Mentalizing and Men's Mental Health: Helping Men to Keep Mind in Mind in Clinical Settings

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Introduction

The ways that masculinities influence the presentation of psychological distress have been well-summarised in previous chapters. In this chapter, we explore what contribution research into mentalization, and its use in treatment, offer in addressing the particular challenges apparent for men's mental well-being.

Summary of Mentalization

Mentalization is a neurodevelopmentally acquired ability to think about intentional mental states—thoughts, feelings, desires, beliefs, hopes—in oneself and other people and is key to the interpretation of behaviour. It plays a central role in the regulation of affect, managing interpersonal relationships, and the development of a coherent sense of self (Fonagy et al. 2002). It develops initially within the context of early attachment relationships. A young child learns to mentalize robustly because he/she was mentalized in turn by an attuned, responsive caregiver. More parental mentalizing,

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or mind-mindedness, has been linked with secure attachment in childhood. Secure attachment is associated with a range of indices of adjustment, such as resilience under stress, ability to recruit support, and a creative response to adversity (Luyten et al. 2012). Insecure attachment, on the other hand, has been associated with behavioural difficulties, poorer peer relationships, and later adult mental health difficulties (e.g. Allen et al. 2008).

An increasing evidence base suggests that mentalizing comprises a range of processes and is therefore formulated as a multi-dimensional concept. These seem to be underpinned by distinct neurobiological pathways, described as the 'mentalizing network' (e.g. Frith and Frith 2003) or 'social brain'.

Mentalization is being widely researched and evaluated, across the fields of child development, neuroscience, evolutionary psychology, and in the treatment of a range of mental health problems. It has been proposed as a core effective ingredient in any psychological therapy and possibly 'the most fundamental common factor among psychotherapeutic treatments' (Allen et al. 2008).

In this chapter, we summarise the evidence base as it pertains to gender differences and men's mental health in particular. A range of overlapping ideas have been conceptually linked to mentalization in the literature, including theory of mind, empathy, and social cognition, and these will also be referenced where relevant. We then describe the treatment applications in areas where the prevalence rate is higher for men and offer suggestions for use of the mentalizing stance (Bateman and Fonagy 2016) to address the difficulties for men in seeking timely access to treatment.

Gender Differences in Attachment Patterns and Development of Mentalizing Skills

The literature on gender differences in the development of childhood attachment, mentalizing, and related concepts is summarised below. Gender differences in prevalence of childhood problems have been widely identified. Boys present on average with more 'externalising' problems, such as aggression and conduct disorder, while girls present with more 'internalising' difficulties, such as mood and anxiety problems.

As young as 12 months old, baby girls and boys show differences in their sensitivity to internal and external cues (Watson et al. 2011); boys appear less sensitive than girls to internal stimulation. This is consistent with findings of an 'interiority bias' for women over men—an attentional orientation to internal states that may help females be more socially aware (e.g. Bloise and Johnson 2007).

Gender-related differences have been noted in the development of theory of mind (ToM). Walker (2005) described sex differences in ToM in children aged 3–5, with girls performing better than boys on false-belief tasks. Devine and Hughes (2013) studied 8–13 year olds. Gender contrasts were found on tests of ToM, with performance improving with age, but girls out-performing boys, even when verbal ability was controlled for. This latter point is important as girls' verbal ability tends on average to be ahead of boys at the same age. They cited Maccoby's (1990) work on friendship styles in middle childhood and adolescence. Gender differences were described, with boys more likely to socialise in larger, less intimate, groups, while girls showed closer relationships with a smaller number of friends. They suggested that girls may have more opportunities to practise and refine ToM and mentalizing skills, through turn-taking in conversation, expressions of agreement, and acknowledging other points of view. Boys' social experiences on the other hand may instead promote the development of spatial skills.

David and Lyons-Ruth (2005) summarised the literature on gender differences in attachment responses in early childhood. They noted that gender differences have not usually been identified in secure attachment. However, significantly, when there are threats, and insecure attachment is apparent, boys are more likely than girls to show behaviours consistent with a 'disorganised' pattern of attachment. For example, 4-year-old boys who were insecurely attached were more likely to show attention-seeking, disruptive, and aggressive behaviours with peers than insecurely attached girls, or securely attached boys (Turner 1991). They suggested substantial literature indicates that boys are more likely than girls to exhibit behaviour problems in response to stress. Insecurely attached girls by contrast show more compliance, dependence, and affiliative behaviours.

