Mentalization Based Treatment

Training Workshop
The study of mentalizing has been an extraordinarily important addition to the mental health field. Bateman and Fonagy, who are largely responsible for the development of this concept, have done a magnificent job in this edition of their classic textbook. They have added new clinical and research data that will be relevant to all mental health practitioners. This book is a 'must-read' contribution, and I highly recommend it.

Glen O. Gabbard, M.D., Author, Psychodynamic Psychiatry in Clinical Practice

The timely second edition of the Handbook of Mentalizing in Mental Health Practice illustrates the vast growth in both research and clinical treatment on mentalization. As a transdiagnostic concept, the process of mentalizing is applicable to a wide variety of mental health conditions. This essential, groundbreaking volume belongs in the libraries of all clinicians, regardless of their theoretical persuasion. The editors, Anthony Bateman and Peter Fonagy, deserve high praise for producing this major interdisciplinary work.

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Exercise – mentalization or mentalizing?

- What is mentalization or mentalizing?
  - Give 3 key aspects of the psychological processes that the concept tries to encapsulate
  - Should we use mentalization or mentalizing?
What is mentalizing?

Mentalizing is a form of *imaginative* mental activity about *others* or *oneself*, namely, perceiving and interpreting *human* behaviour in terms of *intentional* mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
1. The learner’s imagined self narrative

2. The informer’s image of the learner’s self narrative

3. The learner’s image of the informer’s image of the learner’s self narrative

4. The epistemic match

5. Opening of epistemic channel for knowledge transfer

The informer

The learner
What I don’t like about mentalizing

- Off-putting jargon for a concept intended to capture the essence of our humanity
- Sounds too cognitive and intellectual, ironic when
  - (a) we are most keen to promote mentalizing of emotion and mentalizing in the midst of emotional states (e.g., “holding heart and mind in heart and mind” captures the spirit better than holding mind in mind)
  - (b) a lot of mentalizing is not conscious, deliberate, and reflective but rather automatic, intuitive, and implicit
- Concept is too broad and all-encompassing such that it can explain virtually anything; we need to focus on different facets of mentalizing
Mentalizing as an Integrative framework

**CBT:** The value of understanding the relationship between my thoughts and feelings and my behaviour.

**SYSTEMIC:** The value of understanding the relationship between the thoughts and feelings of family members and their behaviours, and the impact of these on each other.

**COMMON LANGUAGE**

**PSYCHODYNAMIC:** The value of understanding the nature of resistance to therapy, and the dynamics of here-and-now in the therapeutic relationship.

**SOCIAL ECOLOGICAL:** The value of understanding the impact of context upon mental states; deprivation, hunger, fear, etc...
Introduction to theory of mentalisation

- The normal ability to ascribe intentions and meaning to human behaviour
- Ideas that shape interpersonal behaviour
- Make reference to emotions, feelings, thoughts, intentions, desires
- Shapes our understanding of others and ourselves
- Central to human communication and relationships
- Underpins clinical understanding, the therapeutic relationship and therapeutic change
Being misunderstood

- Although skill in reading minds is important, recognising the limits of one’s skill is essential
- First, acting on false assumptions causes confusion
- Second, being misunderstood is highly aversive
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection
Successful mentalizing of people and relationships

The person...

- Is relaxed and **flexible**, not ‘stuck’ in one point of view
- Can be **playful**, with humour that engages rather than hurting or distancing
- Can solve problems by **give-and-take** between own and others’ perspectives
- Describes their **own experience**, rather than defining other people’s experience or intentions
- Conveys ‘**ownership**’ of their **behaviour** rather than a sense that it ‘happens’ to them
- Is **curious** about other people’s perspectives, and expect to have their own views extended by others’
Mentalization: The basics

- Attachment and mentalization are **loosely coupled** systems existing in a state of partial exclusivity.

- Mentalization has its roots in the sense of being understood by an attachment figure,
  - it can be more challenging to maintain mentalization in the context of an attachment relationship (e.g. the relationship with the therapist) (Gunderson, 1996).

- BPD associated with **hyperactive attachment systems** as a result of their **history** and/or **biological predisposition**

- But without **activation** of the attachment system in **therapy** borderline PD patients will never learn to function psychologically in the context of **interpersonal relationships**.
Attachments and the development of social understanding
The development of the ‘mentalizing self’

- The capacity to mentalize emerges through interaction with the caregiver:
- The quality of the attachment relationship

➢ If the parent is:
  - Able to reflect on infant’s intentions accurately
  - Does not overwhelm the infant

➢ Then this:
  - Assists in developing affect regulation
  - Helps develop child’s sense of a mind and of a reflective self
Affect & Self Regulation Through Mirroring

Psychological Self: 2nd Order Representations

Physical Self: Primary Representations

Constitutional self in state of arousal

Representation of self-state: Internalization of object’s image

symbolic organisation of internal state

Expression

Reflection

Resonance

Infant

CAREGIVER

Fonagy, Gergely, Jurist & Target (2002)

How Attachment Links to Affect Regulation

The forming of an attachment bond
How Attachment Links to Affect Regulation

The forming of an attachment bond
Attachment Disorganisation in Disrupted Early Relationships

Adverse Emotional Experience

The ‘hyperactivation’ of the attachment system
Attachment Disorganisation in Disrupted Early Relationships

The ‘hyperactivation’ of the attachment system
A biobehavioral switch model of the relationship between stress and controlled versus automatic mentalization (Based on Luyten et al., 2009)
Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse.
Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse

- Adverse emotional experience rooted in traumatic relationships
- Intensification of attachment needs
- Inhibition of mentalisation
- Inaccurate judgements of affect, delayed development of mentalization understanding, failure to understand how emotions relate to situations and behavior
Mentalizing subcomponents

The Dimensions
Multifaceted Nature of Mentalization

**Implicit-Automatic-Non-conscious-Immediate.**

Mental interior cue focused

- amygdala, basal ganglia, ventromedial prefrontal cortex (VMPFC), lateral temporal cortex (LTC) and the dorsal anterior cingulate cortex (dACC)

Mental exterior cue focused

- lateral and medial prefrontal cortex (LPFC & MPFC), lateral and medial parietal cortex (LPAC & MPAC), medial temporal lobe (MTL), rostral anterior cingulate cortex (rACC)

**Explicit-Controlled-Conscious-Reflective.**

- recruits lateral fronto-temporal network

**Cognitive agent: attitude propositions**

- Associated with several areas of prefrontal cortex

- Associated with inferior prefrontal gyrus

**Affective self:affect state propositions**

**Imitative frontoparietal mirror neurone system**

- frontoparietal mirror-neuron system

- the medial prefrontal cortex, ACC, and the precuneus

**Belief-desire MPFC/ACC inhibitory system**
### Imbalance of mentalization generates problems


<table>
<thead>
<tr>
<th>Implicit-Automatic-Non-conscious-Immediate.</th>
<th>BPD</th>
<th>Explicit-Controlled-Conscious-Reflective</th>
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</thead>
<tbody>
<tr>
<td><strong>Mental interior cue focused</strong></td>
<td>Impulsive, quick assumptions about others thoughts and feelings not reflected on or tested, cruelly</td>
<td>Does not genuinely appreciate others perspective. Pseudo-mentalizing, Interpersonal conflict ‘cos hard to consider/reflect on impact of self on others</td>
</tr>
<tr>
<td><strong>Cognitive agent:attitude propositions</strong></td>
<td>Lack of conviction about own ideas, Seeking external reassurance, Overwhelming emptiness, Seeking intense experiences</td>
<td>Hyper-vigilant, judging by appearance. Evidence for attitudes and other internal states has to come from outside</td>
</tr>
<tr>
<td><strong>Self</strong></td>
<td>Unnatural certainty about ideas, Anything that is thought is REAL Intolerance of alternative ways of seeing things.</td>
<td>Overwhelming dysregulated emotions, Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Hyper-sensitive to others’ Moods, what others say, Fears ‘disappearing’</td>
<td>Rigid assertion of self, controlling others’ thoughts and feelings.</td>
</tr>
</tbody>
</table>
Prementalizing Modes of Subjectivity

