

A Quality Manual for MBT

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This manual is not a new clinical manual for Mentalization Based Treatment (MBT). Readers who are interested in the specifics of MBT, its theoretical background, treatment approach and intervention spectrum are referred to the practical guide. The aim of this manual is somewhat different. It is a map to guide practitioners who wish to develop MBT skills and become supervisors in MBT. It provides an outline against which organisations can assess their MBT services. It offers a guide to establish, monitor and improve the quality of MBT in daily practice. It will describe in a series of chapters the necessary competencies of therapists, supervisors and programmes to possible supposed working mechanisms of MBT, while decreasing potentially harmful processes. Both are supposed to help in successfully implementing MBT. Further, this manual also offers a dynamic perspective on quality control. It not only describes necessary competencies and skills – assumed to contribute to the quality of MBT treatments - but will also show you how the quality of MBT therapists, supervisors and programs can be monitored and improved in clinical services. To do so, the manual introduces a multi-level approach on adherence, which will be introduced in chapter 1. In this chapter, the basic concepts of the quality monitoring approach will be discussed. We will briefly introduce MBT, with a focus on the supposed working mechanisms and treatment principles and we will introduce this multi-level perspective on treatment integrity. The following chapters will elaborate each aspect in more detail. Chapter 2 will translate the treatment principles to interventions and competencies at the level of the therapist, while chapter 3 will do the same at the level of the supervisor. Chapter 4 will discuss the implementation of the treatment principles in a complete programme. The focus of chapter 5 is on the organisational development of a new programme, while chapter 6 introduces the Quality monitoring system, now being developed. This chapter describes the development of a series of instruments, designed to monitor adherence at each relevant systemic level. The final chapter, chapter 7, describes accreditation and requirements for MBT-therapists and programs.

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Chapter 1: Introduction to the Quality system for MBT

This chapter introduces the Quality system by briefly introducing MBT (1.1.) and discussing how MBT is distinct from other psychotherapeutic approaches for borderline personality disorder (1.2.). Focus is on outlining the core treatment principles of MBT (1.3.). In a last paragraph, the organisation of this quality manual is linked to the general aim of being adherent to these treatment principles (1.4.).

1.1. What is MBT?

MBT is an evidence-based treatment approach, initially developed and investigated for the treatment of adults with borderline personality disorder. It is by no means a novel approach although it has some distinct components. Its origins lie in psychodynamic psychotherapy and, in its original format for borderline personality disorder (BPD), was organised as a combination of group and individual psychotherapy. More recently it has been developed in different formats for other groups of patients. The MBT approach is based on a view that a core problem for many patients, emblematically those with BPD, is their vulnerability to a loss of mentalizing. This vulnerability develops within the early attachment relationships and becomes associated with interpersonal sensitivity which triggers dysregulated emotions and impulsivity.

Mentalization based treatment is, to put it succinctly, a therapy that places mentalizing at the centre of the therapeutic process. It is a therapy not defined primarily by a clustering of specific and related techniques but more a therapy defined by the process that is stimulated in therapy. At the core of MBT is the argument that MBT works through establishing an enduring attachment relationship with the patient while continuously stimulating a mentalizing process in the patient. Its aim is to develop a therapeutic process in which the mind of the patient becomes the focus of treatment. The objective is for patients to find out more about how they think and feel about themselves and others, how those thoughts and feelings influence their behavior, and how distortions in understanding themselves and others lead to maladaptive actions, albeit intended to maintain stability and manage incomprehensible feelings. It is not the therapist's job to tell patients how they feel, what they think, or how they should behave—or to explain the underlying conscious or unconscious reasons for their difficulties to them. On the contrary, we believe that any therapy approach that moves towards *knowing* how patients are, how they should behave and think, and why they are like they are, is likely to be harmful. Therapists must ensure that they hold to an approach that focuses on the mind of their patients as they experience themselves and others at any given moment. The spirit of this approach is what we have endeavoured to capture in the phrase, the mentalizing stance, that is, one of inquisitiveness, curiosity, open-mindedness and, ironically, not-knowing. Inevitably this requires a modesty and authenticity on the part of the MBT therapist.

The treatment's basic aim is to re-establish mentalizing when it is lost and maintain mentalizing when it's present. Therapists are expected to focus on the patient's subjective sense of self. To do so they need to a) identify and work with the patient's mentalizing capacities; b) represent internal states in themselves and in their patient; c) focus on these internal states; and d) sustain this in the face of constant challenges by the patient over a significant period of time. In order to achieve this level of focus, mentalizing techniques will need to be a) offered in the context of an attachment relationship; b) consistently applied over time; c) used to reinforce the therapist's capacity to retain mental closeness with the patient. The treatment is manualized to facilitate the achievement of these primary goals. The manner in which we have organized MBT ensures a felicitous context for therapists and patients to focus their work in these ways and to concentrate on mentalization techniques whilst avoiding harm to a group of patients who may be particularly vulnerable to the negative effects of psychotherapeutic interventions. MBT for BPD was the first programme to be developed. It was only novel in the way that the components were woven together and in the rather dogged manner in which the therapist was exhorted to enhance mentalizing. It is the latter which remains the single most important factor distinguishing mentalizing therapies from other psychotherapies.

1.2. How is MBT different from other psychotherapeutic approaches for BPD?

The aim of a mentalizing therapy has to be to enhance a mentalizing process, irrespective of the context in which it is being delivered. The mentalizing therapist is not engaged in cognitive restructuring, he is not working to provide insight and he does not attempt to alter behaviour directly. The focus is on mental

processes. It is inaccurate to state that cognitive and behavioral changes do not happen in MBT or that patients in a mentalizing therapy do not recognize underlying meanings or identify reasons why they are as they are. The evidence is there that these things do occur, but the changes occur almost as an epiphenomenon. They are consequences of the change in mentalizing, rather like positive side-effects.

MBT is not an insight oriented therapy. It does not focus on understanding unconscious determinants of mental life. It does not emphasize causal correlations between events of the past and the present. It is not a cognitively focused therapy. There is no emphasis on abnormal cognitions as a primary determinant of symptoms. Technically it is more pluralistic and accommodating than either dynamic or cognitive therapy to the extent that any technique used in the service of improving mentalizing within the context of attachment relationships is permitted.

MBT differs from other therapies in a number of other respects but inevitably has many similarities to dynamic and cognitive therapies. There are some key areas that separate MBT from these therapies:

1. Developmental theory
2. Treatment theory
3. Treatment organisation
4. Focus of treatment
5. Training requirements

Detailed discussion about these aspects of MBT can be found in the many publications on the subject. A summary of the research and associated papers can be found by following this link ([UCL Website research papers](#)). This document is primarily concerned with developing a quality system and identifying key components of training and education.

1.3. The MBT treatment principles

MBT is supposed to be most effective when it succeeds in creating an attachment relationship between the patient and the therapist, team, and even programme or institution. Within the context of this developing attachment relationship, the therapist(s) stimulates the patient to keep being involved in a mentalizing process, exploring each other's minds, while the therapist retains mental closeness. In doing so, the therapist(s) stays attuned to the mentalizing abilities of the patient by helping him/her to regulate affects and by offering alternative perspectives for his/her experiences. These processes happen within a safe and reliable environment, generated by a consistent and coherent approach of the team.

The core treatment principles can be inferred from this brief.. Two major goals are 1) the establishment of a safe attachment environment and 2) the stimulation of a mentalizing process. The following treatment principles can be derived from this basic view (they are not meant to be exhaustive, but rather are more concrete operationalizations of some basic requirements for effective therapy).

- High level of structure.
- Consistent, coherent and reliable approach.
- Focus on (attachment) relations.
- Focus on mentalizing process.
- A process-oriented and goal-focused approach in treatment.

Any MBT-approach should be guided by these core principles. They create a sort of meta-framework for an MBT-programme. While keeping the goals and themes for a particular patient in mind, the MBT therapist should focus on the process of mentalizing within the relationship with the patient, which is in turn embedded in a reliable and predictable environment, characterized by a clear structure and a consistent team. To do so requires the collaborative effort at three systemic levels: individual therapists, team, and

programme/institution. For example, the institution should help the team to create a predictable and reliable environment in which the team can work. If a team does not get the support of the organization to create a reliable environment, for example by cutting budgets without discussion, it won't succeed in its mission. And if a team is split and is not able to offer a consistent approach, the efforts of the individual therapists to involve the patient in a mentalizing process will be doomed to fail. The implication involved herein, is that the core treatment principles should be translated at each of the identified levels, involved in treatment. Treatment integrity requires competence and adherence at the level of individual therapists, teams and programs or institutions. This quality manual essentially deals with improving and maintaining treatment integrity at each level. In the last paragraph of this introductory chapter, we will discuss this more in detail.

1.4. A quality manual to establish, monitor and improve treatment integrity.

We can assume that the better therapists, teams and programs succeed in meeting these principles, the better the outcome of their treatment will be as the underlying working mechanisms are maximized. This refers to the concept of treatment integrity. Treatment integrity is usually used within the context of research, referring to the need to establish that the intended treatment is also the performed treatment. The concept involves three aspects: treatment adherence, therapist competence and treatment differentiation (Perepletchikova & Kazdin, 2005). Adherence refers to the degree of utilization of specified procedures by the therapist. Competence refers to the level of skill and judgment shown by the therapist in delivering the treatment. Differentiation refers to whether treatments under investigation differ from each other along critical dimensions. In short, treatment integrity classically refers to 'good therapists', i.e., therapists having the skills (competence) to perform the procedures as prescribed by the treatment manual (adherence). Based on our experiences with implementing MBT, we propose to extend the concept to include also adherence and competence at the level of teams and programs or institutions. Especially in cases of the implementation of complex, innovative interventions for highly challenging patient groups, the reduction of the concept of treatment integrity to therapist adherence and competence might severely underestimate the influence of organisational and team issues in acquiring treatment integrity for such programs.

Accordingly, the aim of this manual is to describe, assess and improve the essential aspects of treatment integrity at the level of individual therapists, teams and programs. This requires a translation and concretization of the different core principles at each level, if relevant, which will be the content of the next chapters. For example, at the level of the individual therapist, Karterud and Bateman previously described 17 intervention principles (see chapter 2). These intervention principles are the concrete manifestations of the treatment principles at the therapist level. More specifically, they mainly further concretize the treatment principles of 'focus on attachment relations' and 'focus on mentalizing process'. At the level of the team, the treatment principles return in a similar way. The team approach should be consistent, reliable, and integrated. Communication should be effective, and the team should try to adopt and maintain a mentalizing stance towards patients and towards each other. This last example shows that the core principle of 'focus on mentalizing process' also returns in the team approach. Finally, at the level of the organization, the principles return in the efforts of an organization to provide a reliable, clearly structured, and supportive environment. What's important at team level – a high level of structure combined with a consistent and reliable approach – is also important at organizational level.

To put it briefly, the quality system for MBT describes how your service can implement MBT by offering a step-by-step approach, outlining relevant clinical processes, identifying pitfalls, and offering a philosophy of monitoring outcome and adherence at different level. It offers supportive protocols for introducing MBT in your institution and introduces an empirically informed approach to the clinical process and to the supervision of treatment integrity.

The remainder of this book will elaborate this further. Chapter 2 will demonstrate how the treatment principles guide the designing of a treatment framework and of the clinical processes within a MBT programme. Chapter 3 will discuss the competencies related to the therapist while chapter 4 does the same for the supervisor. Chapter 5 will illustrate how these principles return in the organisational and managerial implementation of a new programme. Finally, chapter 6 illustrates how treatment integrity should also be monitored in clinical practice, giving opportunities to detect flaws in treatment integrity at each level.

Chapter 2: The MBT Therapist: competences and skills

In this chapter we will elaborate the individual competences required to be an effective MBT therapist who practices safely. They are organized in this chapter according to overarching competency areas, covering the identified therapeutic principles. Therefore, we will first outline the treatment principles relevant for the individual therapist (2.1.). In the second paragraph, competencies are described belonging to each of the competency areas (2.2.). The competences discussed in this chapter mainly refer to the capacity to stay attuned to the therapeutic process in MBT. An overview is listed in the last paragraph (2.3.).

2.1. Individual therapist treatment principles and associated competency areas.

The individual therapist should be able to keep the patient involved in a mentalizing process while staying mentally close to the patient within the context of a developing attachment relationship. At the level of the individual therapist, the treatment principles consider mainly the focus on relationships (including mentalizing the transference/relationship), the stimulation of a mentalizing process (including a focus on affects) and the keeping of a process and goal-oriented approach. In chapter 1 we referred to earlier work of Karterud and Bateman to concretize these principles more in detail. These authors mentioned 17 aspects of the therapeutic stance and interventions. These are:

1. Engagement, interest, warmth and authenticity
2. Exploration, curiosity and a not-knowing stance
3. Challenging unwarranted beliefs
4. Adaptation to mentalizing capacity
5. Regulation of arousal
6. Stimulating mentalization through the process
7. acknowledging positive mentalizing
8. Pretend mode
9. Psychic equivalence
10. Affect focus
11. Affect and interpersonal events
12. Stop and rewind
13. Validation of emotional reactions
14. Transference and the relation to the therapist
15. Use of countertransference
16. Monitoring own understanding and correcting misunderstanding
17. Integrating experiences from concurrent group therapy

These intervention principles refer to 7 competency areas:

1. Not-knowing, genuine and inquisitive therapist stance
2. Support and empathy
3. Clarification
4. Exploration
5. Challenge
6. Affect focus
7. Relationship

In the following paragraph, we will describe each of these competency areas more in detail. For each area, specific competences will be detailed and the link to Karterud and Bateman's Adherence and Competence Scale will be made.

2.2. Competencies of MBT therapist

2.2.1. Not-knowing, genuine, and inquisitive therapist stance

The competency area of **therapist stance** requires the following competences from an MBT therapist:

- An ability to communicate with the client in a direct, authentic, transparent manner, using simple and unambiguous statements so as to minimize the risk of over-arousing the client.
- An ability to adopt a stance of 'not knowing' which communicates to the client a genuine attempt to find out about their mental experience.
- An ability to sustain an active, non-judgmental mentalizing stance that prioritizes the joint exploration of the client's mental states.
- An ability to communicate genuine curiosity about the client's mental states through actively enquiring about interpersonal processes and their connection with the client's mental states.
- An ability to follow shifts and changes in the client's understanding of their own and others' thoughts and feelings.
- An ability to become aware of and respond sensitively to sudden and dramatic failures of mentalization in the client.

The basic therapist stance is one of authenticity, genuineness and openness, with the therapist being able to take a not-knowing position. In MBT the therapist takes an inquisitive, active and exploring stance towards the subjective experience of the patient, preventing him from ruminating, but instead helping him to focus on the details of his experience.

Patients with BPD have an external focus and are heavily reliant on facial expression, tone of voice, and body movement, for example. Acting on these cues rather than using them to explore internal mental states, they are compromised in their interpersonal interaction. The MBT therapist ensures that his responses are unambiguous and not easily open to misinterpretation by making them straightforward, sometimes even by using a slight exaggeration of reaction appropriate to the circumstance. He does not limit excessively the external cues given to the patient and maintains a frankness about his own states of mind in relation to the patient or the subject matter.

Further, the MBT therapist does not act for the patient but remains alongside him, helping him explore areas of uncertainty and encouraging him to live with doubt. The therapist needs to keep an image in his mind of two people looking at a mental map, trying to decide on which way to go; although they may have agreed on the final destination in a formulation, neither party knows the route or what obstacles or help they will meet on the way. Indeed, there may be many ways to reach the same destination. In taking this position the MBT therapist demonstrates that he is seeing things from the perspective of the patient; he takes the patient's subjective experience seriously. To aid this stance he uses a range of interventions in the service of increasing the patient's mentalizing capacities.

The competency to take a not-knowing stance while exploring the subjective experience is the key to effective treatment. Your position is one in which you attempt to demonstrate a willingness to find out about your patient, what makes him 'tick', how he feels, and the reasons for his underlying problems. To do this you need to become an active questioning therapist discouraging excessive free association by the patient in favor of detailed monitoring and understanding of the interpersonal processes and how they relate to the patient's mental states. When you take a different perspective to the patient this should be verbalized and explored in relation to the patient's alternative perspective with no assumption being made about whose viewpoint has greater validity. The task is to determine the mental processes which have led to alternative viewpoints and to consider each perspective in relation to the other, accepting that diverse outlooks may

be acceptable. The therapist's mentalizing therapeutic stance should include: (a) humility deriving from a sense of 'not-knowing', (b) authenticity about curiosity of states of mind in self and the patient (c) patience in taking time to identify differences in perspectives, (d) legitimizing and accepting different perspectives, (e) actively questioning the patient about their experience -- asking for detailed descriptions of experience ('what questions') rather than explanations ('why questions'), (f) careful eschewing of the need to understand what makes no sense (i.e. saying explicitly that something is unclear).

While exploring the patient's subjective experience, the MBT therapist communicates a non-judgmental attitude by being interested in all aspects of the patient's experience, by being open-minded, and by retaining a focus on exploration of mental processes without suggesting that they are wrong. In addition, the MBT therapist will question the patient when he dismisses thoughts and feelings about himself and others and challenge judgments the patient makes about himself.

MBT assumes interpersonal sensitivity to be a core feature of BPD. Exploring the interaction between interpersonal events and mental processes therefore becomes essential if the patient is to pay increasing attention to the influence of relationships on his mental states. The aim is to bring rapidly changing mental states to the attention of the patient and to consider their interpersonal precipitants not so much to help the patient 'manage' the other person but more to help him manage his own feelings before they become uncontrollable. The capacity of the MBT therapist to track the movements of the patient's mental states is crucial and yet tiring for both patient and therapist. The therapist needs to respect this. But for his part it requires rigorous concentration and focus and an ability to recognize rapidly that a mental move in the patient makes no sense to him and yet seems to do so to the patient. Capturing these moves of the patient's mental processes sensitively without distorting the session and interrupting the dialogue allows the patient to feel respected and taken seriously.

