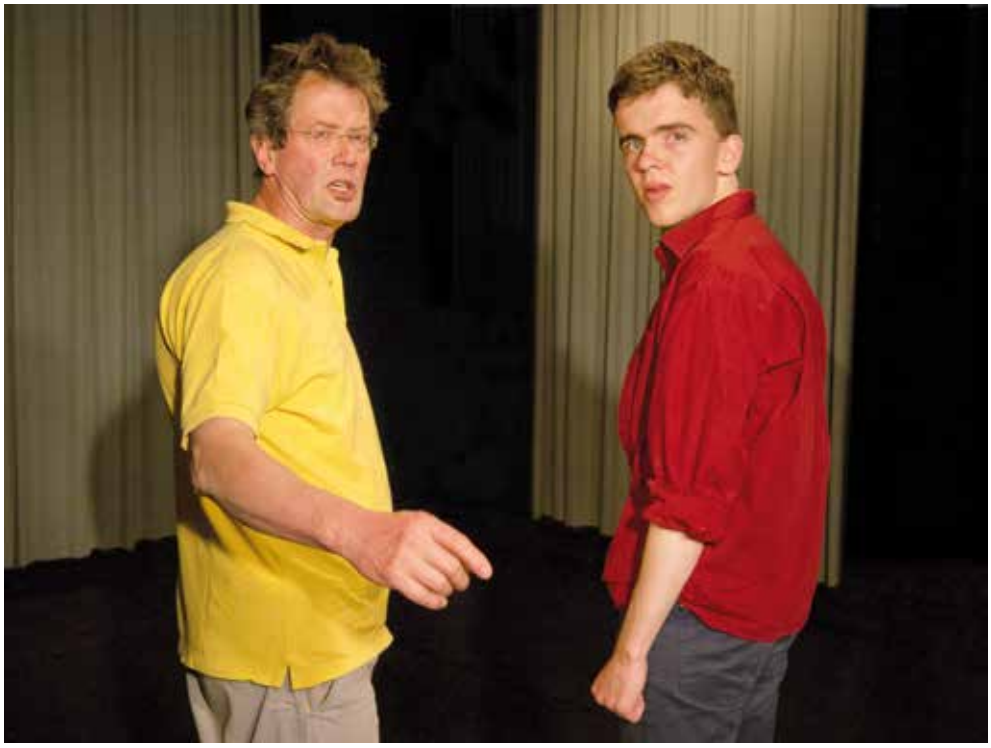
Being sure that you are right and relying too much on your own interpretations and preconceptions. Responding rigidly, very emotionally and in a preconceived manner.

Example ‘The caregiver thinks I’m stupid’

Jolene is a 17-year-old girl with a visual impairment and mild intellectual disability. She has many behavioural problems and is constantly arguing with her caregivers. Jolene is quick to have negative feelings about herself. She assumes that her caregivers think she is stupid or are unwilling to waste time with her. When she is angry she withdraws to her room and refuses contact with the caregiver. Jolene is in therapy and very gradually learns to think about herself in less negative terms, which makes her less rigid and more willing to talk about things. Together with the therapist and caregivers, she learns to look at herself, to investigate what is bothering her and to find a solution for this.

What does this mean for caregivers?

It is important to tell your client what is going well and what the client has learned in recent years. Clients with a moderate or mild intellectual disability are not always aware of this. By zooming in on small, positive changes, you stimulate your client to constantly improve the way he mentalizes.



Practical suggestions
Check the above-mentioned list for effective mentalization about yourself: what do you recognise in yourself and in your client?

In short
When you are angry, you cannot think clearly at the same time. First try to calm down. Inquisitiveness and curiosity are part of learning to mentalize effectively and they make you flexible. One precondition for this is that you are feeling safe.

How does this work for you in practice?
How do you help your client learn to look at himself, at what he is thinking or feeling? How are things for you? Do you feel secure and at ease with your colleagues? How flexible are you? Do you dare think about that? Do you ever ask your colleagues for feedback? Has your client ever been in therapy? What did he learn there and discover about himself? Therapy reports often describe this in detail.

3) The didactic attitude: how do you learn things about yourself and the other person?

- Can you listen attentively to the other person and can you explain situations, emotions and intentions to the other person? We refer to these as listening and didactic skills. Sometimes you suddenly have a good discussion and you as a caregiver or parent can explain something very clearly. The parent is in 'didactic mode'; the child listens. This capacity is probably an innate one, to ensure that knowledge and skills are transferred smoothly from one generation to the next.
- Can you remember when you were a child? Can you use your memories to create a coherent, autobiographical story with the past, present and future?
- Children often enjoy hearing their parents or caregivers talk about when they were young. This is also true of adult clients, as it helps them to get closer to their own self.
- Do you have a rich internal life? Do you experience varied and intense emotions? Are you inquisitive and curious about what other people experience? Are you interested in the other person?

What is the opposite?
You will learn less and may even stagnate if you are not inquisitive or unable to listen to what someone else has to say. And in that case you are also unable to mentalize effectively.

Example 'Thunderstorm'
Ella is a 7-year-old blind girl who is very afraid of thunderstorms. Her mother says that she was also afraid of thunderstorms when she was a little girl but that she got over it as she grew older. That reassures Ella somewhat.

Example 'Secure atmosphere'
Carla is a caregiver for a group of children with a visual impairment. During the evening meal, Pete, a 10-year-old boy, says that his eyes are getting worse and that he is unsettled about this. Carla responds sympathetically. She says that this is unpleasant for him and that it makes sense that he should feel unsettled about it. There is a secure atmosphere. Other children also talk about their visual impairment and how they experience it for themselves. Carla listens attentively and explains things now and again. She tells the children, for example, that it takes longer for them to learn some things at school and it takes much more effort and energy when your eyes start to get worse. The children in the group can identify with this and listen to each other with interest. Here, Carla is setting a fine example of the listening and didactic attitude that is associated with mentalization. She immediately sets the right example for the children in the hope that they will copy her behaviour.

Example 'Deadlock?'

Frank is a 14-year-old boy with a mild intellectual disability and considerable behavioural problems. His caregivers have the impression that there are no improvements and the situation would appear to be in a deadlock. During a team meeting they discuss Frank's situation with the psychologist. They discover that the behavioural problems in the grouphome remain unchanged but that things have improved somewhat at school and at home with his mother. Frank's personal caregiver listens to how his mother and the teacher approach Frank. Frank is more active there than in the grouphome. It is possible that boredom during his free time is influencing the behavioural problems. The team tries to resolve this together with Frank by setting up a new daily programme. This gives the team the energy to carry on and to investigate new lines of approach for better understanding Frank and to offer him distractions in the hope that this will reduce his behavioural problems. Searching for a new line of approach helps the team to continue mentalizing about Frank. An open, listening attitude help with this.

What does this mean for caregivers?

Ensure that there is a secure atmosphere in the grouphome in which you alternately listen to the clients and also explain things when they ask questions. Do you recognise the 'didactic' attitude in yourself?

Practical suggestions
Stimulate the curiosity of your clients and allow them to discover things about themselves and other people.

In short
Didactic and listening skills are important for the transfer of knowledge and learning new things. It is easier to remember the things you have learned when you articulate what you have learned and how it has affected you. Being aware of what you have learned is a precondition for effective mentalization. This is true both for your client and for you as a caregiver.

