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Commentary on: A Sequenced, Relationship-Based Approach to the Treatment of Complex Posttraumatic Stress Disorder (CPTSD): The Hybrid Case Study of "Chloe"

Mentalization—A Uniting Thread in the Treatment of Complex Posttraumatic Stress Disorder (CPTSD): Commentary on Phoebe Shepard's Case Study of "Chloe"

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ABSTRACT

Phoebe Shepard's (2022) hybrid case study of "Chloe" describes a young woman struggling with a constellation of difficulties rooted in the relational trauma of her childhood. Shepard's treatment approach with Chloe is anchored in Courtois and Ford's (2013) Sequenced, Relationship-Based Approach to treating complex trauma. Within the structure provided by Courtois and Ford's model, Shepard integrated techniques from a wide array of treatment perspectives including Cognitive Behavioral Therapy (CBT), Sensorimotor Psychotherapy (SP), and Accelerated Experiential Dynamic Psychotherapy (AEDP). Despite pulling from such seemingly disparate sources, Shepard presents a cohesive treatment anchored in a focus on the healing potential of the therapeutic relationship. In the approximately two years that she worked with Chloe, this emphasis on safety and connectedness yielded deeply meaningful and clinically significant change. In this commentary I hope to simultaneously honor the deeply reflective and compassionate approach taken by Shepard and to present a simplified guiding conceptualization of Chloe's presentation and treatment—one rooted in "mentalization." Mentalization, sometimes summarized as "thinking about thinking," is the process of thinking about one's self from the outside in and thinking about others from the inside out—considering the thoughts, feelings, and needs underlying our own and others' behavior. I propose that many of Chloe's difficulties can be viewed through a lens of mentalization lapses, and much of the beautiful and transformative work Shepard accomplished with this client may have been driven by improvements in Chloe's capacity to mentalize. By simplifying what is an undoubtedly complicated clinical presentation—rich with history, multilayered interpersonal dynamics, transient self-states, and overlapping symptom profiles—I hope to present the perspective that treating complex trauma need not be quite so complex.

Key words: mentalization; mentalizing; Mentalization Based Treatment (MBT); trauma; complex trauma; complex posttraumatic stress disorder (CPTSD); psychodynamic theory; attachment theory; case study; clinical case study.

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Phoebe Shepard's (2022) description of the case of "Chloe" demonstrates the multifaceted, mutable, and arduous aspects of working with complex trauma presentations. Shepard's case study compassionately reflects a deep understanding of how the traumatic and invalidating experiences of Chloe's early environment contributed to her fragmented sense of self, overwhelming feelings of guilt and shame, depression and trauma-related symptoms, and interpersonal difficulties.

Throughout the description of the case, Shepard maintains a focus on a therapeutic relationship rooted in genuineness, patience, and trust between her and Chloe, and provides robust theoretical and empirical evidence to support the importance of this focus. Furthermore, Shepard reflects thoughtfully on the dynamics that arose within the therapy room such as the pressure Chloe may have felt to replicate her "good child" role by being a compliant and "good" client, and illustrates the challenges and importance of meta-processing the therapeutic relationship.

Shepard's multidimensional conceptualization of Chloe's case and her choice of interventions borrowed from many theoretical perspectives demonstrate the abundance of trauma-focused tools and treatments available to clinicians. By employing theoretical and practical elements from various schools of psychotherapeutic thought, including Cognitive Behavioral Therapy (CBT), Sensorimotor Psychotherapy (SP), Accelerated Experiential Dynamic Psychotherapy (AEDP), and Courtois and Ford's (2013) multiphasic, relationship-based approach to trauma, Shepard developed a truly unique and customized treatment, tailored in an effort meet the needs of this one complex client.

What I intend to offer with this commentary is an alternative guiding conceptualization for the treatment of Chloe's Complex Post Traumatic Stress Disorder (CPTSD). I believe that by viewing Chloe's history, presentation, and treatment through the lens of mentalization, this incredibly rich, nuanced, and complicated case may be captured with a bit more simplicity. Furthermore, many of the interventions Shepard utilized in her treatment of Chloe fit neatly and easily within a mentalizing perspective. I believe that shifting to frame Chloe's treatment through a lens of mentalizing would leave many of the details of Shepard's work with her unchanged. However, I posit that this simplified conceptual approach may streamline and demystify the process of working with CPTSD presentations in a manner that could embolden tentative clinicians to approach this clinical population with the confidence encouraged by a solid yet simple theoretical grounding.