Examples of non-mentalizing are given in Appendix X. Dramatic failures are often context dependent, occurring suddenly when a particular topic is probed. The therapist is alert to changes in mentalizing and at a moment when the patient's mentalizing collapses the therapist needs to calm the situation and rewind to a point before the collapse when the patient was able to mentalize. In doing so the therapist can explore delicately the mental processes, including the affects, that may have contributed to the sudden failure in mentalizing.

This competency area is covered by the following items of the Adherence and Competence Scale:

Item 1: Engagement, interest and warmth
Item 2: Exploration, curiosity and a not-knowing stance
Item 13: Validation of emotional reactions
Item 11: Affect and interpersonal events

2.2.2. Support and Empathy

The competency area of **support and empathy** requires the following competences from an MBT therapist:

- An ability to establish and maintain a supportive, reassuring and empathic relationship with the client.
- An ability to sustain a positive, supportive stance without undermining the client's autonomy.
- An ability to critically consider the appropriateness of supportive interventions that may involve taking concrete action within therapeutic boundaries.
- An ability to judiciously praise the client when the client uses mentalizing with a positive outcome so as to encourage and support change.

Empathic statements deepen the rapport between patient and therapist and give the patient a sense that the therapist is on their side. But accurately reflecting underlying emotional states may be more problematic in treatment of borderline patients than in others. Borderline patients cannot readily discern their own subjective state and they cannot benefit from being told how they feel. In MBT empathy is not

solely stating the feeling expressed by the patient as the therapist sees it – ‘you feel so hurt by him’, ‘you must have been so angry about that’. It is more an identification of the current feeling of the patient in relation to the subject – ‘what is it like to feel so vulnerable to what he does’, ‘how did you manage such a strong feeling’. So empathy becomes not only the patient’s feeling at the time *but also the effect that the feeling has on him*. Feelings invoke a state of mind and, depending on the feeling, the ramifications may be complex. It is the task of the practitioner to identify both the feeling itself and the psychological consequences. Ask yourself – ‘how does having this feeling leave the person now whilst talking to me? What effect is it having on his interaction with me?’.

If a patient does not know how they feel the MBT empathic stance is ‘oh dear I imagine that it must be really nervy not to know how you feel a lot of the time’. You must refrain from telling the patient what they are saying or what they are ‘really feeling’; the danger is for the therapist to take over the description of the patient’s emotional states as they empathize. Some examples of proscribed statements in MBT commonly given in therapies are listed in Appendix 5.

The MBT therapist fosters the patient’s ability to remain autonomous and responsible for finding solutions. Practical guidance is not routinely given although if an obvious solution is apparent, but the patient is seemingly blind to it, the therapist may bring this to the patient’s attention to consider why the obvious is being missed. Support comes through being respectful of the patient’s narrative, with positive and hopeful questioning. The therapist demonstrates a desire to know and to understand, constantly checking back his understanding. The therapist and patient tease out the detail of the emotional impact of a narrative basing it on common sense psychology and personal experience. At times the MBT therapist will also ‘do’ something for the patient. Patients with BPD who are functioning in psychic equivalence will only experience support through teleological physical outcomes. Something has to be done in the physical world as proof of the therapist’s support. This can range from writing a letter on behalf of the patient to visiting them at home to demonstrate continuing concern about their welfare.

Appropriate use of praise creates a reassuring atmosphere within therapy and positive attitudes from the therapist are commonly used to instill hope and to suggest a pathway for change. We do not suggest that the MBT therapist is unwaveringly positive but that he expressly recognizes when a patient has used mentalizing with positive results. The principle to follow is: use praise judiciously to highlight positive mentalizing and to explore its beneficial effects. For example, the therapist emphasizes how the patient has understood a complex interpersonal situation and examines how this helps him not only to understand how he felt but also to recognize the other person’s feelings, all of which are to the benefit of the interaction. Examples include statements such as ‘that is really impressive, you have really managed to understand what went on between you’. The therapist explores the detail from a perspective of self and other - ‘how did working that out make you feel’; ‘how do you think they felt about it when you explained it to them’.

This competency areas is covered by the following items of the Adherence and Competence Scale:

Item 4: adaptation to mentalizing capacity
Item 5: Regulation of arousal
Item 7: acknowledging positive mentalizing.

2.2.3. Clarification

The competency area of **clarification** requires the following competences from an MBT therapist:

- An ability to respond to requests by the client for clarification in a direct and clear manner that models a self-reflective stance open to correction.
- An ability to use clarification and elaboration to gather a detailed picture of a behavioral sequence and associated feelings.
- An ability to help the client make connections between actions and feelings.

- An ability to clearly restate and elaborate for the client the therapist's understanding of thoughts, feelings, beliefs and other mental states described by the client and to do so in a way that opens discourse about these rather than closing it off.

The competence to respond to requests in a direct and clear manner links with the overall competence of appropriate self-disclosure. The MBT therapist answers direct questions in a manner that openly demonstrates a self-reflective stance. This applies even if the therapist does not know the answer to the question or feels uncomfortable about answering the question. In these circumstances the MBT therapist explores his own state of mind 'in front' of the patient – 'I am not sure what the answer is to that question and yet I can see that I could be expected to do so'; 'There is something in the question that makes me uncomfortable about answering you. I am not sure what it is. Can we consider it for a moment?' The therapist then needs to consider his discomfort. In less difficult circumstances the therapist clarifies his current state of mind for the patient in relation to the topic.

Actions should always be traced to feelings whenever possible by rewinding the events and establishing the moment by moment mental processes leading to an action. In elaboration the therapist should be alert to any failures of the patient to 'read minds' or to understand his own mind and when this is apparent in the story, he should question it and seek an alternative understanding of the failed mentalization. Open questions, re-stating facts, and focusing on moment-to-moment events are common clarification techniques. Each component needs to be elaborated in detail. It is not enough to obtain a detailed history of events - 'what happened then?' is not a question that will establish what was happening in the patient's cognitive and affective processes. So questions such as 'what was that like' are more useful to stimulate exploration and will naturally lead to linking actions with feelings. An inappropriate or impulsive action is considered to be the end result of a break in mentalizing stimulated by unmanageable feelings. The MBT therapist gradually traces links between emotions and actions identifying how some feelings presage an action and can be useful as an alert that something untoward is going to happen. Bodily experiences may also be an early warning system to be used by some patients. The principle to follow for the therapist is helping the patient to develop an increasing awareness of the association between actions and their mental precursors.

MBT therapists summarize their understanding of what a patient has said but in doing so will recapitulate their own understanding and not state 'what the patient has been saying'. The latter implies that the therapists understanding of the dialogue and its meaning is 'the' understanding when in fact it is the perspective of the therapist. The patient may have a different perspective and rather than imposing an understanding on the patient the primary aim of the therapist is to help the patient elaborate his perspective. The competence being considered here is the ability of the therapist to summarize clearly, weaving the content into a more coherent focus by using different aspects of the dialogue - thoughts, feeling, beliefs and other mental states – and yet not bringing the exploration to a halt. The summary enables the patient to take the initiative about further self-reflection.

This competency areas is covered by the following items of the Adherence and Competence Scale:

Item 12: Stop and rewind.

Item 16: Monitoring own understanding and correcting misunderstanding.

2.2.4. Exploration

The competency area of **exploration** requires the following competences from an MBT therapist:

- An ability to help the client develop curiosity about their motivations.
- An ability to help the client identify the failure to read minds and its consequences.
- An ability to share the therapist's perspective so as to help the client to consider an alternative experience of the same event.
- An ability to help the client shift the focus from non-mentalizing interaction with the therapist towards an exploration of the current feelings and thoughts, as manifest in the client-therapist interaction.

- An ability to draw the client's/group's attention to the rupture or impasse so as to explore what has happened, focusing on the felt experience of each participant.

Whilst accepting the importance of external or extrinsic factors in determining motivations, the MBT therapist is interested in stimulating the patient's curiosity about his internal or intrinsic motivations. Patients gradually need to be aware that they themselves can be an effective agent in reaching desired goals.

The aim is for the patient to become interested in mastering themselves and learning self-control through a capacity to understand and represent their internal states in increasingly complex ways. To facilitate this the therapist has to model curiosity about his own motivations particularly in relation to the patient and can do so firstly by respecting that no single idea has primacy in explaining motivations and secondly by openly considering his own motivation – when a patient asks, for example, why did you ask that, the therapist may respond by saying 'that's a good question. I am not sure. Thinking about it, I suddenly felt that there was more to what you were saying and it made me think that perhaps we were missing something and then I thought that perhaps it was related to... '.

Central to BPD are problems with understanding fully the mind states of others and this competence is specifically related to reading others mind states accurately. Patients with BPD are externally focused and base assumptions about internal mental states on information gleaned from the external focus – the movement of the eyes, posture, tone of voice etc. They respond to another person according to their externally derived understanding without probing for internal understanding thereby often missing the underlying mind states of the person they are interacting with. At best the consequence is confusion, uncertainty, and bewilderment in the other person, at worst the person with BPD becomes paranoid. Both parties are likely to feel misunderstood. The MBT therapist is alert to narrative in which the patient has potentially misunderstood what was going on in another person's mind and is able to explore this with the patient without making the patient sensitive or guilty about the consequences. This is a particularly important competency to develop when treating patients who evince more systematic paranoid processes.

MBT is characterized by the juxtaposition of the therapist's state of mind with that of the patient. The patient needs to be able to represent the therapist's mind whilst maintaining his own state of mind. Equally the therapist needs to be able to contrast his state of mind with his representation of the patient's whilst keeping them mentally discreet. The therapist has to be able to share his perspective with the patient if he is to facilitate the patient's capacity to explore a different or a more detailed view of an event, perhaps in the patient's life, and consider different possibilities about what has happened or is happening in therapy. In the context of therapy both patient and therapist have experienced the same event and so therapy becomes a vital playground on which to explore alternative perspectives different standpoints. It is essential to remember that neither perspective has primacy over the other and both can be valid. The importance for MBT is that both viewpoints are assessed within the mentalizing framework.

In therapy non-mentalizing interactions occur between the patient and therapist about what is going on in their relationship – is the therapist responsive enough, is he paying attention, does he care, is he any good? These are excellent questions to be asked and are not in themselves non-mentalizing questions, but they may become so if the patient, without apparent consideration, states them as bald facts – you are not responsive enough, you are not paying enough attention, you don't care. Exploring the interaction represents both an opportunity and a danger. The therapist needs to identify what has happened so that the problem can be explored. Yet, in doing so he may stimulate the emotional interaction to the extent that it overwhelms the patient's ability to manage the intensity of the communication, thereby increasing non-mentalizing at the time when he is trying to promote it (see competence X). The competence described here is how the therapist addresses these non-mentalizing interactions without making the situation worse and inadvertently increasing the patient's non-mentalizing.

Therapy may not progress over time, or a session may become stuck. The MBT therapist has to address this from both his perspective and that of the patient. An impasse is not the responsibility of the patient. The MBT therapist accepts equal responsibility for the development of the impasse and for negotiating a way out of the impasse. To do so he openly explores his understanding of his contribution to the situation before considering the patient's role. This involves use of mentalizing the countertransference (see competence

'relationship') followed by a rewind of the session of therapy sessions to a point when the therapist thought some progress was being made.

This competency areas is covered by the following items of the Adherence and Competence Scale:

Item 6: Stimulating mentalizing through the process.

Item 9: Psychic equivalence

Item 12: Stop and rewind.

2.2.5. Challenge

The competency area of **challenge** requires the following competence from an MBT therapist:

- An ability to challenge the client's perspective whilst exploring their underlying emotional state.

The MBT therapist is not required to agree fully with the patient's point of view and indeed the MBT therapist is always trying to increase the patient's understanding by expanding the frame of the patient's experience. At times a patient will engage in persistent non-mentalizing, for example when functioning in pretend mode, which is unresponsive to the therapist's attempts to shift it. Challenging the patient's perspective is recommended at these times. The acquisition of this competence is through the development of the ability to:

- a) mount the challenge at an intensity that matches the patient's way of thinking and functioning.
- b) grasp the moment to explore the underlying experience of the patient in relation to a rigid psychological state.
- c) monitor their reaction to the challenge.

The therapist interrupts the dialogue of the session to insist that the patient focuses on the moment of rupture in order to re-instate mentalizing. This is a 'stop and stand' giving a breathing space and is a pivotal moment when exploration in a session may become more focused.

Challenging the patient's perspective is most effective when it comes as a great surprise to the patient, when it is outside the normal therapy dialogue, when in it is unheralded, when it confronts severe non-mentalizing with an alternative perspective, and when the maneuver 'trips' the patient's mental processes and halts them in the middle of a 'rant'.

This competency areas is covered by the following items of the Adherence and Competence Scale:

Item 3: challenging unwarranted beliefs

Item 8: Pretend mode

2.2.6. Affect Focus

The competency area of **affect focus** requires the following competences from an MBT therapist:

- An ability to communicate to the client/group the affective process that inhibits the capacity to mentalize.
- An ability to identify emotional states jointly with the patient without labeling them unilaterally.
- Capacity to use subjective states to identify an affect shared between patient and therapist.

Emotional states disrupt mentalizing and loss of mentalizing leads to dysregulated emotional states. The MBT therapist, in exploring emotional states, identifies this interactional 'top down/bottom up process making the patient increasingly aware of how emotions destabilize mental processes. Discussion of

affective processes may take place in introductory sessions and so the patient may already know about the importance of emotions in borderline personality disorder and how they disrupt mental processes. The competency described here is helping the patient to use the experience of emotional states as an early warning system to pay special attention to his mental processes and to consider how to manage impending disruption before it is too late.

The MBT therapist helps patients identify emotions and differentiate between them. This competence requires the therapist to stimulate a process in which the feelings of the patient are explored without the therapist labelling the feeling for the patient; to do so takes over the mentalizing of the patient which is the very thing that the therapist is trying to help the patient do for themselves. But people with BPD may find identifying emotions problematic.

There are two contexts in which the MBT therapist does not ask a patient how they feel. Firstly, if the patient has severe difficulties in identifying emotions, they can be sensitive if the therapist continually asks them how they feel. So the MBT therapist does not focus on trying to label a feeling at this point but empathically emphasizes the disabling experience of not being able to differentiate emotional states easily. Secondly the MBT therapist does not state the obvious to a patient as this can too easily be patronizing - it is at best irritating and at worse provocative to ask a patient who is manifestly angry what they are feeling.

The affect focus is the current affect shared between patient and therapist at any given point in a session. It fluctuates and tends to operate just beneath the level of awareness of both the patient and therapist. It is the therapist's task to try to identify it and to express it so that it becomes available as part of the joint work. Identification of the affect focus is subjective and requires the therapist to monitor his own mental states extremely carefully - he might begin to worry about the patient, notice something about how the patient behaves towards him, find himself unable to think clearly, and yet not understand what is contributing to his experience. All of these are examples of information that can be used to identify the affect focus. Eschewing the need to have a fully formed understanding, the MBT therapist expresses his experience to the patient for joint consideration, ensuring that he describes his experience as arising from within himself.

This competency areas is covered by the following items of the Adherence and Competence Scale:

Item 10: Affect focus.

Item 11: Affect and interpersonal events.

Item 13: Validation of emotional reactions

2.2.7 Relationship

The competency area of **relationship** requires the following competences from an MBT therapist:

- An ability to critically reflect on when and how to self-disclose:
- An ability to communicate to the client the therapist's own way of thinking about experiences brought by the client (disclosing the therapist's probable emotional reactions and thoughts in the relational context described by the client)
- An ability to communicate to the client, through relevant questions and observations, the therapist's openness to reflecting on their own 'non-mentalizing errors' and how they may have impacted on the client.
- An ability to model honesty by acknowledging the therapist's own errors.
- An ability to make use of the here-and-now relationship with the therapist to help the client identify failures of mentalization and explore their consequences.
- An ability to identify collapses in mentalizing, as they occur in the patient, the therapist or both in order to identify the rupture or impasse and re-establish mentalizing.

The MBT therapist tactfully discloses what is in their mind. It is essential that the therapist explains the reasons for his reaction especially when challenged by the patient. In MBT the therapist has to juxtapose his own mental processes against those of the patient and carefully appraise similarities and differences. Equally the patient is asked to do this even though their ability to do so may be limited at times. In psychic

equivalence they will assume the states of mind of the therapist rather than ask about them and in doing so will assume a primacy of what is going on in the therapist's mind. At these times self-disclosure is important. But it can be equally important when a patient correctly perceives what the therapist is thinking and feeling. Careful self-disclosure verifies a patient's accurate perception and underscores the reality that you feel things in relation to the patient and that understanding the origins of these experiences is a key aspect of full mentalizing. The patient has to know what he creates in you if he is to understand himself. Failure to self-disclose is likely to lead to enactments on the part of the therapist either by persistent interpretation or use of other techniques or by inappropriate actions. Rigorous non-reactivity is iatrogenic because it makes the patient panic as he tries to find himself in another mind and when he fails to do so there is collapse in his representational world just when he requires another mind to provide that representation which is so essential for his stability. It is for these reasons that the MBT therapist does not immediately reflect questions but answers them prior to exploring them.

Therapists make errors in their understanding of patients. The MBT therapist eschews the need to understand and concurrently accepts that he will misunderstand aspects of the patient's experience. His task is to doggedly attempt to improve his accuracy by eliciting increasingly detailed exploration of the problem; in doing so he will make further errors. Understanding the impact this has on the patient furthers the process of mentalizing. In pursuit of this aim the MBT therapist takes responsibility for the distortions, openly accepting the error. Therapist error becomes an opportunity to re-visit what happened to learn more about contexts, experiences, and feelings.

This competence refers to the ability to focus the session on what is happening between patient and therapist and the ability to do this in the 'heat' of the moment without inducing panic in the patient. MBT focuses on the relationship between the patient and therapist to understand the detail of how a patient's mental function is played out with others. The MBT therapist captures breaks in the continuity of interpersonal interaction between him and the patient in the immediacy of the relationship and explores how the failure in mentalization occurred and what then happened in the session itself.

