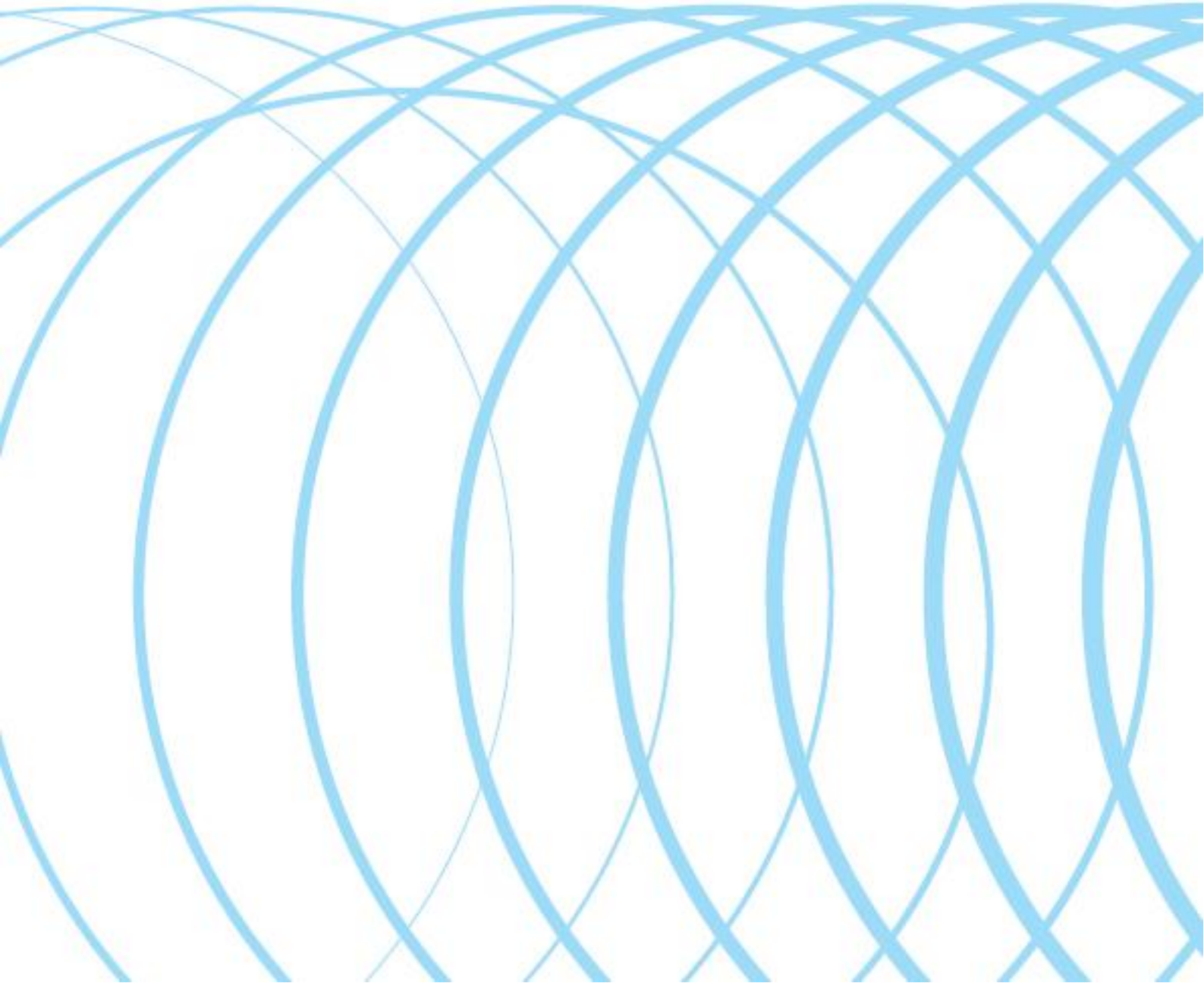
Anna Freud Centre

Caring for young minds

UCL

MBT-Introduction Manual



Contents

Anna Freud Centre

MBT-Introduction

This file gives an outline of MBT-I as it is currently organised by Sigmund Karterud and Anthony Bateman in London. If you wish to use it please register your interest with Davina Metters at the Anna Freud Centre. You will be asked to collect some baseline/mid-point/end point data.

The introductory course is precursor of the MBT programme and has a number of aims:

a) Inform/educate patients about mentalizing and BPD and associated areas of knowledge
b) Prepare patients for long term treatment
c) Elicit more detail about mentalizing capacities
d) Confirm initial assessment and diagnosis.

Anna Freud Centre

All patients have a meeting with a senior member of the team to review their experience of MBT-I at the end of the 12 sessions and to plan further treatment. The sessions have been run by some practitioners as a continuous programme with patients joining at any time. In Oslo patients attend the course in parallel to the MBT programme itself.

Role of Group leader

The group leader remains 'in charge' of the group throughout each group and over the 12 sessions. 'In charge' is not used here to suggest that the group leader is autocratic but to imply that the group leader manages the group carefully to ensure that each topic is covered adequately and discussed in enough detail to ensure that patients are aware of the relevance of the topic. Crucially, the group leader models a mentalizing stance throughout any discussion, whilst maintaining an expert stance in terms of knowledge about mentalizing and personality disorder. This balance is important. A mentalizing or "not-knowing" stance can become confused with being without knowledge or understanding. Nothing could be further from the truth. The application of our knowledge to inform our own mental states and to stimulate thought in others is the very essence of mentalizing. The group leader models the stance by demonstrating that his knowledge, whilst being that of an expert, can be extended, clarified, and enriched by the contributions of group members. Critically, his mind can be changed by the minds of others; the patient's understanding of and ideas about the topic in question feed back to the question itself. Hence the emphasis we recommend on the group leader stimulating discussion. Maintaining equilibrium between providing information on the one hand and learning from the perspectives of the patients on the other is a key skill for group leaders. The group leader should be careful not to be too lecturing in his/her style, as this tends to encourage passivity in the group members. On the other hand, he/she should not give too much detail when giving personal examples, as this can dominate the process.

The group leader should use a flip chart and play an active role in structuring the group. There is a certain amount of material that must be covered in each session. He/she should therefore follow the manual closely. Experience has shown that it is easy to digress and get lost which impede the completion of the programme. It is also important that the learning takes place through the participants' own activities. The group leader must, all the time, maintain a psychoeducational perspective.

He/she shall comment on the degree to which personal examples illustrate theoretical points, and make sure that participants understand the theory properly through their own examples. When the group leader stops further personal exploration, the patients should be encouraged to pursue the topic in their individual or group therapy.

The patients should work actively with the material on their worksheets. The worksheet for patients can be downloaded at the webpage XXXXX. The worksheets contain brief summaries of content, key words and space to make notes in connection with the group exercises and homework.

The group leader should follow the manual and the themes indicated herein and not stray beyond these. The manual's topics are comprehensive enough and it is important to get through all the topics each time since there is a logic that builds up under the given homework assignment. Most of the other themes that will pop up will be covered in later group sessions, and this can be mentioned when the leader "parks" digressions and questions.

Anna Freud
Centre

1. Session One: What is Mentalization and a mentalizing stance?

The group leader welcomes the participants to the session and presents himself/ herself.

If the group is part of an on-going MBT program, the leader explains that all group members are attending the MBT program in different groups, and asks each of them to present themselves briefly by saying their first name and describing why they were referred to the programme.

Alternatively, the group leader explains that the group is a refresher group for old members and an introductory group for the new members. The old members are asked to take a lead in the work in the group to help the new participants engage in the process and to explain some of the topics that have been covered. The new members are asked to introduce themselves and to describe why they were referred to the programme.

The group leader describes the purpose of the groups, which is that the members shall learn about mentalization, emotions, attachment, interpersonal interaction and mental health. The aim of this session is to better understand what the treatment programme is about, to appreciate what mentalizing is, and to participate as actively as possible.

The group leader hands out worksheets and encourages the participants to make good use of them.

The group leader briefly describes the structure of the group –

- there are a total of twelve groups,
- the group leader will give a short introduction each time
- examples based on the participants' own experiences will be discussed
- some texts will be used
- some role playing will be undertaken.

The group leader emphasizes that the group is educational, and that each participant will not be asked to into depth about their personal problems, but that they will all have an opportunity to do this in individual and group therapy sessions later in treatment if it appropriate after completion of the group. In Oslo the patients are already in individual and group sessions and so the patients are encouraged to explore their problems in more detail in these contexts. The group leader states that he will continuously summarize what can be learned from the examples discussed.

The group leader then explains that it is important that everyone attends every session. It is important for group cohesion that everyone is present at every session, and it will allow everyone to gradually become more comfortable with each other. Participants are advised that they will also get to know each other better through the exercises and discussions, and the hope is that everyone can participate actively with their own stories.

Group activity: The group leader writes up "What is mentalizing?' on the board and gives his own explanation, writing key points down as he does so. Alternatively, the group leader writes up "What is mentalizing?' on the board and asks the old members of the group to outline their understanding of it for the new members.

The group leader then moves on to take what the participants have understood from this and expands his explanation of *what mentalization is* using examples and comments from the group. He/she can now use a flip chart to emphasise key points. He/she can say that there is nothing mysterious about mentalization, that it is essentially a very simple concept and that it is something that we all do much of the time.