Their own study of mother-infant pairs tended to support this finding. There were gender differences in infants' responses to frightening maternal behaviour. Boys showed more 'disorganised' attachment behaviours, and the less adequate the mother's response, the more likely the boys were to show overt conflict behaviours. In contrast, girls tended to approach their mothers more.

A number of studies link such gender differences to an evolutionary hypothesis. Taylor et al. (2000) proposed that males and females behavioural responses to fear and threat differ. While men and women share the same 'fight-or-flight' response at the physiological level, they may differ in their behavioural expression of this. Specifically, males are thought to show more visible, action-oriented, fight-or-flight behaviours, depending on the nature of the stressor. Females on the other hand show more 'tend-and-befriend', social-affiliative behaviours in response to stress. 'Tending' behaviours refer

to the nurturing of offspring, while 'befriending' refers to the active building and maintenance of social relationships as a way to deal more effectively with the stressor.

In adolescence, gender differences in mentalization were explored by Rutherford et al. (2012). Fourteen to eighteen year olds completed two measures of implicit and explicit mentalizing. Implicit mentalizing is a more automatic process, requiring less cognitive effort, and less of a verbal component; explicit mentalizing is a more effortful activity, involving greater cognitive control, and a greater verbal component (Fonagy et al. 2012). Distinct neurobiological circuits underpin each of these functions, with more subcortical and cortical processes involved in the former and predominantly cortical networks underpinning the latter. Results suggested that girls scored more highly on both kinds of mentalizing than boys. The authors proposed an evolutionary perspective, consistent with the 'tend-and-befriend' hypothesis, where girls may have more 'intrinsic motivation to understand the mental states of others', and hence develop this ability earlier than boys.

An interesting finding for boys was a closer relationship between language and explicit mentalizing, suggesting that for boys, language ability may be a more important mediator for making sense of mental states. It is possible to conceive a link with the findings of David and Lyons-Ruth (2005), above. If fewer behavioural differences are noted between boys and girls within a secure attachment relationship, this may have provided the context for the development of language for mental states, which in turn provided the scaffolding needed for boys to mentalize robustly.

Weimer et al. (2017) described the development of a related concept, 'constructivist theory of mind'. This relates to understanding 'the nature of mental processes', for example that people can easily misinterpret mental states. No sex differences were apparent in a mixed-age sample of 8–15 year olds. However in a larger sample of 14–15 year olds, boys performed less well than girls, even when academic performance was taken into account. Importantly, lower scores on this task linked to poorer prosocial reasoning about conflict, and more serious behaviour problems in school. Again, this suggests a mediational mechanism, where differences in the ability to mentalize may contribute to the gender differences in behaviour.

In terms of brain development, Mills et al. (2014) examined brain scans in children and young people aged between 7 and 30, specifically in relation to brain regions associated with mentalizing and the 'social brain'. Some gender differences were identified in brain structure. Sex differences have previously been described in the changes of white and grey matter volume—in the frontal and parietal lobes, grey matter volume increased in both sexes

pre-adolescence and decreased again post-adolescence (Giedd 2004). A gender difference in the time this volume peaked, in particular in the temporo-parietal junction, was identified in the current study, occurring earlier in girls than boys. This brain region is described as 'activated specifically in situations when one is inferring the mental states of others' and is part of the 'mentalizing network' (Frith and Frith 2003: 5). Mills et al. hypothesised that these brain differences could be related to the gender differences in language and mentalizing abilities, however, did not directly examine connections with social cognitive functioning.

Gender Differences in Adult Mentalizing

With regard to adults, women performed better than men in the general population on a measure of empathy (Baron-Cohen and Wheelwright 2004). A further study by Baron-Cohen et al. (2015) confirmed findings that women perform better than men on a test of theory of mind, the Reading the Mind in the Eyes Test.