How does this work for you in practice?
Try articulating for your clients how they have changed in a positive sense and how you can see that they really are doing their best. By doing this you help your clients become aware of it.

5 Reverting to a non-mentalizing way of thinking

The three steps that precede mentalization are not only phases in the normal development of the child, but also frames of mind to which you may (temporarily) revert as an older child, adolescent or adult, especially if you are tensed. This means that when you are experiencing stress or intense emotions, you cannot mentalize effectively and may experience the situation over-realistically or over-imaginatively. We refer to this as the partial reversion to a more primitive or 'immature' way of thinking. If you can recognise this in yourself and can stop it, for example by talking to someone about it, you will return to 'mentalization mode'. There are also children, adolescents and adults whose mentalization capacity is not sufficiently stable and where chronic stress prevents them from mentalizing. They then respond to difficult situations with inner restlessness, chaos or rigidity. This occurs in clients with, for example, problematic attachment, complex post-traumatic stress disorder or (borderline) personality disorder. It is important that a licensed psychologist, therapist and/or psychiatrist investigates the problems in the client's mentalization capacity and studies how a deficiency in that capacity may be explained. For example: a child with a moderate intellectual disability may have a problem associated with linguistic development, making it more difficult to express itself, although this need not suggest a deficiency in the child's mentalization capacity. Clients who are unable to mentalize may be suffering from severe problems. That is why it is important to collaborate in a multidisciplinary team. Do not take it upon yourself to determine what the problem might be, but interpret what you observe and discuss this information with the other stakeholders. Draw up a joint treatment plan.

How can you recognise disruptions in the mentalization process?

The most serious form is an *inability to mentalize*. You observe a constant rigid attitude in your client, a tendency to become rapidly emotionally irritated, or chaos. Also if the client blames others, this may suggest an inability to mentalize. Section 7 of the first chapter of this book describes the 'window of tolerance'. Reverting to the less mature way of thinking can be associated with excessive (*hyperarousal*) or insufficient (*hypoarousal*) stress.

There is a *partial deficiency in mentalization*: the individual can mentalize well enough in neutral situations, but a deficiency in mentalization arises when he thinks back to a trauma, or when coming into contact with certain people, certain emotions or situations.

It is impossible to know if someone has a complete or partial deficiency in mentalization capacity just by looking at him, but you might consider it if your client is constantly unable to keep his emotions under control or is hardly able to collaborate. When an individual reverts to the 'immature' way of thinking, there are several forms that may alternate or occur simultaneously.

- thinking in an overly action-oriented manner
- thinking in overly concrete terms
- thinking too much in terms of pretend mode
- mentalizing overly egocentrically, i.e. primarily to your own advantage

The inability of young people and adults to mentalize effectively can be recognised by:

- Relating things with excessive or a lack of detail, without referring to feelings, motives or thoughts.
- Focusing on external factors, such as the problem is caused by school or the group.
- Focusing on labels: tired, lazy, clever.
- Focusing on rules: what isn't allowed, what you have to do.
- Denying involvement in a problem.
- Blaming others, finding fault or being sure about what the other person is thinking.
- Having no empathy for the other person and focusing excessively on one's own interest to the detriment of the other person.
- Lack of humour.

If one person is unable to mentalize effectively, this may inhibit the mentalization of the other person. In families we refer to this as the 'inhibiting circle' of non-mentalization. For example: a child who is furious can no longer mentalize. If the parent becomes fearful of this, it may also inhibit his mentalization capacity. An ill-considered response ensues. And this in turn provokes an intense response from the child. The parent tries to gain control of the child, but the child withdraws from the interaction. (Muller & Kate ten, 2008).

1) Reversion to the action-oriented manner of thinking

1.1 Focused on oneself

'Teleological mode' is psychotherapy jargon. The term refers to a physically visible action geared to a particular goal. Previously, when discussing the development of mentalization, we used an example of a 9-month-old baby who follows the shortest path (the action) to get the ball (the goal). The goal is something that is visible, tangible or audible. This process can take place without words, without language, without fantasy. The child cannot yet consider what it wants, but acts immediately. This reaction and primitive way of thinking is normal for a baby aged between 9 and around 15 months. If the action-oriented way of thinking prevails in adults, they are unable to use words well enough to express their emotions and thoughts, only in goal-oriented actions. For example by breaking something as an expression of anger. Social relationships are also mainly assessed for their visible, physical consequences. For example a mother's love for her child is not genuine until she has kissed it. If someone accidentally trips over your leg, you see that as having been deliberate. Or: the caregiver is not really involved until he makes some extra time for you as the client. This is a non-mentalizing way of thinking and feeling. In the case of stress or emotions that are unbearable, you may revert to the action-oriented way of thinking. Actions speak louder than words. This is a primitive or immature way of thinking.

There are also positive aspects to an action-oriented way of thinking. For example, if you give someone a (tangible) pat on the back during a conversation in support of a compliment or a gesture of comfort. It becomes a problem if this is the dominant way of experiencing things under stress and intense emotions. In that case, the individual is only capable of interpreting the visible actions of the other person in order to understand their intentions. The client is no longer capable of using words to ask for help. In that case, the client's stress may be so acute that it becomes unbearable, sometimes leading to self-harming or suicidal behaviour.

What is the opposite?

In a mentalizing way of thinking and feeling, the client can use words to express what is wrong and seek help and comfort from his parent or a trusted caregiver.

Example 'Growing confidence'

Yvette is a 15-year-old girl with a visual impairment, mild intellectual disability and a traumatic past. She has a growing, yet still fragile, trust in her permanent caregivers. She assesses her relationship with her personal caregiver on the basis of visible facts: How many minutes does she talk to me and how many with a different client. She becomes hypervigilant by constantly noting this, and that demands a great deal of energy. If she's not feeling very well, she withdraws to her room and breaks things. Her caregivers are concerned about her behaviour that is difficult to understand. They themselves try to remain calm. Together with Yvette, her caregiver is constantly trying to understand her behaviour. As it turns out, Yvette sometimes feels so terrible that words are not enough to express this, which is why something has to be broken. Yvette adopts the action-oriented way of thinking in the face of tension: she expresses

her feelings in the form of concrete action. She feels so awful that she finds it difficult to ask for help and withdraws to her room. Her caregivers try to help her use words to express her emotions. Yvette is happy that she is getting better and better at this. What is especially helpful is the understanding that the caregivers cannot know what she is thinking or feeling at a certain moment. For a long time, Yvette thought the caregivers did know this. She thought that her behaviour was the fault of the caregivers, because they did not stop her in time.

What does this mean for caregivers?
Clients who act in an action-oriented way are difficult to understand. Their behaviour can be confrontational. It is important for you to remain calm and articulate the client's emotions and thoughts. Remain alert if the client angrily breaks off contact with you as the caregiver or quietly withdraws. Try to restore contact with your client. Consider the message the client wish to give to you.

Practical suggestions

It is important that you try to understand destructive or self-harming behaviour. Offer your client more supervision and security in such a situation. If your client withdraws under tension, disappointment or denies that something is wrong, check how things are going by regular contact with the client. Show that you are thinking about the client. Articulate the client's feelings. He cannot do so at that time, so you are important for him. You can help him by putting his emotions, feelings and potential thoughts into words and by showing your understanding. Then it is important to guide his emotions in the right direction.