It is important that the group leader covers specific aspects of mentalizing in a way that is comprehensible to the participants. Mentalization is when we attribute intentions to each other, when we understand each other and ourselves as driven by underlying motives and recognise that these take the form of thoughts, wishes and various emotions, etc. A precondition for good interpersonal relations is that we understand each other, ourselves included, reasonably accurately.

When we interact with others in a spontaneous and natural manner, mentalization takes place *automatically*. We do not need to exert ourselves and do not even notice that we are mentalizing (i.e. that we are interpreting other people's intentions and feelings). We simply respond to people reciprocally by making reasonable assumptions about their motives. It is only when they depart from an expected response that we are surprised. At this point there is an interruption in the spontaneous interaction. We stop and wonder: "What happened now? Did he really understand what I meant? That's not what I meant. Let me try one more time." Or: "Shit, the same thing is happening again, he won't listen. Fine, if he wants to be like that…, I've had enough of explaining things to him." Then we resort to *controlled or explicit mentalizing.*

In the review of automatic versus explicit mentalizing, it is not uncommon to discover that someone is overly concerned about what others are thinking and feeling. This tendency can be described as *hypermentalizing,* and most patients will understand that hypermentalizing is counterproductive and consumes large amounts of energy.

Group activity: What would you think if in your home town you saw a foreign-looking man standing at the corner of an intersection studying a map, looking up and down the various streets with a questioning expression on his face? Make some notes.

This simple exercise is suitable for demonstrating:

1) That people interpret the same event in different ways;
2) That some interpretations are more plausible than others;
3) That some statements about the object is mentalizing (e.g. "I believe that he is confused"), while others are not (e.g. "he comes from a foreign country").

The group leader proceeds by saying that mentalizing is both advantageous and important. It is beneficial to mentalize for example when …

You are going to console a friend who is sad. You are going to straighten up misunderstandings with a friend. You are going to quieten down a child who is angry. You feel like getting blind drunk or smashed on drugs You wish to convince your boss to give you a higher salary. You are going out on your first date.

… and the participants can add their own examples.

In summary, mentalization is important for the following reasons:

To understand what is taking place between people. To understand yourself, who you are, your preferences, your own values, etc. To communicate well with your close friends. To regulate your own feelings. To regulate other people's feelings. To avoid misunderstandings. To see the connection between emotions and actions more easily, so that you can escape destructive patterns of thoughts and feelings more easily.

It may help to clarify things if you say something about *situations in which one does not mentalize a lot,* or that do not require much mentalizing skill, in order to emphasise that we are focusing on one's own and others' minds. When you are, for example, performing math tasks or exercising, or resting or eating, you are not necessarily mentalizing as the focus is not on the mind but on the task itself. This distinction is illustrated in the exercise given above and it is helpful if the group leader uses aspects of the group activity just undertaken to illustrate the difference between mentalizing as a skill of the mind about minds and descriptive narrative for example. The group leader agrees that the man could be a tourist, and it is important to register this thought and think about it; this is not necessarily mentalizing, rather it is a descriptive statement about him. If it does involve mentalizing, it only involves a small component, as you are not thinking about his mind.

At this point it is helpful to draw out the other different poles of mentalizing to place them alongside the discussion about explicit/controlled and automatic mentalizing as it provides a preview of later groups. The additional poles of mentalizing that are discussed are:

- emotional/thoughts
- self/other
- external/internal.

The group leader offers examples of each of these to illustrate the points and asks the participants if they can think about when they feel that other people have relied heavily on any one of these. Mentalizing is a balance of these aspects of mental function and using one excessively results in poor quality mentalizing such as hypermentalizing mentioned earlier. Relying too heavily on emotional cues may also be unreliable; conversely relying on cognitive understanding without attention to subjective feelings may also cause trouble – someone may be convincing about what they are selling you and yet, if your feeling is one of distrust, it is probably best not to purchase from that individual.

At the end of the discussion the flip chart should contain all four mentalizing poles with some examples identified to illustrate them, preferably provided by the patients.

These can be added to as the discussion develops further using the other group activities.

As this introduction suggests, mentalizing has a lot to do with *misunderstandings*.

Group leader: Let's discuss why we so often misunderstand others and ourselves? Any suggestions?
Group activity: Suggestions about why we so often misunderstand each other.

The group leader notes down all the suggestions and comments on them. The point here is to encourage a discussion about the characteristics of the mind, how individuals' have different values and different life experiences and how people use different strategies to hide aspects of themselves.

Suggestions are commonly related to one of the following issues:

The mind's non-transparency. This is a key point: how can we know what is going on in another person's mind?

Our tendency to *attribute thoughts to others* (e.g. think that others are thinking the same way as we do). This is also known as *Projection* which refers to the possibility that we may *project* our own unacknowledged feelings or thoughts onto other people.

Experience that *others understand without you having to say it yourself*. The group leader also mentions here about the importance of not succumbing to this wish or assumption in individual and group therapy. Therapists aren't able to read other people's minds either.

Layers of the mind. This refers to the fact that it is also impossible to fully understand what is going on in our own minds. It is easy to misunderstand oneself; you may have access to *some* thoughts and feelings, but underneath these lie unclear thoughts and emotions that can be difficult to understand.

Differences in interpretations and actions. Individuals vary with respect to how they interpret things, how they arrive at judgments and their ability to deal with situations; in short, individuals have different perspectives on the world. To acknowledge this difference involves acknowledging that wishes and interpretations depend on perspectives, and that, by wishing and believing differently, an individual can behave differently even in similar situations. An individual's wish and interpretation of a situation is not only influenced by the here and now, but it is also influenced by the person's interpretation of the situation in light of his or her views about the future and understanding of the past. Wishes and interpretations about specific situations also influence memories, preferences, hopes and other mental experiences. The significant effect that cultural differences can have on our perspectives, wishes and beliefs also needs to be emphasized, not least because group members may have different ethnic backgrounds.

Defensiveness. When another person adopts a defensive attitude or position and holds back feelings and/or thoughts because he or she is afraid of something (e.g. of being embarrassed or judged) then this will inevitably affect one's ability to understand what is going on in their mind.

Having difficulty finding words to express inner thoughts and feelings.

Deliberate concealment or 'playing mind games'. If the other person is hiding his or her intentions, playing a game or being dishonest it adds to the difficulty of interpreting their mental states. It is the minds non-transparency which makes it possible for people to hide things in this way.

This is then followed up by a new group activity.

Group activity: The group leader asks for examples involving someone misunderstanding himself or herself.

This exercise emphasises the 'self' component of mentalizing and the strong feelings that can result from misunderstanding oneself. Two to three examples should be sufficient. The group leader helps to clarify possible reasons for the misunderstandings. The group leader may bring up own examples from everyday life and even personal experiences, in order to convey that mentalization problems and misunderstandings are not just something that apply to patients. It could be a misunderstanding in a shop, a meeting, etc.

Anna Freud Centre

Group activity: The group leader asks for examples in which the person himself/herself has misunderstood others.

This exercise focuses on the opposite pole, namely the 'other' and how misunderstanding others can cause problems. Again, a few examples will suffice. The group leader assists by relating the points to key words on the flip chart and by discussing possible explanations for the misunderstandings.

Mentalizing stance. With reference to what has been discussed, the group leader suggests discussing some typical examples of poor mentalising skills. For example: arrogant claims about other people's motives; black-white thinking (i.e. without nuances and uncertainty); thinking without taking account of emotions and overlooking the fact that people influence each other.

Group activity: The group leader asks about more examples of poor mentalizing abilities.

The group leader then defines a mentalizing stance as markedly different from these examples. Instead, it is characterised by a curiosity about the other person's experiences, thoughts and feelings; it is a not-knowing, exploratory stance.

Group activity: Two patients are invited to role-play. The one will be interviewing the other. The task is to find out how the other person was yesterday afternoon, using a mentalising stance.

Patients, especially new patients, may sometimes be reluctant to participate in role playing at this stage. If nobody is willing to be the interviewer, the group leader can take this role; often other patients will feel more able to take over once the role playing has started. The experiences are then discussed. How was it to apply a curious and not-knowing stance about another person's state of mind? How was it to encounter this type of attitude? Does it help to mentalize, i.e. becoming more aware of your own state of mind?

The group leader explains that the individual therapist tries to meet the patient with this type of attitude and each person in the group therapy is encouraged to strive to do the same.

Homework: Practice using a mentalising stance. Those who are able to, are encouraged to find a friend or someone in their family to interview in the same way, i.e. about how the other person was earlier in the day or yesterday.. Patients are encouraged to ask questions in a curious, non-knowing and non-judgmental way and to try to bring out as many moods, thoughts and emotions as possible. They should note how it makes them feel and also ask their interviewees how it makes them feel.

Anna Freud
Centre

2. Session Two: What does it mean to have problems with mentalizing?

The group leader starts by briefly summarizing the last meeting. The main points to re-iterate are:

- Mentalizing is an ability that everyone has and that it makes us meaningful to each other
- We interpret each other automatically and do so more explicitly at times, particularly when we are muddled or uncertain. Even then we can easily misunderstand others and ourselves because of the mind's complexity and lack opacity

- We react differently to the same situations, our minds are multi-layered and these layers can be in conflict with each other. We often do not recognise or appreciate that others misunderstand, we can have difficulties expressing unclear thoughts and feelings, we may become defensive, and we deliberately hide aspects of ourselves.