A patient stated that she realized that one way in which she managed to talk about problems was to manipulate a conversation so that the other person would ask her appropriate questions. This gave her a sense that she was allowed to talk about her difficulties. The therapist asked her if there were any questions that she would like to be asked now. She responded by saying that he could ask her how about her thoughts of stopping group therapy.

The competence described here centres around the ability of the therapist to manage the mentalizing capacity of the patient in relation to arousal. Complex interventions such as those related to detail of patient-therapist interaction or the genesis from the past of current states require a thoughtful and reflective patient if they are to be effective. A non-mentalizing patient who holds rigid mental perspectives and who has limited access to the richness of past experience is unlikely to be able to hold other perspectives in mind whilst he compares them to his own, particularly if they are complex and subtle. He is likely to feel overwhelmed; far from stimulating a mentalizing process the intervention compounds non-mentalizing by increasing anxiety. The patient panics, feeling incapable of considering the therapist's fully mentalized and coherent intervention. Structuring of mental processes occurs and the patient becomes more rigid and insistent about his own point of view. To prevent this, we take a stepwise procedure to the exploration of the relationship with the patient.

Our first step is the validation of the feeling about the therapist through the second step of exploration. The danger of the genetic approach to the transference is that it might implicitly invalidate the patient's experience. The MBT therapist spends considerable time within the not-knowing stance, verifying how the patient is experiencing what he states he is experiencing. As a result of this exploration the third step will be generated. As the events which generated the transference feelings are identified and the behaviors that the thoughts or feelings are tied to are made explicit, sometimes in painful detail, the contribution of the therapist to these feeling and thoughts will become apparent. The third step is for the therapist to accept his enactment and contribution towards the patient's experience. The patient's experience of his interaction with the therapist is likely to be based on a partially accurate perception of the interaction, even if they are based on a small component of it. It is often the case that the therapist has been drawn into the transference

and acted in some way that is consistent with the patient's perception of her. It may be easy to attribute this to the patient, but this would be completely unhelpful. Rather, the therapist should initially explicitly acknowledge even partial enactments of the transference as inexplicable voluntary actions that she or he accepts agency for rather than identifying them as a distortion of the patient. Authenticity is required to do this well. Drawing attention to the therapist's contribution may be particularly significant in that it shows the patient that it is possible to accept agency for involuntary acts and that such acts do not invalidate the general attitude which the therapist is trying to convey. Only after this consideration of the therapist's contribution can distortions be explored. The fourth step is collaboration in arriving at an alternative perspective. Mentalizing alternative perspectives about the patient-therapist relationship must be arrived at in the same spirit of collaboration as any other form of mentalizing. The metaphor we use in training is that the therapist must imagine sitting side-by-side with the patient rather than opposite him. They sit side-by-side looking at the patient's thoughts and feelings, where possible both adopting an inquisitive stance about them. The fifth step is for the therapist to present an alternative perspective, and the final step is to monitor carefully the patient's reaction as well as one's own.

We suggest these steps are taken in sequence, and we talk about mentalizing the transference or mentalizing the relationship to distinguish the process from transference interpretation which is commonly viewed as a technique to provide insight. Mentalizing the transference is a shorthand term for encouraging patients to think about the relationship they are in at the current moment (the therapist relationship) with the aim of focusing the patient's attention on another mind, the mind of a therapist, and to assist the patient in the task of contrasting their own perception of themselves with how they are perceived by another, by the therapist or indeed by members of a therapeutic group. Whilst we might point to similarities in patterns of relationships in the therapy and in childhood or currently outside of the therapy, the aim of this is not to provide the patient with an explanation (insight) that they might be able to use to control their behavior, but far more simply as just one other puzzling phenomenon that requires thought and contemplation, part of our general inquisitive stance aimed to facilitate the recovery of mentalization within affective states which we see as the overall aim of treatment.

The patient may suddenly lose their mentalizing capacity in a session. This may be exemplified in many ways, for example by an affect storm, excessive anxiety, sudden change in emotional states. The therapist needs to be able to identify these states of mind rapidly and decrease the level of arousal. Initially this is done by the therapist taking responsibility for triggering the sudden loss of mentalizing in the patient. The therapist explores openly what he might have said or not said, was it the tone of voice, the use of a particular word that might have been the cause of the problem. He refrains from asking the patient to do more therapeutic work at a time when they do not have the capacity to do so. This ability to mentalize in the face of high arousal in the session is an important aspect of MBT if only from the perspective that the patient can identify with the process.

At other times the therapist may lose his own capacity to mentalize. The ability to recognize this, as it is happening, is a key skill as is a capacity to regain mentalizing. When loss of mentalizing in the therapist occurs, it is necessary to identify the collapse openly with the patient before retracing the session to seek reasons for why it might have occurred. The best position at this point for the MBT therapist is to accept the difficulty – 'I can't think at the moment about this'; 'I am losing the focus of the session' and then to immediately focus on rewinding the session to a point at which both patient and therapist were able to reflect adequately.

This competency areas is covered by the following items of the Adherence and Competence Scale:

- Item 11: Affect and interpersonal events
- Item 14: Transference and the relation to the therapist
- Item 15: Use of countertransference

2.4. List of general competences of MBT therapists

We end this chapter by listing all the required competences per competency area.

Not-knowing, genuine and inquisitive therapist stance:

- An ability to communicate with the client in a direct, authentic, transparent manner, using simple and unambiguous statements so as to minimize the risk of over-arousing the client.
- An ability to adopt a stance of 'not knowing' which communicates to the client a genuine attempt to find out about their mental experience.
- An ability to sustain an active, non-judgmental mentalizing stance that prioritizes the joint exploration of the client's mental states.
- An ability to communicate genuine curiosity about the client's mental states through actively enquiring about interpersonal processes and their connection with the client's mental states
- An ability to follow shifts and changes in the client's understanding of their own and others' thoughts and feelings.
- An ability to become aware of and respond sensitively to sudden and dramatic failures of mentalization in the client.

Support and empathy:

- An ability to establish and maintain a supportive, reassuring and empathic relationship with the client.
- An ability to sustain a positive, supportive stance without undermining the client's autonomy.
- An ability to critically consider the appropriateness of supportive interventions that may involve taking concrete action within therapeutic boundaries.
- An ability to judiciously praise the client when the client uses mentalizing with a positive outcome so as to encourage and support change.

Clarification:

- An ability to respond to requests by the client for clarification in a direct and clear manner that models a self-reflective stance open to correction.
- An ability to use clarification and elaboration to gather a detailed picture of a behavioral sequence and associated feelings.
- An ability to help the client make connections between actions and feelings.
- An ability to clearly restate and elaborate for the client the therapist's understanding of thoughts, feelings, beliefs and other mental states described by the client and to do so in a way that opens discourse about these rather than closing it off.

Exploration:

- An ability to help the client develop curiosity about their motivations.
- An ability to help the client identify the failure to read minds and its consequences.
- An ability to share the therapist's perspective so as to help the client to consider an alternative experience of the same event.
- An ability to help the client shift the focus from non-mentalizing interaction with the therapist towards an exploration of the current feelings and thoughts, as manifest in the client-therapist interaction.
- An ability to draw the client's/group's attention to the rupture or impasse so as to explore what has happened, focusing on the felt experience of each participant.

Challenge:

- An ability to challenge the client's perspective whilst exploring their underlying emotional state

Affect focus:

- An ability to communicate to the client/group the affective process that inhibits the capacity to mentalize.

- An ability to identify emotional states jointly with the patient without labelling them unilaterally.
- Capacity to use subjective states to identify an affect shared between patient and therapist.

Relationship:

- An ability to critically reflect on when and how to self-disclose:
- An ability to communicate to the client the therapist's own way of thinking about experiences brought by the client (disclosing the therapist's probable emotional reactions and thoughts in the relational context described by the client.
- An ability to communicate to the client, through relevant questions and observations, the therapist's openness to reflecting on their own 'non-mentalizing errors' and how they may have impacted on the client.
- An ability to model honesty by acknowledging the therapist's own errors.
- An ability to make use of the here-and-now relationship with the therapist to help the client identify failures of mentalization and explore their consequences.
- An ability to identify collapses in mentalizing, as they occur in the patient, the therapist or both in order to identify the rupture or impasse and re-establish mentalizing.

Chapter 3: The MBT supervisor

The aims of supervision are articulated in this manual in terms of realizing treatment principles, for example maintaining a mentalizing stance in clinical treatment and/or within the team, ensuring the therapist stimulates a mentalizing process, and ensuring the supervisor is able to convey the core model to supervisees both theoretically and clinically.

MBT integrates supervision within the organizational structure of treatment. It is expected that all therapists and MBT teams will have access to supervision and team support. It is therefore important that good supervision systems develop as part of the overall implementation of MBT within services.

The supervision system is not modelled on an expert coming in from 'outside'. The supervisor is either a senior member of the treatment team or alternatively a member of another MBT team working in a different treatment programme. The former allows for integration of all aspects of treatment whilst the latter facilitates new ideas and promotes cross-fertilization. If an MBT team runs, for example, two groups, the therapists crossover, supervising each other's group as long as they have the prerequisite skills. We advise against supervising a team from within the teams as enhancing the mentalizing within a team is more effective when a supervisor is less directly involved in the team processes him- or herself.

Development as a supervisor requires supervision skills and adequate development as a competent practitioner.

Supervision is a skill in itself and it cannot be assumed that someone will automatically become a supervisor simply because they have been practising as a therapist for a period of time and seen a specific number of patients in treatment. Equally important are the supervisory skills of an individual and their ability to stimulate a mentalizing process within supervision itself. This section outlines some of the requirements to become a supervisor in MBT. It is assumed that individuals wishing to become supervisors will have a relaxed, facilitative, and generous interpersonal style and a flexibility of mind that is consistent with being an accomplished MBT practitioner.

Supervisors will be able to show:

- Depth of knowledge of the theoretical underpinnings of mentalizing and MBT.
- Experience and skill in the application of MBT in clinical practice in both group and individual therapy.
- Familiarity and understanding and skill in teaching, training and clinical supervision in psychotherapy.
- An understanding of parallel process and group process within teams
- A commitment to reflective practice and continuing professional development.

3.1. What is mentalizing supervision?

A primary goal of mentalizing supervision is to facilitate the mentalizing of the therapist in his clinical practice and to ensure that the clinical skills of MBT are understood and applied skilfully in the clinical setting. It is not to help the therapist see what he missed in a session or to advocate a specific understanding of the material that is being presented. Just as the therapist's task is to promote mentalizing between himself and the patient so the supervisor's task is to stimulate mentalizing in the supervision with a specific focus on the patient. The supervision meeting should allow therapists to feel increasingly confident in their work and result in them maintaining mentalizing when it would hitherto have been lost. In order for this to happen the supervisor needs to take seriously the therapists subjective experiences of their own ability in therapy, both positive and negative, and explore those in relation to the patient and the patient/therapist relationship.

The importance of supervision being integral to the MBT service and process of treatment cannot be over-emphasized. There is considerable evidence that therapists find it extraordinarily difficult to maintain mental equilibrium during treatment sessions with people with BPD. Therapists have been found to have significantly more negative responses towards patients with BPD and experience them as less responsive and more withdrawn (Bourke 2010 Psychotherapy Research). Combining this with the hostility and/or high dependence that therapists experience as being directed towards them in the context of suicide attempts and self-harm, the scene is set for therapists to feel useless and undermined. Inevitably this leads to rapid loss on mentalizing within sessions. Non-mentalizing begets non-mentalizing which is, of course, the antithesis of the primary aim of MBT.

3.2. Structure of supervision

Supervision is provided in a number of different contexts:

- Supervision of the MBT team with a focus on knowledge and case discussion.
- Supervision of the team, also known as intervision, with a focus on team functioning. This is essential for the day hospital programme and desirable for out-patient programmes.
- Supervision of group and individual therapist.

Individual and group therapists are supervised jointly whenever possible to promote integration of perspectives. The number of group and individual therapists supervised together will depend on the experience of the therapists and the skills of the supervisor. In general, the number is unlikely to exceed 4 participants, two individual therapists with their associated group therapists. Similarly, the frequency of supervision will depend on the experience of the therapists. Current models suggest supervision of a team, focusing on knowledge, and case discussion one week alternating with intervision the next week, works well with weekly supervision for the individual and group therapists.

3.3. Responsibilities of the supervisor

The supervisor needs to ensure that:

- The supervision structure is implemented properly.
- Reflection between therapists occurs after each group in the clinical programme.
- Group and individual therapists communicate effectively and develop an integrated perspective.
- Review meetings between all professionals involved in the treatment of the patient take place at appropriate intervals.
- Therapists and teams are supported emotionally through the supervision structure and process and able to manage strong countertransference responses.
- A report is provided at agreed intervals about the functioning of the supervision.

3.4. Initial tasks

- Pre-arrange administrative requirements of supervision, agreeing mutually convenient times.

The supervisor will have responsibility for ensuring that all the basic administrative requirements associated with practicing MBT are adhered to. In addition, there may be local policies that need to be followed and the therapist and supervisor need to ensure that these are respected. It is important that the supervisor takes any organisational problems seriously and supports the therapists in any negotiation with managers

and other clinical teams. Some therapists may be working across clinical systems, be part time, and have other responsibilities. The therapist and supervisor need to ensure that the work pattern is commensurate with the practice of MBT.

- Outline knowledge base of MBT and provide appropriate reading

A number of meetings may be necessary to cover some of the basic knowledge about MBT. The trainee does not need to have completed a basic training course and so the supervisor will assess the number of meetings required to establish that the therapist has understood the basic aims of MBT.

- Identify therapist practitioner competence in other therapies

Therapists may be competent in other therapies and so be well-practised in basic therapy skills. In this situation the supervisor may need to focus on those aspects of the therapist's technical skills that do not complement MBT along with emphasizing the use of techniques that do. We have found that it is the highly skilled practitioners who often find it hard to re-orientate themselves to MBT and default too easily to their standard practice with patients with BPD particularly when they become anxious or are uncertain about how to respond. Understanding the process that leads to this is a key element of the supervision process.

- Set the framework.

To a large extent the focus of any supervision session is determined by the therapist but at the start it is the supervisor who will have to develop the framework within which supervision takes place. This mirrors the framework of MBT itself. There is structure, commitment, openness on part of supervisor and supervisees, and clarity about the process, including agreement about confidentiality of the supervisory process.

- Agree the basic material for supervision.

The supervisor and therapist need to agree on the material on which they are going to base their discussion. A number of methods are used ranging from self-reported verbatim material to video recording of all sessions. MBT has used video recording or audio recording of sessions. **It is now a requirement for video material to be used for supervision.** This is essential to enhance treatment competencies and for the supervisor and supervisee to reflect on the clinical work. Role play may also help shape clinical understanding with the clinician and supervisor taking patient of therapist roles at different times. The use of video material reduces the potential for distortion. A case history or verbatim report of a session is essentially a sophisticated creation in which events of a session are filtered, shaped, tidied up, reflected upon and even romanticized or at least condensed and tailored to fit preconceptions. Whenever possible 'harder' evidence about the patient/therapist interaction is required for the supervisor to begin to understand the difficulties a particular therapist may be having with a patient and vice versa.

- Discussion of basic therapy structure and confidentiality

Special attention is paid to the initial consultation between therapist and patient, ensuring that the preparatory work of diagnosis, discussion of the model with the patient, and crisis planning, and formulation has been undertaken appropriately. The supervisor should check that these basic underpinnings of MBT treatment have been successfully completed if offering supervision after treatment has started. The therapist may have to revisit the crisis plan and formulation at regular intervals and so it is important that time is spent developing it in detail. Similarly, the risk assessment needs to be completed fully so that indicators of increasing risk are apparent whenever possible. The supervisor has a responsibility to check that these basic requirements of therapy are complete and that the therapist has used a mentalizing stance to develop the plans collaboratively.

The patient is informed that the therapist will be talking about treatment on a weekly basis to a treatment team who have the support of a supervisor. The reasons for this are explained. The therapist may need other perspectives to treat the patient effectively, in a crisis any member of the team may talk to the patient

and it is helpful if they are aware of the patient's problems, the therapist himself may need some support during treatment, and it is a method to ensure that quality of treatment is maintained.

3.5. Supervision of the MBT team with a focus on knowledge and case discussion

This supervision session is varied. The team may present patients that are presenting difficulties for them, role plays may be used to identify helpful interventions in tricky therapeutic interactions, clinical and theoretical papers may be presented for discussion, the MBT manual may be used to inform daily practice and to consider specific aspects of MBT in greater depth. The aim here is to ensure that the team maintain their knowledge of the model and continually develop their therapeutic skills.

3.6. Supervision of the team, also known as intervention

A team's cohesiveness can be enhanced through staff mentalizing about themselves and each other - 'practicing what they preach'. During supervision of the whole team a broad range of team issues can be discussed. These issues are often more personal than in other supervision which is more theoretically and practically oriented. For the team to be able to work together effectively, it is very important that all members feel secure enough to talk openly with each other about their own personal emotional responses in working together and in treating the patients. This can be more important when disagreement occurs in the team, which is a danger to effective treatment because it will cause inconsistencies and undermine patients' (and therapists') mentalizing capacity.

Disagreements in the team, often conceived of as 'splitting', can have several causes. When they occur, the most important point is to try to establish their meaning. Possible causes include the internal processes of the patient, poor team communication ending in fragmentation, team members' own personally unresolved transferences and difficulties experienced by the staff. Sometimes they have little to do with the patient. Often it is a mixture of factors. Parallel processes become transparent, needing to be dealt with in the supervision process. Parallel processes are elements of longer lasting processes found in the patient group that at the same time are found in the staff and sometimes simultaneously in the organization. Often it is unclear where the process first originated, within the patient group or within the staff. Reinstating mentalizing about these processes and establishing meaning helps to (re)integrate the team and enables the team to offer consistency in treatment. Different causes of 'splitting' need different interventions. 'Splitting' arising in the context of unresolved transferences or because of poor communication needs teamwork (intervention) rather than patient work.

