Mentalization Based Treatment

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

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

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

Dante Cicchetti, Ph.D., McKnight Presidential Chair, William Harris Professor, Institute of Child Development and Department of Psychiatry, University of Minnesota; Editor, Development and Psychopathology

Anthony W. Bateman, M.A., FRCPsych, is Visiting Professor at University College London, Affiliate Professor in Psychotherapy at Copenhagen University, and Consultant to Anna Freud National Centre for Children and Families in London.

Peter Fonagy, Ph.D., FBA, FMedSci, FACSS, is Professor of Contemporary Psychoanalysis and Developmental Science at University College London.

Edited by
Anthony Bateman, M.A., FRCPsych
Peter Fonagy, Ph.D., FBA, FMedSci, FACSS
Exercise – mentalization or mentalizing?

What is mentalization or mentalizing?

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

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

1. The learner’s imagined self narrative

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

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

4. The epistemic match

5. Opening of epistemic channel for knowledge transfer

The informer

The learner
What I don’t like about mentalizing

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

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

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

**COMMON**

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

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

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

- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Past, present, and future
- Introspection for subjective self-construction – know yourself as others know you but also know your subjective self
Mentalizing interactively and emotionally

- Mentalizing interactively
  - Each person has the other person’s mind in mind (as well as their own)
  - Self-awareness + other awareness

- Mentalizing emotionally
  - Mentalizing in midst of emotional states
  - Feeling and thinking about feeling (mentalized affectivity)
  - Feeling felt
Being misunderstood

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

The person….

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

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

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

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

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

- The capacity to mentalize emerges through interaction with the caregiver:
- The quality of the attachment relationship
  - If the parent is:
    - Able to reflect on infant’s intentions accurately
    - Does not overwhelm the infant
  - Then this:
    - Assists in developing affect regulation
    - Helps develop child’s sense of a mind and of a reflective self
Affect & Self Regulation Through Mirroring

Psychological Self: 2nd Order Representations

Physical Self: Primary Representations

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

Constitutional self in state of arousal

Expression → Reflection → Resonance

non-verbal expression

signal

contingent display

expression of understood affect

symbolic organisation of internal state

Infant

CAREGIVER

Fonagy, Gergely, Jurist & Target (2002)

With apologies to Gergely & Watson (1996)
How Attachment Links to Affect Regulation

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

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

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

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

Adverse emotional experience rooted in traumatic relationships → Inhibition of mentalisation

Inaccurate judgements of affect, Delayed development of mentalization understanding, Failure to understand how emotions relate to situations and behavior

Intensification of attachment needs →

DISTRESS/FEAR

Inhibition of mentalisation → Adverse emotional experience rooted in traumatic relationships
Mentalizing subcomponents

The Dimensions
## Multifaceted Nature of Mentalization


<table>
<thead>
<tr>
<th>Implicit-Automatic-Non-conscious-Immediate</th>
<th>Explicit-Controlled-Conscious-Reflective</th>
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<tr>
<td><strong>Mental interior cue focused</strong></td>
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<td>Cognitive agent: attitude propositions</td>
<td>Affective self:affect state propositions</td>
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<td>Imitative frontoparietal mirror neurone system</td>
<td>Belief-desire MPFC/ACC inhibitory system</td>
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- **Implicit-Automatic-Non-conscious-Immediate:**
  - amygdala, basal ganglia, ventromedial prefrontal cortex (VMPFC), lateral temporal cortex (LTC) and the dorsal anterior cingulate cortex (dACC)
  - medial frontoparietal network activated

- **Explicit-Controlled-Conscious-Reflective:**
  - lateral and medial prefrontal cortex (LPFC & MPFC), lateral and medial parietal cortex (LPAC & MPAC), medial temporal lobe (MTL), rostral anterior cingulate cortex (rACC)
  - recruits lateral fronto-temporal network

- **Cognitive agent: attitude propositions**
  - Associated with several areas of prefrontal cortex
  - Associated with inferior prefrontal gyrus

- **Imitative frontoparietal mirror neurone system**
  - frontoparietal mirror-neuron system
  - the medial prefrontal cortex, ACC, and the precuneus

- **Multifaceted Nature of Mentalization**
  - Associated with several areas of prefrontal cortex
  - Associated with inferior prefrontal gyrus

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

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

- **Medial frontoparietal network activated**

- **Recruits lateral fronto-temporal network**

- **Associated with several areas of prefrontal cortex**

- **Associated with inferior prefrontal gyrus**

- **Frontoparietal mirror-neuron system**

- **The medial prefrontal cortex, ACC, and the precuneus**
Implicit-Automatic-Non-conscious-Immediate.

