Push and Pull: Role of Therapist Mentalizing in Navigating Therapeutic Distance

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ABSTRACT

In the relational playground of psychotherapy, negotiating therapeutic distance is crucial for the process as well as the outcome of treatment. The challenge of navigating this closeness and distance may be accentuated during emotionally charged interactions in therapy. Therapist and client may get locked in complementary, rigid positions, leading to either submission or resistance to the others' demands. The therapist's ability to respond appropriately to these pushes and pulls is supported by their ability to mentalize, which is their ability to attend to and understand their own states of mind while being aware of others' states of mind. Therapists are expected to maintain a mentalizing stance throughout and despite the relevance and impact of therapist mentalization, there is relatively less research, training, or practice-related guidance on how to maintain this balance. We use case illustrations to demonstrate therapeutic interactions that can trigger non-mentalizing for the therapist and reflect on ways of recognizing and addressing these patterns related to closeness and distance. We also share recommendations for reflective practice and supervision, training as well as research on therapist mentalization.

Keywords: Psychotherapy, mentalization, therapeutic distance, therapeutic alliance

MeSH terms: Psychotherapy, Therapeutic alliance, Mentalization

Interpersonal interactions require individuals to mentalize, conceptualized as the ability to attend to and understand their own states of mind while being aware of others' states of mind, which enables people to make sense of behaviours.[1,2] Empathic engagement between client and therapist requires recognition and modulation of closeness and distance.[3] A therapist's ability to respond appropriately to these pushes and pulls is a relational skill which can be supported by their ability to mentalize.

As therapists, we are exhorted to maintain a mentalizing stance while identifying and addressing clients' mentalizing difficulties, but there is relatively less emphasis and direction on how to maintain this balance. The core feature of a mentalizing stance is to operate from a position of curiosity which aids in flexible and detailed exploration of our client's experiences and internal world. In this process, therapists need to guard against making rapid assumptions about clients' mental states while monitoring and collaboratively working on any misunderstandings and relational disruptions.[4] Research indicates emergent links between therapists' mentalizing ability, and their experience of countertransference, resolution of alliance ruptures, depth of work on personality functioning, in-session exploration, and client-rated change.[5–8]

As 'non-mentalizing begets non-mentalizing',[9] therapists and clients are at risk while engaging with non-mentalized responses from the other. A therapist can be thrown off the mentalizing 'throne' in situations where they feel stuck and frustrated by the client's push for more distance or overwhelmed by their pulls for more intimacy. During such interactional cycles, it is useful for therapists to not only recognize clients' mentalizing difficulties but also stay tuned to the understanding of their own and others' mental states, and their interactions.

We use case illustrations to demonstrate therapeutic interactions that can trigger non-mentalizing for the therapist and reflect on ways of recognizing and addressing these patterns, within and outside of sessions.

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No Time to Die (Pushing Away)

Puneet, 35 years old male, divorced, living alone, had been in therapy for eight years, and with the current therapist over the past one year. His life was punctuated with multiple losses beginning in adolescence, emotional and relational difficulties, and few social connections or support. After the diagnosis of an autoimmune condition, he informed the therapist of his decision to apply for euthanasia. Any response by the therapist was met by stoic statements that a decision had been made, that there was no expectation of care or help from anyone, and no need for discussions in the therapy room.*

The therapist was thrown off not only by the client's decision to apply for euthanasia but also by the 'unemotional' way this decision was shared with her. She felt stuck in a loop—the more she tried to pull closer and explore this abrupt decision, the more the client pushed her away. Hearing his decision instilled fear in the therapist, fear of being unable to convince him otherwise. Given that Puneet had not disclosed this decision to other members of the treating team, therapist felt immense pressure as if she had to take on the sole responsibility of ensuring Puneet's safety. While the therapist saw the therapeutic space as one of the anchors in Puneet's life, she felt as if he was disconnecting from her and the world in the most tangible way. Questions like 'what did I do wrong?', 'why did I not see this coming?', 'how can I save him?' dominated the therapist's mind.