To this end, I will present an overview of mentalization as a psychological construct and will use content presented in Shepard's description of her work with Chloe to illustrate the

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implementation and impact of mentalization-based interventions for clients presenting with complex trauma.

MENTALIZATION AS A FUNDAMENTAL THERAPEUTIC CONSTRUCT

The ability to mentalize, that is, the ability to think and reflect on our thinking and experience, is a uniquely and fundamentally human experience with immense relevance in the psychotherapy process. Mentalization (also referred to in the literature as "reflective functioning") is the process of curiously considering the mind of another person, and reflecting on one's own mind. When mentalizing we are able to reflect on our own thoughts, feelings, and needs, and we can imagine the internal experience of those around us. Mentalization allows us the capacity to both anticipate and understand the behavior of others in meaningful ways and to understand how our own internal experiences and behaviors are linked (Fonagy et al., 2002). Interpersonally, mentalization facilitates engagement in meaningful, reciprocal, connected relationships; and intrapersonally, it allows us to organize and revise coherent narratives about the self, and understand the emotional roots of our behaviors.

Infants are not born into the world as mentalizing beings. They do not understand the concept of a "mind," nor that they and those around them have unique and somewhat opaque minds of their own (Allen, 2013). Rather, the capacity to mentalize is a developmental achievement that advances over time in the context of early attachment relationships, specifically those relationships in which the child is acknowledged as someone who possesses their own mind and is responded to with sensitivity, care, and ongoing attempts at understanding on the part of their caregivers (Fonagy & Bateman, 2008; Fonagy, et al., 2002; Berthelot et al, 2019).

Because mentalization develops in an interpersonal sphere, there are many factors of early life that can lead to disruptions in the development of this psychological capacity (Allen, 2005). Caregivers' trauma, dissociation, depression, and personality pathology, for example, can contribute to misattunement in the child-caregiver relationship which may give rise to long-lasting mentalization difficulties for the child (Fonagy et al, 2002; Slade, 2005; Ensink et al., 2016). Furthermore, mentalization deficits can be transmitted across generations, as poor mentalizing begets poor mentalizing. As Allen and Fonagy (2006) describe:

> [I]nteracting in the mentalizing mode we aspire to understand each other as autonomous persons and to influence each other on the basis of our understanding. In the nonmentalizing mode, we can dehumanize and treat each other as objects, becoming coercive and controlling (p. 7).

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Although mentalization is a relatively simple framework and has a great deal of overlap with related and likely familiar concepts such as mindfulness, empathy, psychological-mindedness, theory of mind, and metacognition; understanding the many ways that mentalization processes can fail is a more complicated undertaking (Allen, 2005; Bateman and Fonagy, 2012; Allen, 2013). Mentalizing difficulties described in the literature tend take two primary forms—non-mentalizing modes (also described as pre-mentalizing modes) and "pseudomentalizing" (Bateman & Fonagy, 2012; Allen, 2013).

The three non-mentalizing modes described by Allen (2013) are: Psychic Equivalence Mode, Pretend Mode, and Teleological Mode. In Psychic Equivalence Mode, one equates their mental state with external reality in a "if I think it, then it must be real" manner. This phenomenon can be seen in individuals experiencing psychotic states, in the act of dreaming, and in trauma-associated flashbacks. Pretend Mode is essentially the opposite of Psychic Equivalence Mode. In Pretend Mode, rather than being too real, mental states are too disconnected from reality (Allen, 2013). In therapy this can present as the illusion that hard work is being done, without any real progress occurring. In the Teleological Mode of non-mentalizing action and goal-directed behavior replace true mentalizing (Allen, 2013). In this mode, all that can be interpreted is what is physically observable—there is no consideration of the internal states associated with actions and behaviors.

The difficulties termed "pseudomentalizing" have been described as falling into three major categories: intrusive pseudomentalizing, overactive pseudomentalizing (hypermentalizing), and destructively inaccurate pseudomentalizing. The intrusive variety of pseudomentalizing involves "knowing" with unrealistic certainty what others are thinking and feeling. Overactive pseudomentalizing has been described as thinking that is "excessively detailed, decoupled from (affective) reality;" and destructively inaccurate pseudomentalizing involves the outright denial and rejection of other's internal states and fervently replacing them with one's own assumptions and/or fantasies (Bateman & Fonagy, 2012).