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<td>Impulsive, quick assumptions about others thoughts and feelings not reflected on or tested, cruelty</td>
<td>Unnatural certainty about ideas</td>
</tr>
<tr>
<td>Overwhelming emptiness, Seeking intense experiences</td>
<td>Overwhelming dysregulated emotions, Not balanced by cognition come</td>
</tr>
<tr>
<td>Hypersensitive to others’ Moods, what others say. Fears ‘disappearing’</td>
<td>Hyper-vigilant, judging by appearance.</td>
</tr>
<tr>
<td>Rigid assertion of self, controlling others’ thoughts and feelings.</td>
<td>Evidence for attitudes and other internal states hasto come from outside</td>
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Cognitive agent:attitude propositions

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BPD


Impulsive, quick assumptions about others’ thoughts and feelings not reflected on or tested, cruelty does not genuinely appreciate others’ perspective. Pseudo-mentalizing, Interpersonal conflict ‘cos hard to consider/reflect on impact of self on others.

Unnatural certainty about ideas Anything that is thought is REAL Intolerance of alternative ways of seeing things. Overwhelming dysregulated emotions, Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing.
Prementalizing Modes of Subjectivity

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

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

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

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

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

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

- **Implicit-Automatic**
  - Mental interior focused
  - Cognitive agent: attitude propositions
  - Imitative frontoparietal mirror neurone system

- **Explicit-Controlled**
  - Mental exterior focused
  - Affective self: affect state propositions
  - Belief-desire MPFC/ACC inhibitory system

**Impression-driven**

**Inference-driven**

**Certainty of cognition**

**Sensitivity to others**
Additional Slides

Further information
Ineffective mentalizing – definition and results

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

Ineffective mentalizing

Content

Style
Indicators of ineffective mentalizing – **content**

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

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

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

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

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

- Implicit
  - Perceived
    - Nonconscious
    - Nonverbal
    - Unreflective
      - e.g. mirroring
  - Conscous

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

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

Psychological understanding drops and is rapidly replaced by confusion about mental states under high arousal
Psychotherapist’s demand to explore issues that trigger intense emotional reactions involving conscious reflection and explicit mentalization are inconsistent with the patient’s ability to perform these tasks when arousal is high.
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

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

Torturing alien self

Self representation

Perceived other

Unbearably painful emotional states:
Self experienced as evil/hateful

Self-harm state

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

Self-experienced as evil and hateful

Theory:

Self-destructiveness and Self-destructive relationships

Self (Torturing alien self) → Self representation → Unbearably painful emotional states:
Self experienced as evil/hateful

Perceived other

Externalization

Torturing alien self

Self experienced as hated and attacked

Container

Addictive bond

Self-harm state

Victimized state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops
If someone was causing you pain or simply tormenting you, perhaps not everyday for the whole day, parts of a day, or for days and weeks on end,

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

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

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

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

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

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

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

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

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

Maybe you don’t have a problem anyway.
You are a child, quite possibly you are just making this up for some attention, finding an excuse for why you can’t stay in college or get a job. Maybe you don’t have an excuse, you are just a stubborn little child. From what everyone tells you perhaps that is true.

You have doubt. You are willing to listen to someone else.

For now that is the only reason why you are not, at this moment trying to do it.
Self-experienced as evil and hateful

**Externalisation & Violence Following Trauma**

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death, the violent act protects against experience of intrusion and addictive bond and terror of loss of abused object can develop.
Overview of the MBT model: Key Domains
Higher Order Representation

Us/We Representation
# Domains of MBT

<table>
<thead>
<tr>
<th>General Domains</th>
<th>Major Component Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can be evaluated by viewing a whole session</td>
<td>Can be evaluated on the basis of the therapist’s interventions</td>
</tr>
<tr>
<td>Two general core domains</td>
<td>Four major component domains</td>
</tr>
<tr>
<td><strong>1- Sessional Structure</strong></td>
<td><strong>3- Mentalizing Process</strong></td>
</tr>
<tr>
<td><strong>2- Not-Knowing Stance</strong></td>
<td><strong>4- Non-Mentalizing Modes</strong></td>
</tr>
<tr>
<td>Both general domains provide the basis for delivering MBT</td>
<td><strong>5- Mentalizing Affective Narrative</strong></td>
</tr>
<tr>
<td>Impossible to focus work on mentalizing without the two core elements</td>
<td><strong>6- Relational Mentalizing</strong></td>
</tr>
<tr>
<td></td>
<td>A typical MBT session involves interventions within these 4 domains</td>
</tr>
<tr>
<td></td>
<td>MBT therapist will train on skills to deliver each type of intervention</td>
</tr>
</tbody>
</table>
Domains of MBT