Proverbio (2017) used neuroimaging to study face processing, an aspect of social cognition. Results suggested a gender difference with females showing more responsiveness to face stimuli than males. They suggested this supported other findings that women show a greater empathic attitude and more interest in social information than men.

The effects of psychosocial stress on social cognition were examined by Smeets et al. (2009). Men and women appeared to differ in the impact stress had on their ability to interpret mental states. In men who had a higher cortisol response to stress, social cognition seemed to improve, relative to men with a lower cortisol response, or controls. Women on the other hand showed better performance with a low cortisol stress response, rather than a high, or non-stress condition. The authors concluded this lent support to the Taylor et al. (2000) hypothesis of gender-typical behavioural responses to stress.

The impact of stress on another aspect of social cognition, the ability to distinguish self- from other-related mental representations, was explored by Tomova et al. (2014). This 'self-other distinction' is important because it contributes to flexibly regulated interactions, helps to maintain the boundaries between one's own and another's emotions, and is crucial in perspective-taking. By contrast, a self-centred response reduces both the capacity for empathy and the use of prosocial behaviours. The study compared males' and females' responses, initially hypothesising that increased psychosocial

stress would generally reduce the ability to make self-other distinctions. Groups were matched for socio-cognitive abilities, and interestingly, no gender differences were found in physiological responses to stress, or subjective stress ratings. However, men and women did differ in their responses to tasks under stress vs control conditions. Women became better at making 'self-other distinctions' under stress, whereas men showed an increase in 'emotional egocentricity', taking longer to distinguish their own from another's perspective. This was seen as evidence for the protective 'fight-or-flight' stress response and as lending support to the 'tend and befriend' hypothesis. The authors concluded that 'men respond to stress by defaulting to less resource demanding and more automatic processing strategies. As representing the feelings and intentions of others is resource demanding, they display a fall back towards more self-related or <egocentric> processes, when having to judge emotions or the perspective of others' (p. 101).

In mentalizing terms, this can be conceived of as a quicker resort to 'non-mentalizing modes' of functioning for men under stress. These modes are described more fully below. The cognitive-behavioural framework for understanding male responses to distress, proposed by Kingerlee (2012), echoes these ideas, describing a 'reflection abandonment mechanism' which serves to 'propel the man *away* from further reflection on his psychological condition…and *towards* one or more recognised male externalizing behaviours' (p. 9). Mentalizing theory encapsulates a similar notion that under stress, reflection on mental states is easily lost to more primitive modes of functioning.

A core component of mentalizing theory is its function in regulating emotions. Fonagy and colleagues (e.g. Fonagy et al. 2002) have described the process whereby in the early caregiver relationship, the child acquires labels and a second-order representation of primary emotional states, because the caregiver provides a 'marked and contingent' response to the child enabling them to make sense of their experience. They described this process leading to 'mentalized affectivity'.

Lecours and Bouchard (1997) delineated a number of steps in this process. Firstly, affect tolerance is required. This brings in delay before an emotion is expressed in action, increases control over how it is enacted and increases distance and objectivity towards the emotion. Secondly, there is cognitive processing, which transforms the sense of the emotion from bodily signs and symptoms to a subjective experience existing in the 'mental' sphere. They proposed a hierarchy of increased elaboration of expression, and alongside this suggested that emotions can be expressed through a range of modalities, from somatic, through behaviour, to verbal expression.

They used this framework to explore the ways that men and women express emotions (Lecours et al. 2017). Summarising previous research, they concluded men are less likely to express a wide range of emotions in words. Their own study analysed interview transcripts of men and women attending a psychotherapy assessment. They explored two hypotheses—whether women used the 'verbal modality' and owned their affects more than men, and whether men used more externalising methods to express their emotions. The results tended to support these proposals. Men appeared to 'mentally externalize' more (where '…an affect is explicitly recognized but is not yet completely tolerated as one's own. It is either mentally externalized and perceived as if caused by some external event or agency, or disowned and generalized to a group of people'). Men also used the motor modality of expression more often than women ('Motor expression involves the description of behaviour…', Lecours et al. 2017, p. 231). They suggested this lent support to the view that women are more apt at mentalizing affects than men.