The capacity to mentalize exists on a spectrum and is fluid rather than fixed. Even within those individuals who possess a high capacity to mentalize, there are inevitably mentalizing failures that occur. There exists variability in proneness to these failures, also known as mentalizing breakdowns. These breakdowns in mentalizing can occur for a myriad of reasons (stress, exhaustion, distraction), but often occur in the presence of strong or overwhelming affect (Fonagy et al., 2002). Just as individuals vary in their susceptibility to mentalizing breakdowns, they also vary in the time it takes to reestablish mentalizing after a breakdown (Luyten et al., 2019).

When one reflects on Arietta Slade's (2005) description of mentalization, it is clear to see how this concept is deeply interwoven with the psychotherapy process. Slade describes that through mentalization, self-knowledge is developed both in terms of depth and breadth, and mentalization allows for the ability to understand and express one's subjective experience. Slade also notes that mentalization is an emotionally significant process and encompasses:

> the capacity to hold, regulate, and fully experience emotion, in this sense akin to, but not the same as, empathy (which does not imply regulation). It refers to non-defensive willingness to engage emotionally, to make meaning of feelings and internal experiences without becoming overwhelmed or shutting down. The complex processing and integrating that is inherent in high reflective functioning bespeaks emotional richness and depth, and a capacity to appreciate and experience the dynamics of an internal and interpersonal emotional life (p. 271).

Mentalization-based therapies developed out of psychodynamic, psychoanalytic, and attachment theory-based therapeutic traditions, and were first described in the 1990's as an approach to treating Borderline Personality Disorder (BPD; Bateman & Fonagy, 2016). Since that time, mentalization deficits have been implicated in many psychological presentations, including depression, eating disorders, self-harm, substance abuse, and trauma (Malda-Castillo, et al. 2019; Stein & Allen, 2007); and the implementation of mentalization-based treatment has broadened. Regardless of the population being treated, the primary aim of mentalization-based treatment is to strengthen one's ability to reflect upon their own affective states, thoughts, and desires, as well as the affective states, thoughts, and desires of others (Conway et. al, 2022).

A mentalization-based therapeutic approach endeavors to enhance the skill of mentalizing, specifically by promoting "a pro-mentalizing attitude of inquisitiveness, coupled with tentativeness and open-mindedness" (Allen & Fonagy, 2006, p. 17). This means that therapist and patient can be "imaginative without entering into the imaginary" (Allen & Fonagy, 2006, p. 17), remaining simultaneously safe/grounded and curious/exploratory. When used as a framework to guide case conceptualization and treatment, mentalization is transdiagnostic and transtheoretical—profound in both its simplicity and its potential for transformational impact.

TRAUMA AND THE CASE OF "CHLOE" THROUGH A MENTALIZATION LENS

Anyone who has experienced trauma firsthand or has been close to someone with a history of trauma has undoubtedly witnessed the ways in which trauma interferes with the capacity to mentalize. The actions taken in response to trauma and the ways in which trauma exists in memory are often divorced from the hallmark reflective, curious, and introspective components of mentalizing. Mentalizing failures are particularly implicated in relational trauma,

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as perpetrators of this sort of emotional damage are typically in their own state of lapsed mentalizing, and because relational trauma disrupts the trajectory of how mentalization ideally develops (Fonagy & Target, 1997; Allen, 2013).

Given that mentalization-based therapy was initially developed to treat Borderline Personality Disorder (BPD), and that adverse events of childhood and relational trauma are particularly implicated in BPD presentations, it is reasonable to believe that mentalization-based therapies would be clinically applicable to a broader population of trauma survivors, including those with CPTSD (Porter et al, 2020; Stein & Allen, 2007). Considering mentalization as a potential cornerstone of healing for traumatized patients in psychotherapy follows naturally from the manifold links between mentalization and trauma. For example, trauma and neglect in childhood can lead to fragile or impaired mentalization in the trauma survivor. Additionally, mentalizing disruptions in early attachment relationships contribute to the destructive impact of relational trauma (Oestergaard, 2016; Stein & Allen, 2007). Furthermore, individuals with underdeveloped capacities for mentalizing may be particularly prone to maladaptive responses to complex or discrete trauma, as they may not be able to spontaneously engage in protective acts of meaning-making and "may not have the ability to switch perspectives and disidentify from the old pain so easily" (Braehler & Neff, 2020, p. 583).