In short

Actions speak louder than words for clients whose frame of mind is more action-oriented. Their perception is driven by physical expression, for example a touch as a sign of love or affection. If a young person or adult under stress functions in an action-oriented way of thinking, emotional pain may be unbearable and may be expressed in a physical action, such as the destruction of an object or self-harm. Moreover, a client assesses his relationship with you as his caregiver purely on the basis of visible facts, not the intentions behind what you do. The client needs guidance, supervision and reassurance. Try to articulate the client's emotions and thoughts. This helps to get him mentalizing.

How does this work for you in practice?

Can you recognise a pattern in your client in which he thinks and acts in an action-oriented mode? Are you able to restore your contact with the client at such a time by offering support and empathy? Can your client put into words what is wrong? Let the client know that you cannot be sure what he thinks, feels or wants. Are you able to help your client with this? In very difficult situations with clients, it is important to work together with the psychologist and the manager to draw up a crisis plan and a risk analysis.

1.2 Mentalization to your own advantage

Another form of thinking in an action-oriented manner is to mentalize to your own advantage. A young child that wants a chocolate, asks: "Mummy, don't you want a chocolate?" You are then prompting the other person to do something in your own interest. The other person is sometimes put under so much pressure that his vulnerability is being abused, such as the need for affection. So-called 'loverboys' (*young pimps*) do this by telling their 'girlfriend': "You'll do this for me if you really love me, otherwise we're through." In exceptional situations, thinking to your own advantage may lead to serious forms of transgressive or even criminal behaviour. This is a non-mentalizing way of thinking and responding, as it exploits the other person. This is goal and action-oriented thinking, i.e. the individual's own advantage is the central objective. If the client exhibits this way of thinking, it is attributable to a poorly developed mentalization capacity because of a lack of empathy. The client may at that time have difficulty observing the fear in the other person.

What is the opposite

If you are capable of mentalizing, you are empathetic to the other person and your conscience is developed. You can observe emotions in the other person, such as fear. You can reassure the other person.

Example 'Alfred wants fewer rules'

Alfred is a 20-year-old man with a visual impairment and mild intellectual disability. He may have an antisocial personality disorder. Alfred thinks in the action-oriented manner. He assesses whether the therapist is 'right' on the basis of what she can do for him in his own interest. For example, he wants her to impose fewer rules for him when he is in the grouphome. He can put the therapist under pressure to arrange this for him. But at the same time, he is unable to think about his own thoughts and feelings; he is inhibited in this. The therapist and caregivers must maintain a balance between making contact with him and supporting him, but also challenging his antisocial behaviour and restricting this.

What does this mean for caregivers?

As a caregiver, when confronted with someone thinking in his own interest or exhibiting antisocial behaviour, you have to restrict this and not give in to it. At the same time, you endeavour to maintain a line of contact and support the client in expressing his own emotions. The main thing is to articulate what kind of behaviour you would like to see from the client.

Practical suggestions
If the client mentalizes in his own interest, it is important not to go along with this. Restrict the behaviour and do not allow yourself to be put under pressure. Seek support from your colleagues. Show that you accept the client as a person, but that you disapprove of his behaviour. If possible, articulate what you think is the motive for his mentalizing in one's own interest. Check whether there might be a different way to fulfil this underlying desire or need. It is also important to articulate why the behaviour in question is undesirable.

In short
When a client 'mentalizes in his own interest', it appears as though the client is capable of mentalization, because he can observe the other person's vulnerability. It is a form of non-mentalization, because there is no empathy or respect for the other person, but the other person's vulnerability is being exploited. In a severe form this may lead to transgressive or even criminal behaviour.

How does this work for you in practice?
How do you cope with a client with transgressive behaviour? Are you able to set boundaries for the behaviour? Do you explicitly indicate what kind of behaviour is desirable? How do you maintain your contact with the client? Can you indicate the underlying reason for the behaviour? Does the client show empathy for the other person? How do you maintain empathy for your client?

2) Thinking in overly concrete terms: reverting to reality

When reverting to this way of thinking, the client does not distinguish between fantasy and reality; between what is 'on the inside' (feelings, thoughts, wishes, intentions) and what is 'on the outside' (behaviour, facial expressions). If I'm afraid of something, there must also be something threatening in reality. The understanding that your own feelings, thoughts or imagination can influence and distort your perception of the outside world does not (yet) exist. This leads to rigidity, preconceptions, absolute ideas about the other person and misunderstandings in social contacts. Mentalization fails. This way of thinking occurs frequently. This overly concrete thinking is manifested in various ways:

- The thinking is very concrete in communication and interaction: this is what I feel; so that's the way it is. There is thinking in black and white. The individual's own perceptions are idealised.
- You start to see negative thoughts about yourself like: 'I'm depressed' as reality. You are unable to qualify the thought by thinking 'it will pass' or 'thoughts come and go'.
- There is no difference between facts and convictions. If someone treats us badly, then we *are* bad. There is still no understanding of a 'self' that is capable of interpreting a situation, rather a 'me' with no control over circumstances.
- About the other person: 'being sure' what the other person is thinking, or having the idea that you can read the other person's thoughts, without this being based on proof. The impenetrability of the other person's thoughts and autonomy is not recognised. There is a lack of attention to thoughts, feelings, intentions, wishes of the other person. This leads to rigidity and wrong interpretations.
- Finding faults in the other person. Blaming the other person. This is often associated with hostility and mistrust, in which the client may break off contact. It can also be destructive: 'you deserved this or you were asking for …' which is an incorrect interpretation.
- Internal experiences can be terrifyingly real, for example flashbacks to a trauma: the client relives the frightening situation. The traumatised individual is afraid of what is happening inside his own head.
- In disorganised attachment: old negative, frightening patterns are repeated in the present, for example in the relationship with the foster/adoption parent, caregiver or teacher. After these patterns have been treated, they may return as the child loses its attachment figures. This results in a reversion to the old behaviour.
- Some clients interpret the words the other person uses very literally, because they do not understand the message behind the other person's words. This form of literal use of language also occurs in clients with autism spectrum disorder, who do not understand the meaning of the words correctly.
- Some clients lack fantasy. Their imagination capacity has failed to develop.
- Blaming the situation or physical factors, without thinking about one's own feelings, thoughts and behaviour.

How did this develop?

There may have been insecure attachment, potential traumas and heightened stress. Presumably the parent failed to mirror the emotions of the young child well enough. For example: when the child was angry, its mother got angry too. The child does not learn to distinguish between its own perceptions and those of the other person, equating one with the other. The lack of a playful attitude to the child is also a form of neglect, as a result of which the child does not learn that thoughts, feelings, wishes are important, but that they are not the same as reality.

How do you recognise this in children's play?

A child that primarily functions in reality (*actual mode*), simply creates order in its play, for example arranging toy cars in neat rows, or creates families of animals, but fails to develop any imaginative stories. Or the child becomes fearful or angry during imaginative play: it's too real. The child plays that there is a lion in the playroom and becomes truly afraid. The child may also re-experience traumas and you can recognise this in its play if the child repeatedly plays about disasters, fires, abductions and extreme aggression without any positive developments.

What is the opposite?
Children integrate the reality of their lives and their fantasy into their play and are therefore capable of processing their emotions and experiences. An adult client who is able to mentalize tries to repair misunderstandings, has a basis of trust and wants to cooperate. A conflict can be resolved. The client is inclined to be forgiving and understands that the caregiver may have forgotten something or have made an error.