In summary, previous findings more often than not suggest that gender differences may exist in mentalizing and related concepts such as ToM and empathy, with men seeming to have more difficulties in this area than women. Some researchers have offered an evolutionary explanation for this, while others have theorised a biopsychosocial framework (Kingerlee 2012). There is the implication that mentalizing is an important mechanism underpinning, and helping explain, the differing behavioural expressions of distress between men and women. In the next section, we draw links between these areas of mental health, mentalizing formulations, and interventions.

Mentalizing Approaches to Male-Specific Mental Health Problems

The mentalizing literature has addressed violent behaviour and antisocial personality disorder (ASPD), as well as alexithymia, compulsive sexual behaviour (CSB), and functional somatic disorders (FSD). All are areas of psychological difficulty more prevalent amongst men.

As described elsewhere, male psychological distress is more likely to be indirectly expressed, to go unreported and result in less help-seeking behaviour than in females (Morison et al. 2014). Externalising behaviour is more common amongst men and has been understood as a manifestation of distress (Lohan 2007). Men have higher rates of suicide (Kingerlee et al. 2014) and are more likely to perpetrate purposeful injury and to be its victims than women (Logan et al. 2008). In England and Wales, men produced

around 80% of antisocial behaviour (UK Government 2012) and have higher rates of incarceration (Wilkins 2010). Additionally, as reported by Haggett (2014) men are more likely to exhibit psychological distress by presenting with somatic complaints. Men also represent the majority of those with major addiction problems (Health and Social Care Information Centre 2012), including sexual addiction (Kuzma and Black 2008).

Formulating Mental Health Issues with Mentalization-Based Applications

Mentalizing is an ability that can be temporarily sent 'offline' by normal life events, such as stress, fatigue, or threat. The more primitive areas of the brain (involved in survival responses fight/flight/freeze) then come into play, as well as the attachment system. When insecure attachment patterns are present, this disruption of mentalizing can occur more rapidly and frequently and can impact on how quickly and effectively mentalizing is restored.

When mentalization goes offline, *prementalizing modes* of functioning emerge. These are understood as developmentally preceding mentalization (Bateman and Fonagy 2016).

1. *Psychic equivalence* corresponds to a thinking style where the mental state is no longer a possible representation or a tentative way to look at the reality but becomes the reality itself (Allen et al. 2008), often attributing to others thoughts and feelings with certainty, rigidity, and inflexibility. For instance, a man admitted to secure services might become fixated on the Ministry of Justice (MOJ) not granting leave as a way to punish them, rather than considering the backlogs public services often have.
2. *Teleological mode* is characterised by a thinking style focused on tangible and visible changes, and 'quick fix' actions to resolve mental states, rather than considering what might be happening in the mind of the person. For instance, it is not infrequent for men in an inpatient unit to make pressing demands for changes in medication to support their negative emotional states even when the multi-disciplinary team encourages them to explore these issues psychologically.
3. Finally, *pretend mode* involves a decoupling and disconnection of thoughts and feelings from the present experience. Conversations with an individual in pretend mode can be felt as inconsequential, boring, repetitive, or missing something undefinable, like the presence of the proverbial

'elephant in the room'. This mode can also lead to externalising behaviours, sometimes dangerously, because thoughts and feelings are decoupled from consequences, as if it was not real or happening in a film. In a recent supervision with a psychologist working on a male ward, we reflected on how the patient and staff were perceiving her attempts to provide therapy for a man with delusions, in order for him to be able to socialise more, as 'unhelpful' since the patient did not cause 'any management problems'. Staff and patient both seemed in pretend mode, avoiding thinking about whether living in a hospital bedroom and avoiding triggers for his delusions, really constituted 'wellbeing' for this patient.

In formulating mentalizing problems, consideration of the dimensions is also important. As described earlier, mentalizing is conceived as multidimensional, with distinct, if overlapping, neurobiological pathways underpinning these.