Epistemic Trust

A concept discussed frequently when working from a mentalizing framework that holds immense relevance in trauma treatment is that of "epistemic trust." Epistemic trust has been described as "an individual's willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self" (Fonagy & Alison, 2014 p. 4). With that definition in mind, it is clear how epistemic trust is a cornerstone of psychotherapeutic change and one element of what we commonly describe as "rapport" or "the therapeutic relationship."

Clients present to treatment with varying degrees of preexisting epistemic trust, just as they present with varying strengths and challenges in terms of mentalization more broadly. Clients for whom epistemic trust comes easily and naturally likely develop security and connection in the therapeutic relationship without much explicit focus needing to be placed on building trust. However, the early stage of work with clients who lack a natural, felt sense of epistemic trust is often much more fraught and intentional in its focus on the therapeutic relationship. As Oestergaard (2016) described:

> [W]ork with clients of this type begins by giving them a feeling that their therapist understands them. This shows them that they can connect and listen to other people. For these clients, there is a long way to go before mentalization can begin (p. 28).

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Shepard's description of the early weeks and months of her work with Chloe clearly illustrates a client that falls in the latter category—a person who lacks a strong preexisting sense of epistemic trust. Even without framing it as such, Shepard spends a great deal of time toward the beginning of Chloe's treatment working towards establishing the foundations of epistemic trust. For example, Shepard describes her use of "consistent validation, empathy, and attunement to [Chloe's] current emotions and physiological state…to begin to establish rapport and develop a therapeutic alliance" (p. 147, 151-152). Shepard also describes explicit efforts at building trust with Chloe early in the treatment when she and Chloe openly discussed Chloe's prior difficulties with trust and how those would likely manifest in the treatment relationship. It is clear that Chloe appreciated these efforts and that these foci helped her establish a sense of epistemic trust within the therapeutic relationship.

Non-Mentalizing and Pseudomentalizing Modes

From the secure base provided by the development of epistemic trust, mentalization difficulties can be explored and strengthened. Before outlining several strategies and techniques of mentalization-based treatment and how these apply to the case of Chloe, I will use the case to illustrate the common non-mentalizing modes described previously.

First, there are several examples of mentalizing breakdowns or moments of non-mentalizing in Shepard's case description, including Chloe's dissociative episodes. These episodes are inherently non-mentalizing, because when one is in a dissociative state, they are unable to make links between their inner experience and their behavior. Chloe's overly apologetic and shame-filled reactions to her in-session dissociation is also an example of a mentalizing breakdown. This can be seen when, in response to her dissociation being identified in session, Chloe loses her ability to curiously consider her therapist's inner world and begins making assumptions of judgement and expresses sweeping statements about herself and others by saying "I'm always wrong and it's always my fault," "people can't be trusted," and "people are mean." (p. 142-143). While in this state of non-mentalizing, Chloe is unable to take in Shepard's offerings of kindness and compassion, which keeps her stuck in a place of disavowed suffering.

Within the case description there are also poignant illustrations of Chloe exhibiting each of the three non-mentalizing modes described in the literature. Psychic Equivalence Mode is evident in Chloe's flashbacks, during which she is unable to distinguish between what feels to be true (I am unsafe, I am in a dangerous situation from my past) and what is actually true (I am safe, I am in the office with my therapist). The Teleological Mode of non-mentalizing is seen when Chloe's actions reveal a truth that her words do not. This is most clearly depicted by

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Chloe's missing several sessions following an increase in the focus on trauma processing, despite her explicit claims that she was unbothered by the intensity of the work.

Examples of the Pretend Mode of non-mentalizing are harder to identify with clarity in the written case description, as much of what defines Pretend Mode is a felt sense that the client's mental states are not concordant with reality. I believe that Shepard may have been describing Chloe existing in Pretend Mode when she stated that in response to questions about moving to Phase 2 of treatment

> Chloe was very clear that she wanted to start "dealing with" her traumatic memories because she really wanted to "feel better." However, while she verbalized her enthusiasm, her affect and body language expressed hesitation and anxiety (p. 158).