- Provide some examples of poor mentalizing ability, such as a arrogant and stubborn attitude and black-and-white thinking; use of certain words such as 'just' 'clearly' 'always'.

- End on what typifies a mentalizing stance, i.e. curious exploration and a non-knowing attitude.

The group leader asks if the group members were able to do their homework and, if so, how they found it. The group leader asks if anything that has been discussed thus far is unclear, and whether there is anything that they have thought about since the last time, that they wish to discuss in the group.

If patients give examples from their homework, these are discussed briefly and positive aspects of the work are identified. Similarly, if patients are unclear about what has been covered so far, this is pursued only briefly, because group members often have a tendency to ask about things that will be addressed later in the programme.

Since the last meeting, the group leader will have noticed who was active and who was reticent, and should address those members who have been quiet so far, with the intention of getting them more involved.

The group leader explains that in today's meeting they will go further with respect to good and poor mentalizing abilities and the consequences of each. First, however, they will tackle some mentalizing exercises. The following task is written on the worksheet:

Group activity: It is Sarah's birthday. She is planning to celebrate with Mike, her boyfriend, and has invited him home for dinner. She has purchased wine to go with the food, and is looking forward to him coming after work. When Mike arrives, he does not have a gift with him, and he says to her "wow, what a dinner you have

made, and on a Tuesday". During dinner Sarah is quiet and drinks most of the wine herself.
What happened? Why do you think Sarah behaves the way she does?[1]

The group leader makes a note of all the suggestions on the board. At the end he or she summarizes that there are several possible motives that could underlie Sarah's behaviour and that they are not mutually exclusive but rather can complement each other. Still, some motives are perhaps more important than others and there are some interpretations that are less likely than others. Answers like "Sarah usually drinks on Tuesdays", or "Sarah usually turns silent when she drinks" are examples of low mentalization. An interpretation such as "Sarah likes the wine better than Mike" also represents a low mentalization level. An interpretation that Sarah is upset and is trying to manage her feelings represents good mentalizing, not simply because it is likely to be more accurate, but also because it tries to establish Sarah's mental state in relation to her behaviour. Some patients may think that Sarah should have said something; if this is the case, the group leader should ask the patients to consider why Sarah did not express what was going on in her mind. The raising of this issue is very positive, not because the patients seem to 'know' how someone 'should' behave (this would be a non-mentalizing position because it included knowing and absolutes), but because discussion of this issue can stimulate further mentalizing about Sarah's state of mind.

Anna Freud Centre

The example serves as a "warm up" exercise and an introduction to the theme of the consequences of poor mentalizing skills. The group leader summarises again what was discussed the last time with respect to what typifies poor mentalizing:

- Feeling certain about other people's motives
- Thinking in black-white terms (i.e. without nuances)
- Poor acknowledgement of accompanying feelings (reduced empathy)
- Overlooking the fact that people influence each other
- Interpretation of others without careful consideration may be irrelevant, be off the point, or even be very concrete (i.e. that first this happened then that happened, etc.)
- Little curiosity about mental states
- Lots of words are spoken with poor content
- Speech is filled with clichés and fancy words that do not seem to have been digested and that tend to alienate the discussion partner
- External factors are emphasised at the expense of mental states, for example that it rained, or that one had a headache, or the situation is described as being "just how it was", without any more explanation.

Group activity: The group leader asks about possible consequences of poor mentalizing:
1) in relation to others, and
2) in relation to oneself

The group leader writes suggestions on the flip chart. Typical answers are that

- It is easy to misunderstand each other and that this can have negative consequences (e.g. others feel overlooked, not heard or wrongly interpreted and become upset about this, etc.)

[1] This exercise was provided by Randi Kristine Abrahamsen, Clinical Psychologist, Bergen Clinics, Norway.

- One's actually behaviour may differ from the other person's expectations, which can confuse the other person
- One may react in a very emotional way, based on misunderstandings and become afraid, angry, disappointed, etc.

- Poor mentalizing of one's own thoughts and emotions means that one does not always understand one's own reasons for acting the way one does. and may second guess oneself

- Feeling insecure or needing constant confirmation from others

- Becoming overwhelmed by emotions or acting without reflection (i.e. letting the surroundings or one's own impulses govern ones actions, etc.)

Anna Freud Centre

Some patients may give other responses such as "I can always understand other people" or "I find that no one understands me". The group leader has to take such suggestions sensitively and empathise initially with such experiences, but should only do this for a short time and may close the conversation by suggesting that it is something that can be explored further in the forthcoming or continuing therapy. The emphasis should be on using such statements as examples of early warning signs of compromised mentalizing – the use of the words 'always' and 'no one' are the key. The group therapist suggests that being alert to such words might help to prevent a collapse into non-mentalizing by making the individual 'think twice' about what he is saying and experiencing. Could there be other possibilities? Is it likely that someone will *always* be right?

The group leader summarises that poor mentalizing leads to:
1) Recurrent problems in relationships with other people
2) Insecurity, an unstable sense of self, poor emotional control, impulsivity, and more

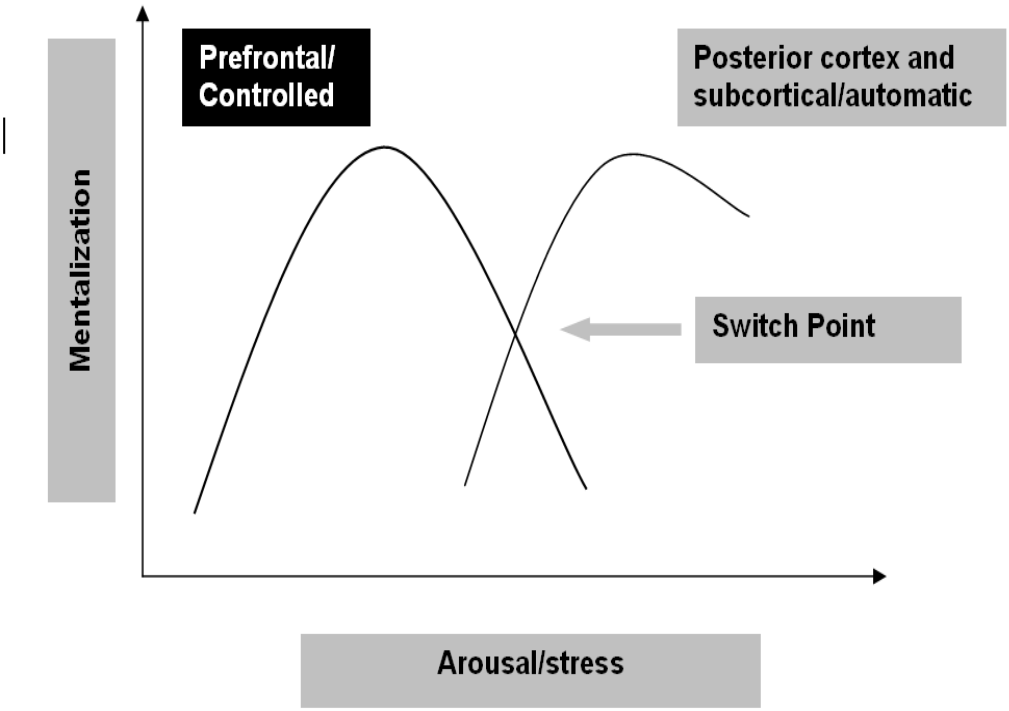
The group leader says that he/she now is getting a bit ahead of the programme since this is a topic for the next session, but that it is important in this context to emphasize that the most important cause of poor mentalizing is strong emotional activation. When emotions are intense, a person's mentalizing ability is undermined, and may even be shut down completely, exemplified by expressions such as "everything turned black", "I just froze up", "I couldn't say a thing", "I wasn't able to think", with additional phrases formulated by the group participants.

Group activity: the participants are asked to think through their own experiences and make some notes about what a typical reaction pattern is for themselves as they become emotional.

The group leader asks if anyone would like to share their own experiences. These are then discussed.

The group leader draws up a curve to illustrate the connection between mentalizing and emotional activation and the transition to fight/flight response:

automatic mentalization (Based on Luyten et al., 2009).



Anna Freud Centre

The group leader emphasises three important points:

1) Feelings are activated faster and more strongly in some people than others
2) The fight/flight response can kick in at different times for different people, depending on the individual's personal threshold
3) The time it takes to return to a normal state after intense emotional activation varies among people

Group task: Participants are asked to reflect and make notes on the worksheet about what they think about themselves with respect to emotional activation, the threshold of their fight/flight response and time to regain their normal state of mind after intense activation.

The group leader asks if anyone wishes to share their reflections. These are discussed.

The group leader emphasises that these three points are important themes for the treatment, that emotional intensity can be controlled, that the threshold can be raised and that the time it takes before one gets back to one's normal state can be reduced. We will return to this later.

Homework: Make a note of a situation during the week in which you have noticed that your ability to mentalize was undermined.

Anna Freud Centre

3. Session Three: Why do we have emotions and what are the basic types?

The group leader summarizes the topic from the last session. The session addressed problems with mentalizing that typically lead to problems in interaction with others. Some key points were:

- one's own insecurity
- unstable sense of self
- problems regulating emotions and impulsivity.

The most important reasons for poor mentalizing are:

- emotional activation which can make a person unable to function;
- the intensity of emotions which varies between individuals;
- the threshold for fight/flight response varies
- the variable time it takes to regain one's composure after activation

.
The group leader reminds the group about the homework assignment and asks if anyone was able to make a note of anything that they wished to share.