Not-Knowing Stance
- Mentalizing Process
- Mentalizing Affective Narrative

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

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

Safe in Low Anxiety

High Anxiety
Interventions: Spectrum

- **Supportive/empathic**
- Clarification, elaboration, challenge
- Basic mentalizing – affect and affect focus
- Relational Mentalizing
(1) Structure of Mentalization Based Treatment

Core Domain
Trajectory of Treatment

Assessment and assessment of mentalizing

Giving Diagnosis

Formulation

Crisis Plan and risk assessment

Contracting including barriers to treatment

Outcome monitoring

MBT-I

MBT
Crisis Plans

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

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

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

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

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

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

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

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

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

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

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

- Current aims
- Vulnerability factors – distal and proximal
- Crisis Plan and Risk – separate from formulation
- Mentalizing profile – common mentalizing modes; dimensional profile
- Relationships – attachment strategies
- Treatment
Examples of Formulation
**Current Aims**
Your aims are to go out more and stop avoiding other people. Your concern is that you spend too much time alone, you are lonely, and you start thinking that people are against you.
Reduce arguments with other people.

**Vulnerability factors**
You were unable to trust anyone when you were a child. You experienced abuse and there was no one who cared about you.
By the time you were 12 you started smoking and drinking.
Formulation

Crisis Plan

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

Mentalizing profile

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

**Relationships**

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

_Treatment_
You think that you will come to the group but are naturally anxious that people will not like you. Your tendency will be to avoid this and even not come to the group. We will explain this to the group when you start.
Story formulation (for a child)

Once there was a little turtle. When he hatched he raced down the beach, excited to get into the water. He thought the waves would treat him gently, but instead they threw him about. He had to hide in his shell because every time he came out, the waves would throw him about again. When he hid, he felt safe. He wished the bigger turtles would protect him and help him to swim better, but they often left him on his own, which he felt sad about. He moved between different turtle families, but none of them helped him learn to swim. And because he hid so often, none of the other sea creatures knew that he struggled so much. The poor turtle learned to survive on his own in his shell.
MBT-Introduction (MBT-I)
Psychoeducation for BPD

Manual available in Practical Guide
Handouts:
MBT-I Structure

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

**Exercises**

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

- Introductions
- Details of group times, duration, structure etc
- Rules of group (eg confidentiality, alcohol)
- Information sheet provided

Topics
- Personality structure
- Emotions, cognitions, behaviours
- The interpersonal realm
Structure of each session

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

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

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

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

Core Domain
Therapist Stance

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Over and under arousal are antithetical to robust mentalizing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High arousal</strong></td>
</tr>
<tr>
<td>Empathic validation of patient perspective</td>
</tr>
<tr>
<td>Move affective pole to cognitive pole</td>
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<tr>
<td>Move self to other mentalizing</td>
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<tr>
<td>Reduce focus on personal interaction</td>
</tr>
<tr>
<td>Clinician responsibility</td>
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</tbody>
</table>
Imbalance of mentalization generates problems

<table>
<thead>
<tr>
<th>Implicit-Automatic-Non-conscious-Immediate</th>
<th>Explicit-Controlled-Conscious-Reflective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental interior cue focused</strong></td>
<td><strong>Mental exterior cue focused</strong></td>
</tr>
<tr>
<td>Lack of conviction about own ideas</td>
<td>Hyper-vigilant, judging by appearance.</td>
</tr>
<tr>
<td>Seeking external reassurance</td>
<td>Evidence for attitudes and other internal states hasto come from outside</td>
</tr>
<tr>
<td>Overwhelming emptiness, Seeking intense experiences</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cognitive agent:attitude propositions</th>
<th>Affective self:affect state propositions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnatural certainty about ideas</td>
<td>Overwhelming dysregulated emotions, Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing</td>
</tr>
<tr>
<td>Anything that is thought is REAL</td>
<td></td>
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<tr>
<td>Intolerance of alternative ways of seeing things.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Imitative frontoparietal mirror neurone system</th>
<th>Belief-desire MPFC/ACC inhibitory system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypersensitive to others’ Moods, what others say. Fears ‘disappearing’</td>
<td>Rigid assertion of self, controlling others’ thoughts and feelings.</td>
</tr>
</tbody>
</table>
## Theory to Practice: Contrary Moves