With increasing anxiety and fear, therapist's repeated attempts to pull closer to the client stemmed from her rigid assumption that the only way of helping Puneet was by getting him to talk about the reasons for his decision. While the therapist was able to pick up on Puneet's non-mentalizing position, she was not able to do the same with respect to herself. As mentalizing is thought to occur in a relational context, wherein the focus is on self and the other[9], selective focus only on the other made negotiating the therapeutic distance more difficult in this context. Eventually, the session ended in a therapeutic impasse with the client still unreceptive, and the therapist caught up with a sense of disconnect from her client's mind and actions.

Trying to pull closer to the client and being met with continuous resistance brought anxiety, anger, and frustration within the therapist. While she was not aware of the exact manifestation of these processes and moments of non-mentalizing during the session, she understood that something had not gone right. Supervision became the space to share her feelings of inadequacy and rejection at being 'shut out', and tune into her own loss of mentalizing.

In supervision, the therapist was encouraged to 'step out of the historical drama'[10] by stepping out of the non-mentalizing interaction in a validating space. When she began to explore how she may have been feeling in the session, she came to realize the enormous sense of responsibility, anxiety and fear that came with the belief that she was the only person who could change Puneet's mind. While shouldering the responsibility of changing Puneet's mind came from a 'position of power', the realization that all her efforts were being dismissed by him brought a sense of powerlessness and failure. She never considered herself to be a 'messiah' and would often help her supervisees recognize and process these ideas. She came to realize that throughout the session, she was trying to hold on to the position of power, while Puneet may have been trying to communicate the need to be heard and validated.

This helped her in realizing that her desperate attempts in trying to get Puneet to listen to her were also indicative of non-mentalizing. She was able to think about Puneet's mind which had earlier seemed opaque to her. While the idea of euthanasia may have been unforeseen, in previous sessions the therapist had exhibited the capacity to simultaneously think flexibly about her own as well as Puneet's mental states during discussions about his suicidal thoughts and behaviours (STB). As therapists' own personality features, emotional responses, attachment patterns have been known to influence their response to client's disclosure of STB in session,[11] therapist explored reasons for present impairment in mentalization. She explored the concept of consistent improvement in Puneet's mental health over the past few months. This unexpected disclosure then prompted the therapist to explore the intricacies of her own emotional and cognitive responses in relation to Puneet's evolving mental state.

Further reflection and discussion with the supervisor brought up questions like 'Could the disclosure of applying for euthanasia be more important than the decision itself?' and 'What could Puneet be trying to communicate through this disclosure?' Being aware of the rigidity of her own beliefs provided an opportunity to own up to it in the subsequent sessions with the client.[12] In the next session, therapist began by exploring how the previous session was like for Puneet. As Puneet initially dismissed the question by shrugging and saying 'it was okay', the therapist decided to take a leap and be authentic about her reactions in the previous session. Wanting to break complementarity,[13] she took responsibility for initiating metacommunication. She expressed to the client that 'I feel I was not able to focus on your needs in the previous session and was focused more on your decision to opt for euthanasia. It may have taken a lot of courage to share this decision with me. I am sorry that I was not able to prioritize what you needed from me and could not be there for you in a way that you may have wanted me to be there'. Therapist sensed a shift in Puneet's body language at this point. He looked down with drooped shoulders and said, 'I am just tired'. Puneet opened up to the therapist about his mind, which helped in creating space to collaboratively focus on the client's experience and their earlier therapeutic interaction, using *what questions* rather than seeking explanations through *why questions*.[4]

Keeping the Door Open (Pulling Close)

Sayli, 29-years-old single female, unemployed, living with her parents, transitioned to a new therapist during the course of her treatment. Both client and therapist were tentative and experienced some anxiety about making this connection. The first session was dominated by the client's concerns about the frequency and duration of sessions, and an insistence on being able to reach the therapist via phone in between sessions as needed. Efforts to discuss the therapy frame and arrive at a consensus culminated in the client's agreement to an initial frequency of once-a-week sessions with a review after a month. Minutes after the end of the session, Sayli re-entered the room with more questions about the therapy process, but the therapist was engaged with another client. At the next meeting, Sayli expressed her dissatisfaction with the therapist and insisted on two-hour sessions and meeting more frequently.*