Having illustrated the ways in which Chloe was prone to both mentalizing breakdowns and non-mentalizing modes inside and outside of the therapy room, we can turn our focus to the ways in which Shepard's interventions served to identify and address mentalizing deficits and improve Chloe's overall reflective functioning.

Mentalizing Interventions

Bateman and Fonagy (2006) described many specific elements emblematic of a mentalization-based treatment approach, several of which can been seen clearly in Shepard's work in this case of Chloe, despite the word "mentalization" not appearing once in her write up of the case. One such primary element is the therapist's stance. In describing this broad philosophical underpinning to mentalization-based work, Bateman and Fonagy (2006) describe that mentalization-based therapy is a "process of joint attention in which the patient's mental states are the object of attention" (p. 94). This process takes the form of a curious stance in which the therapist genuinely strives to understand the inner world of the client while holding in mind the recognition that they cannot know with certainty what is going on inside another— that any efforts at interpretations are merely best guesses.

Another key feature of this treatment approach is active questioning that is employed with the intention of eliciting the client's mentalizing with others and with the self. Although Shepard did not frame her interventions as designed to stimulate mentalization, she did so nevertheless when she tracked changes in Chloe's physical state and made what she termed "contact statements" such as "I notice that you're smiling and laughing while telling me some pretty painful things" (p. 161). Additionally, Shepard's beautiful description of the AEDP intervention of "portrayal" in which Chloe interacts with the 8-year-old version of herself while

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in the library looking for a book that would help her to address her father's alcoholism, can also be viewed as strengthening Chloe's ability to mentalize the self (p. 169).

In mentalization-based treatment the therapist also models reflection and helps the client to mentalize the therapeutic relationship. This can take the form of the therapist acknowledging and exploring moments of misattunement, reflecting on the co-constructed nature of enactments that inevitably emerge between therapist and client, and/or processing differences between the therapist's perspective and the client's perspective. There are many examples of such efforts to mentalize the therapeutic relationship in the case of Chloe.

One particularly poignant instance is illustrated by Shepard's description of the therapeutic rupture that occurred in response to her voicing her concerns about Chloe's possible abuse of sleep aids (p. 171). Thanks to the epistemic trust that had been developed earlier in treatment, Chloe was able to express that she felt judged by Shepard's statements and Shepard, in turn, maintained her own mentalizing stance, welcomed Chloe's expression of hurt, and offered a sincere apology. This rupture culminated in Shepard and Chloe mentalizing the therapeutic relationship together and reflecting on how the process of openly discussing and working through a rupture was a new and powerful experience for the client, unlike anything she had known in her family of origin.

A final core component of mentalizing treatment that was undoubtedly woven throughout Shepard's depiction of the work with Chloe is a focus on the affective experience. Fonagy and Bateman (2006) described that it is essential in mentalization-based treatment for the therapist to create a space in which the client feels validated and affirmed, and they emphasize that a primary goal of this affective focus is for the client to feel that they are not alone while experiencing difficult emotions.

Shepard recognized early on that a focus on emotional experience was important for Chloe, as she presented with high levels of affect phobia driven by "the fact that any expression of emotion throughout her life had been deemed invalid and selfish by her mother and her grandparents" (p. 145). Furthermore, Shepard took special attention to address feelings of aloneness such as when she offered to hold Chloe's hand (p. 182); when they explored Chloe's fantasy of being together in her imagined garden (p. 174); and during the exploration of Chloe's memory of her mother's suicide attempt when Shepard stated to Chloe "You were so alone. You're not alone anymore. I'm here with you now" (p. 160).

In addition to the many examples of how Shepard's work can be viewed through the lens of mentalizing, there are also several interventions in the case description that would solidly capture a mentalizing focus with slight alterations. For example, Shepard describes Chloe being

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emotionally dysregulated during a session early in treatment—a reaction to a particularly stressful week. Shepard explains her efforts to "slow Chloe down so she could connect more to her affective experience and access her core emotions" (p. 153). Shepard goes on to note that:

> Chloe still was unable to truly connect to any feelings in that moment. She did stop talking, but then we just sat in silence staring at each other. Because I sensed that Chloe was beginning to dissociate, I asked her if it would be okay if we took a deep breath together, since I did not want to overwhelm her. During this time, Chloe showed a pattern of changing the topic and shifting into an intellectualized discussion lacking any emotion, and this pattern continued in future sessions (p. 153).