- **Psychic equivalence:**
  - Mind-world *isomorphism*; mental reality = outer reality; internal has power of external
  - *Intolerance* of alternative perspectives ➔ concrete understanding
  - Reflects domination of self: *affect state* thinking with limited internal focus

- **Pretend mode:**
  - Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
  - “dissociation” of thought, hyper-mentalizing or pseudo-mentalizing
  - Reflects explicit mentalizing being dominated by implicit, inadequate internal focus, poor belief-desire reasoning and vulnerability to fusion with others

- **Teleological stance:**
  - A focus on understanding actions in terms of their *physical* as opposed to mental *constraints*
  - Cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
  - Extreme *exterior focus*, momentary loss of controlled mentalizing
  - *Misuse* of mentalization for teleological ends (harming others) becomes possible because of lack of implicit as well as explicit mentalizing
Non-mentalizing: Psychic Equivalence

- Mind-world **isomorphism**; **mental** reality = outer **reality**; internal has power of external
- **Intolerance** of alternative perspectives ➔ concrete understanding
- Reflects domination of **self:affect state** thinking with **limited internal focus**
- Managed by **avoiding being drawn into** non-mentalizing discourse
Non-mentalizing: Teleological stance

- **Teleological** (Greek root *tele-*; *telos*, meaning "end or purpose")
- Entered English in the 18th century, followed by teleologist in the 19th century.
- **Teleology** is "the study of ends or purposes."
- A teleologist attempts to understand the purpose of something by looking at its results.
  - A teleological philosopher might argue that we should judge whether an act is good or bad by seeing if it produces a good or bad result
  - teleological explanation of evolutionary changes claims that all such changes occur for a definite purpose
  - Part of philosophy of Immanuel Kant and George Hegel
Non-mentalizing: Teleological stance

- In mentalizing terms a person using teleological mental process:
  - focuses on understanding actions in terms of their **physical** as opposed to mental **constraints**
  - Cannot accept anything other than a modification in the realm of the **physical** as a true index of the intentions of the other.
  - Extreme **exterior focus**, momentary **loss of controlled** mentalizing
  - **Misuse** of mentalization for teleological ends (e.g. controlling others) becomes possible because of lack of **implicit as well as explicit** mentalizing
“Dear Diary: So I texted Julie and I told her that just because I'm hanging out with Linda a lot it doesn't mean I'm not her friend anymore and she said she knows that but she just feels weird because she thinks that Linda doesn't like her and because she thinks Linda and I have more in common, so I told her to stop worrying about what Linda thinks and she said fine but I could tell she was upset so I talked to Linda about it and she said she does like Julie and was trying really hard to be nice to her and when I told Julie what Linda had said she said she felt bad because she had been saying a lot of mean things about Linda. Anyway, I had a day off so I decided to go to the aquarium…”
Principles

- Manage anxiety and especially attachment anxiety
  - Titrate closeness
  - Affect/Cognitive. Relational/Practical/Functional
- Take care to be contingent and marked in response
- Do not join with non-mentalizing
- Do not take over patient mentalizing
- Do not mentalize non-mentalizing
- Do not meet low mentalizing with your high mentalizing
- Only follow the affect if mentalizing is stable – otherwise contrary move
- Roll with the reaction.
- Do not respond to patient as if he was mentalizing
Additional Slides

Further information
Ineffective mentalizing – definition and results

- Ineffective mentalizing = poor outcomes of attempts to mentalize due to restrictions in components of mentalizing
  - No ability to consider complexity of mental states of self and other
  - Constructive and progressive interpersonal and social involvement reduced
  - Unable to calibrate self states of mind through others
  - No ability to identify and manage own emotions
  - Poorer recognition and acceptance of alternative perspectives
  - Failure to negotiate shared positions/viewpoints
Indicators of ineffective mentalizing

Ineffective mentalizing

Content

Style
Indicators of ineffective mentalizing – **content**

- Focus on **external** social **factors**, such as the school, the council, the neighbours
- Focus on **physical or structural** labels (tired, lazy, clever, self-destructive, depressed, short-fuse)
- **Labelling** others - stereotypes
- **Absence of content** – paucity of thought in depression
Indicators of ineffective mentalizing – content

- **Preoccupation with rules**, responsibilities, ‘shoulds’ and ‘should nots’
- **Denial** of **responsibility**, involvement in problem
- **Blaming** or fault-finding
Indicators of ineffective mentalizing – **style**

- **Excessive detail** to the exclusion of motivations, feelings or thoughts
- States of **mind missing** from the narrative
- **Assumptions** of mental states
- **Lack of appropriate emphasis** on important areas
- How something is thought about
  - Expressions of **certainty** about thoughts or feelings of others
  - **Rigidity**
  - **Fixed** perspective with **no** consideration of **alternative viewpoints**
Indicators of ineffective mentalizing – style

- Conversation is **unquestioning**
  - Categorical
  - **No ordered progression** in development of content
  - **Assumptions** of mental states
  - **Words restrict complexity**
    - Just
    - Clearly
    - Obviously
    - All
Mentalization and Overlapping Constructs
(Choi-Kain & Gunderson, Am J Psychiat 2008)

- Affect Consciousness
- Mindfulness
- Empathy
- Psychological Mindedness

Self

Emphasis on Affective Aspect

Equal emphasis on cognitive and affective aspects

Implicit & Explicit

Explicit

Other
### Mentalisation and conceptual cousins

<table>
<thead>
<tr>
<th>Component</th>
<th>Mindfulness</th>
<th>Psychological Mindedness</th>
<th>Empathy</th>
<th>Affect consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implicit</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Explicit</td>
<td>yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-orientated</td>
<td>Yes</td>
<td>Yes</td>
<td>Minimal</td>
<td>Yes</td>
</tr>
<tr>
<td>Other orientated</td>
<td>No</td>
<td>Minimal</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cognitive/Affect</td>
<td>Cog=Affect</td>
<td>Cog=Affect</td>
<td>Affect&gt;Cog</td>
<td>Affect&gt;Cog</td>
</tr>
</tbody>
</table>
Mentalizing: Implicit ‘v’ Explicit

- IMPLICIT
  - Perceived
  - Nonconsciousness
  - Nonverbal
  - Unreflective
    - e.g., mirroring

- EXPLICIT
  - Interpreted
  - Conscious
  - Verbal
  - Reflective
    - e.g., explaining
Shared neural circuits for mentalizing about the self and others (Lombardo et al., 2009; J. Cog. Neurosc.)
Relational Aspects of Mentalization

- Overlap between neural locations of mentalizing self and other may be linked to **intersubjective origin of sense of self**
  - We find our mind initially in the minds of our parents and later other attachment figures thinking about us
  - The parent’s capacity to mirror effectively her child’s internal state is at the heart of affect regulation
  - Infant is dependent on contingent response of caregiver which in turn depends on her capacity to be reflective about her child as a psychological being
  - **Failure to find the constitutional self** in the other has potential to profoundly distort the self representation (exaggerated mirroring of child’s anxiety aggravates anxiety rather than soothe)
  - The same applies to child with inadequate sense of independent self within therapeutic relationship
Dimensions of mentalization: implicit/automatic vs explicit/controlled

Psychological understanding drops and is rapidly replaced by confusion about mental states under high arousal

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By heaven, I saw my handkerchief in's hand.