1. Mentalizing can be *automatic/implicit* versus *explicit/controlled* as described earlier, with the former being more preconscious, and the latter more effortful, controlled and overt.
2. Mentalizing also requires the ability to shift between an *internal* focus (thoughts, feelings, desires, beliefs, etc.) and *external* features (tone of voice, posture and actions), both in oneself and other people. For instance, as a result of traumatic experiences, individuals may become hyperalert to 'external' clues to interpret human behaviour, but struggle to make sense of their 'internal' experience. They may infer their own mental states from their behaviour (e.g. 'I got drunk, so I must be stressed') or misattribute the behaviour of others (e.g. 'You slammed the door so you must be angry with me').
3. The third dimension is between a focus on the *self* versus the *other*. Individuals with insecure attachment might find it harder to shift from focusing almost exclusively on themselves or others therefore missing the opportunity to accurately understand how mental states mutually interact to determine behaviours. Individuals with ASPD, for instance, can be surprisingly skilled at reading other people's mental states (Dolan and Fullam 2004) but can fail at reading their own internal experience.
4. The fourth dimension is between *cognition* and *affect*. Cognitive mentalizing reflects the ability to reason, name, and think about mental states. Affective mentalizing refers to understanding the feeling associated with the mental states, which fosters empathy (Bateman and Fonagy 2016). Individuals with ASPD can be skewed towards the cognitive dimension

of mentalizing, failing to understand the affective implications of their actions on themselves and others, and therefore acting callously and appearing unempathic.

Mentalization-based therapy (MBT) aims to develop more robust mentalizing, by helping to bring mentalizing back on line when pre-mentalizing modes are present and promoting balance and flexibility across the dimensions. This allows a more accurate understanding of mental states in oneself and others, helps regulate emotions, and brings a more balanced view of self and interpersonal relationships.

Aggressive Behaviour, Violence, and Antisocial Personality Disorder (ASPD)

The victims of most severe violence are related to the perpetrator by attachment relationships (Smith et al. 2010). The activation of neural systems associated with attachment lowers the ability to mentalize, and in turn low levels of mentalizing increase the risk of violence (Adshead et al. 2013). There is considerable evidence that violent offenders present with higher levels of insecure attachment compared to the general population (Bakermans-Kranenburg and van IJzendoorn 2009).

Studies of children suggest that there may be a subgroup of boys who, from an early age, manifest callous and unempathic attitudes, and later in life display violent behaviour (Wootton et al. 1997). A neurobiological correlate of this lack of empathy is the hypo-activation of the amygdala. This may be genetic or be the result of traumatization which will tend to reduce its size. 'The amygdala is central in the recognition of fearful expressions. It is therefore linked to experiencing empathy as well as experiencing fear' (Marsh and Blair 2008). A lack of fear can prevent the infant from regularly seeking attachment figures to be mentalized to downregulate their distress. This in turn restricts the development of mentalizing skills (Bateman et al. 2013).

As a result of trauma, attachment can be disrupted by a combination of social circumstances and inadequate parenting; alternatively, a child might find themselves in the position of wishing to avoid thinking about their caregiver's mental states, which would expose them to the awareness of being thought of in a hostile way. This repeated avoidance of thinking of mental states can affect the ability to take perspectives (O'Connor 2006).

Not surprisingly, forensic populations present with higher levels of dismissing or avoidant attachment (Adshead 2004), with patterns of thinking

which deny vulnerability (Hesse 2008). This can lead to objectifying and dehumanising the other and an increased risk of perpetrating violence.

In adolescents, the failure of mentalizing can be observed not only in juvenile delinquency but in problematic behaviours such as bullying. Twemlow et al. (2005) illustrated this with the story of an 11-year-old boy who was disruptive at school as a result of emotional abuse and neglect from his mother and how the school system responded in a way that further inhibited mentalization, such as being excluded from lessons. The Peaceful Schools Experiment, modelled on mentalization theory, aimed to create a school environment which reduced the occurrence of violent behaviour. The focus was on increasing mentalization in the whole system and not just in the 'problematic boy'. The study was conducted for 3600 children across 9 elementary schools in the Midwest (USA) and found decreased peer-reported victimisation, aggression, and aggressive by-standing compared to control schools. These findings were maintained in the follow-up year (Fonagy et al. 2009). In a similar study conducted over three years, in a Jamaican school for children with previous failure in entrance examinations, the implementation of the Peaceful School Project led to the teachers feeling more comfortable in the school, a decrease of serious dangerous fights from 18 to 3 per year, reduced victimisation for boys from a reported prevalence of 70 to 30%, and decreased numbers of children carrying weapons at school from 40 to 20% (Twemlow et al. 2011).