Example 'Angela practices stressful situations'
Angela is a 9-year-old blind girl. She thinks in terms of reality. She says to her caregiver: "Don't talk about my parents, because then I'll miss them so much." Feelings or thoughts coincide with reality for Angela. She does not have the fantasy to think: it's just a thought or feeling. Angela suffers a great deal from anxieties which form an obstruction for her. If she is startled by a situation, it is difficult for her to recover. She then avoids the situation and becomes inflexible. Angela learns to cope with this when she receives reassurance and her anxiety is taken seriously, and when she 'faces up to the situation' instead of avoiding it. Together with her caregiver, she acts out situations in a very practical way in which she has been startled. Angela's caregiver teaches her that she is likely to be fearful sooner on account of her blindness. After all, the world is less predictable for her. Her games hardly ever develop into imaginative play. She prefers to play with a ball or engage in sensopathic play involving sand and water.

Example 'The meeting with Fatima has been cancelled'
Fatima is a woman with a visual impairment and mild intellectual disability. A meeting has been scheduled for this evening with Elsa, her personal caregiver. Another client had an epileptic fit just before the meeting, and the doctor had to be called. Elsa quickly says to Fatima: "I'm afraid I'm going to have to cancel our meeting for this evening." Fatima is disappointed and is still

angry the next morning. Elsa mirrors this: "You're disappointed, I understand," and tries to restore contact. Fatima grumbles that she feels as though Elsa has rejected her and that Elsa thinks the other client is more important, and refuses to make up. Elsa continues to mirror this: "I understand that you're angry, but this was out of my hands, there was nothing else I could do. If you have to see the doctor in an emergency, that is more important than a meeting with another client. Come along, let's go and have a cup of tea and do something nice." Fatima gradually comes round, but these kinds of situations are difficult for her. Fatima thinks in overly concrete terms when she is disappointed and fails to appreciate the intentions and the perspective of Elsa, which leads her to draw the wrong conclusions and may rapidly lead to misunderstandings and mistrust. Because Elsa restores the contact and is honest and reliable, Fatima gradually starts to learn to handle these situations more flexibly and with greater confidence.

What does this mean for caregivers?

If your client thinks in overly concrete terms or reverts to this under stress, frequent misunderstandings and inflexible reactions are to be expected. The client interprets reality incorrectly and sometimes even distorts it. By understanding how the client thinks, you can cope with this and support the client. Make sure that you yourself continue to mentalize and are not provoked into responding in a similar manner. This has a counterproductive effect and leads to conflict or the contact being broken.

Practical suggestions
Try to restore contact with the client in the event of a misunderstanding. The client can only reflect on what has happened once the stress has diminished and contact is restored. Try to emphasize your client's perspective and that of yourself while mirroring: this is what you are feeling and that is different from what I am feeling.

In short
If your client thinks in overly concrete terms (*actual mode*), there is no difference between the world within and the outside world, which leads to inflexibility, misunderstandings and preconceptions. Everything that happens on the inside is too real, or regarded as being equal to reality. By recognising and understanding this, you can reassure your client and resolve the misunderstanding. You can recognise the concrete thinking of children by the way they play. For example endlessly arranging playing pieces without imaginative play.

How does this work for you in practice?
Do you recognise your client's thinking in terms of reality? Are you able to restore contact in the event of a misunderstanding or conflict? How do you do this? Are you able to help your client understand the other person's perspective when your client is calm?

3) Thinking in pretend mode or pseudomentalization

Thinking in *pretend mode* does not occur as frequently as thinking in terms of reality, but it is important to learn to recognise this form of thinking. Reality and fantasy have very little in common when thinking in pretend mode. It is a non-mentalizing way of thinking, feeling and observing, as there is no link between the present emotions, the actual problems and the imagination. The client cannot investigate or mentalize his feelings and thoughts in an open and unbiased manner. If the client only thinks in imaginative terms, we refer to this as pseudomentalization. What he imagines is real, and it does not matter what facts are ignored. The inner world (the imagination) is disconnected from external reality (the reality). Clients who suffer from dissociation as the result of a trauma, withdraw from reality in order to survive a threatening situation. They are then functioning in *pretend mode*.

How can you recognise thinking in pretend mode?

- Clients use fine words to describe how they think, but have no contact with their real feelings. So they rather 'imagine' how they work than providing a report based on real life.
- Expressing clichés and empty words, such as: 'I don't know', 'That's just the way it is'. Echoing 'or repeating the caregivers' language, parrot fashion' may also be in *pretend mode*, which means it has been adopted and has nothing to do with actual emotion.
- It is linked to emptiness, meaninglessness, denial of feelings or idealised delusions of grandeur.
- There are problems with feeling emotions in the here and now or experiencing them from a distance.
- Some clients find it so difficult to handle their feelings of emptiness that they fill them with risky behaviour, such as alcohol abuse or compulsive buying. The client hopes that this will help him feel better.

What causes this?

A key reason for the development of '*pretend mode*' is that the parent had a pattern of mirroring the wrong emotion (incongruent mirroring), such as anger instead of fear. In that case, the parent's mirroring does not match the perception, the child's internal feelings. The child does not learn to recognise its own feelings correctly and has a feeling of emptiness, of pretence. This leads to an unstable self-image, a *false self*. The child is confused because the parent has mirrored its own emotion in response to the child and the child becomes caught up in this.

How do you recognise the pretend mode in children's play?

The child's fantasy is now a factor in his play and at first sight it would appear as though the child is playing well. In time it becomes evident that the play of children in *pretend mode* is repetitive and disconnected from the problems and emotions in reality. The child escapes into play in order to avoid reality. The child does not involve its own emotions in the play; the play does not promote the processing of emotional experiences and it does not resolve the problems.

What is the opposite?
The child plays out what it has experienced during the day in terms of fun, exciting, difficult situations, which helps it to process the experiences. The child can integrate the emotions from reality into its imaginative play. The child can represent the emotion in its fantasy, by means of a drawing or play story, for example. A girl that has become blind makes up a story about a child who is sad because she can no longer see the rainbow. This girl is capable of mentalization and expresses in a symbolic narrative way what she is feeling and thinking in the here and now.

Example 'Connecting with your feeling'
Manuel says: "I'm depressed because of what I experienced when I was younger." The therapist listening to this thinks it is an acceptable explanation. The therapist asks: "Manuel, how do you feel here, now?" Manuel indicates that he does not feel anything. It appears that he is unable to recognise his own feelings. Manuel has not learned to recognise and articulate his emotions properly. Manual is engaged in pseudomentalization: it appears as though he understands his problems, but it is cliché and he is unable to connect with what he is feeling in the here and now.

Example 'Ingrid tries to escape from her illness'
Ingrid is an 18-year-old visually impaired woman with a mild intellectual disability. She is suffering from various life-threatening medical conditions. She was very often in hospital when younger and underwent painful medical procedures. Her prognosis is not favourable. She has a vivid imagination and spends a lot of time watching Disney films. She refuses to discuss her illness as it is too painful, she said during therapy. The coping process has not started because Ingrid cannot handle it. She escapes into a world of fantasy.

What does this mean for caregivers?
It requires skill to recognise *pretend mode* because it sometimes appears as though the client is thinking about his problems. If this talking and reflection do not help to resolve the emotional problems and they are constantly being repeated, the client may be thinking in *pretend mode*.