As it is described, it seems that Chloe's high level of stress triggered a mentalizing breakdown, and Shepard (using her own keen mentalizing capacity) was cautious about not wanting to overwhelm her client further. This interaction may have been deepened if Shepard had approached the mentalizing breakdown with more explicit curiosity – slowing it down and investigating it together in a slow motion, in a frame by frame manner –compassionately wondering about what triggered Chloe's lapse in mentalizing.

Another example of a missed opportunity for a deeper mentalizing intervention was in Shepard's thoughtful reflection on how the act of assigning homework to Chloe was a double-edged sword. Shepard astutely notes that the homework seemed to serve the function of helping activate Chloe and dislodge her from the depth of her depression. But it also served as an enactment between the two of them in which Shepard may have represented members of Chloe's family of origin, and Chloe was put in the position of feeling the need to be the "good client" just as she had needed to be the "good daughter" while growing up (p 157). Had Shepard chosen to bring this dynamic into the room for exploration between her and the client rather than leaving it to be privately reflected upon, this intervention could have served as an opportunity to foster higher level mentalization in the client through the act of mentalizing the therapeutic relationship and openly exploring this enactment.

Another hallmark of mentalizing in treatment is highlighting and exploring alternate perspectives. This approach serves to "to free the client from being stuck in a single reality /single affective experience" (Bateman & Fonagy, 2006, p 100). This sort of intervention often emerges when interpersonal conflicts from the client's life are explored in treatment and take the form of the therapist encouraging the client to wonder about the inner experience of those they are interacting with. In Shepard's presentation of Chloe, there are not many opportunities presented for this sort of mentalizing, although I wonder if they may have occurred in the treatment but were not included in the case study. The primary interpersonal difficulties discussed in this case are Chloe's relationships with her mother and father. These relationships

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may not have been good targets for interventions designed to increase the capacity to mentalize others, as these relationships were the root of much of Chloe's trauma, and considering the inner world of these traumatic attachment figures may have been too threatening for Chloe's sense of self at the time of treatment. It is possible, however, that at some future point, attempting to mentalize with the inner experience of her parents could provide Chloe with a meaningful sense of insight and understanding.

The Therapist as a Model of Mentalizing

In addition to the therapist's curious, compassionate stance and the focus on interventions designed to foster mentalizing, a therapist has another powerful tool at their disposal in a mentalization-based treatment—their own mentalization abilities. The benefit of the client having an experience of being mentalized by the therapist is twofold—the therapist models the mind of a mentalizer *and* provides the client the experience of being mentalized, which replicates the structure under which mentalization abilities naturally emerge in a caregiver-child relationship.

Arietta Slade's (2005) description of the development of mentalizing comes to mind, and can easily be applied to the process of psychotherapy with minor linguistic substitutions (replacing "mother" for "therapist," "child" for "client," and "caregiving" for "therapy"). Slade described:

> [that a] mother's capacity to hold in her own mind a representation of her child as having feelings, desires, and intentions allows the child to discover his own internal experience via his mother's representation of it; this re-presentation takes place in different ways at different stages of the child's development and of the mother—
>
> child interaction. It is the mother's observations of the moment to moment changes in the child's mental state, and her representation of these first in gesture and action, and later in words and play, that is at the heart of sensitive caregiving, and is crucial to the child's ultimately developing mentalizing capacities of his own" (p. 271).

It is clear how this process of modeling and scaffolding unfolded in Shepard's work with Chloe and created the environment necessary for Chloe's deepening mentalization. The description of the case is rife with examples of Shepard's deep, nuanced understanding of her client and reveals her own exquisite reflective capacity as she mentalizes Chloe both implicitly and explicitly.

The most prominent example of how Shepard mentalized Chloe, seen on multiple occasions in the case description, is in her attention to Chloe's non-verbal communication.

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Shepard eloquently describes how she would track "Chloe's body language throughout sessions and noticed that her body positioning would change depending on how depressed she was or how present in the room she was" (p. 163). Another example of this process occurs in Shepard's description of session four, when Chloe talked about the impact of her intrusive memories and "zoning out" during class. In exploring this incident, the client became quiet. Shepard describes how she "was paying careful attention to Chloe's presentation in order to figure out whether she was using the silence to gather her thoughts, or if the silence was indicative of Chloe dissociating" (p. 142).