That handkerchief which I so loved and gave thee

Thou gavest to Cassio.
Psychotherapist’s demand to explore issues that trigger intense emotional reactions involving conscious reflection and explicit mentalization are inconsistent with the patient’s ability to perform these tasks when arousal is high.
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

Attachment Figure

Mirroring fails

Child

Absence of a representation of the infant’s mental state

Internalisation of a non-contingent mental state as part of the self

The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics which disorganizes the self creating splits within the self structure
Theory: Self-destructiveness and Externalisation Following Adversity

Torturing alien self

Self representation

Perceived other

Unbearably painful emotional states:
Self experienced as evil/hateful

Self-harm state

Attack from within is turned against body and/or mind.
**Theory:** Self-destructiveness and Self-destructive relationships

- **Torturing alien self**
- **Self representation**
- **Perceived other**
- **Unbearably painful emotional states:**
  - Self experienced as evil/hateful

**Self-harm state**

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops.

**Victimized state**
If someone was causing you pain or simply tormenting you, perhaps not everyday for the whole day, parts of a day, or for days and weeks on end,

You could if you were brave or desperate enough, defend yourself, by perhaps attacking (and eliminating) your persecutor.

But what if this thing you hate, was inhabiting your head?

You can’t exactly say please leave my body, you can’t do anything to get it to just pack up and leave because technically, physically that isn’t possible.

You can say fuck you. I hate you. You can self-harm with the hugest force your body can withstand, with all you can muster.
You can do that. You can be very very angry and show them who’s boss, you won’t stand for it, you won’t take it lying down. You want to be heard, you want to say right, you think you can hurt me? I’ll show you, I’ll show you how much I can hurt you!

But you and this thing, you are inhabiting one body. You attack this thing you attack yourself. You don’t have a choice though. That’s a sacrifice you make over and over.

Eventually, you realise the only way to get rid of this thing, once and for all is getting rid of yourself. What choice do you really have?
No doctor can specify the problem. No medication can fix the problem that can’t be specified.

You fail to understand yourself. You can’t explain to your family and docs, they can’t help you because you do not talk.

You doubt yourself “do I even have a problem?”

People in real life often treat you like you don’t have a real problem. They talk to you stupidly, you complain that they don’t understand, you look a fool. Perhaps that is why you don’t talk to them anymore.

Maybe you don’t have a problem anyway.
You are a child, quite possibly you are just making this up for some attention, finding an excuse for why you can’t stay in college or get a job. Maybe you don’t have an excuse, you are just a stubborn little child. From what everyone tells you perhaps that is true. You have doubt. You are willing to listen to someone else. For now that is the only reason why you are not, at this moment trying to do it.
Self experienced as evil and hateful

Externalisation & Violence Following Trauma

Perceived other

Unbearably painful emotional states: Self experienced as evil/hateful

Self-harm state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death, the violent act protects against experience of intrusion and addictive bond and terror of loss of abused object can develop

Violent state
Understanding suicide and self-harm in terms of the temporary loss of mentalization

- Loss ➔
  - Increase attachment needs ➔ triggering of attachment system ➔

- Failure of mentalization ➔
  - Psychic equivalence ➔ intensification of unbearable experience ➔
  - Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔
  - Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting
Overview of the MBT model: Key Domains
Higher Order Representation

Us/We Representation
# Domains of MBT

<table>
<thead>
<tr>
<th>General Domains</th>
<th>Major Component Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can be evaluated by viewing a whole session</td>
<td>• Can be evaluated on the basis of the therapist’s interventions</td>
</tr>
<tr>
<td>• Two general core domains</td>
<td>• Four major component domains</td>
</tr>
<tr>
<td>2. Not-Knowing Stance</td>
<td>4. Non-Mentalizing Modes</td>
</tr>
<tr>
<td>• Both general domains provide the basis for delivering MBT</td>
<td>5. Mentalizing Affective Narrative</td>
</tr>
<tr>
<td>• Impossible to focus work on mentalizing without the two core elements</td>
<td>6. Relational Mentalizing</td>
</tr>
<tr>
<td>• A typical MBT session involves interventions within these 4 domains</td>
<td>• MBT therapist will train on skills to deliver each type of intervention</td>
</tr>
</tbody>
</table>
Domains of MBT

Not-Knowing Stance
- Mentalizing Process
- Mentalizing Affective Narrative

Sessional Structure
- Non-Mentalizing Modes
- Relational Mentalizing
Topology: relationships between domains in therapist interventions

- Mentalizing Process
- Addressing Non-Mentalizing Modes
- Mentalizing the Affective Narrative
- Relational Mentalizing

Safe in Low Anxiety

Safe in High Anxiety
Interventions: Spectrum

- Supportive/empathic
  - Clarification, elaboration, challenge
  - Basic mentalizing – affect and affect focus
  - Relational Mentalizing

- Safe in high Anxiety
- Safe in low Anxiety
(1) Structure of Mentalization Based Treatment

Core Domain
Assessment → MBT-I → MBT
MBT in a Nutshell (1)

Mentalizing

Self-Other
Cog-Affective
Implicit-Explicit
External-Internal

Not Knowing Stance
Authenticity of interest in mental states
Uncertainty
Focusing
Meaning
Expanding
Rewarding
Regulating

Contrary Moves
Rebalancing
Exercises/Games

Psychic Equivalence
Teleological Mode
Pretend Mode

Probe
Explore
Diversion/Expansion
Challenge
MBT in a Nutshell (2)

- **Attachment Strategies**
  - Identification
    - Anxious
    - Preoccupied
    - Disorganised

- **Affective Processing**
  - MBT Psychoeducation
    - Emotional Management

- **Assessment Formulation**
  - MBT Psychoeducation

- **Empathic Validation**
  - Mentalizing Process

- **Affect Focus**
  - Self-other representation
  - Relational Mentalizing
  - Self-disclosure

- **Supportive/Rephrasing**
  - Normalise
  - Identification of basic/social emotion complexity
  - Marking of intensity
  - Contextualise
  - Effect
  - Recognition of affects
Trajectory of Treatment

- Assessment and assessment of mentalizing
- Giving Diagnosis
- Formulation
- Crisis Plan and risk assessment
- Contracting including barriers to treatment
- Outcome monitoring
- MBT-I
- MBT
Crisis Plans

- Integrate with normal crisis planning system
- 3 major components
  - Information for patient – what can he do?
  - Information for health care professionals – what can they do?
  - Information for others including what not to do
Aims of Formulation

- **Aims**
  - Organise thinking for therapist and patient – each sees different minds
  - Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exampled)
  - Modelling humility about nature of truth

- **Management of risk**
  - Analysis of components of risk in intentional terms
  - Avoid over-stimulation through formulation

- **Beliefs about the self**
  - Relationship of these to specific (varying) internal states
  - Historical aspects placed into context

- **Central current concerns in relational terms**
  - Identification of attachment patterns – what is activated
  - Challenges that are entailed

- **Positive aspects**
  - When mentalisation worked and had effect of improving situation

- **Anticipation for the unfolding of treatment**
  - Impact of individual and group therapy
Formulation Exercise

- Read the referral letter provided
- Small group
  - Identify important areas for probe questions in the assessment – what questions will you ask
  - What mentalizing problems will you probe for in the assessment
  - Consider a draft mentalizing formulation
  - From this formulation indicate what you predict will occur in treatment
Formulation: Executive Summary

- Attachment Strategies and Interpersonal Problems
  - Vulnerability factors from past experience
  - Current use of alcohol and drugs
  - Dependent, anxious with others, avoidant and devaluing
  - Defers to others and vulnerable to exploitation

- Impulsivity and emotional problems
  - Self-destructive behaviour, high risk of self harm
  - Anxiety

- Mentalizing process
  - Concrete, anti-reflective, sensitive
Formulation headings to think about

- Current aims
- Vulnerability factors – distal and proximal
- Crisis Plan and Risk – separate from formulation
- Mentalizing profile – common mentalizing modes; dimensional profile
- Relationships – attachment strategies
- Treatment prediction
I have been picking a few things out of all this as we have been talking.