As noted earlier, ASPD is more common in men than in women with an estimated ratio of 3:1 (Alegria et al. 2013); men also account for 80% of antisocial behaviour (UK Government 2012). ASPD is linked to increased likelihood of committing violence (Coid et al. 2006) and is a very good predictor of future violence, reconviction, re-incarceration, and recidivism rates (Wormith et al. 2007). There is growing research suggesting that men with ASPD show impairment in social cognition and the ability to link mental states to behaviour (Bateman et al. 2013). They also have difficulty recognising negative affects such as sadness, fear, anger, and disgust in facial recognition tasks (Hastings et al. 2008; Dolan and Fullam 2004). These findings are in line with deficits in the amygdala mentioned previously. Individuals with ASPD can generally perform tasks where ToM is involved but can fail in higher levels tasks involving more subtle understanding of others' intentions. Furthermore, men with ASPD have shown more impairments understanding basic emotions than men who also meet criteria for psychopathy (Dolan and Fullam 2004).

This might indicate a specific group of men who are susceptible to manifesting violence, namely those with high affectivity and impulsivity.

Typically, these men might be socially isolated, misusing substances, and showing antisocial behaviour from late childhood. When feeling overwhelmed, for instance by a perceived threat, they may fail to mentalize and violence can erupt (teleological mode, as described above).

Individuals with ASPD can become 'experts' at reading others' internal states, albeit with the motivation to manipulate them. This can be to the detriment of their own internal, and especially affective, experience. They can also lack the ability to read certain emotions accurately, as previously explained. Reading other people superficially can be problematic, leading to non-mentalizing modes. In psychic equivalence mode, there can be excessive reliance on rapidly identifying, through external and unchecked features, reasons behind a certain behaviour. For instance, a denial of a request is seen as an attempt to establish a pecking order, rather than to the difficulties inherent in the request (psychic equivalence). This is further complicated by the failure to consider the affective component of metalizing, as it makes the mind of the perpetrator blind to the full consequences for the victim of abusive or violent behaviour (e.g. 'I did not hit him that hard').

Bateman and Fonagy (2012) have illustrated how rather than being a stereotype, the image of the antisocial man with jewellery, expensive cars and surrounded by good looking women, might be an expression of their reliance on the importance of 'face' (teleological mode).

Adaptations of MBT for ASPD have taken into consideration the propensity to over-control emotions, often achieved by seeking highly hierarchically oriented relationships. Threats to the hierarchy arouse the attachment system and a sense of threat to self-esteem. This leads to psychic equivalence mode, demanding respect from and controlling others, and creating an atmosphere of fear and intimidation. Group therapy is an essential component of the treatment as the group stimulates the attachment system less intensely than individual therapy, and men with ASPD are more likely to acknowledge comments from peers with similar experiences than from a therapist (Bateman et al. 2013).

MBT-ASPD focuses on rebalancing those dimensions of mentalizing that can be more easily destabilised, for instance by focusing on understanding emotional cues and recognising emotions in other people, by exploring how the individual with ASPD can be sensitive to threats to hierarchy and authority and how that can elicit emotional responses that impair mentalizing, and finally by refining the understanding of interpersonal situations in their complexity. These aims are pursued with a combination of *mentalizing education* and *mentalizing process*. The former includes a series of introductory groups focusing on the nature of emotions, facial expressions, and other

nonverbal behaviours. Self-disclosure is encouraged in a gradual way, letting men use examples that do not trigger shame which could destabilise mentalizing. Following the psychoeducational sessions, possible difficulties engaging with the process treatment are discussed, such as feeling diminished by another group member or disliking the therapist. The second part of the treatment (process mentalizing) establishes the group leader as an 'authority', to meet the need for a clearly structured and hierarchical relationship. The leader establishes this by actively checking in with each participant at the start of the session, directing the group towards mentalizing, and interrupting non-mentalizing when it occurs. The therapist keeps the focus on affect, and the internal dimension, preventing participants from talking about others and their 'faults'. Rather than focusing on 'victim empathy', MBT-ASPD aims to improve the management of violent impulses by enhancing the curiosity and therefore the understanding of how other people came to behave the way they did (Bateman et al. 2013).