The group leader introduces the day's topic and invites everyone to brainstorm the topic and writes down points on the flip chart:

Group activity: What types of emotions are there? Any suggestions …

When the activity starts to ebb, the group leader adds some emotions if the ones written down are insufficient. The group leader suggests there is a *difference between basic emotions and newer (social) emotions.* Basic emotions are emotions that exist in all mammals, while newer emotions exist in more developed primates and humans. Basic emotions are localized in the same area in the brain, evoke the same physical reactions and each of them are linked to a set reaction pattern. The group leader explains that there is some disagreement about which emotions are basic, and that we have chosen to present one version (Panksepp, 1998). The group leader asks the members to suggest which emotions are basic emotions.

The group leader summarises the seven basic emotions as follows:

1) Interest and curiosity, exploratory behaviour
2) Fear
3) Anger
4) Sexual lust
5) Separation anxiety/sadness
6) Love/caring
7) Play/joy

The group leader asks if anyone has any comments and if anyone is surprised that other emotions are not found on the list. The group leader reminds everyone that there is a certain degree of disagreement about this list. And the list is not meant to diminish the importance of emotions like envy, jealousy, greed, gratitude, guilt, shame, etc.

The group leader asks rhetorically, why would these basic emotions be important for us? He/she confirms any suggestions that are related to evolution (e.g. that these feelings have been shown to be important with respect to survival and reproduction) and that they represent an innate reactional preparedness. We do not need to learn these emotions or reaction patterns because they are determined by nature (but we can still distance ourselves from them, a topic that will be discussed later). They supply us with automatic responses that have been important for human survival over the course of 100 millions of years. The group leader then describes the purpose of the emotions.

The main purpose of the seven fundamental emotions are as follows:

1) *Interest and curiosity/exploratory behaviour:* This motivates us to find out useful information about our surroundings (e.g. what resources are available, where food and water can be obtained, whether there is a safe place to hide, whether there are any sexual partners around etc.).
2) *Fear:* This stimulates us to ask ourselves questions such as: is what I am facing dangerous; can it injure me; could it kill me; Is he/she a rival who is stronger than I am; is he or she an enemy? When the fear becomes intense enough and the source seems stronger than oneself, it prompts our decision to flee or submit. Fear can also prompt us to freeze/play dead if the threat is overwhelming and we are in mortal danger.
3) *Anger:* If we identify someone or something that is standing in our way, we may show anger and see if he/she submits. If the person resists, the intensity of anger will increase and possibly lead us to attack.
4) *Sexual lust:* This encourages reproduction and the continuation of one's genes.
5) *Love/caring:* This motivates us to care for our offspring, family, partner and friends.
6) *Separation anxiety/sadness:* These emotions function as an appeal for others to take care of oneself. They signal to potential caregivers that one is in danger/in need of protection or that one has become isolated from the group/family, or that one has lost someone close who one depends on.,
7) *Play/joy:* This stimulates interaction with others so that one remains a 'pack animal' rather than a hermit, increases our skills of interacting with others, introduces the limits to one's own excitement, and enables the development of strategies for dealing with anger through rough and tumble play.

The group leader discusses reactions to this exposition. As the descriptions suggest, emotions are basically different action programmes.

The group leader explains that humans, unlike other animals have the ability to suppress the feelings of emotional reactions. That is why the relationship between emotions and feelings sometimes seems obscure.

The group leader emphasises the difference between:

1) *Emotions that are the organism's bodily reaction, as action programmes, to specific stimuli.*
2) *2) Feelings, which are the conscious experience of the body state during emotional activation.*

The group leader explains that because of their upbringing and socialization, people can be distanced from their natural, emotional reactions. This means that people can react emotionally, but that they do not necessarily feel their emotions. Emotions can be suppressed. You can therefore be emotionally activated, but at the same time be unaware of the specific nature of the emotions involved. One can for example, feel heart palpitations or bodily unease without knowing why. The group leader explains that the reason for this will be addressed and discussed later.

Anna Freud Centre

Group activity: The group are encouraged to discuss the emotions listed above in relation to themselves and their individual differences. Questions to be addressed include whether *everyone* in the group feels these emotions and whether each person experiences them with equal frequency and intensity?

The participants' different reactions and experiences are discussed. The group leader reminds them about a mentalizing attitude (i.e. an openness and curiosity in relation to people's differences).

Homework: What emotions have been the most prominent the past week? Or has the emotional activation been diffuse, i.e. more of a physical unease?

4. Session Four: How do we register and regulate emotions? Mentalising emotions.

The group leader summarises what they learned in the last meeting:

That everyone has a wide range of emotions, but that some are more fundamental than others. All mammals experience these emotions, and they are as follows:

1) Interest and curiosity,
2) Fear,
3) Anger,
4) Sexual desire,
5) Love and caring,
6) Separation anxiety and sadness, and
7) Play and joy.

The emotions are triggered by specific stimuli and consist of physiological reactions. Feelings are conscious awareness of these bodily reactions. In humans, it is possible to become emotionally activated without having a conscious awareness of the feelings.

The group leader then asks if anyone has made any notes about emotions and/or feelings they have experienced in the past week that they wish to share with the group.

The topic this time is how to deal with emotions and feelings. As we have discussed earlier, this is a very important mental health topic. First of all, the question of how we register emotions needs to be addressed.

Group activity: How do we register emotions:
1) In others?
2) In ourselves?

The group leader encourages discussion and has an overall aim of identifying two primary ways in which emotions are registered. The ensuing discussion commonly gradually identifies the first of these, namely we register others' emotions by *interpreting* others' facial expressions (the soul's mirror); this is consistent across all cultures and, to some extent, across animal species. We also interpret others body language, what they do and say. This is external mentalizing that was discussed in session 1. The second pathway by which we understand others emotions is via identification. There are nerve cells called *mirror neurons* in the brain that enable us to experience what someone else is experiencing when they do or feel something. For example, when we see another person feeling sad, we can become sad ourselves. This is part of the basis of empathy.

The discussion can then move onto the ways in which we register bodily reactions (examples of these should be given) and feeling states (which may be referred to as affect consciousness) in ourselves. . The group leader can remind members that they touched upon this in their last session, when they discussed how people differ with respect to their feelings and how they register their emotions – some people do so more easily than others.

Most often the group participants are better at giving examples of how feelings are expressed in others than how they feel themselves. The group leader can offer some examples, such as “lump in one’s throat”, “pressure behind the eyes”, “weak at the knees,” “hairs standing on end”, etc.

The group leader then introduces a group exercise that stimulates thinking about emotional awareness. Some improvement can be made simply by being more aware and “being more present in one’s own body”.

Group activity: The group leader asks the members to close their eyes and forget the surroundings and focus on themselves. He/she directs their attention inwards, asking such questions as:

- Is there any place in your body that attracts your attention?
- What do you feel?
- Try to feel if there is any trace of emotional activation? Perhaps not, but there often are.
- What types of feelings are you experiencing? (If it’s very uncomfortable, leave it alone but if it’s positive, try to stay with it).

This should not last long and the leader should be clear that the most important thing is that each group member is turning his/her attention towards his/her inner experience.

Participants’ experiences are discussed. For some, this exercise may evoke feelings of anxiety and this should be acknowledged by the group leader Occasionally, a patient may unable to do the exercise at all and may even have a paranoid reaction (one patient said that he thought that the group therapist was trying to control him). Redefine this as fear which ensures that it is on the list of basic emotions, and emphasise that the person can retain control after all. Some people will report that their physical experiences blocked feelings during the exercise (e.g. that they were too busy breathing to pay attention to what they were feeling), while others may report different emotional states.

The group leader then turns to the subject of *emotional regulation through others.* He/she briefly introduces the topic and says that they are going to take an emotional regulation exercise that everyone is familiar with: namely, consoling another person.

Group activity: Role-play about emotional regulation through others. The group leader asks one of the participants to act being emotionally upset, perhaps a mixture of disappointment and anger. If none of the participants feel comfortable taking the role, the group leader himself or herself can play the role. Another group member is given the following assignment: 1) to find out what feelings the person has; 2) to find out why he/she feels this way; 3) to try to console the person.

The participants’ experiences are discussed with a focus on the issue of the patients’ willingness or unwillingness to let someone else console them. The group can then discuss, based on other experiences, what behaviour/actions from other they have found most consoling (e.g. empathic understanding, emotional resonance, physical contact etc.) with an acknowledgement that each person will be different.

The group leader brings up the topic of impaired emotional regulation. Impairment means that one is stuck in a painful, uncomfortable and often unclear emotional state and resorts to dramatic means (such as getting high or self-harm) to escape it.

Group activity: The group leader asks the group members to suggest names for

such unpleasant emotional states and writes these on a flip chart.
The group leader asks for examples of what the participants have done to get out of such emotional states.

The group leader then labels such emotional states *unmentalised feelings* and emphasises the importance of talking about such experiences in therapy. While in such a state, you can do very dumb things. It is important to try to reduce the time spent in such a state, and therapy can help with this.

Anthony: Here I have added 10 lines on self-harm

Homework: Make a note of at least one occasion during the last week, on which you managed to effectively regulate an upsetting emotional state.