People person
- It seems that you really like other people but find it hard to be on your own. You have to go out and then try really hard to find out if people do like you.

Being on your own
- When you have been on your own you said you start to self harm sometimes although it is really good that that has now stopped for quite a long time as has your drug use.
- Feelings are difficult to describe when this happens
- When you are with your daughter you feel so much better

Not being sure
When you are thinking about your self you seem terribly unsure about what you think – your boyfriend and what he feels for you is a really important example of this
- When you are not sure about how someone feels about you it makes you really have to find out – you ask and ask. This happened with the father of your daughter until he left you. You then decided not to go back to him and I think we might work out how you managed that as you realized that your instinct was to go back to him even though you ‘knew’ it was best not to.

Doing stuff
- You find that when you try to think about you and what you want and think you end up not being sure and so ask others. Perhaps we can think about your uncertainty about what you think and feel about things especially with your boyfriend.

Relationships
- You really want to protect your relationship with your boyfriend
- Your last relationship which is still going on with the father of your daughter was really difficult for you and he was violent and you felt trapped. You want to make your current relationship different and not get stuck in it.

Treatment
- Check that we think you are OK – how might you do that if in between sessions you panic
- Really want to be helped and worry that it might not work.

Aims
- Being alone
- Not being sure with your boyfriend
Examples of Formulation
**Current Aims**

Your aims are to go out more and stop avoiding other people. Your concern is that you spend too much time alone, you are lonely, and you start thinking that people are against you.

Reduce arguments with other people.

**Vulnerability factors**

You were unable to trust anyone when you were a child. You experienced abuse and there was no one who cared about you.

By the time you were 12 you started smoking and drinking
Formulation

Crisis Plan
We have developed a way for you to manage your anxiety when you are out in the streets. You focus too much on ‘the look’.

Mentalizing profile
You are sensitive to others and their expressions. You make quick decisions about their motives. You often feel you have to protect yourself and you feel better than others much of the time. You tend to work things out rather than feel your way with other people.
Formulation

Relationships
You describe trying to meet with people and get to know them better but quickly you feel that they do not like you and you then feel anxious and avoid seeing them. You tend to assume this without finding out if it is true.
Dave is an exception to this. You see him and can relax. We agreed that we will explore what is different about your relationship with him and other relationships.
Formulation

Treatment
You think that you will come to the group but are naturally anxious that people will not like you. Your tendency will be to avoid this and even not come to the group.
We will explain this to the group when you start.
Once there was a little turtle. When he hatched he raced down the beach, excited to get into the water. He thought the waves would treat him gently, but instead they threw him about. He had to hide in his shell because every time he came out, the waves would throw him about again. When he hid, he felt safe. He wished the bigger turtles would protect him and help him to swim better, but they often left him on his own, which he felt sad about. He moved between different turtle families, but none of them helped him learn to swim. And because he hid so often, none of the other sea creatures knew that he struggled so much. The poor turtle learned to survive on his own in his shell.
MBT-Introduction (MBT-I)  
Psychoeducation for BPD

Manual available in Practical Guide  
Handouts:
MBT-I Structure

- 2 therapists
- Observer(s)
- 6-12 members
- 12 sessions of 1.5 hours
- Diagnoses definite or probable BPD
Explicit Mentalizing Group

**Exercises**

- are arranged in a sequence progressing from emotionally ‘distant’ scenarios to some which are more personalized.
- Are related to personal experience only when the group have developed a cohesive atmosphere and some trust has been established between participants.
- are developed to ensure that there is a focus on ‘self’ or ‘other’ and on the perceptions and experiences of others about self or self about others.
- Move between explicit and implicit mentalizing
Introductory part of 1st session

- Introductions
- Details of group times, duration, structure etc
- Rules of group (eg confidentiality, alcohol)
- Information sheet provided
- Topics
  - Personality structure
  - Emotions, cognitions, behaviours
  - The interpersonal realm
Structure of each session

- Feedback from previous session and task
- Activity to explore mentalising
- Information provided
- Task for the week
12 Structured Sessions

- Session 1 What is mentalizing and a mentalizing attitude
- Session 2 What does it mean to have problems with mentalizing
- Session 3 Why do we have emotions and what are the basic types
- Session 4 How do we register and regulate emotions? Mentalizing emotions
- Session 5 The significance of attachment relationships
- Session 6 Attachment and mentalization
12 Structured Sessions

- Session 7 What is personality disorder with focus on BPD
- Session 8 Mentalization Based Treatment
- Sessions 9 Mentalization Based Treatment
- Session 10 Anxiety, attachment and mentalizing
- Session 11 Depression, attachment and mentalizing
- Session 12 Summary and Conclusion
Therapist stance

Not-knowing
Curiosity around mental states
(2) Not Knowing Stance

Core Domain
Therapist Stance

- **Not-Knowing**
  - Neither therapist nor patient experiences interactions other than impressionistically
  - Identify difference – ‘I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you’.
  - Acceptance of different perspectives
  - Active questioning – open questions, reflective questions - ‘what is it like’; ‘what would make a difference’, ‘how did you manage that?’
  - Eschew your need to understand – do not feel under obligation to understand the non-understandable.

- **Monitor you own misunderstandings**
  - Model honesty and courage via acknowledgement of your own misunderstanding
    - Current
    - Future
  - Suggest that errors offer opportunities to re-visit to learn more about contexts, experiences, and feelings
Mentalizing process

- Not directly concerned with content/narrative but with helping the patient ➔

  Generate multiple perspectives ➔ to free himself up from being stuck in the “reality” of one view (primary representations and psychic equivalence) ➔ to experience an array of mental states (secondary representations) and ➔ to recognize them as such (meta-representation)
Basic Mentalizing: Process
(3) Mentalizing Process

Major Component Domain
Contrary moves / basic mentalizing (diachrony) / elaboration of narrative / empathic validation
Interventions:
Basic Mentalizing

- **‘Stop, Listen, Look’**
  - During a typical non-mentalizing story
    - stop and investigate
    - let the interaction slowly unfold – control it/microslice
    - highlight who feels what
    - identify how each aspect is understood from multiple perspectives
    - Challenge reactive “fillers”
    - Identify how messages feel and are understood, what reactions occur

- **When patient able to mentalize to some degree**
  - What do you think it feels like for X?
  - Can you explain why he did that?
  - Can you think of other ways you might be able to help her really understand what you feel like?
  - How do you explain her distress/overdose
  - If someone else was in that position what would you tell them to do
Interventions:
Basic Mentalizing

- **Stop, Re-wind, Explore**
  - Lets go back and see what happened just then. At first you/I seemed to understand what was going on but then…
  - Lets try to trace exactly how that came about
  - Hang-on, before we move off lets just re-wind and see if we can understand something in all this.