<table>
<thead>
<tr>
<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>External focus</td>
<td>Internal focus</td>
</tr>
<tr>
<td>Self- reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
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<tr>
<td>Cognitive</td>
<td>Affective</td>
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<tr>
<td>Explicit</td>
<td>Implicit</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
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</tbody>
</table>
Process of Rewind and Exploration

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

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

**Process**
- ‘Stop, Listen, Look’
- Stop, Re-wind, Explore
- Stop and Stand
- Affect and Interpersonal regulation in session

**Intervention**
- Empathy
- Clarification
- Exploration
- Challenge
- Affect identification
- Affect Focus
- Interpersonal
Empathic Validation:
Underpinning mentalizing process
Empathic Validation – Affect and Effect

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

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

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

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

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

Note: The measure of an effective intervention is that it results in a strengthening of the therapeutic alliance
Interventions: Supportive & empathic

- **Identifying and exploring positive mentalizing**
  - judicious praise – ‘you have really managed to understand what went on between you. Did it make a difference’.
  - Examine how it feels to others when such mentalizing occurs – ‘how do you think they felt about it when you explained it to them
  - Explore how it feels to self when an emotional situation is mentalized – ‘how did working that out make you feel’

- **Identifying non-mentalizing fillers**
  - Fillers: typical non-mentalizing thinking or speaking, trite explanations
  - Highlight these and explore lack of practical success associated with them
Ineffective mentalizing and low level of mentalizing
(4) Addressing Non-Mentalizing Modes

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

## PSYCHIC EQUIVALENCE

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

Patient and therapist Notice and Name Psychic Equivalence

Re-visit if mentalizing returns

Checking Do not argue

Sensitively move exploration

Diversion To Linked Exploration

Clinician
### Modes of non-mentalizing

<table>
<thead>
<tr>
<th><strong>TELEOLOGICAL MODE</strong></th>
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<tbody>
<tr>
<td><strong>Clinical form</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Therapist experience</strong></td>
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<tr>
<td><strong>Intervention</strong></td>
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<tr>
<td><strong>Iatrogenic</strong></td>
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</table>
The MBT Loop

- **Patient and therapist**
  - Notice and Name
  - Teleological Understanding

- **Clinician**
  - Empathises with intensity of experience
  - Checking
  - Do not argue

- **Diversion**
  - Re-visit if mentalizing returns
  - Sensitively move exploration

- **Clinician**
  - Concern about having to ‘act’ to demonstrate painful mental states. Or action restricting understanding of others mental states

- **Diversion**
  - To clinician concern about having to ‘act’ to demonstrate painful mental states. Or action restricting understanding of others mental states
## Modes of non-mentalizing

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

**Therapist experience**

- Boredom
- Detachment
- Patient agrees with your concepts and ideas
- Identification with your model
- Feels progress is made in therapy

**Intervention**

- Probe extent.
- Current in-session focus
- Counter-intuitive
- Challenge

**Iatrogenic**

- Non-recognition
- Joining it with acceptance as real
- Insight orientated/skill acquisition intervention
Challenge

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

- Counter-intuitive statements – low level

- Therapist emotional expression to re-balance patient emotional expression – moderate level

- Mischievous or Whacky comments – high level
Low level challenge for fluctuating pretend mode

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

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

Narrative of event → Experience at time → Reflection on events

Alternative perspective → Experience talking about it in therapy → Current feeling about events
Intervention:
Clarification & Affect elaboration

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

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

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

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

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

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

- If someone else was in that position what would you tell them to do
Affect
and
implicit sessional interaction
Affect Focus: Making implicit mentalizing explicit

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

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

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

Major Component Domain
Challenge / Relational Mentalizing / Transference markers / Intervention Algorithm for self-harm / Mentalizing Functional Analysis
Challenge

A precursor of relational mentalizing
Challenge and relational process

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

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

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

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

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

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

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

**Transference tracers – always current**

- Linking statements and generalization
  - ‘That seems to be the same as before and it may be that..
  - ‘So often when something like this happens you begin to feel desperate and that they don’t like you’

- Identifying patterns
  - It seems that whenever you feel hurt you hit out or shout at people and that gets you into trouble. May be we need to consider what happens.