Practical suggestions
Introduce everyday reality by mirroring emotions in the here and now. For example: "I can see that you're angry right now." Stimulate the client to mentalize. You can stimulate mentalization by linking reality and fantasy and by mirroring emotions. Beware when explaining behaviour to your client, for that may only result in strengthening the *pretend mode*, which will not be beneficial.

In short
While the fantasy has been sparked in *pretend mode*, reality has been excluded. The client may be engaged in pseudomentalization. In severe cases the client may not even be able to feel his emotions. They are suppressed and avoided. The client uses his fantasy to escape from reality.

How does this work for you in practice?
Do you recognise that your client is thinking in pretend mode? Are you able to mirror emotions in the here and now? How does your client respond to this?

Practice

6 Summary of potential interventions

Toolbox of interventions that promote mentalization

Practical suggestions are contained throughout this book, and we have summarised and supplemented them here. Three strands characterise the interventions:

A what do you as a caregiver need

B interventions while supporting a client in the event of a low/average level of stress

C interventions while supporting a client in the event of a high level of high stress.

A What do you as a caregiver need?

Intervention 1: Be aware of yourself and take your own reactions and those of the client seriously

What is it that took you out of your mentalization mode; what is your 'weak' spot? Don't be ashamed of an unsubtle response, but investigate it. Don't think too quickly: It's probably my fault. Be aware of your own non-mentalizing thoughts and feelings, such as: what makes you angry or fearful; what makes you reject your client or become over-involved? How do you respond to accusatory, hostile behaviour of the client? Consider that if your client has a previous history of problematic attachment, the lack of safety in relationships may repeat itself with you. This has nothing to do with you as a person, but is due to the client's own problems. You can only encourage the other person to mentalize if you yourself continue to do so. If you as a parent, caregiver, therapist fail to mentalize, this will be to the detriment of your client's mentalization.

Key point: retention of your mentalization capacity and emotional availability for your client.

What can you say and do?
"I'm being quiet for a moment. I need to think about this. This confuses me. This has startled me, I need a little time to recover." Slow down.

Intervention 2: Try to recover and take your time for this.

If you are unable to recover, seek support from a colleague if possible, or discuss it with the team later. A good working environment is a precondition for learning from each other's experiences with this particular client. Each team member is different and responds differently. It is important to investigate why each team member responds differently and whether there is a connection with the client's problems. There may be a parallel process between what occurs in the relationship between caregivers and a client and the relationships within a team. You mentalize best if you yourself feel secure, supported and appreciated by your colleagues and the organisation in which you work. A team that can mentalize together effectively is honest and open; you feel free to express your feelings and thoughts; there is tolerance for differences of opinion and respect for each other's (emotional) reactions.

Your psychologist is familiar with the sometimes intense response of teams to clients with severe psychological problems and can help sort out what belongs to your client and what belongs to yourself. If you as a parent do not understand your child well or if your child has behavioural problems, discuss this with a counsellor who can analyse this with you and who can work with you to find a solution.

Key point: Continue to mentalize about the problems you are experiencing in your relationship with your client. That is the basis for understanding and change.

What can you say and do?
Discuss your experiences with your colleague, manager of the team and/or psychologist. What do you find difficult or tiring? What is the best way to respond? You can tell your client that you think it's interesting to investigate what has just happened and that you're thinking about it.

Intervention 3: Remain calm and assess any risks. Ask for help if necessary

Discuss security with your team. How do you ensure that it is secure for yourself and the client? Sometimes you have to discuss as a team how to handle aggressive or self-harming behaviour of your client and follow special training courses for this.

Key point: in the event of tension, attempt to reduce the stress in your client in order to pre-empt aggressive reactions (think of impulsive fight/flight reactions). Intervene promptly to prevent escalation. As a caregiver, your security and that of the client are paramount.

What can you say and do?

"It's important that it's secure for you and for me. I do not have a good feeling about this. I'm stopping this now. I'm going to discuss this and I'll get back to you.

I can see that you're very tense and restless. Take it easy and remain calm. You should go to your room or outside for a while so that you can calm down. You know what we've agreed about security, we're going to keep to those agreements now."

Intervention 4: Apply the basic attitude that promotes mentalization

1. You yourself are calm 'within' and have learned to check this with yourself.
2. You do not pass judgement on the other person, but maintain an open attitude.
3. You are curious and exhibit an interest in the other person.
4. You cannot be sure what the other person is thinking or feeling (the *not-knowing stance*), but are willing to investigate this.
5. You are being yourself and are honest.
6. You are flexible and prepared to adjust your opinion.
7. You are transparent and therefore respond predictably for the other person.
8. You do not make a difference of opinion with your client too personal and you view this from a certain distance.
9. You focus more on what your client is experiencing within (thinking, feeling, wanting, wishing) than on his behaviour.
10. The relationship you have with your client is the tool or instrument you use for your work. So you are very alert to disruptions in the contact.
11. As a parent/caregiver/teacher/counsellor you are responsible for finding solutions for misunderstandings in communication; you take ownership of that responsibility. Caregivers sometimes call this the 'fool method'. In that case you might say: "what a fool I am for not understanding you properly". This can reduce the level of stress.
12. You are stimulating skills and insights that promote mentalization, both in yourself and in your client.

Key point: stimulate the mentalization capacity of yourself and your client.

What can you say and do?
"I don't know for sure what you are thinking or feeling, but I really want to understand you. So why don't you tell me how you are? Interesting that you call it that." Use humour: "I really have to laugh at what you're saying."

B Interventions while supporting a client in the event of a low/ average level of stress

Intervention 1: Take the visual impairment into consideration

You can do this by using words to subtitle your client's and your own facial expressions; by describing social situations and asking clients to be alert to certain signals during interactions with others.

Key point: compensate for the lack of facial expressions by being alert to vocal sounds, mobility.

What can you say and do?

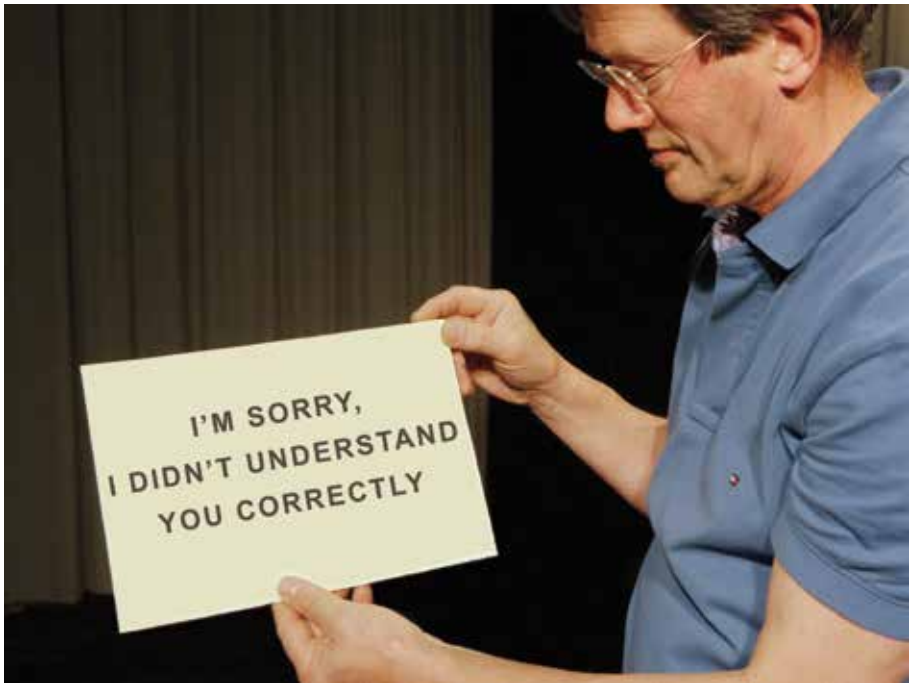
"How do you think the other person is feeling? How can you see this?" In blind children: "Can you hear that in his voice? Or is there something else? What makes you think or feel that way? Does the other person know how you feel or what you think or want? Did you tell him/her? What do you think happened then, and then (rewinding the situation as though it were a film). You're frowning. You look tense. Are you tense? Am I right?"