Mentalization-informed treatments have been shown to reduce violence in men with ASPD. In a high secure setting, men with a variety of severe psychopathology increased their capacity to manage negative affect, and showed improved reality-testing and perspective-taking. This followed a course of 48 mentalizing group sessions across 14 months. At 18-month follow-up enduring changes in personal relationships were noted, with sustained decreases in levels of interpersonal violence (Adshead et al. 2013). Another study delivered MBT to male patients diagnosed with ASPD, in an outpatient setting over 18 months. They showed a decrease in aggressive or violent behaviours. They also rated their aggression towards others and themselves as decreasing in severity in the first six and a half months of treatment. Dropout rates with this client group can however be a significant issue, and in this study almost half the participants did not complete the treatment (McGauley et al. 2011).

Other Applications of MBT with Male Clients

Alexithymia

The term alexithymia refers to a difficulty identifying and naming emotions, with particular reference to the distinction between bodily sensations, feelings, and how they are elaborated internally in the mind (Levant et al. 2014). Alexithymia is more common in men than women in non-clinical populations (Levant et al. 2006). Alexithymia overlaps with

the notion of impaired thinking and expression of affective states characteristic of affective mentalizing. The inability to symbolise inner experiences in language can contribute to a sense of chaos and confusion. This can be overwhelming and further impair mentalizing, setting the scene for non-mentalizing modes to emerge. Using MBT, a therapist might tentatively 'fill the room' with a language of possible feelings (Skårderud and Fonagy 2012). This explicit mentalizing on the part of the therapist is 'marked' as his own hypothesis, to avoid superimposing his mind on the client, which can result in pretend mode emerging. Psychoeducational group interventions, based on mentalization and mindfulness, showed promising outcomes relative to controls, in decreasing alexithymia characteristics (Byrne et al. 2014).

Sexual Addiction

Failures in mentalizing can also underpin sexual addiction, again more prevalent amongst men (Berry and Berry 2014). This can involve pretend mode, with retreat into a fantasy world. A man may perceive himself as powerful by identifying with pornographic actors performing sex on submissive women, or by observing a woman performing sex acts for him in front of a webcam. Underlying these 'escapes', a man might be trying to decouple himself from painful realities.

Specific protocols based on mentalization-based therapy have been recently applied to sexual addiction (Berry and Berry 2014), and these encourage men to mentalize how their behaviour may impact on, and be affected by, the thoughts and feelings of self and others.

Functional Somatic Disorders (FSD)

According to Luyten et al. (2013), FSD are more prevalent amongst men. Some authors specifically highlight how psychosomatic disorders can indicate a deficit of 'affective mentalizing' (Fonagy et al. 2002). There is consensus that increasing the ability to mentalize is a first and important step for individuals with FSD to access further psychological treatment (Gubb 2013). In a study conducted in the Netherlands, Houtveen et al. (2015) describe how an inpatient and outpatient treatment was developed for individuals with chronic FSD to help them benefit from therapies such as CBT and ACT. The programme aimed to increase 'body-related mentalization' to improve engagement with further treatments. A study involving 183

patients showed a reduction in somatic symptoms and increase in health-related quality of life. These improvements were maintained at 2-year follow-up. Beutel et al. (2008) suggest that 'multimodal' treatments, including engagement with the body, through art or body-oriented therapy, are ways to promote mentalization in individuals with FSD.