Such demands to shrink the therapeutic distance may evoke immediate non-mentalizing responses from the therapist, either reflected in withdrawal from

the client; 'No, I don't think that would be possible', or in commitments that might blur the therapeutic frame; 'Sure, we can extend the session for longer, if needed'.

From the first two interactions, therapist could gauge that *Sayli* did not find it easy to be comfortable with and trust the therapist. Even though there could have been numerous possibilities contributing to this discomfort, the therapist did not have extensive information at that time about Sayli's past interpersonal experiences. Epistemic trust is experienced when the receiver of knowledge believes that the source as well as the information being disseminated is reliable.[14] Past attachment trauma has been found to exacerbate epistemic petrification to protect self from misinformation.[12] While theoretically, the therapist understood these possible formulations, the situation on ground seemed to suggest a loss of mentalizing at both ends.

While Sayli and the therapist struggled to establish the bedrock of trust and communication in the session, Sayli kept the therapist psychologically at a distance but demanded extended physical presence. It appeared that the more Sayli became anxious about her relationship with the therapist and made attempts to pull closer, the more therapist began to experience discomfort from failing to establish boundaries and responded by pushing away. She felt like the client wanted her to be present with her at all times; 'almost as if being carried around in her pocket'.

Attachment theory suggests that individuals usually evoke responses from others that confirm their internal working models of attachment. However, in the context of psychotherapy, a securely attached psychotherapist with adequate training is believed to step away from this cyclic process and instead provide an emotionally corrective experience to the client.[15] While theoretically, this is accurate, it is important to break down the process of how a therapist comes to provide a secure space while feeling all the difficult and conflicting emotions like the ones being faced by the therapist in this vignette. Enhancing therapist's mentalization involves simultaneously and tentatively keeping a note of their own as well as client's reactions within a session.[8] However, such pulls may evoke affective responses within the therapist, shaking their mentalizing ground. Therapists may then benefit from acknowledging the client's worries, and their own affect and slowing down the interaction to be able to delineate this process.

In this vignette, the therapist felt overwhelmed by the thought that she was failing to establish the frame of therapy. While she was unable to identify this shift in her thoughts during this interaction with *Sayli*, peer supervision helped the therapist in accepting and validating the frustration, self-reflection facilitated the process of tracing the frustration to her earlier attachment experiences, and supervision provided a space to discuss possible ways of dealing with the impasse and moving forward to help the client. These practices led to the realization within the therapist that both *Sayli* and the therapist were at a place where mentalization had shut down. Being cognizant of shifts in mental states is considered to be the first step in the process of mentalizing,[10] which can be gauged from shifts in attachment patterns.[16] Awareness of these countertransferential responses is key in navigating through the therapy process.[5] Being able to discuss her own anxieties and fears helped create space to think about the possible worries of the client, which helped in adopting a not-knowing stance in subsequent sessions.

Maintaining genuine curiosity (e.g., *I wonder what is going on in your mind right now?*) about the client's emotions helped the therapist in understanding Sayli's thoughts and emotions as well. Rewinding back to the previous incident together, with a focus on 'what' had transpired between them, helped in opening the door to explore the client's worries about being ill-equipped to deal with the challenges of life. Sayli shared her associated anxieties about being left alone by the therapist, as by others in the past. The therapist could see the client's sensitivity to the physical presence and concrete actions of others in relationships. This reflective process aided the navigation of the inevitable pushes and pulls in the client–therapist interaction throughout the course of therapy.