3.7. Clinical supervision training requirements

The MBT supervisor delivers supervision to (new) programmes and therapists in training and may apply for recognition as a supervisor.

Essential Application Criteria

- 1) Mental health professional registered with professional organisation (country specific)
- 2) Meet criteria for practitioner MBT therapist (or on country specific MBT register) and evidence of continued status.
- 3) Show evidence of continuing education in MBT through attendance at additional training/learning events annually.
- 4) Supervision: evidence of treatment and completion of at least 6 MBT-individual cases with supervision from an accredited supervisor dating from period after having acquired MBT practitioner therapist registration (supervision individually or in group)
- 5) Completed 2 x 18-month MBT groups as primary clinician following practitioner level with supervision individually or within group supervision.
- 5) Supervision from a minimum of two recognised supervisors.
- 6) Satisfactory report from two or more MBT supervisors

7) Application to become a supervisor may be made by highly experienced clinicians (e.g. other therapy trained and a supervisor role in current job plan) after 2 years practitioner status (normally 3 years post-practitioner status - see page 63).

Requirements

Expertise and competences

The supervisor is an experienced MBT therapist with additional expertise and competences on the following domains:

- Theoretical knowledge
 - Thorough knowledge of the theoretical background of mentalizing theory and therapy
 - Understanding of parallel processes and group processes in teams
- Clinical experience
 - Extensive experience and good skills in performing individual and group therapy in MBT.
- Didactical qualities
 - Experience and good skills in teaching, training, and clinical supervision in psychotherapy
 - Capacity to establish a framework for mentalizing supervision.
 - Capacity to clarify and explain therapy processes from a mentalizing framework.
 - Ability to compare similarities and differences between MBT and its clinical techniques with those of other therapies.
- Personal qualities
 - Capacity to take an open, transparent and supportive attitude towards supervisees.
 - Capacity to stimulate a mentalizing process among supervisees and teams.
 - Capacity to empower self-confidence of therapists in their therapy sessions.
 - Capacity to support therapists to keep their mentalizing stance longer in sessions.
- Meta-competences
 - Capacity to take a meta-position towards the team processes in order to detect and manage team processes and parallel processes.
 - Capacity to understand the self-appraisal of therapists regarding their own qualities in relation to a particular client.

Application Process

- Application should be made to Anna Freud or to country specific approved organisation (for information of approved organisation contact Anna Freud)
- Provision of evidence of training through assessment of CV
- Evidence of assessment of clinical skills by brief video (10 minutes) of two MBT sessions with reflection about therapist aim and intervention.
 - a) Preference is for one individual and one group to be shown at a meeting of other participants in the Supervisor Course. OR
 - b) Video reports from accredited supervisor of treatments (two) within the past 1 year
- Assessment of didactic and supervisory skills via observation – usually around 10 sessions of observation required to ensure all competences are achieved.
- Agreement of development plan following clinical assessment for meeting supervisor competencies in MBT e.g., number of additional clinical supervision sessions + number of supervision of supervision sessions (minimum 10 supervision of supervision sessions).

Evaluation

- Meeting requirements outlined in development plan.
- Demonstrating understanding of scoring of adherence scale and use in supervision.

- Formal evaluation by MBT Supervisor or Expert regarding specified competences based upon demonstration of supervision as seen on recorded supervision sessions or demonstration of competencies in live supervision sessions.

Maintenance

- Continuous clinical work as a MBT therapist and supervisor
- Evidence of maintenance of knowledge of developments in mentalizing and its applications and in clinical skills of MBT e.g., conferences, reading, case discussion.
- Meeting with other supervisors at least once a year
- Attendance at supervisors refresher course AFC/ MBT Netherlands annually. if possible.

3.8 Role Play in supervision.

Role play is an essential component of maintaining skills in MBT because it provides an opportunity for practitioners to practise mentalizing whilst being observed by others. A practitioner chooses a recent situation with a patient in which he was uncertain about how to respond. The practitioner then becomes the patient in a role play whilst a colleague acts as the therapist. The pair are observed by the team who act as 'auxiliary' therapists and step in if the interviewing practitioner becomes equally stuck. Overcome by anxiety, therapists and trainees initially resist role play, with many more volunteers offering to be the patient than the therapist. The supervisor can help here by becoming the therapist himself and modelling the process. Watching the process go wrong emboldens the supervisee who can then step in and take over as therapist. The 'patient' needs to monitor carefully his responses as these can be used as an indicator of effective mentalizing and non-mentalizing interventions. Commonly the 'patient' who is asked something that turns on mentalizing will be suddenly uncertain about how to answer whereas non-mentalizing questions tend to allow the 'patient' to continue in their role easily.

CPD

All supervisors will be committed to a programme of CPD as part of their professional activity. This will include a commitment to increasing knowledge and skills in mentalizing based treatment approaches.

Chapter 4: The MBT-programme: treatment framework and clinical process

The aim of MBT is to enhance the ability of patients to mentalize about themselves, others, and the relationships between themselves and others. Interventions should be designed to help patients to mentalize, while iatrogenic processes that might undermine mentalizing are reduced. This also includes designing interventions to help therapists to keep mentalizing and to prevent inconsistencies that could endanger this process. In the MBT-programme as described below, these principles are the corner stone of the programme. The programme is designed with the aim of helping therapists to mentalize about themselves and their patients, prevent inconsistencies, provide continuity, and keep the multidisciplinary teamwork integrated. The description below is meant to give the team a concrete framework that should function as background and support for their interventions. Outlining the treatment framework and clinical process in detail and providing supportive protocols might help to establish the necessary structure and consistency in treatment. In terms of the identified treatment principles, the format of the programme as described should help to enhance the different principles, with probably most attention going to a high level of structure, a consistent, coherent, and reliable approach and a process-oriented and goal-focused approach (see chapter 1). The chapter falls apart in two major paragraphs. First, we will describe the treatment framework, including the different components of the treatment programme and the different roles in the multidisciplinary team (4.1.). In the second part, we will describe the clinical process throughout the programme from referral to follow-up and discharge (4.2.). While the treatment framework constitutes the basic structure for the therapy, the clinical process describes the blueprint for an MBT programme. Together they deliver the fundamentals for a programme in which the focus can be kept on mentalizing within a safe and predictable environment. The last paragraph lists the competencies and expertise involved in these clinical processes (4.3.). This chapter is completed with some protocols that describe sub-components of the clinical process. Using them can help to improve consistency and constancy.

4.1. Treatment framework

In this section we will describe the more structural, static aspects of the MBT-programme: the treatment framework and the team roles. In the first paragraph, the different MBT programmes will be described (4.1.1.). Second, the different components for these programmes will be described (4.1.2.). Third, we will discuss the different team roles (4.1.3.). In this chapter we will limit ourselves to the tasks and functions associated with each team role. In chapter 5 we will discuss team composition in terms of personnel recruitment.

4.1.1. Short description of the different MBT-programmes

At the moment two MBT programmes for BPD are supported by evidence from randomized controlled trials: the Partial Hospitalization (PH) and Intensive Outpatient Programmes (IOP). Evidence is on its way for the adaptation of MBT for adolescents. Further, MBT has been adapted for antisocial PD, families (MBT-F) and parents (MBT-P), eating disorders (MBT-ED), and substance abuse MBT- SUD). Finally, there also exists a short introductory MBT-course (MBT-I).

Partial Hospitalization

This is the original programme, serving as a framework for the first treatment manual. The programme still runs at different locations. It consists of a five-day programme, involving individual and group therapy, medication consultation and expressive therapies. The programme offers the best opportunities for offering structure and managing extremely chaotic patients. More information on the programme format can be found in the treatment manual (REF).

Intensive outpatient Programme

This adaptation was made to offer a less intensive and more cost-effective variant of the partial hospitalization programme. The research programme consists of one session and one individual session per week, along with medication consultation and crisis management. An RCT to investigate the (cost-)effectiveness of both programmes is currently underway.

Mentalization-Based Treatment for adolescents (MBT-A)

MBT has been adapted for young people being treated in different settings in the US, UK and Europe. It usually involves family work (MBT-F) besides the traditional individual and group therapies. Mentalization Based Therapy in families follows core principles and aims at improving mentalizing in families.

A specific manualized type of MBT for seriously disturbed adolescents is Adolescent Mentalization Based Integrative Treatment (AMBIT), developed at Anna Freud. AMBIT was developed in response to the need for a well-structured, evidence-based intervention that could be realistically implemented for those adolescents labelled as “hard-to-reach”. It is an innovative approach which brings mental health, education, and social interventions together to provide direct help to troubled young people, who are not yet able to access mainstream help.

Mentalization Based Family Therapy (MBT-F)

A specific format for mentalizing in families has been developed named Mentalization Based Family Therapy (MBT-F), which outlines the therapeutic work in families. It has been developed from work in families with small children and integrates the basic concepts of mentalizing theory within a systemic approach. It aims to improve the interactions between parents and children, increasing the parental competence and improving mentalizing, communicative and problem-solving skills in families.

Mentalization Based Treatment for Parents

Mentalization-based Treatment for Parents adds a specific module to the standard IOP or PH programmes. It focuses on the parental skills (sensitivity, mirroring, attunement) of (BPD) parents being pregnant or having just given birth to a new born child. By using video feedback and other mentalizing improving techniques it aims at enhancing reflective functioning in parents. Sessions are biweekly and involve the parent-child dyad.

Mentalization Based Treatment for Antisocial PD (MBT-ASPD)

In a pilot project MBT has been adapted for difficult-to-treat antisocial PD patients

Introductory MBT (MBT-I)

A protocol has been developed for an introduction course to MBT. This module is often scheduled as a preparation (waiting list) module before starting the actual MBT treatment, but it can also be offered as a parallel treatment. It provides psycho-educational information and exercises in mentalizing. An adapted version for parents of adolescents with BPD has been developed too.

4.1.2. Description of therapy components

Even though there are different therapy components in each MBT programme, they all share the same aim of helping the patient to enhance mentalizing capacities. All components of the programme are highly structured in time, content, method and therapists and thus predictable for the patients. Below we will discuss possible programme components, discussing their aims and methods. It is clear that not all programmes will contain all components. In outpatient programmes focus will be on mentalizing group therapy, individual therapy, and medication review and crisis management, while in more extensive day hospital programmes writing group, art therapy and unit meeting will complete the programme.

Mentalizing Group Psychotherapy

Aims: mentalizing group psychotherapy is one of the most important components of a MBT programme. It creates a powerful context in which patients can focus on their own mental states and those of others in the immediacy of peer interaction. Group therapy stimulates highly complex emotional interactions which can be used for all patients to explore their own subjective understanding of the motives of others. Patients have to describe what is in their mind whilst reflecting on their own motives and attempting to understand others motives. For many patients this feature of the programme is one of the most difficult aspects of treatment in that they have the task of monitoring and responding to 8-9 minds rather than being able to focus on only two as in individual therapy.

Method: Mentalizing group therapy lasts 1-1.5 hours and is led by one or two therapists. The group starts with a therapist or patient informing the group about absences or other relevant issues related to the group

(messages from other patients, introducing a new patient or therapist, et cetera.). After announcements have been made, the patients are each asked to report any problems they would like help with from the group. The therapist takes a lead in this process and may also highlight some of the areas left over from the previous group. Both techniques encourage focus by the group and ensure continuity of process. Therapists do not leave patients in silence for too long as this might elicit unhelpful anxiety. Therapists can help patients by stimulating mentalizing about the silence or by bringing up issues from previous sessions, for example actively bringing in a conflict between group members that has not been fully considered in other sessions. It is the therapist's task to stimulate the mentalizing of self, others and constructive interaction between as many patients as possible. To do this the most difficult task is keeping the arousal level at an optimum. The danger of the arousal being too low is that the session may become meaningless, further stimulating pretend mode. When too high, however, patient's attachment systems will become over-stimulated due to anxiety and rigid schematic representations of others will be mobilised, leading to action rather than reflection. These possible iatrogenic effects have to be minimised.

Mentalizing cognitive therapy (MCT)

Aims: Mentalizing cognitive therapy is an explicit mentalizing group focusing on a wide range of mentalizing processes. In MCT, cognitions, but also other aspects of mental states, are explored in a structured way. Cognitions are a key part within MBT, as in all psychosocial treatments. The MCT uses some aspects of CBT structure and strategies. The structured form of the session is very similar to cognitive therapy, but there are some essential differences. CBT has its roots in social learning theory and has a model of behaviour which doesn't include dynamic determinants and thus is less process and more content oriented. MBT's model is a model of mind and the therapist is encouraged to think dynamically about the patient's experience. It thus becomes more process and less content oriented. This allows consideration of pre- or unconscious thoughts, feelings, wishes and desires and the patient's struggle with these complex mental experiences in the context of the interpersonal pressures of their lives, particularly attachment relationships. The cognitive therapist focuses on changing maladaptive cognitions; the MBT therapist is less interested in restructuring the content of the cognitions and more in changing the process by reinstating mentalization. In MCT, unlike many forms of CBT, there is no specific use of problem-solving skills or teaching fundamental communication skills; there is no attempt to delineate cognitive distortions outside the current patient-therapist relationship or to focus on behaviour itself; there is no explicit work on schema-identification; and finally, there is no homework.

Method: MCT is done in a small group commonly once a week in the PH programme. The sessions are 75 minutes. A patient brings in a situation in which he experienced (or is currently experiencing) strong, overwhelming emotion or in which he engaged in (self)destructive behaviour. The situation is represented on a white board and the mental state of the patient (but also the possible mental state of other person(s) if involved) and behaviour are explored, and components of the event and the associated feelings are written down. The focus of the therapist is mainly on exploring the mental states broadly and not solely focusing on cognitions, identifying feelings, wishes, or desires in detail. The main focus of the session is the mentalizing process and much less the end product/content of the events and interaction. If the patient wants to explore his (self)destructive behaviour, the therapist's main focus is to help the patient 'tidy up the behaviour' which has resulted from a failure of mentalization, tracing action back to feeling, and thus stimulating mentalizing about the (recent) past. The therapist helps the patient take his mind back to the problematic experience, from the safety of emotional distance. In the case of overwhelming emotion, the therapist tries to help bridge the gap between the primary affective experience and its symbolic representation by helping the patient understand and label the emotional state, helping him place it within the present context, sometimes further exploring linking narrative to the recent and remote past. When the events and interactions are clarified, the therapist and group help the patient by bringing in alternative perspectives; the difference with CBT is that here the alternative perspectives aren't a result of a Socratic dialogue/of disputing 'irrational or maladaptive' cognitions but are just alternative perspectives brought up by other patients. This helps patients question their assumptions. Sometimes problematic interactions within the group are identified and explored in a structured way with the mental states of several group members highlighted, focussing on different perspectives about a turbulent issue in the group.

Creative/Art therapy

Aims: The aim of art therapy in MBT is to offer an alternative way of promoting mentalization – sometimes conceived of as external mentalizing [Allen, 2003]. The use of art allows the internal to be expressed externally so that it can be verbalised at a distance through an alternative medium and from a different perspective. Experience and feeling is placed outside of the mind and into the world to facilitate explicit mentalizing. Under these circumstances mentalizing becomes conscious, verbal, deliberate, and reflective. In effect, patients generate something of themselves outside which is part of them but separate, and so at one moment represents an aspect of themselves and yet at another is simply a drawing, a piece of clay, and so on. To this extent, the therapy creates transitional objects, and the therapists have to work at developing a transitional space within the group in which the created objects can be used to facilitate expression whilst maintaining stability of the self. The difference between creative therapy and other programme components is that in creative therapy the patient makes a concrete 'product'. The product gives the opportunity for the group and patient to focus specifically on a certain area of reflection. Some patients find that expressive therapies produce less anxiety than directly reflecting internally on themselves in relation to others. With their 'product' made, an aspect of the self is outside and is therefore rendered less dangerous, less controlling, and less overwhelming. Feelings become manageable and the understanding of oneself and others is more tolerable because of the distance created. In contrast others, often patients predominantly functioning in psychic equivalent mode, can be more anxious during creative therapy. The 'product' they make, now also visible on the outside and to others, makes that aspect of themselves too 'real'. They become overwhelmed. It is therefore very important for the art therapist to tailor her work individually with different patients at different phases of their therapy.

Method: Art therapy is done in a small group, once or twice weekly. The sessions are 75 minutes. The form varies from working individually on personal goals in the group, working individually on a group theme, to making a group work piece / project together. Each session starts by helping the patient focus on how he/she is feeling at the moment and what he would like to work on; sometimes a prominent issue in the group is brought in by the therapist, sometimes by the patients. In this way patients contribute to the development of the topic to be used in the expressive therapy. After the form of the session (theme, individual versus group work, etc.) is decided on, the patients choose where in the room they want to work on their 'project' for 30 minutes. After completing their work, the patients gather again as a group to discuss each other's work. In this discussion, as in all programme components, the therapist's task is to promote mentalizing by focussing on the expression of affects, their identification, and their personal and interpersonal context. The therapist should also ensure that patients consider the meaning of the expressive efforts of others and can help patients recognise that others may see their work in a different way to the way they see them, helping create alternative perspectives. The expertise of the art is not important in itself; the process of expression and discussing the work is of greater significance. It is important that therapists continually bring back the discussion to the agreed focus of the group rather than follow other avenues of exploration as might be more the case in a mentalizing group or individual therapy. The intention is to increase the patient and therapist's ability to attend to a task without being diverted by other themes, in order to increase effortful control. Often patients will be distracted by emotional reactions and will fail to attend to the dominant theme and find themselves pre-occupied with sub-dominant themes.