- Making transference hints
  - I can see that it might happen here if you feel that something I say is hurtful

- Indicating relevance to therapy
  - That might interfere with us working together
Components of mentalizing the therapeutic relationship

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

Dangers of using the relationship

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

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

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

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

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

- **Psychic equivalence**
  - Puzzlement, confused, unclear, excessive nodding
  - Not sure what to say, just going
  - Anger with the patient
Guidance on intervention for self-harm
Self-harm

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

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

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

- **Failure of mentalization ➔**
  - Psychic equivalence ➔ intensification of unbearable experience ➔
  - Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔
  - Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting
Current 'inurmountable' mental challenges

- Excessive demand for excellence
- Becoming adult
- Rejection

Disruption of mentalization

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

The Disorganised Self

- PSYCHIC EQUIVALENCE
- PRETEND MODE
- TELEOLOGICAL SOLUTIONS

Self Harm/Violence to Restabilise Disorganized Self

Adverse parenting

History of physical maltreatment

CSA
Step-wise Intervention

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

Self-Harm/Suicide

No agreement to explore
- Explore difficulty of talking about events
  - Psychic Equivalence
  - Restore mentalizing
- Affect focus the shared problem Elephant in Room
- Counter-relationship presentation

Collaborative agreement to explore
- Mentalizing functional analysis
- Rewind to point of mentalizing
Mentalizing Functional Analysis

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

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

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

- **DO NOT**
  - mentalize the relationship in the immediacy of a suicide attempt or self-harm
  - Interpret the patient’s actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the ‘heat’ of the moment. It will alienate the patient.
Mentalizing and Group Psychotherapy
Mentalizing and Groups

Two types of groups

MBT Group

MBT- I
MBT Group

- Primary task of the group is to provide a training ground for mentalization
- Based on fusion of group process and interpersonal therapy groups
- Interpersonally directed by clinician
- Clinician maintains authority of group process
Why a change in emphasis in groups for severe PD?

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

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

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

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

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

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

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

- Developed by clinicians in post-group discussion
- Develop culture of patient contribution
- Includes examples of successful mentalizing
- Identifies self-other mentalizing problems
- Maintains over-arching themes
Mentalizing Group

Clinical stance and managing process
MBT-G: Clinician Authority

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

- Manage process:
  - Not allowing non-mentalizing to escalate
  - Stopping the group process when it is off task or is missing important opportunities for mentalizing exploration in the here and now
  - Initiating careful step for step explorations of crucial intersubjective transactions
  - Demonstrating and explaining the primacy of the here and now.
MBT-G: Clinician Stance

- Maintain clinician mentalizing
- Maintain focus and do not allow persistent non-mentalizing dialogue
- Monitor arousal levels and non-mentalizing modes, beware hypermentalizing
- Work in current mental reality when possible
- Model mentalizing
MBT Group

- Attention to implicit-explicit dimension of mentalizing
- Intervene when there is an opportunity for, or need for, mentalizing work.
- Actively promote group interaction
- Principle of ‘No Advice Given’ – Explain carefully!
Mentalizing Group: Generic techniques
Facilitating epistemic trust in group

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

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

Narrative of event → Experience at time → Reflection on events from others

Alternative perspective ← Experience talking about it in therapy ← Current feeling about events from patient and others
Mentalizing interaction and affect

Statement of current emotional state of self or other

Identify emotion and explore its ‘granularity’

Identify how self or other picked up the feeling

Jointly contextualise the feeling in patient

Check out if their external focus and description is congruent with patient internal feeling

Alternative perspective
Powerful emotion

Inability to understand or even pay attention to feelings of others

Others seem incomprehensible

Frightening, undermining, frustrating, distressing or coercive interactions

Try to control or change others or oneself

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

Person 1

Poor mentalising

Inability to understand or even pay attention to feelings of others

Others seem incomprehensible

Frightening, undermining, frustrating, distressing or coercive interactions

Try to control or change others or oneself

Person 2

Poor mentalising

Inability to understand or even pay attention to feelings of others

Others seem incomprehensible

Powerful emotion
The MBT Loop

- Notice And Name Interpersonal interaction
- Generalise (and Consider Change)
- Mentalize The Moment Between patients
- Checking
Clarification of problem

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

- Encourage patients to articulate explicitly what would otherwise be privately ascertained/assumed about mental states of others.

- Support patients to make explicit their working through of story (detail) so that rest of group (clinician and patients) can identify when mentalizing and non-mentalizing has occurred.
Mentalizing the moment

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

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

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

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

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

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

- **Active** stance (very active at times!)
- **Collaborative**
- **Exploratory**
- Able to take control when needed
- ‘Stop’ ‘Rewind’ and ‘Consider’ early when evidence of non-mentalizing in group
- Talk to co-therapist and question them if present
- Participate using concordant affective experience
RFQ web address

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

For further information
anthony@mullins.plus.com

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