Discussion

In psychotherapeutic work that involves rupture and repair processes, therapist's mentalization ability must be viewed as being relationship-specific and situation-specific instead of a trait-like capacity.[2] While therapists are required to take responsibility for the shared loss of mentalizing, it is not necessary that relational exchange is explained accurately. Genuine mentalizing requires a sense of tentativeness, which is what is required even when the therapist is making sense of deadlocks or impasses. The eventual goal is to communicate responsibility for the possible impact they may have had on the client.[4] Given that the ability to navigate through the pushes and pulls in the therapeutic process is not a static skill, we propose certain recommendations for reflective practice and supervision, training as well as research.

The recognition of one's own and the client's state of mind and responsive adjustments in the therapeutic distance calls for continued reflective work. Existing literature has shed light on the importance of therapists understanding their own needs, emotions, reasons, and processes within a session.[2,5] Although existing literature mentions steps to strengthen therapist mentalization within sessions, there is a need for enhanced empirical scrutiny of their utility and efficacy.

A specific focus on therapists' implicit, self-focused mentalization in supervision can help them explore their patterns of responses across different situations with varied clients, thereby fostering relational mentalizing.[2] As clients come to mentalize the therapeutic relationship only when they have sufficiently mentalized themselves through affect focus and elaboration, therapists may similarly benefit from engaging in such explorations during supervision.[1,17,18] Adopting a mentalizing lens in supervision can include exploring instances and possible reasons for losing mentalizing in a session along with ways of bringing back the mentalizing stance. Introducing therapists to reflective practice may provide them with a window to explore how the person of the therapist (e.g., attachment experiences) may be activated during therapeutic interactions.[19] Such self-work can support therapists' recognition of their unique triggers for losing mentalizing during specific relational patterns with clients and in the development of responsive strategies to restore mentalizing.[8,20] Experiential training focusing on recognizing, describing, and elaborating one's affective and personal reactions to different clients can foster intersubjective understanding outside of sessions which could facilitate mentalizing interactions during sessions.[19,21]

It is also possible that non-mentalizing patterns trickle into the supervisory interaction while the supervisor focuses on multiple mentalizing agents (the client, therapist and therapist–client interaction) at the same time.[22] The strategy of 'thinking together' in supervision, rather than being directed by the supervisor can be helpful in stepping out of non-mentalizing supervisory interactions[1] and practising similar skills in therapeutic interactions with clients.

Selection of the appropriate measures of client and therapist mentalization from among the range of available self-report questionnaires, interviews and vignette-based tasks[23] should be made keeping in mind one's focus (clinical or research), the target participants, feasibility, training required by the therapist or researcher and most importantly the domains of mentalizing one aims to assess. We also propose that patterns and fluctuations in mentalizing be traced as interactional sequences within the dyad. Qualitative analysis of audio/video recordings and session transcripts can provide a window to identify moments of 'push and pull' in therapy that evoke difficult emotions within the client/therapist contributing to interactions driven by non-mentalizing responses.

Key Notes

1. Negotiating therapeutic distance and closeness in the therapy encounter is a key relational skill for practitioners.
2. Therapists need to recognize non-mentalizing interactions, slow down the interaction and rewind to explore the client's mental states as well as their own.
3. Maintaining a curious, tentative, 'not-knowing' stance is recommended during emotionally charged situations or impasses in therapy.
4. Reflective practice and a focus on the self of the therapist during supervision can support mentalizing interactions in therapy.