Anna Freud Centre

5. Session Five: The significance of attachment relationships?

The group leader summarizes, briefly goes over what they learned in the last session, including: how we register feelings in ourselves and others; interpreting inner emotional signals in ourselves and emotional expressions in others; self-regulation of feelings and how others can help regulate our feelings; unmentalised feelings that are very uncomfortable and how we attempt to get out of such emotional states.

The group leader asks if anyone would like to share an experience of positive emotional regulation from the previous week.

The group leader then introduces the day's main topic: attachment. He/she links this immediately to feelings and emotional regulation and defines it as follows:

Attachment is a positive feeling and emotional bond towards another human being.

The first attachment relationships are with your parents/caregivers and other family members. These attachment relationships will later influence your relationships and interaction patterns with others, for good and for bad. Attachment is a phenomenon we find in all mammals and its purpose is to protect the immature organism against dangers and promote affectionate bonds between relatives. When the child experiences something uncomfortable, (for example, hunger, thirst, frustration or fear) he/she instinctively turns toward the attachment person with an expectation of being comforted. The attachment person has an equally instinctive reaction to the signals of unease on the part of the child (for example, whimpering, and crying) which is a signal that the caregiver needs to attend to the child in some way. To become emotionally regulated in this way –to be given food or something to drink, to become less fearful, smiled to, etc.– leads to an establishment of an inner image of the attachment person that is associated with wellbeing (reward), so just the thought of the attachment person can be enough to calm oneself. This is the standard path to emotional self-regulation. But before one has achieved an ability to self-regulate, being separated from one's attachment person may involve feelings of unease and fear (separation anxiety and sadness). The group leader summarises that this process means we learn to understand and regulate our emotions 'through' someone else, and this process continues throughout life even though we begin to regulate ourselves.

Humans can have different attachment patterns. In children, this is tested by observing how the child reacts when it is separated from the attachment person, which is most often the mother. In the test situation, the mother leaves the room after a while and leaves the child alone; then an unfamiliar person (observer) enters the room. The situation of being both abandoned and in the same room with a complete stranger triggers separation anxiety and fear in most children. An observation is made about how the child deals with this situation and how he/she reacts when the mother enters the room again after some time. Children with so-called *secure attachment*, react with unease and protest when the mother is about to leave, but relax after a while and start to play with some of the toys in the room. When the mother returns, the child goes to the mother and will often whine a bit, but will quickly calm down, possibly by sitting on her lap. After a short period of time the child will usually resume playing.

Some children, however, have what is called an *insecure attachment pattern*. There are two types of insecure attachment patterns: an ambivalent or overinvolved type and a distanced type. In the ambivalent/overinvolved pattern, the child is insecure about his or her attachment person – in all likelihood with good reason, because the person has behaved unpredictably (i.e. has been erratic in response and presence). In order to attract the attachment person's attention, the child has therefore learned to exaggerate his or her emotional expressions (e.g. they express an excessive amount of unease and crying). When such a child is abandoned in the test situation, he or she cries loudly and clings to the mother when she is about to leave the room. The child then has difficulty quietening down and playing while the mother is away. And when the mother returns, the child is ambivalent in relation to her, cries and protests when she wants to pick the child up, but quietens down gradually. It takes a longer time for the insecurely attached child to start playing again after this experience. It is as if the child needs to hold onto mother for fear that she will leave again.

Anna Freud Centre

The other insecure pattern is called distanced. It is in many ways the opposite of the ambivalent type. While the ambivalently attached children have exaggerated emotional reactions, the distanced children exhibit little response. They are detached. They do not react at all on being abandoned in the test situation. It is as if they do not care whether the mother leaves or returns. When these children's physical responses are measured, they have been shown to be stressed in the situation, but they *express this stress to a very little degree.* The have learned to overregulate their feelings. They may have experienced that their feelings are commonly overlooked, consistently misunderstood and thought to be something else, or they may have been ridiculed or tormented for what they were feeling, or experienced other negative consequences.

Attachment patterns are thus dependent on how the interaction with one's early attachment persons and the ensuing patterns develop. Since this has much to do with how the child attracts attention, one can also call these *attachment strategies* on the part of the child. This is not to be confused with the idea of attention seeking behaviour. Some patients and their helpers see certain symptoms of BPD as ways of deliberately trying to get attention, for example taking an overdose. Nothing could be further from the truth and it is important that the group leader emphasises that the idea of attention seeking behaviour is not part of the mentalizing framework of understanding.

It is also possible to mix the insecure attachment strategies, e.g. sometimes acting ambivalently, while at other times acting distanced.

The attachment pattern influences humans from childhood. However, it is not fixed, it can change during childhood. It exerts an influence on one's relationship patterns as an adult. It determines to a large extent how one deals with close relationships and particularly in situations that cause pain or when there is a danger or fear of being abandoned. Is the other person a source of security and enjoyable experiences, or is the relationship characterized by insecurity and drama or is it distanced and emotionally flat? *The way a person regulates his/ her attachment relationship is of major significance for his/her life.*

Group activity: Tom and his girlfriend, Sara, meet again after the university holidays. During the holidays, Tom has not called Sara and when she called or sent an sms he did not answer. Sara did very little during her holidays, but when Tom asked her about it she answered: "I had a fantastic holiday with plenty to do. I wish

the holiday had lasted longer."
Discuss this episode in light of attachment strategies for Tom and Sara. And finally: Why does Sara answer as she does?

This exercise serves as a kind of run-up to the next exercise, in order to activate the participants in thinking about attachment and so that the group leader can correct any misunderstandings.

Group activity: Think about a relationship with an important person in your life (girlfriend, boyfriend, family member, friend) and think about whether it is secure, ambivalent or distanced.

This discussion occupies the main part of the session. The group leader clarifies question about attachment trough the examples of the participants.

Homework: Make notes on what is typical for you in your attachment relationships.

Anna Freud Centre

6. Session Six: Attachment and mentalization

The group leader summarises the last session:

Attachment refers to a positive emotional bond with another person
One's typical attachment strategies as an adult are influenced by the attachment pattern that was established in childhood.
Typical attachment strategies are secure and insecure attachment patterns, ambivalent/overinvolved and distanced/detached attachment patterns.
Each of the participants was encouraged to explore a relationship to an important person in light of what characterizes different attachment strategies.
The home assignment involved thinking more about what has been typical of one's attachment relationships.

Anna Freud Centre

The group leader asks if anyone wishes to share the homework. This is discussed.

The main theme this time is attachment and mentalization:

Growing up in a mentalizing culture promotes a secure attachment which facilitates a person's mentalizing abilities.

A *mentalizing culture* implies a culture with frequent discussions about people and why they behave the way they do, including why people do what they do within the family, for example. A mentalizing culture is necessary to manage any significant events that affect anyone in the family. Discussion about experiences need to be done with a reasonable degree of open-mindedness, minimal certainty and without triggering any oppressive family taboos.

The group are informed that the treatment programme strives toward a mentalizing culture, – in the group s and individual sessions; for example, there is a constant effort to find out about one's own and others' minds and their transactions. This is re-emphasised in Sessions 8 and 9.

Group activity: What characterises the family culture of each individual participant with respect to mentalization?

The group leader leads the discussion on this topic and there will be examples of oppressive silence, heavy family get-togethers, taboo areas, chaotic family discussions, etc. The group leader must be prepared for the possibility that the topic in this session may activate painful memories and strong emotions. Again, the group leader must emphasise that this is a topic one should explore further in the other parts of the treatment, and that the key point in this context is the consequences for each individual in the group. More specifically, it relates to what consequences it has for the person's mentalizing abilities when the relationship to an attachment person is problematic or simply bad. There may be many reasons for such a situation. The attachment person may not have been available physically or mentally, the person may not have had the ability to listen, to understand or be empathic. There may have been, and indeed still be, someone else in the way (sibling, other parent); the person may not have had good caregiving skills or there was an environment of mental or physical abuse or substance abuse. The end result is often *attachment conflict*.

Attachment conflict means that one inhibits or exaggerates signals about one's emotional state because one fears or is insecure about what will happen if one calls for the attachment person.
Attachment conflict means that an impulse to get closer is inhibited by something else (e.g. fear of punishment, or own wish to punish)

Group activity: Make a note of your own examples of attachment conflicts.

The group leader leads the discussion about attachment conflicts that have been noted and brings the conversation onto the subject of the likely consequences that this may have for a person's mentalizing abilities. *He/she brings up the idea that attachment relationships are important, in order for the child to become aware of their own emotional states, to be able to put words on these states, find out the reasons for them, and use emotions to orient themselves in a mental landscape.* There will be negative consequences for a person's mentalizing abilities if the relationship to the attachment person(s) is poor, if the child cannot use the attachment person to understand feelings and relationships between people and that this means that one is very much left alone. In addition, it becomes difficult to think around the attachment relationship itself because the individual lacks reference anchors. This becomes easier over time as one grows up and gains other references and can see things from the outside and compare them with other experiences. It becomes particularly difficult to think about the relationship if it is characterized by violence and sexual abuse – how can one begin to understand why a person, who should be treating one with care and love, is behaving with complete disregard for one's well-being?

Anna Freud Centre

Attachment conflicts inhibit a child's mentalising abilities right from the start, and leave behind emotional scars and confusion.

They undermine the child's ability to deal with attachment conflicts later in adult life.

Group activity: Make a note of something you find difficult to talk about in a close relationship and what the reason(s) for this may be.

The group leader takes notes and leads the discussion on this topic.

Homework: Make a note of something that has been difficult to talk about in a close relationship the past week.