Writing group

Aims: writing is transferring thoughts, ideas, beliefs, wishes, desires, feelings, et cetera with an object (pen) to a surface (paper). Writing is conceptualizing: exploring, searching and transforming an image, or experience of reality into words. You can say / write what is on your mind, reflecting, trying to be explicit about feeling states, giving meaning to meaningless behaviour, tracing actions to feeling; all this is done first on paper, without the interference of other minds and with distance in time if about an earlier event, so with less arousal. Writing ones' experiences, feelings and emotions helps bridge the gap between primary experience and representation and its symbolic representation, further helping develop the reflective process and strengthening the secondary representational system. Through writing, implicit mentalizing becomes explicit mentalizing.

Method: writing therapy is in a small group, commonly once a week in the PH programme. The duration of the session is 90 minutes. To start, everyone (including therapists) writes a theme on a piece of paper that

they feel is a prominent issue in the group or on the unit and place it in a box. In this way each patient has a chance to contribute to the development of the central topic for the writing group. One of the patients picks randomly one of the papers and this is the central theme that all patients write about. They then have 30 minutes to write about the theme, especially about the personal meaning of the theme. Next, every patient reads out loud what they have written and together, led by the therapists, they explore the similarities and differences between their essays. In this discussion the therapist's task is to promote mentalizing, again focussing on the expression of affects, their identification, and their personal and interpersonal context. In discussing the different essays, the therapists need to ensure that the patients truly consider the different meanings, helping create alternative perspectives. Again, as in art therapy, what is written on paper is less important than the process of developing the theme, writing about it and discussing the personal essays.

Partial Hospital - Unit meeting

Aims: when groups of people are together in a unit, consideration of others is important. Arguments can occur about the use of the kitchen, failures to wash up, the disappearance of items of cutlery, the sitting area being left untidy and so on. A brief meeting occurs weekly to deal with these practical problems. The meeting is run by therapists. Individual or more interpersonal issues are not addressed in this meeting; if they are brought up by a patient, the staff suggest that they take the problem to their group or individual therapy.

Method: all patients from the unit and one or two staff members meet once a week for a maximum of 30 minutes. The timeframe depends on the number of issues to discuss; often this meeting is finished in 10 minutes. Patients can bring up issues that have to do with housekeeping on the unit. Some examples include: the use of the kitchen, broken utensils, groceries, an activity they want to plan (such as a Christmas lunch).

Partial Hospital - Social hour

Aims: patients are often prone to crises at the weekend, when contact with the unit is not possible. The therapists do not want to end the week with a component that might induce too much arousal, leaving patients to go home in non-mentalizing states. So, the weekly programme ends with a social hour - a relaxed, low arousal interaction between patients and staff.

Method: social hour is the last component of the week and lasts for one hour. It is in the large group and patients and two staff members pick and play games together.

Medication hour

Aims: The principle is that medication is an enabler of psychotherapy. It enhances the effectiveness of psychotherapy, improves symptoms, stabilizes mood, and may help patients attend sessions. Prescription needs to take into account transference and countertransference phenomena and therefore needs to be integrated into the programme itself.

Method: before the start of treatment the unit's psychiatrist carefully identifies the psychiatric symptoms, current medication and history of medication. The psychiatrist offers open appointments each a week; all patients from the MBT unit can book an appointment in advance. Therapists can advise patients to see the psychiatrist, but it is the patient's own responsibility to go or not. During treatment the patient is responsible for his own medication. To be aware of possible transference or countertransference aspects involved in the use of medication, changes of medication are discussed with the treatment team before being prescribed. Medication should rarely be prescribed during a crisis and never to help manage anxiety of staff.

4.1.3. Team roles

The team is multidisciplinary. The different roles of each team member are described below but in clinical services the roles will be more dependent on the skills of the individual than their professional group. Tasks

and responsibilities should be identified clearly to enhance structure, safety and predictability within the team. We outline here the roles that some professionals take but we emphasise that the roles assigned here are dependent more on skills than on the professional

Team manager

To be completed

Psychotherapist – profession may be nurse, psychiatrist, social worker, other

The individual therapist is the principal therapist. (S)he is involved in individual and group psychotherapy. The psychotherapist develops the treatment plan, including the dynamic formulation of the problem. In the beginning of treatment, the psychotherapist inventories transference tracers and analyzes the interpersonal factors contributing to a crisis in an individual patient. (S)he also makes risk assessments. During treatment, the psychotherapist monitors the main lines in treatment and keeps an overview about the treatment plan. (S)he discusses treatment progress with the patient. His or her main role is to keep the whole team on track considering the goals and treatment process of this particular patient.

Nurses

Nurses are involved in individual therapy and group therapy. They develop together with the patient a practical treatment plan, in which practical goals are derived from the general treatment goals. They work on these goals with the patient. They also construct with the patient a plan to recognize and deal with crises. Nurses often stay in touch with the patient more closely in cases of sudden absence. They are also the first to contact external organisations, like schools or other treatment services. This role is often given to the individual therapist rather than an appointed nurse. A nurse may also act as the individual therapist.

Social worker

The social worker inventories the practical and social living conditions of the patient. (S)he often makes at least one home visit to get a general idea of the neighborhood and household of the patient. Based on their inventory they develop an overview of relevant social problems that might interfere with therapy.

Psychiatrist

The psychiatrist has medication consultation with patients (see before). Prescription of medication usually has to be discussed with the team in order to monitor possible countertransferential issues.

Creative therapist

In day hospital programmes, the creative therapist leads the art therapy group.

Secretary/Administration

The secretary is responsible for the administrative work: invitations, answering general phone calls, monitoring administrative processes... It is recommended that the administrative personnel also follow some basic course in MBT so they know the psychopathology of people with BPD.

Supervisor

The supervisor is an experienced MBT therapist who is associated with a team doing MBT. The supervisor monitors the clinical process, advises therapists in their work to keep them adherent to the model and facilitates an integrated and mentalizing working of the multidisciplinary team. The supervisory tasks are described more in detail in Chapter X.

Others

Other people might be involved. Many teams will have one or more researchers to collect data on treatment progress. An expert might be involved from a distance, coaching the supervisor in weekly consultations.

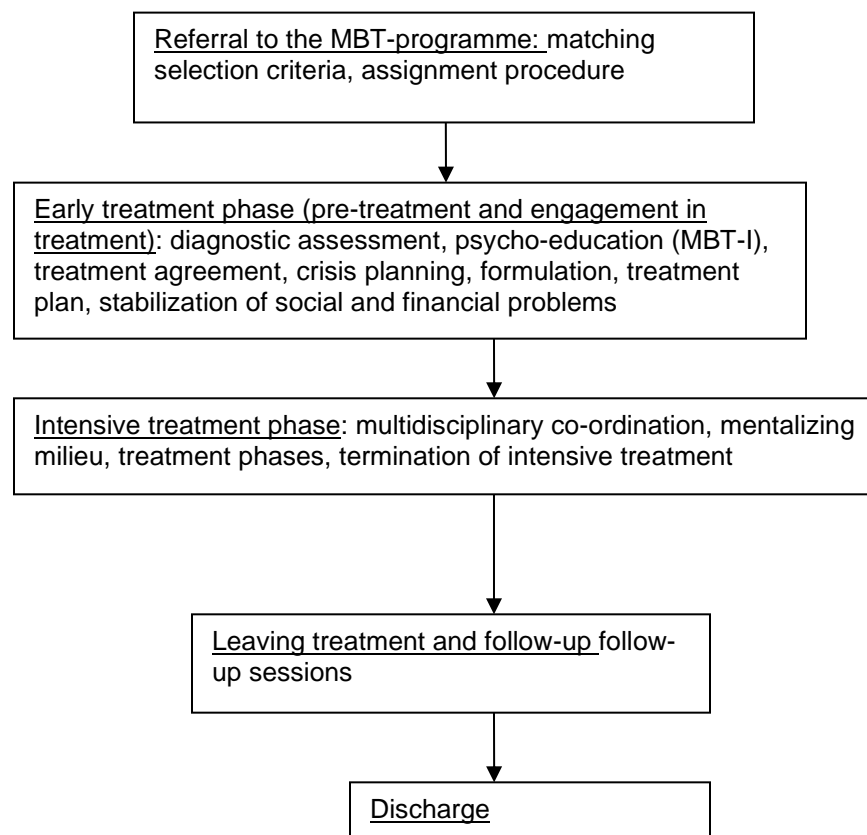
4.2. Clinical process

This section describes the more dynamic aspects of the treatment, the clinical process. It describes the clinical foundations of MBT, the series of processes that should be followed to maximize treatment effectiveness. Together, they shape the blueprint for an MBT treatment programme.

Trajectory of Treatment

Treatment is structured around three primary phases: engagement in treatment following referral and pre-treatment, psychological work within a therapeutic relationship, and leaving treatment and follow-up. Each phase requires a different approach from the therapist and the team using different procedures.

Below is a graphic summary of the different clinical processes from referral to discharge. The different phases are probably in clinical practice not as clearly demarcated as suggested here, but the graph can give a heuristic overview. Below are the topics to be covered in each of the phases.



Possible headings

4.2.1. Referral process

Selection criteria

Assignment procedure and pathway to the MBT service

4.2.2. Pre-treatment procedures

Diagnostic assessment, including medication review.

Psychoeducation about developmental model and rationale of treatment

Treatment agreement

Crisis planning

Formulation

Treatment plan

Stabilization of social and financial problems

4.2.3. Intensive treatment procedures

Clinical reviews of treatment

Multidisciplinary co-ordination and teamwork

The mentalizing environment, including dealing with rules and transgressions.

MBT-service as a holding environment (safe harbour, availability, protocol for shocking events etc)

Some common clinical problems (including absence, near drop out, violence, drug abuse, crisis, PTSD-symptoms etc)

4.2.4. Posttreatment and follow-up

4.2.1. Referral process

Selection criteria

These need to be defined by the service team. MBT services currently target patients with borderline personality disorder, antisocial personality disorder, eating disorders, addiction disorders, and trauma victims. In addition, programmes are available for families, friends and partners, adolescents, and patients with personality disorder who have babies and/or children. Information about a target population commonly includes:

- Age range
- Common symptoms and problematic behaviours
- Additional descriptive features of diagnosis
- Aims of treatment and outline of programme

An **example** is given in Appendix 2 **Still needs to be included**

Assignment procedure and pathway to the MBT service

Clear pathways for referrals need to be established so that patients and referrers have rapid access to MBT services. Referral pathways should have:

- defined procedures and defined target population.
- inclusion and exclusion criteria

- guidelines for managing inappropriate referral
- referral management strategies

The pathway should integrate with other services available to the patient. Prior to treatment with MBT, patients may be receiving other services from, for example, housing, social services, probation; these will need to be integrated in the MBT programme for the patient.

We recommend that a programme manager or lead clinician is identified to manage the referral process. Triage of referrals is usually sufficient to consider a presumptive diagnosis of personality disorder or other target disorder. If there is doubt, further information can be collected from the referrer before the patient is contacted. An example of information for referrers can be found in Appendix 1. **Still needs to be included**

4.2.2. Pre-treatment procedures

Diagnostic assessment

Prior to treatment and during the first stages of treatment, the clinical process involves a thorough assessment of the following issues:

- Assessment of the formal DSM/ICD-diagnosis
- Assessment of suicide risk and other therapy interfering issues
- Assessment of mentalizing
- Assessment of interpersonal functioning
- Medication review
- Assessment of drug and alcohol misuse

Assessment of the formal DSM-diagnosis

A formal diagnosis of personality disorder or other defined target group and associated comorbid condition is made prior to starting treatment with MBT. Formal diagnosis is best done using a structured diagnostic interview such as the SCID. Accurate diagnosis is important because MBT may not be helpful for some groups of patients. Services need to ensure that a core group of the MBT team is trained as diagnosticians. Clinical consensus is used by some services to establish a diagnosis. This will require an assessment meeting attended by appropriate members of the MBT team.

Assessment of suicide risk and other therapy interfering issues

Diagnostic assessment must also include an assessment of risk and other factors that might interfere with therapy e.g., social, family, finance. The MBT therapist takes a detailed history of the patient's acts of self-harm tracing these over time, noting any changes in their frequency and severity. A few examples may need to be discussed before a pattern becomes apparent. The therapist should ask about obvious triggers for self-harm, identify any problems in relationships that may precipitate self-harm or suicide attempts and explore emotional states leading up to self-harm. In MBT it is expected that the assessor will openly note any obvious precipitants arising in interpersonal contexts and link these tentatively to possible problems in therapy. These are the beginning of the use of transference tracers as described in the original manual.

Many organizations require a risk form to be completed by the therapist summarizing different aspects of risk such as previous history, early warning factors etc. The MBT therapist uses a mentalizing process to complete forms. For example, if the form asks, 'What factors are associated with an increased risk', the therapist asks the patient to consider the question and work on an accurate and clinically useful answer. There is no place for unilateral form filling on the part of the therapist. If necessary, the patient is given the form to take home to complete it before the next sessions when the answers can be discussed in more detail. The risk assessment is used to inform the crisis plan and to build individually tailored responses to increasing risk, affect storms, and suicide attempts.

Assessment of mentalizing

Mentalizing is a multi-dimensional construct and breaking it down into dimensional components is helpful for understanding mentalization based treatment. Broadly speaking mentalization can be considered according to four intersecting dimensions: automatic/ controlled or implicit/ explicit, internal/ externally based, self/other orientated and cognitive/affective process. Each of these dimensions possibly relates to a different neurobiological system and the interested reader is referred to (P Fonagy & Bateman, 2006) for further discussion of this. Separating out the different dimensions of mentalizing is important during assessment so that the therapist is aware of any imbalance and tendency to default to a specific aspect of mentalizing, for example using only cognitive components or being driven extensively by affect-state propositions. The key to successful mentalizing is the integration of all the dimensions into a coherent whole and the ability to use them flexibly according to circumstance and context.

The assessor should be able to distinguish good mentalizing from pseudo mentalization, psychic equivalence, pretend mode, and misuse of mentalization. It is obviously neither necessary, nor practical, to assess mentalization in all its forms at the outset of a treatment. However, familiarity with different types of non-mentalizing is essential for the efficient conduct of MBT. An outline is provided in Appendix X

The assessment of mentalization should fulfil the following aims: (1) provide a map of important interpersonal relationships and their connections to key problem behaviours; (2) assess in these contexts the optimal quality of mentalization; (3) probe to assess how robust the mentalizing is under stress; (4) assess whether difficulties in mentalization are generalized or partial; (5) in either case assess whether pseudo-mentalization or concrete understanding predominates and (6) any tendency for the misuse of mentalization needs to be considered separately.

Assessment of Interpersonal Relationships

The assessment of the interpersonal world provides an ideal context for the assessment of contexts which disrupt mentalizing. The assessment of interpersonal relationships is important for the practice of MBT. The clinician is required to identify important current and past relationships and explore these fully. Whilst past relationships are of relevance for MBT, the emphasis is on current important figures in the patient's life. The assessor will avoid linking past to current relationships where similarities between these exist. Just as in the early phases of treatment the past is not presented as the cause of the present, the assessor eschews the causal implications of correlations between past and present. From the point of view of developing a treatment strategy, the assessor needs to come to a conclusion about the overall shape of the relationship hierarchy that describes the patient. Broadly we distinguish two groups:

- those whose important current and past relationships are conceived of as having mental states highly contingent on that of the self.
- those whose relationship representations suggest little contingency between thoughts and feelings of the patient and important figures in their life.

The former type we label 'centralized', whilst the latter we call 'distributed'. The strategy underlying the distributed organization is evidently one of distancing and detachment, often creating a sense of isolation and vulnerability. The centralized organization is evidently far more self-focused but may also be much less stable with a number of relationships being experienced in terms of the self, leaving the self-vulnerable to confusion and disorganization in the context of these actual relationships.

In exploring the individual's current and past relationships the assessor should explore how relationships and interpersonal experiences relate to the problems that the person presents with. Suicide attempts, self-harm, and drug misuse inevitably have an interpersonal context. This interpersonal context is the essential framework for the exploration of mentalization. The representation of the interpersonal events that antedate significant experiences such as episodes of self-harm will give a vivid picture of the quality of mentalization that characterizes an individual's level of functioning. In most individuals a concrete understanding of mental states in self and other will characterize these descriptions (see below). In a minority, pseudo-mentalization (see below) will be more evident. Relatively few will be able to mentalize these interpersonal experiences fully and in these we would assume that the failure of mentalization in which the episode of self-harm is located was partial and context dependent.

The assessor's task is to characterize each relationship according to four parameters. These are the

- form of the relationship
- interpersonal processes it entails.
- change the patient desires in the relationship.
- specific behaviours that these changes might entail.

The assessor should explore how a specific relationship fits into the hierarchy of relationship involvement. This is normally evident from the intensity of emotional investment in the relationship. In highly emotionally invested relationships the representation of the other person's mental state is closely linked to the representation of the self. This does not mean that the thoughts and feelings of self and other are identical but rather that they are highly contingent on each other. A change in the mental state of the self is highly likely to be associated with a change in the mental state of the other. When two minds are seen by the patient as having exactly the same thoughts and feelings or as perfectly reciprocal, they may consciously treat these minds as separate but they operate as if they are not. In either case, in the subject's mind, self and other are unconsciously assumed to merge (identity diffusion).

Medication review

Medication is integrated into the treatment programme in MBT. Medication alone is not recommended for the treatment of borderline personality disorder but it may be helpful for comorbid conditions. MBT teams include both psychiatric and psychotherapeutic expertise to ensure prescribing takes into account the work being undertaken in therapy. The gravest danger is of overmedication which will interfere with mentalizing. Integration of prescribing also protects from strong countertransference urges to prescribe for a patient to manage prescriber anxiety.

An initial review of medication should be performed, and the patient informed that a regular review of medication will take place throughout treatment. Use of medication by patients tends to diminish during MBT treatment.

Assessment of drug and alcohol misuse

A history of past and current drug and/or alcohol misuse is required. Following the principles outlined for assessing self-harm, the assessor makes careful note of the contexts associated with drug or alcohol use. Are these engrained in a lifestyle, are they recreational, do they lead to risky behaviour, are the contexts primarily interpersonal? The aim here is to seek out breaks in mentalizing that lead to drug misuse rather than identify the loss of mentalizing following drug use.