Intervention 2: Take the moderate or mild intellectual disability into consideration

Work at a slower pace, use simple words, repeat yourself frequently and check whether your client understands you. Practice by making one intervention before moving onto the next one. Encourage your client to actively think along with you.

Key point: clients with a moderate or mild intellectual disability can (just like young children) learn to mentalize in a simple manner.

What can you say and do?
"It's good that you are aware of what your parent/fellow client/colleague thinks of this. What are you feeling? What do you think? Does this occur often? What would you like? What does the other person want? How do we solve this? I see that you're angry/afraid/sad/tense. Are you?"



Intervention 3: Take the multiple (visual and intellectual) disability into consideration

Use language to support social situations and mirror facial expressions and body language in a simple manner.

Key point: teaching clients with multiple disabilities to mentalize

What can you say?
"I see tears in your eyes. Tell me what's wrong. I see that you're shocked/afraid/angry/sad. Are you? It might be because of this... or this ... . I understand. It'll work out OK, we're going to try and find a solution."

Intervention 4: Encourage and maintain contact

Be alert to disruptions in the relationship with your client. Positive interactions, involvement and enjoyment in the contact are the strongest way to reinforce growth and change. Ask your client for feedback to discover whether he feels you understand him and feels at ease.

Key point: the relationship with your client is the means to achieving positive change.

What can you say and do?

"Are you happy with how we're talking now? Do you feel at ease? We've just resolved the misunderstanding in which I failed to understand you; please let me know if it happens again. Together we've just discovered why you find this so difficult."

If your client is unable to talk, look for a non-verbal reaction from your client. For example: "I'm going to sit down here, is that OK with you? Raise your hand so I know this is OK."

Intervention 5: Encourage positive mentalization. Zoom in on positive developments, however small the steps may be.

List what is going well and what the client has learned recently by mentalizing**.** Out of optimism of treatment, interest and curiosity.

Key point: it is important that your client is given hope that change is possible.

What can you say and do?

"Do you remember? You would have gotten angry about this a year ago. It's great that you've become confident about finding a solution to your problems and that you can relax more.

Everyone gets a second chance, and so do you. Together we're going to practice to do things differently; when you're practicing you're allowed to make mistakes or fall back again, that doesn't matter."

Intervention 6: Encourage an active attitude and a broad focus

Remember the four dimensions of mentalization and encourage a flexible attitude. If your client remains in the same dimension, make a movement in the opposite direction, such as from automatic to more conscious mentalization; or focus alternately on yourself and on the other person; on both thoughts and feelings; on being outward looking (behaviour and facial expressions) and inward looking (thoughts, feelings, desires). Pay more attention to HOW someone says something than to WHAT they say.

Key point: the client learns to be active within his possibilities and to think about himself and the other person and to see things in a broader scope.

What can you say and do?
"You've been telling me what it's like for you. But what is it like for the other person? Stop for a minute to think about what you are feeling and thinking. Where do you think the fault lies? How are you going to solve this? What do you yourself want? Does the other person know how you feel? Have you told them that?"

C Interventions to support a client with a high level of stress (such as fight or flight responses) and intense emotions (such as anger)

Intervention 1: Be aware of the contact between the client and yourself in the here and now and observe whether the client breaks off contact or avoids it by withdrawing

Because you are in contact with the client, this is a source of information. Mirror and articulate what you observe is happening in your client. Be aware of non-verbal expressions and gestures. Breaking off contact may be a sign of rising tension and may potentially predict impulsive behaviour. If your client is highly stressed, you should not talk too much but rather offer a calm environment or diversion in the form of movement or music, for example.

Key point: remain in contact by telling your client that you are thinking of him and by articulating what you are feeling/thinking.

What can you say and do?
"You're stressed. Do I understand correctly that you want to leave? It's difficult for you right now. You're not alone, I want to help you and think along with you. This is a secure place. We're going to have a rest now. I have to recover because I was getting confused, would you like a cup of coffee too? We'll continue our discussion later."

Intervention 2: Offer reassurance, empathy and support without judgement or confrontation

You are more supportive than confrontational. Be careful not to stir up any sense of guilt. Do not overestimate your client's mentalization capacity: the higher the emotional excitement, the simpler the intervention must be. Mainly offer support and understanding at this stage. Do not try to offer any insights. There is little point in that at this stage for clients with a limited mentalization capacity. Many clients are only capable of thinking about what has happened together with the caregiver some time later. Align with what a client does for himself to calm down and go along with this.

Key point: reduction of stress and restoration of the mentalization capacity

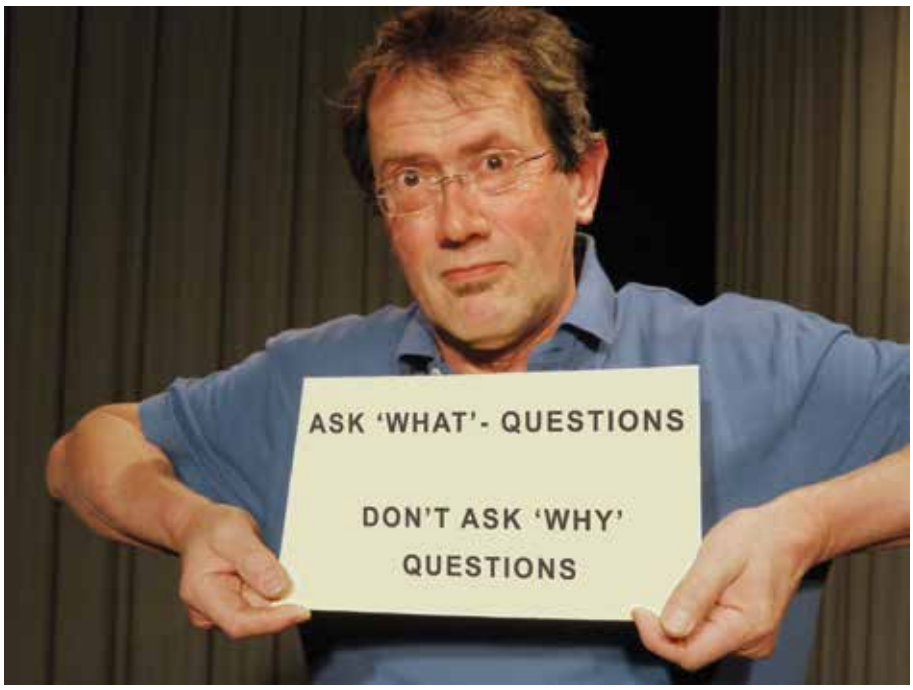
What can you say and do?
"Take it easy and remain calm; we can solve this together; you've always got good ideas; you're really doing your best but it's not working out right now; that doesn't matter, it'll be alright. I'm being quiet for a moment because I need to think about it."