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References

1. Bateman A and Fonagy P. *Handbook of mentalizing in mental health practice*. 2nd ed. American Psychiatric Association Publishing, 2019.
2. Barreto JF and Matos PM. Mentalizing countertransference? A model for research on the elaboration of countertransference experience in psychotherapy. *Clin Psychol Psychother* 2018; 25(3): 427–439.
3. Wiseman H and Slonim DA. Closeness and distance dynamics in the therapeutic relationship. In: Tishby O and Wiseman H (eds) *Developing the therapeutic relationship: integrating case studies, research, and practice*. American Psychological Association, 2018, pp. 81–103.
4. Bateman A and Fonagy P. Mentalization based therapy. *Psychoanal Inq* 2013; 33(6): 595–613.
5. Bhola P and Mehrotra K. Associations between countertransference reactions towards patients with borderline personality disorder and therapist experience levels and mentalization ability. *Trends Psychiatry Psychother* 2021; 43(2): 116–125.
6. de la Cerda C and Dagnino P. In-session reflective functioning: relationship with the presence and depth of work on conflict or personality functioning. *Front Psychol* 2021; 12.
7. Reading RA, Safran JD, Origlieri A, et al. Investigating therapist reflective functioning, therapeutic process, and outcome. *Psychoanal Psychol* 2019; 36(2): 115–121.
8. Cologon J, Schweitzer RD, King R, et al. Therapist reflective functioning, therapist attachment style and therapist effectiveness. *Adm Policy Ment Health Ment Health Serv Res* 2017; 44: 614–625.
9. Allen JG, Fonagy P, and Bateman AW. *Mentalizing in clinical practice*. 1st ed. Washington D.C.: American Psychiatric Press, 2008, p. 22.
10. Wiwe M. *Errare Humanum Est* (To Err Is Human): A mentalizing breakdown in the therapeutic work with an adolescent. *Front Psychol* 2021; 12: 789120.
11. Ying G, Chennapragada L, Musser ED, et al. Behind therapists' emotional responses to suicidal patients: A study of the narrative crisis model of suicide and clinicians' emotions. *Suicide Life Threat Behav* 2021; 51(4): 684–695. URL: https://doi.org/10.1111/sltb.12730
12. von Below C. 'We Just Did Not Get on'. Young adults' experiences of unsuccessful psychodynamic psychotherapy—a lack of meta-communication and mentalization? *Front Psychol* 2020; 11: 1243. URL: https://doi.org/10.3389/fpsyg.2020.01243
13. Sharp C, Shohet C, Givon D, et al. Learning to mentalize: a mediational approach for caregivers and therapists. *Clin Psychol* 2020; 27(3).
14. Fonagy P and Allison E. The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy (Chic)* 2014; 51(3): 372–380.
15. Bucci S, Seymour-Hyde A, Harris A, et al. Client and therapist attachment styles and working alliance. *Clin Psychol Psychother* 2016; 23(2): 155–165. URL: https://doi.org/10.1002/cpp.1944
16. Luyten P, Campbell C, Allison E, et al. The mentalizing approach to psychopathology: state of the art and future directions. *Annu Rev Clin Psychol* 2020; 16: 297–325.
17. Tohme P and Kolev M. Mentalizing glasses: multifocal attention in mentalization-based treatment and the role of the supervision. *Front Psychol* 2021; 12: 1–7.
18. Margola D, Accordini M, and Fava E. Moment-by-moment interpersonal behaviors in poor vs. good psychodynamic psychotherapy outcomes: does complementarity say it all? *Res Psychother: Psychopathol Process Outcome* 2020; 23(2): 167–179.
19. Egozi S, Tishby O, and Wiseman H. Therapeutic distance in client–therapist narratives: client attachment, therapist attachment, and dyadic effects. *Psychother Res* 2021; 31(8): 963–976.
20. Ensink K, Maheux J, Normandin L, et al. The impact of mentalization training on the reflective function of novice therapists: a randomized controlled trial. *Psychother Res* 2013; 23(5): 526–538.
21. Bhola P, Duggal C, and Isaac R. *Reflective practice and professional development in psychotherapy*. New Delhi: Sage Publications India Pvt Ltd, 2022, p. 62.
22. Lu Y, Kivlighan DM, Hill CE, et al. Therapist initial attachment style, changes in attachment style during training, and client outcome in psychodynamic psychotherapy. *J Couns Psychol* 2022; 69(6): 794–802. URL: https://doi.org/10.1037/cou0000557
23. Shaw C, Lo C, Lanceley A, et al. The assessment of mentalization: measures for the patient, the therapist and the interaction. *J Contemp Psychother* 2020; 50(1): 57–65.