Assessment of life circumstances

BPD patients sometimes live in poor social conditions which can impact significantly upon their lives. A home visit by a social worker or other qualified professional of the team is strongly advised to get an idea about life circumstances, including housing, neighbourhood etc.

Psycho-education about developmental model and rationale of treatment

In MBT the patient has an understanding of the rationale underpinning treatment, part of which is an appreciation of the influence of attachment processes on interpersonal interaction and intimate relationships. The therapist needs to be able to explain the developmental model in a way that is understandable to the patient. The explanation is tailored to the patient's current capacity to concentrate on the subject matter. Importantly the therapist must guard against stimulating pretend mode function when introducing explanations about BPD.

The attachment-based discussion naturally leads on to the rationale of treatment itself, namely of maintaining mentalizing in the context of emotional states and interpersonal interactions. To do this the MBT therapist focuses on examples of interactions with others given by the patient. It is important not only to explore examples in which relationships have gone awry and mentalizing lost but also to highlight some examples in which interactions have been successful and good mentalizing has been instrumental in the favorable outcome.

Many treatment programmes now use MBT-I as the psychoeducational element of the treatment programme. In broad terms, a psychoeducational perspective runs through the entire treatment philosophy of MBT – the patient is aware of the purpose and focus of treatment and knows about the primary aims. The therapist attempts to describe in simple terms to the patient the end-result of the diagnostic and functional evaluation. Based on personal episodes from the patient's life story, the mentalization perspective is used, in collaboration with the patient, to arrive at a mentalization-based formulation. This is written down and given to the patient. A crisis plan is developed for many patients and is written with reference to situations in which the person tends to lose his/her ability to mentalize and behaves in a destructive manner. A brochure is available describing the treatment programme in everyday language, and there is a continual effort to inform and educate significant people who are involved with the patient about the reasoning behind MBT. The current MBT-I programme consists of 12 sessions weekly. These are: Session 1: Mentalization and mentalizing stance; 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; Session 7: What is a personality disorder? What is borderline personality disorder?; Session 8: On mentalization-based treatment. Part 1; Session 9: On mentalization-based treatment. Part 2; Session 10: Anxiety, attachment and mentalizing; Session 11: Depression, attachment and mentalizing; Session 12: Summary and conclusion

Treatment agreement

Services and therapists should be able to organize the structure of MBT and the parameters surrounding treatment. There are general, for example attendance, and specific, for example timing of sessions, agreements, some of which are particular to services rather than to MBT itself. In MBT there are no draconian contractual aspects to an agreement, for example not attending consecutive sessions leads to discharge although non-attendance automatically leads to a review of treatment. Nevertheless, the therapist talks about general aspects of sessions, the sharing of information between the group and individual therapist, and the importance of patient and therapist openly discussing all aspects of the therapy itself especially if it is a problem or appears to be unhelpful. The rationale for any aspect of agreement must be explored with the patient and if he feels the boundary is unnecessarily restrictive this in itself has to be explored and the therapist decide with the patient if it is necessary. At times the therapist may decide that he has been persuaded that the agreement is unnecessary and so review his position.

Crisis Planning

A crisis plan will be developed with each patient at the beginning of treatment. Competence assessment of risk will allow the MBT therapist to tailor the plan to the patient's personal circumstances. The patient should be advised to keep the plan with them at all times. At a minimum a crisis plan must include 5 aspects:

- What the patient tries to do for themselves in a crisis.
- Information for the doctor or other professional they might see in a crisis.
- What the professional can and cannot offer.
- Summary of immediate help that has been useful in the past.
- Details of contacts and list of professionals who have the crisis plan e.g. A & E, Crisis Team/House/GP.

The crisis plan is given to all professionals involved in treatment of the patient and to local emergency service whenever possible. An example of a crisis plan is given in Appendix 4. **Still needs to be included.**

The MBT therapist

- revisits and reviews the crisis plan throughout treatment.
- up-dates the plan after every episode in which it is invoked.
- refines it according to the views of the patient.

In addition to patient specific plans, the therapist outlines the emergency system that is available to the patient emphasizing that emergency teams may have access to the crisis plan and will attempt to help the patient manage an acute situation until he is able to discuss the problem with the treatment team on the next working day.

The MBT therapist and/or team may organize an emergency appointment which lasts no more than 30 minutes in between sessions when necessary to ensure the patient is safe between sessions. This is focused entirely on the crisis, how to stabilize the situation, and reinstating psychological and behavioural safety for the patient and others. It should lead to a full review and re-iteration of the crisis plan. Further work on the crisis should be done within the group and individual sessions.

Formulation

Patients often feel 'stuck' and desperate when they present for treatment, yet they do not necessarily approach a new treatment opportunity eagerly. They feel confused and demoralized, and they are often resentful at having to face the confines and restrictions of treatment, into which they may have been coerced by clinicians and family members. Indeed, they may have already tried a number of treatments. To make use of the opportunity of a new treatment, patients engage in a process that facilitates collaborative exploration of problems that have impeded previous treatments. In part, this is an attempt to stimulate a mentalizing process which is directed cognitively and emotionally towards a narrative defining their present, past and future problems and how they might influence treatment. This is a formulation. It is always a work in progress and becomes a central part of the initial phase of MBT.

The MBT therapist develops a written formulation in collaboration with the patient and the treatment team; this formulation is provided to the patient for comment and refinement. In summary the formulation:

- should be developed collaboratively between patient and therapist.
- is considered as work in progress rather than a final document.
- models the mentalizing approach.
- organizes thinking for the patient and therapist.
- makes explicit links to aspects of treatment that will help the patient reach the goals.
- addresses beliefs about the self and their relation to internal states.
- construes the patient's current concerns in relational terms.
- makes reference to historical factors that place current concerns in a developmental context.
- includes commentary on both strengths and weaknesses in mentalizing.
- anticipates problems that might arise in individual and group treatment.

Treatment Plan

The formulation is part of the overall treatment plan. In the treatment plan, goals are personalized by briefly summarizing the joint understanding developed between patient and therapist of the underlying causes of the patient's problems in terms of mentalizing, their development and their function in the present. In general, the goals can be considered under the following headings but should be personalised:

- Engagement in therapy
- Reduction of self-damaging, threatening, or suicidal behaviour
- Reduction of psychiatric symptoms, particularly depression and anxiety
- Improved social and interpersonal function.
- Stimulation of appropriate use of general/mental health services (including prevention of reliance on prolonged hospital stays)

The goals are linked to the components of the program within which the patient and the therapist think most of the work will be done to achieve them. All team members treating the patient need to understand the treatment plan and its implications for their work with the patient. In the regular reviews (see section X.X) they are asked to report their views on the issues described in the treatment plan and current progress towards goals.

Stabilisation of social/financial problems

There is nothing worse than trying to engage a patient in long term treatment if social conditions are unstable. A home visit rapidly gives information about a patient's social circumstances. Individuals with severe personality disorder are frequently evicted from housing and rented accommodation and even from supported accommodation. Although individuals need to be assessed on a case-by-case basis, the majority of patients find intensively supported accommodation too intrusive and lacking in privacy. The constant personal interactions in group homes lead to anxiety and may induce withdrawal or emotional storms. Withdrawal evokes an opposite reaction from support staff who may attempt to coax the patient to interact more which may itself precipitate emotional storms. Generally it is better if patients are given more responsibility for their everyday living in permanent accommodation. It is therefore necessary to:

- Develop close working relationships with housing departments and social services.
- Invite the housing manager and social worker to case conferences if appropriate and certainly to the admission case conference.
- Inform social worker if (s)he is not part of the team about progress of treatment.
- During intake it is wise to explore the patient's financial situation because debts are becoming increasingly common. A financial plan for living with debts and a solution to reduce during treatment them should be part of the initial goals.

4.2.3. Intensive treatment procedures

Clinical Reviews of Treatment

Reviews of patient progress or lack of it should be done regularly throughout treatment. At minimum this should be every three months. The patient and relatives (if agreed by the patient) and all professionals involved in treatment are invited. The formulation is revisited, the crisis plan reviewed, and the goals of treatment considered. At the end of the meeting the patient's progress will have been detailed, consensus

reached about the goals for the next three months, and specific areas identified that need greater focus in group and individual therapy.

Medication should also be reviewed in this meeting so that all mental health professionals are aware of the current prescription, its potential benefits and its limitations. A prescribing plan, for example, weekly dispensing, can also be confirmed.

Multi-disciplinary co-ordination and teamwork

The first task in developing a treatment programme is to create a therapeutic team (See also Chapter 5). An effective team meets the following criteria:

1. Consistency in team functioning
2. Effective communication among team members
3. Integration of different treatment components
4. Reliability of the team
5. Maintaining a mentalizing stance within the team

Certain characteristics of therapists are necessary for cohesive team development and for maximizing the likelihood of successful outcome, but some specific skills must be held within the team including knowledge of prescribing, ability to manage crises, talent in organization of a multi-component programme, and competence in expressive techniques. It is for these reasons that we use a multi-disciplinary team outlined earlier in this chapter.

Effective teamwork can only take place if the team meet regularly for specific purposes and feel secure to talk openly to each other. Hence within the partial hospital programme the team meet after every group to discuss the material of the group session and to hear how it may relate to treatment within the individual session. This allows the team to formulate each patient's problems using material from all aspects of the programme. Development of a cohesive team is easier said than done but can be created through staff mentalizing about themselves and each other – practicing what they preach! One team rule is that each member has to show within a discussion that they have understood the viewpoint of the others before disagreeing or putting forward their perspective. This peer group meeting is part of a cascade of supervision ranging from informal to the formal.

Within IOP the individual and group therapist meet after each group session so that both are aware of the significant themes of therapy. Their joint understanding of the patient is synthesized into a clinical understanding which informs the next session. This forms part of the peer supervisory process.

The emphasis on discussion and consensus between therapists highlights an important principle of MBT, namely the integration of therapists. This contrasts with integration of therapies in which techniques from different therapies are used in treatment to address diverse problems. We consider the cohesive interaction between therapists to be of singular importance.

Sustaining team enthusiasm and morale is primarily through an admixture of serious work with supervision, provision of time for private learning, and the development of a space to laugh and cry together. The latter is rarely discussed openly but there is no doubt that a team that can laugh together and be sad with each other about their professional trials and tribulations as well as some of their personal concerns when appropriate will function supportively and effectively. The humanity of a team will create a secure atmosphere within the treatment milieu allowing disagreement between therapists to take place in safety, for example during a group, and the facilitation of a questioning culture.

The Mentalizing Environment

An important factor within an MBT programme is how well staff function, how predictable they are, how consistently they implement treatment, and how clear boundaries are in terms of roles and

responsibilities. Inconsistency, lack of co-ordination, incoherence of response, unreliability, and arbitrariness are all antithetical to structure.

Important non-specific aspects, such as the interrelationship of the different aspects of the MBT programme, the therapists and their working relationship, the continuity of themes between the groups, and the consistency and coherence with which the treatment is applied over a period of time are likely to be key factors in effective treatment of patients with severe personality disorders. The essential integration is achieved within MBT through our focus on mentalizing. How, then, do you create a framework in which mentalizing becomes and remains the focus?

Creating a Mentalizing Environment

The partial hospital treatment programme requires patients to attend over a long period of time and involves considerable interaction between patients and between patients and staff. The atmosphere that is created, the character of the building, the staff and their functioning, all need to be conducive to the orientation and focus of the treatment. This is the therapeutic milieu, which Janzing and Kerstens (1997) define as 'an organized treatment unit, in which a situation is created in which a patient is offered relationships with a group of patients and staff. These relationships offer the patient the opportunity, within his capacities (and deficits), to work on a solution to his problems.' Within MBT-PH programs the milieu is not a treatment method in its own right as it might be in therapeutic communities (TC's). However, establishing the best possible environment to ensure that MBT is most likely to be effective is seen as a very important aspect in organizing treatment. The material aspects of the milieu include, for example, the building, the location, the entrance, the style of written information, and the available therapy rooms, whilst the non-material aspects have to do with the staff, the quality of their working relationship, their attitude to patients and to each other, the consistency and coherence of the approach, and management support of the programme.

In creating an optimal treatment milieu, the treatment orientation and focus are the primary consideration. Within MBT, the milieu should stimulate mentalizing about self, others and their interactions: a *mentalizing environment*. An open, responsive, mentalizing atmosphere is not only needed for patients, but is essential within the staff. A well-functioning team will create a secure atmosphere within the treatment milieu allowing disagreements between therapists and/or patients to be used constructively, facilitating an inquisitive, curious and open-minded culture, and encouraging attempts to understand differences, generating and accepting alternative perspectives. A mentalizing milieu encourages thought over action: every action beyond protocol is checked with other staff members for possible underlying transference and counter transference processes. Around 75% of the intended (extra) actions are unnecessary and would have possibly even been anti-therapeutic.

In order to offer a safe and supportive environment, strong feelings engendered in staff need to be contained without excessive protection and without overstepping (therapeutic) boundaries and becoming overly permissive. When a well-selected staff, with enough team support, can keep mentalizing in the midst of strong emotions and confusion, and can do what is necessary to reinstate mentalization in patients and groups, patients will experience their own emotions as less frightening and dangerous. This will ensure that they are less likely to become overwhelmed and destabilized. Predictable and consistent staff who are thoughtful and patient in their approach will add further stability to the system. Last, but certainly not least, we want to point out that setting clear boundaries in a respectful way without removing patients' own responsibility, is not only necessary but essential to contain strong emotions, and thus is an essential part of a mentalizing milieu. A protocol outlining how shocking events are managed in the team can offer the necessary structure to contain strong emotions of staff and patients when severe incidents do take place.

Rules or Recommendations?

Rules and the way they are explained to the patient are part of the environment and make-up part of its boundaries. In explaining the 'rules' it is important to maintain a mentalizing stance. First, the rules need to be stated and explained in a straightforward and 'marked' manner, making sure they are as clear and

comprehensible to the patient as they are to the therapist. The reasons for the rules (why they are necessary) should be explained and the patient's responses are explored. We consider the approach in giving the rules has to be one of discussing recommendations rather than the direct giving of rules. This does not mean that if a recommendation or rule is not followed by a patient, the therapist will not decide to take action. For example a therapist will end a session if the patient is under the influence of drugs. The recommendation is that patients do not attend the unit under the influence of drugs or alcohol as they cannot participate effectively in treatment. If they do take drugs they are asked to leave and only to attend once their mind has cleared to discuss what was happening that made them engage in a self-destructive and therapy-destructive behavior (see below).

Within MBT-PH, we choose not to have too many rules, only those necessary to secure a safe environment. Too many rules may lead to an ultra-protective and controlling environment which is antithetical to mentalizing. Furthermore, many rules are unachievable for most patients; they are unable to enter into binding contracts because they cannot predict their future behavior. Introducing extra rules or individualized contracts about attendance, self-harm and suicide for example would be asking the patient to control the very behavior for which he is seeking treatment and asking something of them that they are likely to fail at. Also, the therapists get stuck in a therapeutic corner with limited flexibility, often feeling that he has to 'do' something – an example of non-mentalizing begetting non-mentalizing. We see it as essential to treatment that the disorganized and destructive behavior outside treatment is explored within treatment, so that actions can be traced to feelings by rewinding the events. Patients can give meaning to their behavior which has resulted from a failure of mentalization. Behaviors that are inherently a threat to patient or therapist safety and block mentalizing are seen as anti-therapeutic and thus possibly interfering with treatment of all parties involved. Violence, drugs and alcohol and sexual relationships are such behaviors and the three essential rules are discussed below.

Some common clinical problems

Many clinical problems centre around behaviours, for example self-destructive acts, drug and alcohol misuse, violence, and threats to others. All these clinical problems are brought into the mentalizing frame and seen as the end result of a loss of mentalizing and an attempt to manage extreme emotional states. The MBT therapist will focus on the clinical problem and ensure that it is the core of the patient's therapeutic work.

Drugs and alcohol:

Patients under the influence of drugs or alcohol are not allowed to remain in a group or individual session. When asked to leave, many patients challenge the therapists and demand that blood or urine samples are taken to prove the veracity of their denial. There is no blood or urine testing. The agreed rule at the beginning of treatment is that if two members of staff believe that a patient appears to be under the influence of drugs or alcohol, they are empowered to ask him to leave and only to return when his mind is not altered by drugs or alcohol.

Sexual relationships:

It is impossible to prevent patients meeting during the evening and weekends and at other times, for example after an out-patient group. Some may meet by chance since they live locally, others feel isolated and lonely and so seek out contact, viewing other members of a group as kindred spirits. The dangers of regular outside contact are discussed during the first few meetings, pointing out that it interferes with the treatment of the individual as well as influencing the whole group. If meetings take place they should be discussed within the group and individual session and not kept secret. Sexual relationships between patients are strongly discouraged. Should they occur work needs to be done to decide if one of the patient's withdraws from the programme.

Violence

Violence, verbal or physical, to others is not tolerated. In the case of physical violence, the person responsible may be discharged and the police involved. In other cases, time-out may be given, the length of which is decided by a minimum of two members of the staff team. However, it is policy that an individual is asked not to return to the unit until he feels safe and in control of his impulses. Before he does, he should contact the team by phone or letter to state that this is the case. An appointment is then arranged to discuss the situation in more detail.

Damage to the fabric of the treatment setting results in time out and breakages are charged.

4.2.4. Posttreatment and follow-up

Termination of intensive treatment

Patients with BPD often experience difficulties with leaving treatment. The team should anticipate early the termination of treatment by introducing this theme in the therapy and helping the patient to work towards completion of treatment.

Scheduling follow-up sessions

Towards the end of treatment, a follow up plan is made with the patient., Some patients will be discharged whilst others will be offered follow-up sessions. These can be scheduled, or alternatively patients are given a specific number of sessions to use when they need to (banked sessions to be cashed in). Some may be offered further therapy in other programmes.