"You've had a big shock/You're angry… That's not nice for you. We're going to ensure that you can calm down first, have a drink or go for a walk outside or go to your room and have a rest (etc.)"

"You can't think clearly when you're so angry, fearful or sad. Try to calm down first, and then we'll continue the discussion. How can I help you to calm down? Breathe deeply in and out, 1 - 2 - 3."

"It's fine that you've decided to go to your room. We can discuss things again later, when you've calmed down."

"Come along, let's go for a run outside and blow the tension away."



Intervention 3: Stop, stand still and rewind to the moment things went wrong in your contact with the client. Ask questions starting with WHAT, not WHY!

Try to determine what happened just before the conflict or misunderstanding. What was the cause?

Key point: the client learns to recognise his own emotions and to resolve conflicts.

What can you say and do?

"Just like in a film, we'll rewind the tape to the moment you became angry/irritated/were overcome. What were you feeling and thinking then? I don't understand it very well; did you mean … or … ? It's good that you've indicated that you're feeling bad. I understand that this is very nasty, awkward, difficult for you."

Intervention 4: The fool method: 'I didn't understand you correctly'. Take responsibility for resolving the misunderstanding or conflict

Remain in the here and now in contact when looking back at the situation. Be honest and own up to any errors. Do not blame the client for a misunderstanding. Discuss your own role and make it clear that you did not understand the client clearly.

Key point: reduce stress and restore contact

What can you say and do?

"What is making you so angry, what have I done to make you so angry/fearful/sad? At what moment did you think or feel that? I see that you have understood my behaviour that way, but it was not my intention. I apologise for not understanding you correctly, that is not nice. I'm an fool for not understanding you. Please let me know if I do it wrong again." By doing this, you share responsibility with the client for finding a solution. Clients often see this as a challenge.

Intervention 5: Stop non-mentalizing thoughts and feelings

Check how your client is failing to mentalize. You are more supportive than confrontational. Be careful not to stir up any sense of guilt.

If your client reverts to the *action-oriented* way of thinking, you can attempt to articulate your client's intentions. For example: "You're feeling bad, I'm sure that's got something to do with it. You can also use words to tell me what's wrong. That often helps."

When reverting to the *reality/overly concrete* way of thinking: Voice your doubts if your client reacts too inflexibly or uses preconceptions. Do not go along with this overly concrete way of thinking. Have I understood this correctly?

When reverting to the *pretend* mode: take care when offering insights, as this may enhance the pseudomentalization process, preventing a connection with the inner world, with the emotions. Ask the client how he feels in the here and now.

Key point: restoration of mentalization capacity and contact.

What can you say?
"Just tell me what you're feeling and thinking. I'm not convinced that you can be so sure about this; you cannot be sure what the other person is thinking, you have to ask them (if your client thinks he is sure about what the other person is thinking, without this being based on fact). What do you feel/think/want now? I can see that you're angry. Are you?"

Intervention 6: Clarifying and investigating feelings and thoughts; focusing attention on emotions

Mirror your client's basic emotions and try to refine and nuance this if the client understands you. Mirror physical signals, such as tiredness, energy, physical complaints.

Key point: the client has a clearer view of his emotions, wishes, thoughts, stress and physical performance.

What can you say and do?

"You don't feel very comfortable; you're angry, fearful, sad; you're feeling good; you are relaxed; you are happy."

"You're not only angry, you're also disappointed. Does the fact that you know this help you to find a solution? You're tired; you don't feel very good; you might have a headache; you've got a lot of energy."

Intervention 7: Make an opposite movement during contact

Maintain distance and boundaries in the event of extraordinary claiming behaviour; seek proximity in the case of inhibition and avoidance during contact.

Key point: allow circles of security to develop of alternately seeking support and doing things independently.

What can you say and do?
In the case of claiming behaviour: "Now you're going to do something for yourself. I'll still be around. I need a rest and I'll be remaining silent. Ssshhh, be quiet for a while." Read a newspaper or write your report. Use a timer if necessary.

In the case of clients who avoid contact: "I'm happy to see you. So tell me, what have you been doing at school/work? That's nice. Shall we do the cooking together? What would you like to eat? What do you think is tasty? What would the other person like to eat?"

Intervention 8: Make an opposite movement in the emotions: not too much or too little intensity in feeling

During intense emotion, such as a rage or fight/flight reactions, your client first has to calm down in order to avoid disinhibition.

By expanding on your client's painful emotions, you can prevent these emotions from being suppressed.

Key point: learning to recognise feelings and express them in an appropriate way.

What can you say and do?

"It's good that you've told me that you're angry. Now you're going to learn how to control your anger by calming yourself down. I'll help you with this. You are the master of your anger. You're allowed to be angry, that's fine, but you must also learn to calm down again afterwards."

"You've told me there's nothing wrong but I can tell by your face that you're tense/angry/sad/fearful. So come on, tell me what you're feeling and thinking. What has happened? I'd feel the same if something like that happened to me."

Frequently asked questions

What is the difference between Theory of Mind and mentalization?
Theory of Mind (TOM) is the human capacity to form an image of the other person's perspective and indirectly also of oneself. It is a term from social cognitive psychology. You use the Theory of Mind when you describe what the other person is seeing, feeling and thinking from his perspective. So it is comparable to the term mentalization. The difference is that the theory on Mentalization assumes that the child learns this within the secure attachment relationship with the parent. TOM assumes that children learn this as a matter of course.

Can a client with autism spectrum disorder (ASD) mentalize?
This is very difficult, as the essence of autism spectrum disorder is that the Theory of Mind or the mentalization capacity is not well developed. A normally intelligent adult with ASD can certainly learn a number of facets, but it remains difficult for an autistic person to assess the context of the situation well and to respond flexibly. People with ASD find it difficult to share their emotions and to recognise them in the other person. It also difficult for people with ASD to see things from the perspective of the other person or to show empathy.

What is the difference between mindfulness and mentalization?
Mindful means being perceptive. Mindfulness is being consciously aware of the experience from one moment to the next, without judgement and with a friendly, fresh view. Mindfulness helps to be present in the contact with others. Attention to the here and now helps to mentalize.

How can you relax physically as a caregiver?
(Note: Many thanks to Hannelies Hokke, PMT and Mindfulness therapist)
Relaxation is of course a broad concept. It can mean slightly different things to different people. Relaxation is important for mentalization because it allows you to pay full attention to the other person. If you are relaxed, there is room in your head to empathise. Mentalization will be more difficult if you have many worries. It also works well when your body is as relaxed as possible. This is necessary for picking up signals from your body that tell you how you are feeling. A few small suggestions that may help you to have and maintain a relaxed head and body:

- Ensure that you have a moment for yourself (however short) a few times a day in which you briefly don't have to do anything at all. Such moments are often scarce and there is always work to be done. However, it is important to be able to stand back every so often.
- If you realise that you are rushing around or feeling restless, you can decide to consciously turn your attention to your body. This often makes it clear that certain muscles are tensed, such as your shoulder muscles.
- Relaxation exercises may be beneficial for some people. Exercises can be found on the internet, e.g. in which you clench your fists three times and then relax them. Relaxing them after clenching is particularly important. A relaxation exercise such as this helps you focus on your body, allowing you to become aware of increasing tension in your muscles.