- **Labeling with qualification (beware)** (“I wonder if…” statements)
  - Explore manifest feeling but identify consequential experience – You say you are anxious with others so I wonder if that leaves you feeling a bit left out?
  - ‘I wonder if you are not sure if it’s OK to show your feelings to other people?’
Implicit-Automatic-Non-conscious-Immediate.

Mental interior cue focused

Cognitive agent: attitude propositions

Imitative frontoparietal mirror neurone system

BPD

Explicit-Controlled-Conscious-Reflective

Mental exterior cue focused

Affective self:affect state propositions

Belief-desire MPFC/ACC inhibitory system

Impulsive, quick assumptions about others thoughts and feelings not reflected on or tested, cruelly

Lack of conviction about own ideas Seeking external reassurance Overwhelming emptiness, Seeking intense experiences

Unnatural certainty about ideas Anything that is thought is REAL Intolerance of alternative ways of seeing things.

Hypersensitive to others’ Moods, what others say. Fears ‘disappearing’

Does not genuinely appreciate others' perspective. Pseudo-mentalizing, Interpersonal conflict ‘cos hard to consider/reflect on impact of self on others

Hyper-vigilant, judging by appearance. Evidence for attitudes and other internal states hasto come from outside

Overwhelming dysregulated emotions, Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing

Rigid assertion of self, controlling others’ thoughts and feelings.

BPD

BPD

BPD

BPD

BPD

BPD


Impulse, quick assumptions about others thoughts and feelings not reflected on or tested, cruelly
<table>
<thead>
<tr>
<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>External focus</td>
<td>Internal focus</td>
</tr>
<tr>
<td>Self- reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Affective</td>
</tr>
<tr>
<td>Explicit</td>
<td>Implicit</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
</tr>
</tbody>
</table>
Process of Rewind and Exploration

- Draw attention to disjunction in topic/dialogue/ tone
  - Let’s go back to see what happened just then.
  - At first you seemed to understand what was going on but then…
  - Let’s try to trace exactly how that came about
  - Hang on, before we move off, let’s just rewind and see if we can understand something in all this.
  - Oh I thought we were talking about your child and now you are suddenly on the gearbox in your car? What happened there to make such a jump?
Beware of anti-process statements!

- What you really feel is…
- I think what you are really telling me is …..
- It strikes me that what you are really saying…
- I think your expectations of this situation are distorted
- What you mean is…
## Summary

<table>
<thead>
<tr>
<th>Process</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Stop, Listen, Look’</td>
<td>Empathy</td>
</tr>
<tr>
<td>Stop, Re-wind, Explore</td>
<td>Clarification</td>
</tr>
<tr>
<td>Contrary Moves</td>
<td>Exploration</td>
</tr>
<tr>
<td>Manage anxiety</td>
<td>Challenge</td>
</tr>
<tr>
<td>Affect and Interpersonal regulation in session</td>
<td>Affect identification</td>
</tr>
<tr>
<td></td>
<td>Affect Focus</td>
</tr>
<tr>
<td></td>
<td>Interpersonal</td>
</tr>
</tbody>
</table>
Empathic Validation: 
Underpinning mentalizing process
Empathic Validation – Affect and Effect

- Interest in and Reflection on Affect
- Identification of feelings
- Normalising when possible in context of present and past
- Seeing it through their eyes
- What effect does this experience have on them
Empathic Validation – micro-skills

- Empathic Validation
  - Reflect narrative
  - Recognise and identify the emotion
  - Demonstrate intensity of affect
  - Consequences it has in behavioural and mental terms - the effects.
Empathic Validation - examples

E.g., “I’m asking you to name a feeling that you haven’t got a word for at the moment. You’re doing your best, trying hard, but coming up short, which is embarrassing. And it seems I’m missing that, which is then creating the experience that you’re inferior to me and that I’m rubbing your nose in that, so that it seems like shutting down is the only option left.

E.g. 2, “You’re trying very hard not to do what you usually do, keeping things to yourself. There’s a sense of achievement in that. But then seeing me look at my watch gives you the impression that that I’m bored with you, as though I don’t see or value your effort, and you have to yell at me and force me to take you seriously.”

The most useful empathic validations are those that demonstrate you understand not just how the patient is feeling, but also the present impact and consequence of feeling this way.

Note: The measure of an effective intervention is that it results in a strengthening of the therapeutic alliance
Ineffective mentalizing and low level of mentalizing
(4) Addressing Non-Mentalizing Modes

Major Component Domain
Use and Misuse of Mentalizing / Psychic Equivalence / Teleology / Pretend Mode
## Modes of non-mentalizing

<table>
<thead>
<tr>
<th>PSYCHIC EQUIVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical form</td>
</tr>
<tr>
<td>Certainty/suspension of doubt</td>
</tr>
<tr>
<td>Absolute</td>
</tr>
<tr>
<td>Reality defined by self-experience</td>
</tr>
<tr>
<td>Finality – It just is.</td>
</tr>
<tr>
<td>Internal = external</td>
</tr>
<tr>
<td>Therapist experience</td>
</tr>
<tr>
<td>Puzzled</td>
</tr>
<tr>
<td>Wish to refute</td>
</tr>
<tr>
<td>Statement appears logical but obviously over-generalised</td>
</tr>
<tr>
<td>Not sure what to say</td>
</tr>
<tr>
<td>Angry or fed up and hopeless</td>
</tr>
<tr>
<td>Intervention</td>
</tr>
<tr>
<td>Empathic Validation with subjective experience</td>
</tr>
<tr>
<td>Curious – how did you reach that conclusion</td>
</tr>
<tr>
<td>Presentation of clinician puzzlement (marked)</td>
</tr>
<tr>
<td>Linked topic (diversion) to trigger mentalizing then return to psychic equivalent area</td>
</tr>
<tr>
<td>Iatrogenic</td>
</tr>
<tr>
<td>Argue with patient</td>
</tr>
<tr>
<td>Excessive focus on content</td>
</tr>
<tr>
<td>Cognitive challenge</td>
</tr>
</tbody>
</table>
The MBT Loop

Patient and therapist Notice and Name Psychic Equivalence

Clinician

Re-visit if mentalizing returns

Sensitively move exploration

Diversion To Linked Exploration

Do not argue
## Modes of non-mentalizing

<table>
<thead>
<tr>
<th></th>
<th><strong>TELEOLOGICAL MODE</strong></th>
</tr>
</thead>
</table>
| **Clinical form**   | Expectation of things being ‘done’  
Outcomes in physical world determine understanding of inner state – ‘I took an overdose; I must have been suicidal. 
Motives of others based on what actually happens  
Only actions can change mental process  
‘What you do and not what you say’ |
| **Therapist experience** | Uncertainty and anxiety  
Wish to do something – medication review, letter, phone call, extend session. |
| **Intervention**     | Empathic validation of need  
Do or don’t do according to exploration of need  
Affect focus of dilemma of doing |
| **Iatrogenic**       | Excessive ‘doing’  
Prove you care in belief it will induce positive change  
Elasticity (extending what you do e.g. extra sessions, only to rebound with extra constraints) rather than flexibility |
The MBT Loop

Patient and therapist
Notice and Name
Teleological Understanding

Diversion
to clinician concern about having to ‘act’
to demonstrate painful mental states.
Or action restricting understanding of others mental states