7. Session Seven: What is a personality disorder? What is borderline personality disorder?

The group leader briefly summarizes the topic and discussion from the last session:

- growing up in a mentalizing culture promotes the ability to mentalize
- major attachment conflicts in childhood impair this ability
- Impaired mentalizing ability makes it difficult to deal with conflicts in close relationships (e.g. thinking often becomes black-white, and emotions will tend to overwhelm the ability to think, etc.).

The group leader asks if anyone wants to share experiences from their homework assignment relating to difficulties speaking about something in close relationships.

The group leader then turns attention to the topic of the day which is personality disorders. At this point the group leader takes a didactic approach outlining current understanding of personality disorder. Key areas to cover at this point are:

1. A person has a personality disorder when the person's personality features a certain number of maladaptive personality traits, which are typical ways of thinking, feeling, regulating impulses and relating to other persons. The traits need to have been characteristic of the person since at least late adolescence or early adulthood and have been relatively consistent since that time.

2. Personality traits typically affect self-image and self-esteem, but also influence ways of thinking about others, and will usually cause problems in schooling, work and/or family life (e.g. being shy, not self-assertive, extremely suspicious, dependent on others, uncontrolled temper, always avoiding conflicts, etc.).

3. A personality disorder does not affect the entire personality. One can have many good and positive personality traits and many talents in addition to those that are problematic. For example, Edvard Munch clearly suffered from a personality disorder. He was an extremely skilful and innovative painter, but a difficult person in the sense that he had problems interacting with other people.

Group activity: Ask each group member to make a note of: 1) his/her own problematic personality traits, and 2) his/her good and positive personality traits and any talents.
Or alternatively, ask each member to write down what 'makes me me' (i.e. what are his/her/what are my individual characteristics).

The group leader asks if anyone wishes to share their notes, makes a list of key words on the flip chart and leads the discussion.

Following this discussion the group leader outlines a positive view of personality disorders in terms of their changeability. Personality disorders are not necessarily permanent. Many traits can change with age, which usually results in a person becoming more relaxed, less intense and learning to deal with situations in a better way. Problems can pop up again during times of stress, however (for example, in connection with work problems or problems in close relationships, e.g. separation and divorce). Personality disorders improve quicker through treatment, for example,

through mentalization-based treatment. Personality disorders may also have a better outcome than depression.

Next the group leader discusses the origins of personality but does not go into detail. Personality disorders arise as a result of a combination of genetic influences (temperament and vulnerabilities) and negative environmental influences during childhood. Depending on the balance of these factors, certain characteristics come to dominate our ways of relating to others and these, in turn, define the different personality disorders.

The group leader now outlines the classification of disorders briefly reviewing key words of *the various types:*

1) Schizotypal PD: Very shy and suspicious, few friends, bizarre views.
2) Schizoid PD: Flat affect, little need to be together with others, prefers doing most things alone.
3) Paranoid PD: Suspicious, uncompromising, and temperamental.
4) Antisocial PD: Repeated criminal acts, ruthless, aggressive, little capacity for caregiving.
5) Borderline PD: Unstable relationships, unstable emotions, fluctuating self-image.
6) Narcissistic PD: Grandiose sense of self, arrogant, lacking in empathy.
7) Histrionic PD: Theatricality, exaggerated expression of emotions, plays on sexuality, constantly draws attention to self.
8) Avoidant PD: Anxious, inhibited in new interpersonal situations, reluctant to take personal risks, excessively fearful of criticism or ridicule.
9) Dependent PD: lack of self-confidence, goes to excessive lengths to obtain nurturance from others, constantly needs advice and reassurance from others.
10) Obsessive-Compulsive PD: Rigid and stubborn, preoccupied with order and schedules, difficulty delegating tasks to others, perfectionist.
11) Personality Disorder Not Otherwise Specified: Insufficient traits to meet the threshold for any one of the above personality disorders, but has several traits from many personality disorders.

The group leader leads the discussion about the different personality disorders.

The group leader goes through the criteria for borderline personality disorder with reference to mentalization, with the reasoning that these are the traits that are most often found in persons in the MBT programme, while emphasising that many participants may have other personality traits that they have problems with as well:

Criteria for borderline personality disorder:

1) Intense and unstable relationships, alternating between extremes of idealization and devaluation. Quickly enters into new romantic

relationship, idealizes the person, and allows himself or herself to be seduced or infatuated, which reduces his or her social judgement; does the opposite when disappointment arrives, seeing only the negative where before they could only see the positive.

2) Has difficulties with being alone and strong feelings associated with being abandoned. Therefore he/she carries out desperate efforts to avoid being abandoned, e.g. allowing himself /herself to be treated poorly, acting submissively, carrying out dramatic acts such as injuring himself /herself or threatening to commit suicide

3) Identity problems: Fluctuating self-esteem, unstable self-image, constant changes in life-goals, difficulties in holding on to one's inner core self

4) Impulsivity that can be self-destructive (i.e. impulsive risk-taking): e.g. purchasing things one can't afford, driving and recklessly and/or above the speed limit, acting on poorly considered decisions, promiscuity, abuse/misuse of alcohol and narcotics, etc.

.

5) Self-destructive acts such as self-mutilation and suicide attempts (to regulate painful emotional states).

6) Recurrent feelings of inner emptiness and meaninglessness,

7) Constant mood swings: e.g. fluctuating between intense dysphoria and euphoria in a single day, or between positive moodiness and sadness, bitterness or anger.

8) Intense anger that is difficult to control (e.g. that may result in throwing things, swearing or physical fighting)

.

9) Reacting with suspiciousness or a feeling of being outside of oneself when stressed.

The group leader clarifies and discusses the traits as they are presented. It is important that the group leader maintains a mentalizing perspective during the review and discussion.

Homework assignment: Make a note of the personality traits that have been most problematic for you the past week.

A leaflet is given summarising aspects of BPD (see appendix).

Anna Freud
Centre

8. Session Eight: On mentalization-based treatment. Part 1

The group leader summarizes the topic and discussion from the previous session:

- definition of personality disorders
- what are maladaptive and adaptive personality traits
- how the course of the disorders fluctuate, that most improve with age and that treatment increases the chances of improvement
- various different personality types
- Criteria for borderline PD.

The group leader asks if anyone would like to share notes about what they have experienced as problematic personality traits over the past week or if they have further questions about the diagnosis.

The group leader then addresses the theme for the session and starts with a definition of the aim of mentalization-based treatment.

The aim of MBT is to improve a person's mentalizing ability in close relationships. Improved mentalizing ability means that the person experiences having a more stable inner core self, that the person is less likely to let emotions get the better of himself/herself, and when this happens, that he/she is more quickly able to regain his/her composure, i.e. the person is more robust emotionally, less vulnerable to interpersonal conflicts and better able to deal with arising conflicts.

How does psychotherapy enable people to achieve this?

Psychotherapy means that one talks about one's innermost problems with another person and/or several other people. In this way, one becomes more aware about oneself and one's feelings and how one relates to others. This is a benefit in and of itself, because in general the person has been left on his or her own to figure this out and may have gone astray in these thoughts and feelings. But psychotherapy involves even more. It also deals with getting closer to other people, about letting others into one's life, i.e. daring to trust others and make bonds to others, letting others become significant in one's life. As has been discussed earlier, particularly in the sessions dealing with attachment, this is not an easy process. It requires careful attention to what is happening in one's own mind and in others'. What is happening in other people? Are they ready to accept me and my mind? Do they understand, accept and support me?

The patients are reminded of the session on attachment and mentalizing. Psychotherapy will automatically stimulate attachment feelings and the pattern of attachment that a patient identified in Session 5 is likely to become apparent in therapy. The group leaded explains that this is a natural development and that it will be important to focus on how the relationship between patient and therapist can interfere with taking an interest in what is going on in one's own mind and the mind of others. The group are told that this topic will be discussed in more detail in the next session.

How the treatment is structured:

After agreeing a treatment contract, each receives the following:

1) Mentalization-based problem formulation
2) Crisis plans
3) Appointment(s) with psychiatrist for relevant prescriptions if needed
4) Individual therapy once a week for around 18 months.
5) Psychoeducational group therapy of 12 sessions (in parallel in Oslo; in series in Halliwick)
6) Group therapy 1.5 hours weekly for around 18 months and in some programmes for up to three years
7) Collaboration with other agencies on work-related rehabilitation

The therapists meet regularly and exchange information about how the therapy is progressing. The therapists treating a patient are granted permission to discuss the patient's progress among themselves, but the group therapist does not ordinarily mention anything about the patient in the group. It is up to the patient to decide what he/she wants to talk about and when he or she wants to talk about it. In some circumstances, the group therapist can address specific issues directly, when they relate to violence or threats, serious contract breaches or suicide attempts that the patient does not want to talk about. When it comes to the other group members, the participants are encouraged not to have contact among themselves in person, by telephone/sms or via social media such as Facebook and twitter, outside of the therapy sessions. If they nevertheless chose to meet outside group, then they are encouraged to talk about these encounters in the therapy sessions. Intimate relationships between patients attending the MBT-programme are not permitted, and if such a relationship should develop then at least one of the parties will have to leave and seek therapy elsewhere.