4.3. List of competences to conduct the clinical processes

Several of the clinical processes that have been distinguished require specific knowledge and expertise. These should be included in any formal training for MBT. They can be distinguished from the competences and skills in chapter 2, as the competences listed below refer to the ability to use the basic stance and intervention principles as discussed in chapter 2 to conduct the concrete clinical processes, described in this chapter.

This is a list of competencies and expertise necessary to conduct the clinical processes:

Assessment:

- Knowledge of BPD (or ASPD,...) and associated conditions and having the ability to assess the client's overall functioning to come to a diagnosis of BPD
- An ability to inform patients in a clear and easy way about the general aims of treatment and its link with the presenting problems of the patient.
- An ability to assess level of risk to self and other and other factors that may interfere with therapy.
- Knowledge of the theory of mentalizing, its multidimensional nature and having the ability to assess these different dimensions of mentalizing to define a pattern for the patient across each pole.
- An ability to distinguish mentalization from pseudo-mentalization, psychic equivalence (concrete thinking) , pretend mode function, teleological function, and misuse of mentalization
- An ability to assess the client's capacity to mentalize and factors that undermine mentalization through an exploration of the client's current and past interpersonal context:
 - An ability to elicit a detailed picture of the client's significant relationships and probe their connection with presenting problem behaviors
 - An ability to elicit and probe interpersonal narratives through asking questions that invite the client to elaborate and reflect on their own mental states and those of others.
- An ability to assess the quality of the client's current and past interpersonal functioning, including:
 - Assessment of whether the client's pattern of relationships is 'centralized' (i.e. unstable, self-focused and inflexible) or 'distributed' (i.e. stable, distancing and inflexible).
 - Assessment of the quality of communication between the client and other people

Formulation:

- An ability to capture the core interpersonal patterns and associated vulnerabilities in mentalizing in a diagnostic formulation and to link this to relevant treatment goals.

Psycho-education:

- An ability to introduce the client to an attachment-based understanding of BPD.
- An ability to pitch the level of explanation according to an assessment of the client's capacity to take in new information which in turn depends on their capacity to mentalize at that moment.
- An ability to introduce the client to the treatment rationale and goals primarily through using the live process in the session (e.g. by highlighting for the client examples of his mentalizing strengths and vulnerabilities as he describes himself and his relationships)
- An ability to introduce the client to the agreements about therapy that protect the treatment boundary and to provide a rationale for them in the context of the mentalizing focus of the treatment.
- An ability to engage the client in exploring his reaction to the agreement.

Crisis planning:

- An ability to generate a meaningful and effective crisis plan with a patient using a mentalizing process.

Evaluation:

- An ability to use empirical data from routine outcome measurement to inform treatment progress.

Middle phase work:

- An ability to overview the treatment stages and determine the actual stage of the patient.
- An ability to follow procedures and protocols to deal in a consistent way with frequent clinical problems.

Termination phase work:

- An ability to work towards termination and separation.

Possessing these competences do not yet make someone a skilled MBT-therapist. Therefore, the competences and skills of chapter 2 are of major importance. A skilled MBT therapist should also be able to adhere to the clinical processes in order to be maximally adherent to the treatment principles.

Chapter 5: Management and service organization

In this chapter we will discuss the managerial aspects of designing and maintaining a MBT service. Management focus should be on organizing and enabling the clinical processes as discussed in chapter 4 to occur smoothly. This chapter starts with a discussion of what we assume to be the generic success factors for a MBT service (5.1.). Second, we will describe a stepwise approach for implementing a new MBT service (5.2.). Third, we will discuss managerial tasks of the team manager while the programme is running (5.3).

5.1. Generic factors for success

Important success factors in implementing and maintaining an effective and efficient MBT service are:

- Commitment of the organization to fully implement MBT.
- Continuous efforts to deliver a consistent and coherent treatment and to provide continuity within the treatment.
- Creating and maintaining a well-balanced and mentalizing team
- A process-oriented and goal-focused approach in treatment, including focus on commitment and (self-)destructive behavior

The first success factor is mainly at organizational level. The second and third are important success factors at team level, while the fourth refers to the therapist level. This implies that at each level critical factors need to be met before a programme can run successfully. As a whole these success factors enable a maximal adherence to the treatment principles. In the following section we will describe some general managerial guidelines and strategies to create each of these success factors. The strategies can be targeted at an organizational, team or individual therapist level. The implementation process as described in 3.2. is set up in such a way that these guidelines can be met as much as possible.

5.1.1. *Commitment of the organization to fully implement MBT*

The clinical processes described in chapter X and the quality monitoring and improvement described in chapter X are designed to maximize the adherence to possible crucial working mechanisms, to deliver a consistent and coherent treatment by the whole team and to prevent iatrogenic harm. It is assumed that these not only contribute to good outcome, but also to a professional and supportive working environment, preventing staff turnover or absences. Substantial time and effort is invested in activities that do not directly involve face-to-face patient contact. Still, they are assumed to be necessary for success. We believe risks increase when organizations try to save money by reducing the focus on quality in the system (for example reducing training or supervision, increasing the case load per therapist, insisting on more direct patient contact with loss of reflection time, and so on). In this latter regard, MBT for severe developmental trauma and/or Personality Disorder is necessarily a team approach which requires some indirect and shared reflective spaces for integrating the combined group and individual components of the programme, and for generating coherence in the team. The multiple perspectives of different team members is also an important component in the assessment and management of clinical risk in this patient population. Therefore, it is important that the organization commits itself to implement MBT as it is intended. A list of programme recommendations that might help management judge whether commitment is feasible can be found in appendix X (see also 3.2.). This includes considering the following issues at an organizational level:

- The management of the organization should have some basic knowledge about the programme and the intentions behind the quality system. They should understand MBT well enough to support procedures that can help to improve treatment integrity. The institute should introduce a quality and outcome monitoring protocol from the start, in order not only to be committed at the beginning, but also to be committed while the programme is running.
- Introducing a quality system requires acceptance and understanding of the necessity of investing time and money in activities that are not primarily patient related. This includes reflections, supervision, intervision, adherence measures etc. Roughly estimated, about 60-65% of the time is direct patient-contact in MBT.

- The management should be aware of the specific risks of treating the most complex and crisis-sensitive patients; they shouldn't become overly anxious when confronted with severe incidents like aggression or suicide attempts, which are related to the pathology of these patients.
- The management should also be aware of the intensity for a team of treating emotionally high-demanding patients with chronically high and complex clinical risk. There is a principle here that responsibility for managing clinical risk in this population should be held across the team and not sit with individual clinicians in isolation, but in so doing requires systems and structures that support team integrity, namely shared reflective spaces and opportunities for communication, debrief and feedback.
- The institution should approve that the intended patient population will be treated and that the programme will not be open to inappropriate patients.

At team and therapist level:

- MBT-therapists should be professionals trained in MBT (MBT-interventions, theories and so on). A budget should be provided for training of the whole team (including maintenance training).
- The case load of patients who are actually in treatment per therapist, is limited, enabling the therapist to keep all patients well enough in mind (Maximum of 16-18 cases to whom the therapist is the primary clinician employed on a full-time basis. This amount does not include the patients with low frequent follow up care).
- MBT supervisors should work for sufficient time in the MBT unit, even if they are not directly involved in direct patient care.

5.1.2. Continuous efforts to deliver a consistent and coherent treatment and to provide continuity within the treatment

It is crucial to maintain consistency, continuity and coherence (3 C's) of treatment, because individuals with PDs detect and exploit inconsistency. Patients with BPD are – especially in the initial stages of treatment – severely fragmented. From a psychodynamic perspective, inconsistency arises when 'splitting' occurs within teams, where different team members start to operate independently of each other, providing contradictory responses and decisions related to patients. Splitting can have different causes, including problems in team communication, unresolved transference and countertransference issues, or incomplete understanding of theory and interventions. It is imperative that therapists work together to ensure that they all understand the process of treatment, the reasons for interventions, and how to implement them. Consistency and continuity in therapeutic stance and interventions over time and during sessions should be provided by the team. Confusion within therapists can possibly engender panic in the patient which in turn will lead to destabilization. It is important that all involved therapists react consistently and enhance continuity over sessions. Nevertheless, throughout the course of treatment it is expected that a multiplicity of perspectives will sometimes emerge about patients and how to navigate clinical decisions. A well-functioning, mentalizing team is able to reflect on and synthesize these perspectives in a coherent way. Finally, coherence, consistency and continuity are especially challenging when external services are involved in the treatment (for example crisis services). Therefore, the 3 C's require an active effort from the whole team. The following strategies can help:

At organizational level:

- It is strongly recommended that a new MBT-programme should start with a new group of patients. If not, the old group will experience inconsistencies from start through the change in model and therapeutic attitude. It is difficult for an existing group to understand changes in therapist stance, interventions etc, which may cause bewilderment and destabilize patients. Applying a new model in contact with an existing group could also provide additional difficulties for staff.
- The team should be large enough in order to provide sufficient 'staff mass' to be able to deal with sudden staff absence through illnesses, holidays, pregnancies, staff turnover. Therefore, it is also recommended to start with at least two patient groups, providing sufficient production to recruit extra personnel. A team should have a minimum of four therapists, to deal with unexpected absences. To deliver a safely contained MBT programme there should be a minimum of 3 substantive posts of at least 3 days (22.5 hours) per week.

- It is not sustainable to set up a service with one MBT Team Lead/Supervisor working alone as a sole substantive post, with other therapists just delivering individual and/or group sessions only from within other roles. As a bridge towards establishing the sufficient 'staff mass' to safely deliver a full programme, the job plans of existing positions within transformed community mental health services can be adjusted such that sufficient protected MBT time is achieved.
- Within a five-day service/programme, it is advisable that some team members should work full time for the programme in order to create continuity throughout the whole week, which will especially be necessary in the light of dealing with crises. There is a principle here that when patients are in crisis, their mentalizing capacity is most challenged/compromised, which is absolutely when the team needs to be available to the client to assist with restoring mentalizing and making it more robust. In this respect, delivering MBT involves more than the concrete provision of planned group and individual sessions, but also requires a capacity from within the team to respond outside of those dedicated therapy times, where crisis management and the responsibilities for co-ordinating this is incorporated within the treatment programme and overseen by the MBT team, rather than something that is left to or outsourced to other generic services, even if the latter are ascribed a role within the plan, for instance out of hours.
- There should be clear agreements with external services that are also involved in the treatment. It is recommended that there is an agreement with the local crisis services about the pathway to crisis admission. This can help to prevent iatrogenic harm. This should be agreed upon before the start of the programme. Similarly, collaboration is recommended with specialized services for substance abuse with agreement on roles and responsibilities in the treatment. Both issues will be discussed more in detail in X.X.
- Consideration should be given to how organizations support teams in taking a progressive stance in the assessment and management of clinical risk that doesn't remove all agency from patients for managing themselves and their states of mind, whilst at the same time not abandoning them to manage totally alone. This requires providing some institutional support to MBT Team Leads and their decisions in this regard, such as through the use of risk panels, and through meaningful support from clinical and medical directors.

At team level:

- Team members should be working at least a substantial time for the MBT programme. If many team members are working only some hours in the programme, the risk increases that the programme loses consistency and coherence, and costs will increase disproportionately given the necessary amount of indirect time. Furthermore, not only do team members need to be sufficiently available for patients, but also need access to each others' minds for keeping their own mentalizing 'online' when faced with such circumstances that challenge this, such as acutely suicidal patients.
- After each group session, there is a group reflection in which not only interventions are monitored, but also themes are carried over and linked to other sessions (see chapter X).
- Each team may use interventions based on a mentalizing approach and also team supervision on a regular basis.
- Team members can do other tasks, but we recommended that they do not work with too many different theoretical frameworks. This is to maximize treatment integrity. It is advised that their primary work should be in MBT.

At therapist level:

- An immediate short written report/forumulation with important information about patients (including risk assessment, absence, relapse, aggression incidents, crisis etc) and processes related to treatment goals should be reported after each session. These can be filed in an electronic file, accessible for all team members.
- Regular patient treatment plan evaluations serve to keep all team members on the same track.
- Therapists should commit themselves to use the MBT-model. This might require experienced therapists to un-learn many things that they experienced to be useful in their previous job.
- Consistency should also be accomplished by getting familiar with the MBT concepts and ways of communicating and avoiding the use of more traditional concepts.

5.1.3. *Creating and maintaining a well balanced and mentalizing team*

Implementation problems may be preceded by destructive team processes, creating splitting in the team leading to inconsistent treatment and reactive unreliability and high arousal in the patient group. So, besides committing the organization to take responsibility for implementing MBT completely, it is also necessary that the team maintains a mentalizing stance protecting them from destructive and destabilizing team processes. Team functioning should be characterized by openness and reflectiveness. There are different managerial and organizational strategies that can help to create and maintain a mentalizing environment:

At organizational level:

- The team manager and/or supervisor should have clear leadership qualities, and ideally should be a level B MBT Practitioner. It is important that there is at least one team member who has the authority and personality to create and maintain a holding environment for the team. The team itself may consist of therapists with different levels of experience. There seems no need to recruit a team of only highly specialized therapists. In fact, excellent outcomes have been delivered by non-specialist mental health professionals.
- We recommend that there is a deputy position to any Team Lead post for at least 3 days (22.5 hours) per week, so that there is opportunity for perspective taking in the leadership process.
- Even if the team manager is not involved in treatment, (s)he should also commit to the model. This implies that (s)he does not make important decisions regarding personnel or programme without consulting the supervisor and expert (for example evaluation of staff functioning, programme changes etc).
- The team manager and organization should create an environment in which it is possible to make mistakes and learn from it. If mistakes are being punished explicitly or implicitly by the management, the openness in the team will be reduced.

At team and therapist level:

- It is advised that there should be a minimum of two treatment groups with a minimum of 5 therapists at the start in order to create a team large enough to generate different perspectives.
- If the programme develops and the unit has to be reorganized, teams should still be large enough with a minimum of 4 and small enough with a maximum of 9 therapists. Much larger teams are more vulnerable for destructive processes and more difficult to monitor. In larger teams, a consistent approach by the whole team is also more difficult to achieve. If a team gets too small, there would again be a risk of losing variability of perspective in the team in order to keep a mentalizing stance.
- Individual roles and responsibilities should be clarified. It needs to be clear to each team member who is responsible for what. Clear structure enhances the experience of safety.
- A mentalizing environment should be created and maintained by offering different possibilities to zoom out and reflect from a meta-position on processes at stake. Different layers are: team as reflective stance for the individual therapist, supervisor as reflective stance for the team; expert as reflective stance for supervisor.
- Each team should be supervised by a supervisor who is also enhancing team mentalizing and reinstalling it when lost, in order to prevent possible destructive team processes to interfere with treatment. The supervisor is not involved in the treatment of patients from that particular programme. (S)he should have enough time to supervise the team and attend reflection moments, patient evaluations and so on.
- Team members should be recruited based upon the skills, competencies and characteristics necessary to treat BPD patients from a MBT-model (see p.000).
- The team should be well enough balanced to ensure the possibility of contrary moves by people with different characters if a mentalizing process threatens to get stuck in the team.
- The team should constantly focus on enhancing mentalizing in patients and team. A consensus should exist about using mentalizing as the central focus for discussing team processes, interactions and treatment decisions.

- The team should signal a loss of reflective abilities, help each other restore mentalizing and, if still insufficiently helpful, consult the supervisor to restore mentalizing and guide treatment decisions

5.1.4. *A process-oriented and goal-focused approach in treatment, including focus on commitment and (self-) destructive behaviour*

If the organization is committed to fully implement MBT and the team succeeds in keeping a mentalizing stance and a consistent treatment approach, many important conditions for a successful programme are being met. However, to obtain success in individual treatments, there should be enough focus on obtaining progress in each individual case. This involves a continuous focus on monitoring and facilitating the processes that can lead to improvement in specific goals. Patient and team should be continuously aware of the goals they commonly agreed upon and they should focus on the processes that will eventually lead to obtaining these goals. If a treatment loses its focus on specific (final) goals, there might for example be insufficient reintegration at the end of treatment. Strategies to maintain a process-oriented and goal-focused approach include:

At organizational level:

- Outcome should be monitored through several standardized instruments at several time points (see chapter 4). Outcome should focus on the specific goals in MBT.

At team and therapist level:

- All team members should know the treatment goals of each individual patient and they should know the focus agreed upon in the last patient evaluation.
- During in patient evaluation, focus should be on facilitating processes that might improve progress.
- The treatment plan should be updated regularly.
- The treatment plan should be guiding for patients' evaluations.

5.2. Implementing MBT: a step-by-step approach

This section will give an overview of the different steps required to start a MBT-programme in a local setting. First it describes the general programme requirements to give a programme manager indicators about the feasibility of MBT in his/her setting. Further, it describes a whole range of managerial and practical issues that should be prepared before starting a programme. They're in line with the recommendations mentioned under X.X. In our experience, implementation problems often develop because of underestimation of the necessity of a thorough preparation before the programme runs. We will distinguish six phases:

1. Studying feasibility (project plan)
2. Committing the management within the organization
3. Making a decision: go/no go
4. Making an implementation plan
5. Actual implementation
6. Opening and Start

Each of these phases has its own aims and associated tasks.

Phase 1: Studying feasibility

If a programme manager is interested in implementing a MBT-programme, (s)he might want to contact an MBT expert centre to gain some more information. This information should mainly serve to develop a project plan aiming to study the feasibility of starting a MBT-programme. This project plan should serve to create commitment and support within the organization (phase 2). The following issues should be described as they will determine the feasibility:

- What patient population will be treated?

Information on the selection criteria can be found in chapter 2 and in the treatment manual. MBT has been proven to be effective for (severe) borderline personality disordered adults, with often severe co-morbidity

with other axis 1 and 2 disorders. There are few exclusion criteria. If the patient population that the new programme treats differs, extensive discussion with the MBT-experts is recommended to determine whether MBT might be a promising treatment for this new population too. Still, in such a case, the programme should not be considered evidence based for this particular patient population and should therefore be marked as innovative and experimental. A pilot study might be warranted.