Shepard's body-based interventions (techniques she attributes to SP and AEDP) are, in fact, examples of deep and complex mentalizing. This attunement to the physical (e.g., what is being acted out such as in the teleological mode of non-mentalizing) can help Chloe build links between her internal world and the external world, which is at the core of the healing power of mentalization.

Chloe's Deepening Mentalization

Despite mentalization not being a stated focus on Shepard's work with Chloe, there is evidence that as the therapy process progressed and mentalization was addressed implicitly through the therapist stance and interventions described previously, Chloe's mentalization abilities deepened alongside the other therapeutic gains described in the case study.

It seems that early in the treatment Chloe's mentalization was quite impaired with her being both prone to mentalizing breakdowns in the presence of strong affect and with her frequently existing in non-mentalizing modes. This was evidenced in Chloe's difficulty with "identifying, labeling, and verbalizing her feelings" (p. 158), her general avoidance of affectively charged topics, and her frequent dissociation and flashbacks. As treatment progressed, however, Chloe "began to understand and connect her body sensations to her emotional experiences, enabling her to learn how to better identify and label her emotions" (p. 164), which is to say that her ability to mentalize the self increased.

Chloe's proneness to mentalizing breakdowns did not evaporate as treatment deepened, nor would we expect them to. Over time, however, she did demonstrate an increased ability to tolerate affective experience without losing her ability to mentalize, and when breakdowns did occur, she was able to recover much more quickly than she had been previously. This increased ability to recover following a mentalizing breakdown was evident in the rupture associated with the discussion of sleep aids and Chloe's feelings of being judged by her therapist. In this instance, Chloe lapsed briefly into non-mentalizing but made a quick recovery and gathered

herself back into a mentalizing stance from which she was able talk about the misattunement and process the rupture-repair experience with Shepard.

Perhaps the most eloquently noted shift in Chloe's mentalizing is in the description of how for much of the treatment Chloe saw Shepard as "a blob" (p. 173). A blob has no mind. A blob cannot be mentalized. Presumably without knowing the terminology or theory, when Chloe described the healing experience of seeing her therapist as a full and complete human, she was describing how she developed the ability to truly mentalize Shepard and mentalize *with* Shepard, and the impact that this shift had on her.

Chloe's missed sessions that occurred toward the end of treatment can be conceptualized as a classic regression, as Shepard did, or they can be thought of as a brief return to the non-mentalizing state of teleological mode. Furthermore, Chloe's forgetfulness, her "black out" in a highly affective state, her intense shame, and her fears that she may be crazy—were non-mentalizing relics that re-emerged towards the end of treatment. What this demonstrates is that mentalization is not an all-or-nothing process. Rather it can ebb and flow in response to changing internal and external stimuli. In this case, it seems that Chloe was so overwhelmed by the upcoming end of treatment and the feelings that this evoked, that she had difficulty reflecting on the deeper meaning of her behavior. When she was further triggered by the upsetting incident involving her father (pp. 176), Chloe's nascent mentalizing capacities we pushed past their breaking point. Prior to her experience in therapy, Chloe had many years of practice existing in non-mentalizing and pseudo-mentalizing states. Therefore, it is understandable that times of extreme stress could lead her to revert to these old and familiar ways of functioning.

Despite this regression, Chloe was able to recover in her mentalizing and do powerful, impactful work processing termination with Shepard. The touching letters exchanged by Shepard and Chloe at the conclusion of treatment and Chloe's choice to revisit the shift in her view of her therapist from "blob" to "human" speak to the deep changes that occurred both within Chloe and in the relational space between Chloe and Shepard. Additionally, when Chloe wrote that she "will continue to keep growing" on her own path (p. 185), she accurately portrayed that progress in mentalization-based treatment does not cease when the therapy ends, and that symptoms do not need to be fully resolved for treatment to be a success. Armed with a greater capacity to mentalize and more resilience in the face of mentalizing breakdowns, the hope is that a client can continue to expand their emotional repertoire, develop a deeper understanding of the self, strengthen interpersonal functioning, and grow in meaningful ways following the conclusion of a course of therapy.