MBT involves practicing mentalizing skills in close relationships

MBT therapists provide little direct advice.. They try to engage the patients in a *mentalizing stance* and, in doing so, help the patient gradually develop their own solutions having reflected on their problems in increasing detail. As mentioned earlier, the mentalizing stance means being curious about the other's mind, about experiences, thoughts and feelings– a not-knowing attitude in which one attempts to find out by trying many different alternatives. MBT is a collaborative effort in which the therapists seek to get the patients to come along on the same mentalizing journey. In short, mentalization-based treatment is based on practicing mentalizing skills together with the therapist and other group members. To be good at something, you need to practice it. In this treatment programme, the participants have the opportunity to practice mentalizing skills.

The mentalizing group therapy can be described as a *training arena for mentalization* and requires the following from each individual participant:

1. That they regularly bring in (tell about) events from their own lives, preferably recent events, resulting in poor mentalizing (strong or confusing feelings, impulsive actions poor conflict resolution, etc.), or in which the person has been subjected to stress. (Particularly in relation to others) that put high demands on mentalizing ability.
2. That they try to understand more about these events using a mentalizing stance (exploratory, curious, open for alternative understandings, etc.).
3. That other group members participate in this process by exploring their own problems and those of others through a mentalizing stance.

4. That everyone together tries to find out about events in the group in the same way.
5. That they try to bond to the group, its members and the therapists.

Group activity: Discuss whether you have problems with, 1) bringing in events from your own life, 2) focussing on events in the group, and 3) assuming a mentalizing stance.

Use the rest of the time on the discussion of these issues.

Home work: Did you encounter any problems during your last group meeting talking about a relevant event(s) from your own life?

Anna Freud Centre

9. Session Nine: On mentalization-based treatment. Part 2

The group leader summarizes the topics of the last session:

- Aims of MBT to enhance the mentalizing ability in close relationships;
- The structure of the treatment programme;
- Training in mentalizing in the group...

The group leader asks for the home work of the week and discusses this with the participants.

The main topic for this session is the attachment aspect of MBT.

Group activity: Discuss the difficulties you think you may run up against when you form a therapy relationship with 1) the individual therapist, 2) the group therapist, and 3) the other group members.

Common objections to forming affiliate relationships include the contention that it is both painful and meaningless when one knows that one soon will be separated, that they inevitably go wrong, and concerns about the fact that attachment involves caring about another person. Some will feel that they might care too much about the therapist, but worry excessively that the therapist does not care about them (i.e. that the therapist regards the relationship as 'just part of his/her job). Others may question whether it is possible to bond with all the individuals listed: after all, one needs to like the people one bonds with and one may not like the therapists or other group members. Still others may raise the issue that attachment can lead to wanting more, such as a wish to contact the therapist whenever things are difficult. The question of how you can bond with someone who doesn't say anything about himself or herself may also be raised, As well as the issue of why one cannot have contact with other group members outside of the therapy session, if you become friends.,? Etc…

As indicated above, this group activity activates a wide range of themes, and it can easily turn chaotic. The group leader may, after a while, assist by structuring the discussion. One way to do this is to discuss the relationship with the individual therapist, the group therapist and the other group members separately. Some patients may experience a conflict of loyalties here, similar to that of one own's family. It is hard to say something negative in front of others, in public. This may be vented in the group. Other themes that can be highlighted are the apparent diversity among the participants' concerns regarding attachments to therapists and other group members. How come? How is this transmitted intersubjectively?

To those who have participated in group therapy earlier, it should be explained that the MBT group will use more time investigating what takes place in the here and now. When there are 8-9 persons present, it is natural that things can become quite chaotic at times. One might experience that the therapist has to stop further discussion and try to find out what is going on beyond the spoken words, that things are going too fast, that one has to rewind, etc. It is important to listen to the therapist in such situations.

The group leader changes the theme to common reasons for not opening up or telling others about what is difficult. These are feelings of being let down, not

understood, overlooked or misunderstood by the therapist or one of the other group members.

Group activity: Discuss what your typical reaction is when you feel let down, misunderstood, overlooked or something similar by a therapist, by another group member or by someone who is close to you.

Group discussion of this topic takes the rest of the time. The group leader emphasises that this is a particularly important topic to address in therapy; as such reactions often have a tendency "to go underground". Clarifying misunderstandings and sensitive interpersonal feelings is a central element in mentalization-based treatment.

Homework assignment: Make a note of how you reacted when you experienced being let down, misunderstood, overlooked or something similar the past week, by someone in the therapy group or by someone close to you.

Anna Freud Centre

10. Session Ten: Anxiety, attachment and mentalizing

The group leader summarizes the last session:

- on the significance of bonding
- establishing attachment to the therapists and the other group members,
- how attachment to others activates difficult emotions and represents a challenge to one's mentalizing endeavours,
- how one might experience disappointments in the treatment
- How one's reactions to feeling upset by others might "go underground" instead of being spoken about.

The homework about any interpersonal events that led the individual to feel let down or misunderstood is shared. The theme of experiences of one's needs and wishes not being met (what self psychologists label experiences of self-object failures) –is a very important and a rich pedagogic area to expand understanding of therapy so the group leader may spend some time on this.

The group leader introduces the topic of the day by saying that almost everybody that applies for treatment for an unstable sense of self, unstable emotions and problematic relationships with others, will also have disturbing symptoms in a more narrow sense, and that it is often these symptoms that motivate the individual to seek treatment. The most common symptoms are anxiety and depression. In this session we will deal with anxiety.

Anxiety is intimately connected to one of the basic emotions that was addressed in the third session – fear. Fear is indispensable for survival in a dangerous world; it signals danger and turns on an animals 'alarm button', schematically activating a preparedness for fight or flight.

The group leader explains that the threshold at which fear stimulates a flight and flight reaction and the intensity of the response varies between individuals. To a large extent this is a matter of temperament. Some individuals are more intrinsically fearful than others. This become apparent when we consider *simple phobias*. The word phobia is derived from the Greek word "phobos" and means simply fear. Simple phobias are fear of specific things, animals or situations. It might be spiders, snakes, knives, lifts, tunnels, etc. Most people will experience fear in an encounter with a snake. Reacting emotionally when encountering a snake is not evidence of an illness; it is a natural and purposeful reaction that is grounded in evolution. If the mere sight, or thought of a snake elicits panic, however, or if one harbours a constant fear of encountering a snake in European countries, it approximates a phobia. The fear reaction is stronger than normal and will lead to troublesome consequences for the individual.

Group activity: Make notes on your own possible phobias

The group leader asks each member in the group what they have written down and discusses the kind of simple phobias being reported by the participants. He/she sets aside agoraphobia and social phobia for later discussion.

Then the group leader mentions that there are anxieties that are not confined to special objects or situations. One may experience unspecified anxiety where the source of the emotion is unknown. In such cases we assume that the source is forgotten and that it is buried in unconscious layers of the mind.

The intensity of fear can be so strong that the physical and mental processes may not handle it properly. The autonomic nervous system can become overloaded causing the individual to experience a *panic attack*: increased heart rate, difficulties breathing, dizziness, fear of fainting, dying, or going mad, or simply losing control, etc.

Group activity: Have you had any panic attacks? Note how it felt

The group leader asks all group members about any experiences of panic attacks.

Thereafter he/she proceeds with the theme of panic attacks leading to a focus on how to avoid the sources of possible triggers. Most often these will be situations packed with people and perceived difficulties with the escape route, such as buses, trains, shops, restaurants, cinemas, theatres, concerts, etc. If one avoids such situations to the extent that this avoidance has significant negative consequences, we would describe the individual as suffering from *agoraphobia* (agora being the Greek word for marked place).

Group activity: Make notes on any kind of agoraphobia.

The group leader asks all group members about experiences of agoraphobia. He/she continues by saying that there are other kinds of anxiety disorders that also are common, but which will not be commented on in detail here. There are *social phobias*, which concern the fear of exposure and embarrassment in the presence of others; social phobias are closely connected to excessive performance anxiety, which may prompt the individual to avoid social gatherings such as parties, restaurants, group seminars or situations where the individual feels a burdensome obligation to perform in some way. Then we have *generalized anxiety*, in which the individual is tense and worried about problems with daily living. There is also *obsessive-compulsive anxiety* with its obsessions and rituals, and *post traumatic anxiety*, in which the individual is exposed to painful re-experiences of traumatic memories.

Treatment of anxiety disorders involves controlled exposure. Exposure to the anxiety triggering situation in itself is usually not enough. It is necessary for it to be done in a manner that implies an experience of mastery and control, not defeat. At this point the group leader reminds the participants about what they have learned in previous sessions about emotions and attachment. By default, children's natural reaction when experiencing fear is to *turn to their attachment figure* or another secure person who they trust. The natural reaction of this person is generally to take care of the child and calm him/her down. Multiple experiences of this kind informs the child that fear is an emotion that can be handled. However, this interaction will not always be ideal, for different reasons, and this can leave the child continuing to feel frightened or feeling that it is useless or worse than useless to approach others, leading to the conclusion that fear has to be handled by oneself alone, or even that one has to hide one's experience of fear. The fact remains, however, that the best remedy for anxiety is a calming other person. Everybody that has experienced anxiety must have realized that it helps to be with another trustworthy person in an anxiety provoking situation. This is a principle which is used in the treatment of anxiety. In exposure

therapy, for instance, a therapist treating someone with anxiety about travelling on a bus might accompany the patient on his/her initial travels on buses; travelling with someone who makes you feel secure, helps one to travel without anxiety. This gives an experience of mastery and control when it is accomplished. Thereafter one may experience the same while travelling alone, especially when the other person is waiting at the bus stop, for example.