- Everyone has their own methods for coping with tension in the workplace. One person counts to 10 before resuming contact with others; another person focuses on his breathing to help him calm down. And yet another person helps himself by telling himself something like: "This client cannot do anything about the situation; it's his disability that is causing the tension."
- If you are finding it difficult to relax, pay extra attention to this and identify your barriers. A more intensive means of relaxation with the aid of yoga or mindfulness based therapy might be beneficial in this case.

How can you help your client to relax?
(Note: Many thanks to Hannelies Hokke, PMT and Mindfulness therapist)
Relaxation is not a simple exercise for many of our clients. Being relaxed is the opposite to their tendency to be alert and vigilant. Moreover, a combination of disabilities may make it more difficult for them to relax. Clients with a visual impairment, for example, often use their memory by way of compensation. And if they also have an intellectual disability and need reassurance they can handle their daily programme, they often complain of their head feeling 'full' or 'busy'. Exercise is a good means of allowing the head to empty again.

You have to feel safe in order to allow yourself to relax. You can work together with your client in a safe setting to find out how he is able to relax. Some clients succeed in relaxing using exercise. They enjoy walking, cycling or swimming. Other clients relax with the aid of a calmer activity such as listening to music. The most important thing is to help your client turn his attention from his head to his body. Helping clients relax requires individual approaches. If that is difficult, you might want to consult a specialist, such as a psychomotor therapist. You can try a number of things yourself. Remember that the client sometimes needs a little time to grow accustomed to an activity, so offer it several times.

- In periods in which they are tense, some clients appreciate their caregiver trying to sort out the situation by discussing it with them. Don't allow such a discussion to drag on for too long. During the discussion, the client remains active in his mind, while the goal of the intervention is to achieve a relaxed body.
- Many clients like to rock to and fro. This motion resembles the 'old' familiar rocking motion in the cradle. Rocking helps to calm the restlessness. Look for a swing or hammock that provides sufficient support to promote the feeling of safety.
- Some clients even enjoy being 'wrapped up'. They sometimes look for a cushion to hold tight against their belly, or ask to be tucked in tightly when they go to bed.
- Music often has a soothing effect. There might sometimes be a preference for a certain type of music. You may want to investigate whether there is calming music without lyrics that the client enjoys listening to.
- You can also promote the client's relaxation using your own voice (calmly and peacefully). For example, a whispered voice may be enough to help some clients relax. Other clients may benefit more from a neutral, slow voice.

Are empathy and mentalization one and the same thing?
Empathy is the recognition of emotional reactions of other people and responding to this with appropriate emotion. Mentalization is a broader concept, because it is not only about the other person but also about yourself.

So is mentalization a new concept?
Mentalization is a common factor in various (psycho)therapeutic interventions. It is a skill that we all use on an everyday basis, when raising children, when working together at home and in the workplace, when reflecting on ourselves and our feelings and on those of other people. What is new is that it is now linked to attachment theory and the control of stress and emotions. Research of disrupted mentalization in clients with problematic attachment, other psychiatric disorders and behavioural problems is also innovative. Increased understanding of disrupted mentalization has led to specific interventions that promote mentalization.

Is mentalization the same as responding sensitively and responsively?
Being responsive is connected with your behaviour as an caregiver. It means that you respond immediately, precisely and adequately to an emotional signal from your child. A sensitive mother contributes to the secure attachment of her child. Sensitive behaviour is based on the ability to read the child's emotional signals correctly. You use your mentalization capacity to do this. A parent who is capable of mentalizing effectively is also sensitive, in other words is capable of putting himself in the place of the child, for whom something is wrong, and understanding that the child needs something. For children with a disability it means that the parent understands what a child with this disability needs and understands the child's 'inner world'. Mentalizing is a somewhat broader concept than sensitivity, as it not only focuses on understanding the thoughts and feelings of the child, but also those of yourself. The concepts are closely related and overlap in some respects. Sensitivity mainly refers to the parent's behaviour to the child. Mentalization mainly refers to the ability to read the emotional signals correctly, and hence the 'inner world' of the child.

Glossary

Action-oriented manner of thinking (teleological mode): this is a non-mentalizing way of thinking, and has to do with targeted actions. For example, cutting oneself in the event of emotional pain, because it is not enough to express the emotion in words.

Actual mode or thinking in terms of reality: this is a non-mentalizing way of thinking, in which what a person thinks or feels is reality (for him). The client does not distinguish between fantasy and reality; between what is 'on the inside' (feelings, thoughts, wishes, intentions) and what is 'on the outside' (behaviour, facial expressions). If I'm afraid of something, there must also be something threatening in reality. The understanding that your own feelings, thoughts or imagination can influence and distort your perception of the outside world does not (yet) exist. This can soon lead to misunderstandings and conflicts caused by wrong conclusions.

Circle of Security: the parent focuses on the child's needs by providing both a safe haven and a secure base.

Empathy: recognition of emotional reactions of others and responding to this in an adequate manner. You empathise with a person's sadness and offer support.

Joint attention: is a precursor to mentalization. The young child and the parent together are focusing on a third object. The child learns that if the parent points with his finger, it is not about the finger itself, but what the finger is pointing at, for example an animal in a petting zoo. This helps the child to start seeing different perspectives, both those of himself and of the other person.

Attachment style or quality of the attachment relationship: the child develops expectations about the attachment figure. Is the attachment figure available and always available? The quality of the relationship between parent and child may be secure or insecure (avoidant, ambivalent or disorganised). In adults we refer to these expectations as the attachment style.

Attachment trauma: there is a trauma in attachment relationships. Reasons include the parent's failure in part or in full to mentalize, as a result of which mentalization in the child does not develop adequately. This trauma may also be present between different generations, in which a pattern of inadequate mentalization may occur in consecutive generations.

Hypermentalization: this is an exaggerated level of attention to the 'inner world': to feelings, thoughts and wishes of oneself and the other person. The client may for example have all manner of interpretations for what the other person is thinking or feeling, which go far beyond the actual facts and which are unlikely to be correct.

Mental state: has to do with feelings, thoughts, desires, convictions and intentions that you observe in yourself and another person and that you can use to assess and explain the

behaviour of the other person and yourself. You cannot see a mental state, unlike behaviour such as crying or bullying.

Mentalization: the ability to think about one's own behaviour and that of others in terms of assumed mental states (motives, thoughts, feelings). Mentalization entails thinking about feelings and feeling about thoughts.

Mindfulness: is the conscious observation of the experience from one moment to another without judgement, and with a friendly fresh view. Mindfulness helps to be present in the contact with others.

Taking the perspective: the capacity to see things from the perspective of another person. This has a key role in successful communications and is an essential component of the mentalization capacity.

Pretend mode: the pretend way of thinking, in which fantasy is divorced from reality. It is a normal phase for children between the ages of 2 and 3, but in older children and adults suggests a reversion to a non-mentalizing way of thinking and feeling, as they are thinking in terms of a pretend reality.

Pseudomentalization: is a form of thinking in *pretend mode*, or 'chit-chat, clichés or waffling on'. This way of thinking is disconnected from the emotions of the here and now.

Reflective function: this term is used for adults instead of the term mentalization.

Theory of Mind: the capacity to understand thoughts and experiences of other people by attributing mental states to them, such as wishes, intentions and convictions.

Window of Tolerance: a diagram depicting the control of emotions. The desired state is one in which you are calm and can mentalize. There may also be a deluge of emotions and chaos because of excessive tension (*hyperarousal*) or an absence of emotions and rigidity because of too little tension (*hypoarousal).*

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