At the end of treatment, it seems clear that Chloe was able to internalize the mentalization that Shepard fostered and modeled throughout their time together. Chloe made immense strides

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in her ability to hold a high level of affect and mentalize herself and the therapeutic relationship with much less support. Additionally, she was able to recover from mentalizing breakdowns much more quickly and easily than at the onset of treatment. In the end, Chloe used mentalization to revise her narrative about herself—to grieve, to empathize, and to develop insight—and recognize therapy and the therapeutic relationship as the truly transformational space that it can be.

CONCLUSIONS

In reflecting on the case of Chloe and this mentalization-based lens that I have proposed, I initially felt surprised by how much of the content and process of Shepard's work mirror what would be expected in an intentionally mentalization-focused treatment. I was equally surprised when a review of the literature on mentalization-based approaches to trauma treatment turned up relatively scarce results. However, it seems that many trauma therapy models, including those employed by Shepard in the case of Chloe, have components familiar to clinicians working from a mentalizing perspective. Imaginal or narrative exposure, for example, scaffolds mentalization and allows the client to keep their trauma in mind and explore it with curiosity and compassion. Similarly, mindfulness-based approaches to treatment encourage an accepting, non-judging attitude toward the full range of emotional experience, which overlaps significantly with the curious, "not-knowing" stance of a mentalization-based treatment.

Just as much of the work in the case of Chloe and what is proposed in more thoroughly researched and commonly employed trauma treatments can be viewed through a mentalization lens, it also seems plausible to consider mentalization as a common factor of most trauma treatment approaches (or simply most psychotherapy treatments in general). For example, emerging research suggests that treatment models with an overarching emphasis on the therapeutic relationship are more effective in treating CPTSD, due to the nature of the disorder as one of attachment trauma (Mucci et al., 2018). It has also been described that the therapeutic relationship both can be (a) a "testing ground" in which the client can explore what it is to form and sustain satisfying relationships and healthy attachments, and (b) a context in which client's attachment difficulties can be experienced, explored, understood, and ultimately resolved (Pearlman & Courtois, 2005, p. 450). This exploration of the therapeutic relationship, seen so clearly in the case of Chloe, is an ideal space in which a client's mentalizing difficulties can be strengthened.

As the case study demonstrates, Shepard undoubtedly understood the transformational potential of a focus on the therapeutic relationship. However, I posit that it is not merely the experience of being in a warm, caring, therapeutic relationship that has such healing power for

clients with complex trauma (although this is immensely valuable in and of itself)—it is the improvement in mentalization fostered by the therapeutic relationship that can upend a client's prior, maladaptive ways of moving through the world and relating to themselves and others.

All of the interventions Shepard employed in an effort to support Chloe's ability to understand her trauma and tolerate and/or manage the strong affect associated with it can be concentrated to the essential core of holding her trauma in mind—that is, mentalizing it. However, while interventions that passively address mentalizing in the treatment of trauma can have immense benefit, a more explicit focus on mentalizing may be even more potent. One reason for this is that a lack of attention to mentalizing may undermine the process of trauma treatment, as the very act of engaging in trauma-focused therapy many derail the mentalization process or produce high levels of affect that trigger mentalizing breakdowns (Braehler & Neff, 2020).

Without intending to do so, Shepard's case study of Chloe provides a great deal of support for the notion that a focus on mentalization can have tremendous benefits for clients with complex trauma presentations. I hope that through this commentary I have highlighted this idea by reframing Shepard's relationship-focused, curious, sensorimotor, and insight-building interventions through a mentalizing lens. By presenting several examples of ways that Shepard could have further emphasized mentalization in her treatment of Chloe, my intention was to make additional links between the theory of mentalization-based treatment and its application to complex trauma.

I am charmed by Allen's (2013) description of mentalization-based therapy as "the least novel approach to trauma treatment imaginable" (p. 287) and tend to agree with this assertion. Aspects of mentalization can be found in many approaches to trauma treatment and emerge organically in the presence of a strong therapeutic relationship. The ubiquity and simplicity of mentalization-based interventions do not diminish their impact. Rather, I believe that framing trauma treatment through this intuitive and accessible lens is powerful in its simplicity. I hope that the framework presented in this commentary may encourage others to hold the theory and practice of mentalization in mind in their work with complex trauma presentations.

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