Checking
Do not argue

Clinician empathises with intensity of experience

Re-visit if mentalizing returns

Sensitively move exploration
## Modes of non-mentalizing

<table>
<thead>
<tr>
<th></th>
<th>PRETEND MODE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical form</strong></td>
<td>Inconsequential talk/groundless inferences on mental states</td>
</tr>
<tr>
<td></td>
<td>Lack of affect. Absence of pleasure</td>
</tr>
<tr>
<td></td>
<td>Circularity without conclusion – spinning in sand (hypermentalizing)</td>
</tr>
<tr>
<td></td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>Dissociation – self harm to avoid meaninglessness</td>
</tr>
<tr>
<td></td>
<td>Body-Mind decoupled</td>
</tr>
<tr>
<td><strong>Therapist experience</strong></td>
<td>Boredom</td>
</tr>
<tr>
<td></td>
<td>Detachment</td>
</tr>
<tr>
<td></td>
<td>Patient agrees with your concepts and ideas</td>
</tr>
<tr>
<td></td>
<td>Identification with your model</td>
</tr>
<tr>
<td></td>
<td>Feels progress is made in therapy</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Probe extent. Current in-session focus</td>
</tr>
<tr>
<td></td>
<td>Counter-intuitive</td>
</tr>
<tr>
<td></td>
<td>Challenge</td>
</tr>
<tr>
<td><strong>Iatrogenic</strong></td>
<td>Non-recognition</td>
</tr>
<tr>
<td></td>
<td>Joining it with acceptance as real</td>
</tr>
<tr>
<td></td>
<td>Insight orientated/skill acquisition intervention</td>
</tr>
</tbody>
</table>
Challenge

A technique for pretend mode
CHALLENGE: A Technique for Pretend Mode
Challenge - strategies

- Counter-intuitive statements – low level
- Therapist emotional expression to re-balance patient emotional expression – moderate level
- Mischievous or Whacky comments – high level
Low level challenge for fluctuating pretend mode

- Persistent small challenge in the dialogue
  - Sensitive humour – closest point of two mind states
  - Counter-intuitive remarks
  - Opposites
  - Over or under emphasis in reaction
  - Moderate skepticism
Clarification and Exploration of Affect
Clarification and Exploration of Affect
(5) Mentalizing the Affective Narrative

Major Component Domain
Affect trajectory / Affect Clarification – Elaboration – Exploration – Focus
Mentalizing Process – affect trajectory

- Narrative of event
- Experience at time
- Reflection on events
- Alternative perspective
- Experience talking about it in therapy
- Current feeling about events
Intervention:
Clarification & Affect elaboration

- Clarification is the ‘tidying up’ of behaviour which has resulted from a failure of mentalization
- Establish important ‘facts’ from patient perspective
- Re-construct the events
- Make behaviour explicit – extensive detail of actions
- Avoid mentalizing the behaviours at this point – only begin promoting mentalizing once facts available
- Trace action to feeling
- Seek indicators of lack of reading of minds
Affect elaboration

- Normalise when possible – ‘given your experience it is not surprising that you feel X’
- Identify, name and give context to emotion - labelling
- Explore absence of motivating emotions – relentless negativity is wearing to others
- Identify mixed emotional states
Intervention: Clarification & Affect elaboration

- Labelling feelings
  - During non-mentalizing interaction therapist firmly tries to elicit feelings states
  - Therapist recognises mixed emotions—probe for other feelings than first, particularly if first emotion is unlikely to provoke sympathy in others or lead to rejection (e.g. frustration, or anger) c.f. basic and social emotions
  - Reflect on what it must be like to feel like that in that situation – ’if that was me I would feel X’
  - Try to learn from individual what would need to happen to allow them to feel differently
  - How would you need others to think about you, to feel differently?
Affect and significant/interpersonal events
Process of Exploration of significant interpersonal event

During a typical non-mentalizing interaction in a group or individual session

- Stop and investigate
- Let the interaction slowly unfold – control it
- Highlight who feels what
- Identify how each aspect is understood from multiple perspectives
- Challenge reactive “fillers”
- Identify how messages feel and are understood, what reactions occur
Process of Exploration

- If patient not in psychic equivalence:
  - What do you think it feels like for X
  - Can you explain why he did that?
  - Can you think of other ways you might be able to help her really understand what you feel like?
  - How do you explain her distress/overdose

- If someone else was in that position what would you tell them to do
Guidance on intervention for self-harm
Self-harm

**Function**
- To re-establish the self-structure following loss of mentalizing

**Intervention**
- Explore reasons for destabilisation of self-structure
- ‘Tell me when you first began to feel anxious that you might do something?’ ➔ Mentalizing functional analysis
Understanding suicide and self-harm in terms of the temporary loss of mentalization

- Loss ➔
  - Increase attachment needs ➔ triggering of attachment system ➔

- Failure of mentalization ➔
  - Psychic equivalence ➔ intensification of unbearable experience ➔
  - Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔
  - Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting
Self-Harm/Violence and Failure of Mentalization

- Current ‘insurmountable’ mental challenges
  - Excessive demand for excellence
  - Becoming adult
  - Rejection
  - CSA
  - History of physical maltreatment

- Disruption of mentalization
  - Activation of attachment system
    - Non-contingent response
  - Stress reaction (fight/flight)

- The Disorganised Self
  - PSYCHIC EQUIVALENCE
  - PRETEND MODE
  - TELEOLOGICAL SOLUTIONS

- Self Harm/Violence to Restabilise Disorganized Self
Step-wise Intervention

- Contingent response = empathic validation with current state
- Establish joint reflection on suicide/self-harm/violence
- Affect focus if no joint reflection – presentation of shared dilemma
- Identify moment of ‘loss’, attachment trigger and context
- Work towards recognition/awareness of vulnerability points and context representation
Intervention algorithm

Self-Harm/Suicide

- No agreement to explore
  - Explore difficulty of talking about events
    - Psychic Equivalence
  - Affect focus the shared problem
    - Elephant in Room
  - Counter-relationship presentation
  - Mentalizing functional analysis
-- Collaborative agreement to explore
    - Rewind to point of mentalizing
-- No agreement to explore
  - Affect focus the shared problem
    - Elephant in Room
  - Counter-relationship presentation
  - Mentalizing functional analysis
Mentalizing Functional Analysis

- Seek point of vulnerability
- Stop and Rewind to point before mentalizing was lost
- Stop and Explore a point when mentalizing was taking place
- Micro-slice mental states towards the self destructive act
- Continually move around self and other mental states
- Place responsibility for keeping mind on-line back with the patient
- Ask patient to identify when she could have possibly re-established self-control
Mentalizing Functional Analysis

- Empathy validation and support ➔ collaborative stance
  - You must not have known what to do?
- Define interpersonal context
  - Detailed account of days or hours leading up to self-harm with emphasis on mental/feeling states
  - Moment to moment exploration of actual episode
  - Explore communication problems
  - Identify misunderstandings or over-sensitivity
- Identify affect
  - Explore the affective changes since the previous individual session linking them with events within treatment
  - Review any acts thoroughly in a number of contexts including individual and group therapy – how could treatment focus better to prevent this action again? What can we do better?
Mentalizing Functional Analysis

- Explore conscious motive
  - How do you understand what happened?
  - Who was there at the time or who were you thinking about?
  - What did you make of what they said?
  - Challenge the perspective that the patient provides if therapeutic alliance is robust

- DO NOT
  - mentalize the relationship in the immediacy of a suicide attempt or self-harm
  - Interpret the patient’s actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the ‘heat’ of the moment. It will alienate the patient.
Affect and implicit sessional interaction: Differentiating the dominant and sub-dominant theme
Affect Focus: Making implicit mentalizing explicit

- Not the affect associated with the story or event
- Patient may have different affect related to story
- Affect focus is current affect as experienced in the telling of the story
- Make explicit if important in interpersonal terms in patient/clinician relationship
- Naturally moves towards mentalizing the relationship
Elephant in the room