Group activity: Make notes on how other people have had a calming effect on your anxieties

The group leader asks all group members about this issue and underlines that *the very act of approaching another person when experiencing anxiety is significant because it is the attitude that patients are encouraged to develop towards the therapists and the group members in the MBT programme*. As will be remembered, we have emphasised the importance of trying to bond with the therapists and the group members. This requires that one "brings in", talks about in the sessions, things that one fears, including things that happen within the sessions that activate fear. This is easily said, but may be difficult to do. When trying to be open with respect to one's anxieties, one will often experience a kind of resistance within oneself. It may be related to the fact that fear is often connected with shame, or that one gets an uneasy feeling of being childish and helpless, or that one does not trust that the other has the capacity to be helpful, etc.

Anna Freud Centre

Group activity: Make notes on themes or experiences that one is reluctant to talk about to the individual therapist or to the group

The group leader discusses this with the whole group.

Home work: Note if you managed to approach another person (therapist, the group, family or friends) during last week with something that made you anxious, if it did or did not help, what are your thoughts about the reasons why it succeeded or failed.

11. Session Eleven: Depression, attachment and mentalizing

The group leader briefly summarizes the discussion in the previous session: a

The close association between anxiety and fear.
Fear can be an appropriate response in some situations but that, if it becomes excessive, it can get out of hand (e.g. causing panic attacks) and can develop into a maladaptive response if it begins to be triggered by benign or non-threatening stimuli.
Anxiety can easily generalize to other areas if not addressed
There are effective treatments for anxiety conditions.
Treatments for anxiety disorders typically involve controlled exposure.
Studies have shown that one is able to manage anxiety better when one approaches the triggering situation in the company of someone one trusts.
It is important not to respond to anxiety by avoiding the source of the anxiety, but bravely by involving others in your exposure to it instead.
It is important in therapy that one is daring enough to bring up the issues that are really bothersome to oneself.

The group leader goes through the week's homework assignment discussing the examples brought about approaching others to help with anxiety.

The group leader then turns to the current session's topic: depression.

Like anxiety, depression is also associated with a basic emotion –*separation anxiety and sadness*. This is also a natural reaction related to a break in what we call the attachment system. All children who have established an attachment relationship will respond with separation anxiety when they are abandoned and with sadness when the person they miss does not return when expected. We believe that separation anxiety is a natural part of a type of protest phase and that it is connected to crying and screaming which are used to attract the parent's attention. Sadness belongs to a later phase in which the protest has not had the desired result. When this is because of the death of the caregiver or a close person, then we refer to it as a *grief reaction*. An intense grief reaction is quite similar to depression, although qualitatively different.

Individuals vary with regard to what they react to in terms of sorrow, how strong their grief reaction is and how long it lasts. In most people, the emotion passes after a time and the individual is able to adapt to his/her new life circumstances relatively quickly; but when the emotion remains intense for a longer time, we refer to it as a depression. Some may describe it as a pathological grief reaction. In depression the person is sad and low in mood, tired and with low self-esteem and has ruminative thoughts, feels profoundly negative about life and often guilty. The person has difficulties concentrating, life seems meaningless and there seems to be little hope for the future. The thought of giving up on life may not be far away.

The relationship between depression and grief reaction is therefore quite close. This hypothesis is supported by research on large population studies. The loss of someone dear is the most common trigger for depression. It does not need to be a death. It could be that someone travels away for a long period of time, that you yourself are sent away, that the attachment person is ill and unavailable, that one's

parents divorce or that one moves away and loses close friends. It may also involve the loss of social standing and social position, or being disgraced in public in some way.

If a person has first experienced a serious loss at a young age that has led to a poorly processed grief reaction, one will be more disposed to reacting with depression after a loss in adult age. And the more depressive episodes one has had, the easier it is to experience it again. It is as if one establishes an automatic response pattern to stress and discomfort. The response pattern, a depressive reaction, may also be triggered by things other than loss, but we think that it is in relation to the loss of an attachment person that the reaction pattern is established as part of evolution. Other things that can trigger depression are general stress and physical illness, as well as factors of which we are still unaware.

Group activity: Make a note of what may have triggered a depressive response in you.

This is a sensitive topic. The group leader must spend considerable time reviewing the examples that are given, not because it is important to hear everyone's depressive episodes in detail, but because everyone should have an opportunity to say something on this topic. It is NOT a good idea to ask everyone to think about what may have triggered their own depressions, and then listen empathically to the stories of 2-3 group members, not leaving adequate time for all participants. The group leader must say openly to the group that it is important that *everyone* is given a chance to talk about their experiences and the available time should be divided equally. If five minutes are set aside for each person and there are eight people in the group, then this would take 40 minutes.

The group leader then turns to the topic of *course and treatment*. Most depressive episodes resolve themselves, while some are never completely resolved. The person can continue in a chronic state, which is not as serious in terms of risk as when the depression was at its worst, but is characterized by constant low spirits in which the person has difficulty feeling happy about anything. The individual has low self-esteem and is pessimistic in all aspects of life, including about the future and. Depressive episodes pass quicker with treatment and many chronic depressions can be normalized with treatment. Serious depressions should be treated with medication, with so-called *antidepressants*.

Antidepressants can also be effective for panic attacks and they can also reduce strong mood swings that are due to general emotional instability. Many people with BPD have taken antidepressants in the past and may still be on medication. When someone takes part in a comprehensive treatment programme such as the MBT, they should take advantage of the situation by reducing or ending the antidepressant treatment if possible. This should be done after the treatment is well underway, and the person feels more in control of his/her life. The reason for this is not only that one should learn to deal with life's difficulties without medication, but also because antidepressants have a tendency to blunt emotions. This is particularly true for sexual desire. Accessibility to one's emotions is important in order to get the most out of this treatment programme.

Group activity: Make a note of the experiences you have had with antidepressant medication.

The group leader brings up and discusses the participants' experiences with antidepressants.

The final main topic is *depressive thinking*. The term "depressive thinking" refers to a set of automated thought patterns that tend to accompany a depressed mood and which can establish themselves as part of "normal thinking" after repeated depressive phases or when a depressive state lasts for a long period of time. It refers to thoughts that quickly pop up with content such as "everything is hopeless", "nothing helps", "it's impossible for me", "I am hopeless" etc. Depressive thoughts such as these, which are often the result of adverse life experience, may in themselves sustain a depression or a depressive tendency. The group leader explains that the mentalizing approach to understanding the difficulties of individuals with depression is to view these cognitive distortions as acquiring overwhelming potency because of mentalizing failure. The low mood acts directly on mentalizing capacities, thereby shutting down the mental processes that are needed to recover from the depression. Being able to question fixed negative thoughts is an important part of mentalizing and to recover from depression patients need to begin to mentalize.

Anna Freud Centre

Group activity: Make a note of your own tendency towards depressive thoughts, which you have either experienced in the past or are experiencing now.

The group leader reviews the participants' notes about depressive thinking and underlines that awareness of the nature of one's own thoughts is an important aspect of mentalizing. In addition the leader notes when patients thinking is rigid, fixed, certain, and unquestioned because these qualities suggest non-mentalizing is playing a part in maintaining the depression.

Homework: Make a note if you had depressive thoughts this past week and how you dealt with them. Were you able to stimulate some doubt about them?

12. Session Twelve: Summary and conclusion

The group leader briefly summarizes the last session on depression:

Depression is closely connected to the basic emotions of separation anxiety and sadness
Nature has developed this response system through evolution because it turns out to be beneficial for the relationships between children and their attachment figures.
Loss of attachment figures leads to grief
Strong grief reactions are almost similar to a depressive state.
Other events may trigger grief/depressive reactions, like loss of social esteem or social position, stress or somatic illnesses.
After suffering a first depressive episode, another one becomes more likely. If one has suffered recurrent depressive episodes, or a milder chronic type, often referred to as dysthymia, depressive thinking may have evolved and that in itself may sustain the depression.
Depressive thought patterns indicate a loss of mentalizing.

The group leader then asks if there is anyone who wishes to share their notes from the homework assignment the previous week, and leads the ensuing discussion. This is the last meeting and the group leader makes a decision about how much time he/she can use on the homework. It depends a bit on the group's activity level. It may also be the case that the group leader has put aside a few topics that he/she has not had time to address earlier and that could now be reviewed. The group leader must simply improvise a bit more this last session.

At the appropriate time, the group leader says that they will now spend some time clarifying things that have been discussed during the entire course, but that still may be somewhat unclear to some of the participants. He/she asks if there is anything anyone has on their mind at the moment – something they wish to learn more about, comment on, or discuss further. If nobody brings anything up, the group leader summarizes the subjects that they have been through in the group. He/she starts with the first meeting, about mentalizing, and brings up the main points, including the group exercises. Through this type of reminder, the group members usually get quite involved, both reflecting on what they have been through and wondering about things they may not have fully understood.

Approximately twenty minutes before the end the group leader asks the participants for their feedback:

Group activity: Jot down a few key words about what you think has been particularly educational for you (a topic, a discussion, a homework assignment, an event) in the group.
Make a note of any suggestions you may have for improvements in the programme.

The group leader brings up particularly educational experiences and makes a note of any suggestions for improvements. At the end he/she thanks the members for their active participation and wishes everyone the best of luck on the continuation of their treatment programme.