Adapting the 'Mentalizing Stance' with Men in Clinical Practice

Having described a number of applications of MBT for disorders more common in men, we conclude this chapter by discussing the 'mentalizing stance' as a valuable engagement and treatment strategy with male clients. Bateman and Fonagy (2016) describe this as the core therapeutic attitude for practitioners of MBT. It is characterised by a 'not-knowing' approach, remaining curious, and non-judgemental, and avoiding making assumptions about what is happening in the mind of the other, or oneself. Attention is focused on mental states. The aim is for a flexible balance along the dimensions of mentalizing. We have found this helpful in working with male clients. An example for males with alexithymic difficulties would be to work first on the ability to put mental states into words, before attempting higher level psychological tasks, such as making links between past and present in psychodynamic therapy, or attempting cognitive restructuring in CBT. In our experience, this has proved particularly helpful with clients difficult to engage with more traditional psychological approaches, because it develops a scaffolding for mental processes which are a pre-requisite to engaging successfully. In one case, a male army veteran engaging in trauma work would become overtaken by flashbacks and crouch down on the floor, reliving his combat experiences (psychic equivalence). His early history suggested a non-mentalizing family culture, with an absence of talking about emotions. He identified not knowing how to describe his feelings. Working on developing a language for his emotions generally helped provide a scaffolding for trauma work which could then proceed more effectively.

The mentalizing stance is a less hierarchical approach, with the therapist taking a 'not-knowing stance', 'being ordinarily human', and acknowledging their part in any ruptures or mistakes. This may be helpful in addressing the issues of power, status, or 'loss of face' which may present barriers to men seeking help (e.g. Kingerlee 2012). In the following clinical vignette, an example of how the mentalizing stance can restore meaningful therapeutic interaction for a man with ASPD is illustrated.

Clinical Vignette: Albert

Albert was treated in a secure psychiatric unit. He had engaged fairly well with the individual therapist (MP) over four months, in a mentalization-based intervention, aimed at issues in the here and now, especially interpersonal difficulties.

   An obstacle arose when Albert increasingly made derogatory comments, albeit with some humour, about MP's use of English (English was his second language). MP noted angry feelings towards Albert, fantasised about not seeing him and felt anticipatory anxiety at being on the receiving end of his comments. Despite the temptation to enforce the service policy on racial abuse and discrimination (teleological mode), MP tried to maintain a mentalizing stance to address the impasse. He shared with Albert what he was experiencing. He explained openly how humiliating it felt to be corrected when speaking. He said the way he was feeling was impacting on his ability to think with openness and curiosity about Albert. Albert responded positively to this disclosure and told MP he felt 'really gutted'. MP felt understood and warmer towards Albert. The therapeutic relationship with Albert flourished after this and the therapy was mutually seen as successful when it ended. In a follow-up session, Albert explained that when MP disclosed how he felt, he perceived him as 'human', and this helped to feel a connection with him. This episode illustrates how, after an interpersonal rupture in the therapeutic alliance has occurred, the mentalizing stance can help both the therapist and the client regain mentalizing, and restore engagement. In relation to ASPD, it also illustrates how it helped Albert regain his affective mentalizing of the other, who again became a human being affected by Albert's behaviour, rather than a hostile presence needing to be controlled.

To conclude with a final point, we note the relative flexibility of mentalizing approaches. While there are structured forms of MBT, it has been used in other kinds of interaction with a therapeutic purpose, which could help address the accessibility gap for men engaging with help. Williams et al. (2014) described how psychiatric in-patient staff prefer to work on male rather than female wards. They suggested male patients are less active in seeking staff contact, which places less demand on hard-pressed staff, who 'collude' with the males' lack of psychological engagement. The Star Wards project produced guidance for in-patient staff in psychiatric and acute hospitals, based on mentalization principles. This offered ways to enhance the quality of brief day-to-day interactions with clients, or carers, in a range of health contexts (Bray et al. 2014). This has potential relevance to engaging with men more flexibly in a variety of non-traditional contexts. Diamond (1998) described a community psychology approach conducted outside of traditional healthcare settings. This incorporated an 'Inquiry Paradigm' characterised by a 'not-knowing' rather than 'expert' style of engagement with

clients' experience. Kingerlee et al. (2014) described applying this approach to provide mental health support to men in a non-health setting, with positive results.

Conclusion

In this chapter, we have attempted to show the relevance of a mentalizing perspective to the development of male psychology and the way boys and men may express psychological distress. We discussed the application of MBT to a number of clinical areas which particularly pertain to men's mental health, including the vexed issue of male help-seeking behaviour. We hope this may point towards innovative adaptations to approaching men's psychological needs.

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