“I’m right there in the room, and no one even acknowledges me.”
Current affective interpersonal experience = affect focus = Sub-dominant theme

- Work on sub-dominant themes
- Define the current affective state **shared** between patient and therapist
- Do this tentatively from your own perspective
- Do not attribute it to the patient’s experience
- Link the current affective state to therapeutic work within the session itself
Relational Mentalizing
(5) Relational Mentalizing

Major Component Domain
Challenge / Relational Mentalizing / Transference markers / Intervention Algorithm for self-harm / Mentalizing Functional Analysis
Challenge
A precursor of relational mentalizing
Challenge and relational process

- **Aim**
  - Clinician precipitately present in session – from absent to present
  - Bring non-mentalizing to an abrupt halt even if only momentarily

- **Process**
  - Use relational alliance
  - Surprise the patient’s mind; trip their mind back to a more reflective process
  - Grasp the moment – stop and stand - if they seem to respond
  - Stick with it.
Challenge - indicators

- Clinician
  - Not in room
  - Pretend Mode
  - Inadequate progress in treatment

- Patient
  - Pretend mode
  - Persistent non-mentalizing especially in high risk contexts
  - Fixed position in one or more dimensions of mentalizing
  - Inadequate progress in treatment
Challenge – high level

- Characteristics
  - Infused with compassion
  - Non-judgemental
  - Unheralded, left-field, surprise
  - Outside the normal therapy dialogue but within the frame of professional treatment
  - Targets affect using empathic validation more often than cognition
  - Use humour when possible
Relational mentalizing
Interventions: Relational Mentalizing

- **Reasons for working in the Transference/Relationship**
  - Poor long term outcome
    - Spontaneous improvements (recovery)
    - Relationship problems and life goals
  - Attachment as the root to personality disorder
    - Nature of disorganized attachment
    - Avoidance as long term outcome
  - Thinking about relationships: Internal working model
    - Self
    - Object
    - Affect
Therapist Stance

- **Reflective enactment**
  - Therapist’s occasional enactment is acceptable concomitant of therapeutic alliance
  - Own up to enactment to rewind and explore
  - Check-out understanding
  - Joint responsibility to understand over-determined enactments
Interventions: Relational Mentalizing

- **Transference tracers – always current**
  - Linking statements and generalization
    - ‘That seems to be the same as before and it may be that..’
    - ‘So often when something like this happens you begin to feel desperate and that they don’t like you’
  - Identifying patterns
    - It seems that whenever you feel hurt you hit out or shout at people and that gets you into trouble. May be we need to consider what happens.
  - Making transference hints
    - I can see that it might happen here if you feel that something I say is hurtful
  - Indicating relevance to therapy
    - That might interfere with us working together
Components of mentalizing the therapeutic relationship

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist’s own distortions)
- Collaboration in arriving at an understanding
- Present an alternative/additional perspective
- Monitor the patient’s reaction
- Explore the patient’s reaction to the new understanding
Interventions:
Mentalizing the relationship

- Dangers of using the relationship
  - Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the person with BPD feel that whatever is happening in therapy is unreal
  - Thrown into a pretend mode
  - Elaborates a fantasy of understanding with therapist
  - Little experiential contact with reality
  - No generalization
Counter-relational mentalizing
Components of mentalizing the counter-relationship

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.
Components of mentalizing the counter-relationship

- Anticipation of response/reaction of patient
- Mark your statement
- Do not attribute what you experience to the patient
- Keep in mind your aim
  - Re-instate your own mentalizing
  - Identify important emotional interaction that affects therapy relationship
  - Emphasise that minds influence minds
Typical Counter-relationship emotions

- **Pretend mode**
  - Boredom, temptation to say something trivial
  - Sounding like being on autopilot, tempting to go along
  - Lack of appropriate affect modulation (feeling flat, rigid, no contact,)

- **Teleological**
  - Anxiety
  - Wish to DO something (lists, coping strategies)

- **Psychic equivalence**
  - Puzzlement, confused, unclear, excessive nodding
  - Not sure what to say, just going
  - Anger with the patient
Mentalizing and Group Psychotherapy
Mentalizing and Groups

Two types of groups

MBT Group

MBT- I
Why a change in emphasis in groups for severe PD?

- Poor research evidence behind the Foulkesian claim that groups with severe personality disorders can develop productive group culture by the help of a minimally engaged group therapist.
- Literature is full of anecdotes of chaotic situations with borderline and narcissistic patients.
- Dropout rates are high
  - most often explained by the patients as painful negative affect states being activated, but not being resolved, by the group (Hummelen et al., 2006).
- Tendency to underestimate the mentalizing deficits of borderline patients and to expose them to group situations far beyond their capacity.
MBT Group

- Primary task of the group is to provide a training ground for mentalization
- Based on fusion of group process and interpersonal therapy groups
- Interpersonally directed by clinician
- Clinician maintains authority of group process
Differences from other interpersonal focus groups?

- No interpretations made about unconscious processes
- Group matrix is not a feature of MBT-G
- Refrain from making interpretations ‘about the group’
- Therapist = active participant adopting a not knowing, non-expert stance
- Encourage group culture of relational curiosity rather than suggesting complex relational hypotheses
- Therapist makes own thinking explicit, transparent and understandable
- Therapy relies on active therapist maintaining flow and structure of session rather than adopting position secondary to group process
Mentalizing Group:
Structure
Developing a relational passport: preparation for group

- Psychoeducation
- Explore relational vulnerability from past relationships
- Identify core self and other representations
  - Avatar development between patient and therapist – past and present
- Map attachment strategies in relationships
  - Anticipate unfolding in treatment
- Rehearse prior to group explaining content of relational passport
Format of MBT-G

- Slow open group
- 1-2 clinicians
- 75 minutes
- 6-8 patients
- Agree principles including ‘extra-group’ activity
  - Attendance
  - Drugs and alcohol
  - Attitude
  - Focus
  - Re-iteration at times of MBT-I information
  - Principle of ‘No Advice Given’ – Explain carefully!
Trajectory of Group Session

1. Summary of previous group
2. Problem ‘round’ for all patients
3. Work towards synthesis
4. Exploration
5. Closure
6. Post-group discussion
Problem Round

- Establish individual problems to be discussed
- Ask each patient in turn
  - Explore briefly the core of their problem
  - Collaboratively agree the focus
  - If no problem return to them at the end of the round
  - Suggest a problem for discussion if clinician is aware of difficulties not resolved in the group
Synthesis

- Specific personal problem to general shared problem e.g. boyfriend problem to relational
- Maximum of 2 themes e.g. being excluded and alone; sensitivity and rejection
- Identify common elements between patients
- Patients describing problem become the main protagonists for the discussion.
Summary of previous group

- Developed by clinicians in post-group discussion
- Develop culture of patient contribution
- Includes examples of successful mentalizing
- Identifies self-other mentalizing problems
- Maintains over-arching themes
Mentalizing Group
Clinical stance and managing process
MBT-G: Clinician Authority

- Authority without being authoritarian
- Therapist openly and repeatedly explains the primary task of the group
- Maintains structure and states group principles
- Active and participating clinician stance
- Praise the group by acclaming mentalizing when it happens
- Maintain focus and pace the group
MBT-G: Clinician Stance

- Maintain clinician mentalizing
- Maintain focus and do not allow persistent non-mentalizing dialogue
- Monitor arousal levels and non-mentalizing modes, beware hypermentalizing
- Work in current mental reality when possible
- Model mentalizing
Mentalizing Group: Generic techniques
Facilitating epistemic trust in group

- Authentic clinician curiosity
- Culture of enquiry about mental states
- Exploration of stories
- Clarification of problems
- Mentalizing the detail of the problem
- Mentalizing interpersonal process in group
- Identification of relational patterns
- Mentalizing relationships in group
Identification of relational patterns

- Open sharing by all patients of relational aspects of initial formulation
- Focus on attachment processes in group during individual sessions
- Identify and define relational pattern in ‘stories’ given by patient
- Work to delineate benefits and drawbacks of pattern
Mentalizing interaction and significant events

- Narrative of event
- Experience at time
- Reflection on events from others
- Alternative perspective
- Experience talking about it in therapy
- Current feeling about events from patient and others
Mentalizing interaction and affect

- Statement of current emotional state of self or other
- Identify emotion and explore its ‘granularity’
- Identify how self or other picked up the feeling
- Check out if their external focus and description is congruent with patient internal feeling
- Jointly contextualise the feeling in patient

Alternative perspective
Powerful emotion

Poor mentalising

Inability to understand or even pay attention to feelings of others

Others seem incomprehensible

Frightening, undermining, frustrating, distressing or coercive interactions

Try to control or change others or oneself

Vicious Cycles of Non-Mentalizing Within a Dysfunctional Interaction – the MBT Group
The

MBT Loop
The MBT Loop

Notice And Name Interpersonal interaction

Checking

Generalise (and Consider Change)

Checking

Mentalize The Moment Between patients
Clarification of problem

- Identify the problems within the story
- Stimulate alternative perspectives from patients
- Facilitate discussion of managing mental states as the problem
Noticing and naming: exploration of stories

- Encourage patients to articulate explicitly what would otherwise be privately ascertained/assumed about mental states of others.
- Support patients to make explicit their working through of story (detail) so that rest of group (clinician and patients) can identify when mentalizing and non-mentalizing has occurred.
Mentalizing the moment

- Encourage patient to be aware of what they are thinking and feeling as they tell a story
- Ask other patients to consider the thinking and feeling of themselves and the narrator
- Suggest patients consider why they/others think/feel as they do in the story
  - I heard X saying that he is angry, but I think he is hurt about not being taken seriously
  - What am I feeling, what are they feeling, and why?
Mentalizing the moment: exploration of stories

- Generate a group culture of enquiry about motivations of people in story
- Insist that patients consider others’ perspectives and work to understand someone else’s point of view
- Therapist should directly express own feelings about something that he believes is interfering with understanding of story
Cautions

- Easy to become trapped in individual therapy in the group
- Excessive use of clinician mentalizing to make sense of story and to assume understanding of problem
- Hypermentalizing and rapid interaction about problem masquerade as interpersonal process
- Beware of defining problem based in physical reality and development of teleological solutions
Mentalizing Group: Specific techniques
Triangulation

- Therapist identifies important interaction between participants
- Notes the observer(s)
- Separates the protagonists
- Actively explores the observer(s) own experience of the interaction (talk about self) or about his/her thoughts about the observed interaction (talk about others).
Parking

- Clinician notes that a patient is unable to maintain attentional control
- Identify the experience of the patient rather than the content of the problem
- Actively help the patient focus on a sub-dominant theme
- Keep a lid on the dominant desire by letting off momentary steam
- Don’t forget you have parked a patient – you may have to pause the group if the patient becomes excessively anxious.
Siding

- Clinician notes that a patient is vulnerable to other patients actions/comments/focus
- Actively take the side of the vulnerable patient
- Other clinician (if present) takes position of antagonist
- Support the vulnerable patient until mentalizing is rekindled in the group
- Switch sides if necessary when the vulnerable patient is more stable
RFQ web address

- https://www.ucl.ac.uk/psychoanalysis/research/rfq
Thank you for mentalizing!

For further information
anthony.bateman@ucl.ac.uk

Slides available at:
https://www.ucl.ac.uk/psychoanalysis/people/bateman
Additional slides

Suggested exercises

and

Further information
Workshop Exercises
Role Plays

- **Clinician**
  - Interview as you normally do
  - Don’t try to do anything original!
  - Try to explain to the patient what you are trying to do at some point
  - Observers to help you out whilst monitoring what is a mentalizing intervention and what is not.

- **Patient**
  - Be a moderate and not the extreme person with BPD
  - Respond as you think your patient would
  - Monitor how the clinician makes you feel – misunderstood, secure, s/he is interested, makes you think etc
  - What was it that made you feel like that or altered your mind state?
Large Group Exercise

- A patient calls you to say that he has had enough. He feels that no one cares about him. He doesn’t know what to do.

- Talk to him on the phone
- Observers to note mentalizing and non-mentalizing statements of therapist
Large group exercise

- A patient in emotional crisis telephones you to say that she feels useless and nothing can be done. Even her boyfriend doesn’t answer the phone and she feels something awful is going to happen.

  - Talk to her on the phone for a few minutes
  - Observers to note mentalizing and non-mentalizing statements of therapist
Workshop Exercise

- Patient to talk about incidents in his/her life
- Therapist
  - Inquisitive stance – not knowing/humility
  - Rebalance the mentalizing problem – self to other or other to self
  - Empathic Validation
  - Explore the incident with curiosity
  - Control the process
  - Focus on the incident
  - Labelling of Affect
  - Therapist to focus patient attention on current situation
Workshop Exercise

- Patient reports that she has got into an argument at work and suspended pending an inquiry.
- Therapist
  - Inquisitive stance
  - Therapist to focus patient attention on current situation
  - Explore the incident
  - Elaborate mental states of protagonists
  - Demonstrate humility - not knowing
  - Monitor for non-mentalizing and try to Intervene to move patient to mentalizing
Workshop Exercise

- Patient does not feel that you understand and think that it would be better to have another therapist.

- Therapist
  - Empathic position
  - Clarification
  - Elaboration and affect focus
  - Stop and stand if necessary
  - Rewind and explore
  - Work within the current relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.
Workshop Exercise

- Patient has been shouting at staff and/or complains about another member of staff. Therapist has to address what has been happening.
- Therapist
  - Empathic validation
  - Clarification
  - Elaboration and affect focus
  - Rewind and Explore
  - Stop and stand if necessary
  - (Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.)
Workshop Exercise to use Basic Mentalizing and mentalizing the relationship

- Patient – Discuss an important relationship and allow the story to unfold when prompted

- Therapists: Basic mentalizing
  - Stop, Look, and Listen and explore important content
  - Stop, rewind, and explore
  - Stop and stand if patient uses non-mentalizing

- Therapist: transference tracers and mentalizing the relationship
Workshop Exercise

- Therapist feels that the therapy is stuck and cannot see that it is likely to go anywhere and feels that ending therapy should be considered.
  - Patient has not indicated that she feels similarly
  - Raise the subject with the patient and explore.
Workshop exercise

- Patient describes having cut himself and requiring sutures.

- Therapist
  - Identify feelings
  - Develop context
  - Integrate the relationship with you in the discussion if interfering with exploration
  - Aim to re-instate a continuity of self-structure by kick starting mentalizing
  - If unsuccessful work on what you and patient are to do perhaps by identifying an affect focus
Workshop Exercise

- Patient states that they feel you are a bully because you keep making them talk about things they do not want to talk about.

- Therapist
  - Affect focused clarification
  - Elaboration in context of current relationship
  - Work within the relationship
  - Mentalize the relationship
Workshop Exercise

- Patient tells a story about how she was angry and shouted at her 4 year old child. Then she states that she knows that you are appalled by her.

- Therapist
  - Affect focused clarification
  - Elaboration in context of current relationship
  - Work within the relationship
  - Mentalize the relationship