- Will there be sufficient referrals to 'fill' the programme?

The programme manager should not only determine whether the MBT programme offers an answer to the needs of the institution regarding unserved patient groups but also try to determine whether there will be sufficient inflow of patients. It is recommended that the programme manager contacts the local referrers to discuss whether the programme meets a need in the region and if they will be able to refer sufficient patients to the programme. Another way of estimating the referral rate, is an analysis of the expected inflow based upon an analysis of the patients having entered the intake procedure in the institution in the last (half) year. Finally, it is important to determine whether the new programme will be additional to the services in the region or competitive.

- Can the programme meet the programme recommendations?

In order to be able to offer a consistent and coherent treatment and to provide sufficient continuity, some recommendations apply about the time invested and the numbers of personnel (for example, considering indirect patient time, home visits, team magnitude, logistic requirements et cetera). These recommendations are listed in appendix X. If several of these recommendations are not being met, the programme can be expected to be vulnerable to implementation problems. Therefore, the programme manager should judge to what degree (s)he can fulfil these requirements, practically and financially.

- Is sufficient funding and budget available?

To determine the budget, it is important to know what activity and cost agreements are placed on the service by funders such as insurance companies. Also, overhead costs need to be calculated as they often depend upon the specific setting. Based upon the estimated patient inflow, the programme requirements, overhead costs and the existing budget, the programme manager needs to determine whether a MBT-programme will be a economically sound or what combination of programs is the most optimal from an economical perspective. This will also depend upon the intensity and duration of the treatment. Finally, it is important to include extra costs concerning training and supervision and taking into account a gradual inflow of new patients at the start of the programme. In appendix X one can find some information that might be helpful to make decisions.

In a project plan, each of the above issues should be considered. They will determine the feasibility of the MBT-project in the specific setting. A local programme manager can ask support from the expert center to develop such a project plan.

Phase 2: Committing the institution

Once the manager has designed a project plan, he needs commitment from the management within the institution. The manager should discuss the project plan with the directors and management of the institution. There should be support from the management about the necessary budget, the specific patient population and associated risks, and the need to embed the programme sufficiently in clinical services. The management should know about MBT, which patients will be treated and what financial and personnel needs are to be met. It is also important that the risks involved in treating these complex patients are well understood. The management should agree with the embedding in a continuous quality monitoring and its financial consequences. Finally, the management should also create support within the institution for the new programme.

Phase 3: Making a decision

Based upon the project plan, the management will make a decision whether the programme will be implemented or not. If the decision is positive, which also implies committing to the programme requirements, the programme manager develop an implementation plan.

Phase 4: Making an implementation plan

A good implementation plan is absolutely necessary for the success of of a new service. Although the development of the plan will be described separately from the actual implementation, in reality the manager can start with some implementation activities – like involving stakeholders – while further developing the plan. The implementation plan should cover the following topics:

- The organizational embedding
 - Includes an overview of relevant stakeholders within and without the organization that should be involved in the developing programme, including their role in the new programme. For example, this includes local emergency services and substance abuse centers if possible.
 - Funding and budget: how will the programme be funded and what additional activities are necessary to complete funding?
- Referral process:
 - Selection criteria (see chapter 2)
 - Referral process, including which stakeholders should be included to guarantee a good referral process and ideas about how the referral process will be monitored.
- Treatment programs
 - Decisions about the concrete format of the programs that will be run.
 - Decisions about the gradual inflow of patients to complete the group(s)
- Personnel policy
 - Recruiting personnel for the new programme: how many therapists should be recruited? When and how will recruitment take place?
- Logistics
 - Preparing adequate buildings and rooms, offices and secretary/reception functions
 - Preparing accessibility through telephone, mail
 - Preparing brochures, leaflets, announcements, treatment agreements, house rules etc
- Installing the logistics of the monitoring aspects included in the quality system.
 - Includes decisions about the logistics of test administration (see chapter 5)
- Start date and official opening activity.

Discussing all these topics in detail will lead to a thorough implementation plan, with a concrete description of the programme, the selected patient population, selection criteria, referral process and the way of evaluating treatment and monitoring the quality of the entire programme. This document is a blueprint for the new programme and should be made available regularly for the stakeholders in and outside the institution, so they are kept informed about the developing programme. We will discuss each of these topics more in detail in the next paragraph.

Phase 5: Implementation

Based upon the implementation plan, the manager can start undertaking concrete activities necessary to start the new programme. In this section we will describe some relevant issues. Besides these, it is possible that other activities might be necessary given the specific context the programme will be running in.

1. Involving the relevant stakeholders

It is recommended that the programme manager makes a list of relevant stakeholders that (s)he should involve in the implementation process. Stakeholders can be found in or outside the institution. In general, two sorts of stakeholders are of particular relevance at the start:

- Stakeholders relevant for appropriate referrals. For example, if the intake is organized separately from the programme and patients are assigned to the programme after a central intake procedure, it is important to involve the head of the intake team in order to discuss selection criteria and monitor the referring process. If there is a large second tier mental health service in the region, it might function as an important referrer, it is important to discuss appropriate referrals with this service.
- Stakeholders relevant because of their possible involvement in treatment. This includes local hospitals and crisis services. An important aim of MBT is to prevent crisis admissions and, if admitted, to prevent iatrogenic harm during a crisis admission. Therefore, the pathway to inpatient treatment needs to be clear. The MBT-team needs to have a well-established link with the inpatient service. Therefore, it could be recommended to contact the local crisis service and agree upon the modalities of crisis interventions for MBT-patients. An example of such an agreement can be found in appendix X. Similarly, as so many BPD-patients suffer from co-morbid substance abuse, it might be relevant to develop collaboration with local substance abuse services. For example, an additional module considering substance abuse in line with MBT, could be offered by the specialized center and the additional treatment included in the treatment plan. Again, this requires well-established links between the external service and the MBT-team, discussed and agreed upon before the start ideally.

Depending on the specific context, other stakeholders might be the managers of neighbouring programs. It is important to note that it might not be enough to make good agreements at the start. It is recommended to have a system of follow-up, with repeated meetings twice a year, in which the agreements are being monitored and adjusted if necessary.

2. Recruiting and training personnel

The recruitment of personnel is another important implementation activity. Two issues are important: staff should meet the necessary criteria for treating BPD-patients with MBT and the team composition should be balanced. Experience suggests that qualities to be included in recruiting MBT-therapists are:

- Motivated, professional attitude, feeling responsible, flexible, creative, open minded.
- Gunderson describes therapists that do well with BPD patients as; reliable, somewhat adventurous, action-oriented, good-humored. This all translates into being active and responsive.
- Being able to deal with crises - in situations under high arousal being able to keep mentalizing stance.
- Team player, being reflective in contact with colleagues about their own mental states.
- Open for supervision with colleagues, willing to learn and able to deal with critical remarks.
- Non-defensive, not controlling.

The employment interview should try to evaluate to some degree these qualities. Our experience has taught us that it is not enough to talk about how people will deal with crisis incidents.. Therefore, it is recommended to raise anxieties during the interview and monitor mentalizing when lost and how quickly it is reinstated after being lost.

Further on, it is important that the team should be balanced enough. This is probably not so easy to objectify. What's important is that not all team members cope with high arousal in the same way (for example by taking concrete action). Through different profiles, it might be easier to signal non-mentalizing reactions in other team members and prevent collective non-mentalizing processes from escalating.

If the complete team is recruited, the programme manager schedules a basic MBT course. It is recommended that the training is planned not long before the actual start of the services. The first (half) day of the training could be open for stakeholders too to provide additional information about MBT for stakeholders. Each participant is asked to read the treatment manual prior to training. The content of the training is described in supplement xx. Besides the training in MBT, an organization may also have its own induction programme for new staff. If new personnel are recruited once the programme is running, an introductory programme should be organized (see chapter 4).

3. Logistics and facilities

Buildings and offices

In appendix X one can find some guidelines on suitable accommodation for the buildings for delivering MBT. Most of these guidelines might seem self-evident. However, in our experience, they are not. Rooms should be large enough. There should be daylight in the rooms. We do not recommend installing alarm buttons in each room as they evoke a sense of fear. It might nevertheless feel safer if there is a possibility to look into the room from outside in cases of emergency. There should be enough space to move around etc.

Another important issue is the accessibility of the service through public transport. For example, it is recommended that the building is at walking distance from a train station with easy connections with other cities.

Secretary

We recommend that administration is taken care of by a secretary. This person can also fulfil a reception function for patients. Secretaries can be instructed how to handle patient telephone calls. An electronic file for patient reports should be prepared. It is recommended that secretaries also follow (part of) the basic MBT-course so they get a flavor of what MBT is like.

Communication

The MBT-service should be accessible to patients, also outside therapy hours, to offer necessary support for these patients. However, no 24 hours crisis service is offered (see chapter 2). There should be an email address where patients can mail and a patient telephone with voice mail. Staff should have easy access to computers to check the mail and communicate with the patients if necessary.

Further, it is recommended brochures are provided to inform patients and other interested persons about the treatment. An example can be found in appendix X. This information can also be posted online.

Schedules

A comprehensive therapy schedule should be made, including group reflections, treatment evaluation, supervision and intervision. The working hours of each team member should be determined and adjusted to the therapy schedule with necessary minimal attendance, for example at supervision sessions (see appendix ...). An important principle is that in order to provide continuity there should be at least two primary members of staff in working days. During holidays or sickness absences, there should still always be at least one therapist at the unit.

4. Preparing the quality monitoring

Preparations should be made for the measurement of outcome and therapist adherence, the scheduling of supervision and so on. These issues will be discussed more in detail in chapter 5.

5. Going through the clinical process with staff/checking programme requirements with expert centre

Finally, it might be recommended to go through the clinical process, using the information in chapter 2 as a check list before starting treatment. It is important to ensure that all staff members know the basic procedures adequately including reporting, dealing with incidents, and so on.

Similarly, it might be relevant to double check the different programme requirements with the expert center, in order to reassure all relevant requirements are being met.

6. Starting up the referral process

Some weeks or even months before the actual start, the referral process can commence. In anticipation of the official start of the intensive programme, enough patients for a group can be involved in a preparation trajectory (see chapter 2).

Phase 6: Opening

The kickoff is the official start. It's up to local management how to open the service formally. We recommend to invite stakeholders for an official presentation of the programme and a festive drink (or some other sort of celebration).

5.3. Managerial tasks while the programme runs

The team manager has an essential role in implementing the new programme, providing and maintaining the necessary conditions to run the programme. Once the programme is established, the supervisors have a crucial role in maintaining the quality of the treatment programme. The manager has the following tasks:

- Quality monitoring
- Personnel policy
- Financial management
- Maintaining contact with stakeholders
- Further development of the unit

5.3.1. Quality monitoring

Once the treatment has started, the supervisor will – in cooperation with the expert centre – be largely responsible for monitoring the therapist and teamwork. Supervisors will monitor and supervise the treatment process (see clinical process, chapter 2) in individual cases and enhance treatment adherence in the teamwork. The supervisor is closely involved and keeps the manager informed.

The manager monitors registered data in the quality monitoring system. He will get regular overviews on adherence of therapists and supervisor based upon data collection through the quality monitoring system (see chapter 4). The supervisor will make up a Programme Implementation Report twice a year, which can be consulted by the programme manager. This report consists of three aspects:

- An overview of the programme requirements
- A data report with an overview of cases in treatment, adherence measurements and other relevant quality data, like dropout rates
- An overview of how former recommendations based upon former PIR's are being dealt with by the supervisor.

The supervisor will discuss the report with the programme manager. This report reflects the quality of the programme and can also be discussed with stakeholders. The programme manager can discuss important issues with the supervisor and take responsibility for generating solutions (for example, too many wrong referrals, increase in staff turnover, budgeting problems, etc). If programme requirements are not being met, the manager intervenes and works on solutions to the problems.

5.3.2. Personnel policy

Recruiting good personnel is crucial for the success of the programme. If therapists leave, new personnel have to be recruited on time. The supervisor will play an important role in recruiting new personnel (for example, making up a profile to keep the team balanced, deciding which candidate it will be). The programme manager will negotiate with the candidate and recruit him or her. If a supervisor leaves the programme, the manager will recruit a new supervisor in cooperation with other supervisors of experts. The programme manager ensures proper training and supervision for all new personnel. The manager also deals with sick leave, pregnancy leave, vacations and other (non treatment specific?) personnel issues. He deals with logistic aspects, like working space, computer access and so on. If a supervisor reports personnel problems, the manager will try to find proper solutions in collaboration with the supervisor. Furthermore, the manager has annual performance appraisals (?) with each team member. These annual appraisals are based on information from the dashboard (quality monitoring data), the supervisor and the team member.

5.3.3. Financial management

The team manager ensures a sound financial budget according to an annual financial plan. Monitoring service activity and anticipating if planned activity will be realized is an important aspect. If costs change (for example overhead costs, personnel cost, etc), he is responsible to keep a balanced budget.

5.3.4. Maintaining contact with stakeholders

In the implementation phase, the manager will have contacted different stakeholders (see before). It is important that these contacts are maintained. For example:

- The team manager can discuss the Programme Implementation Report twice a year with the general management.
- The team manager evaluates twice a year the referral process with the important referrers.
- The team manager evaluates the collaboration with the local crisis services twice a year.
- The team manager evaluates the collaboration with other mental health services being closely involved, like a drugs abuse service.

5.3.5. Further development of the unit

In our experience – because of the length of treatment and the unavailability of other services for this population – the programme will quickly reach its maximum capacity. This raises the question of implementing more therapy groups/programs. Expansion will cost less time and effort but should nevertheless be prepared thoroughly. The addition of a new group, for example, will often have an impact on the existing groups and the existing team. If the expansion includes a new programme, we recommend the whole implementation process is followed, including writing a project plan and implementation plan.

Chapter 6: Quality Monitoring System / How to maintain a high quality MBT-programme?

In Chapter 5 we discussed the success factors for an MBT programme and outlined how these can be accomplished in the implementation of a new programme. This chapter focuses on how to maintain and improve quality while the programme is running. The aim is the same as in chapter 5: how to maximize adherence to the clinical focus of MBT and how to minimize iatrogenic damage? While chapter 5 discusses what needs to be organized in setting up a new programme, this chapter will discuss how these aims can be accomplished throughout the running of the programme. To reach these aims, MBT is developing a quality system. The quality monitoring system describes how all the components of a MBT programme and the context in which it is organized, are effectively integrated. It involves all interventions and actions that can maximize adherence and minimize harmful processes. The quality system is not the treatment itself, it serves to enable optimal treatment. The primary aim of this quality system is to monitor continuously the adherence of therapists, supervisors, teams, and organizations to the MBT model and to improve adherence or treatment integrity at each level when necessary. In paragraph 6.1. the idea of a quality monitoring will be described in detail. The following paragraphs deal with different aspects of the quality system and related aims: continuously monitoring the outcome (6.2.), assessing and improving the therapist and team adherence (6.3), and finally, assessing and improving organizational adherence (6.4.).

6.1. The idea of quality monitoring

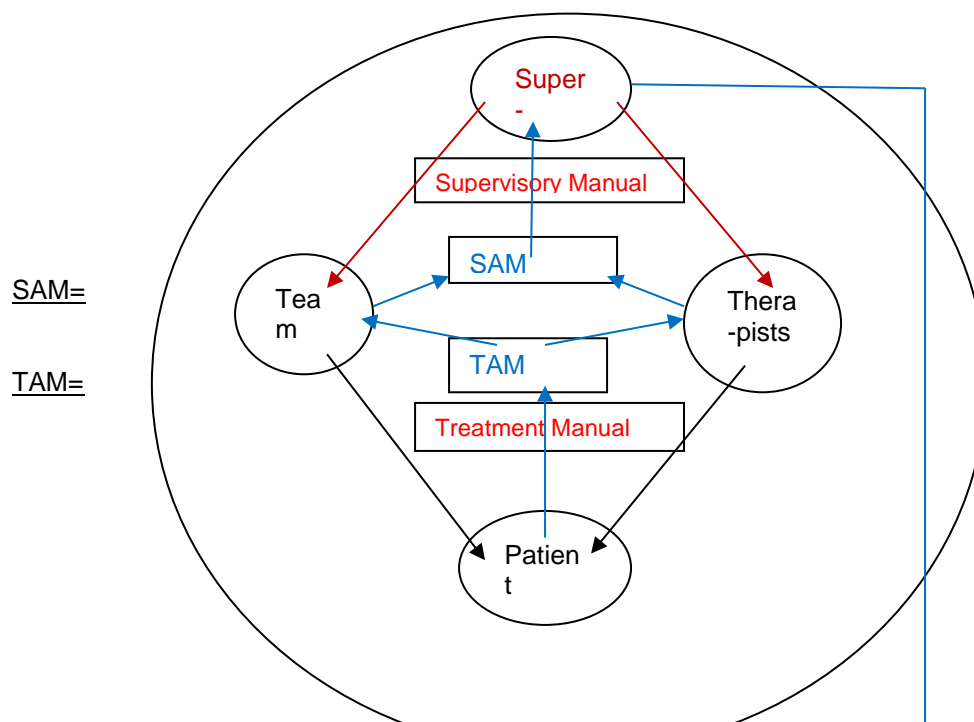
It is assumed that MBT works through developing an attachment relationship and helping to enhance mentalizing within this relationship (see chapter 1). A high level of structure, a consistent, reliable approach, a focus on the relationship and on the process of mentalizing, and a process-oriented and goal-directed approach are assumed to help these processes develop. It is assumed that the more a programme is adherent to these principles, the better the outcome will be as one maximizes the supposed effectiveness of the theoretical mechanisms of change. Also, effectiveness improves if the programme minimizes harmful processes, often encountered in the treatment of BPD patients (for example excessive use of medication, not attuning to level of arousal, not dealing properly with splitting processes in the team, mismanaging crises etcetera).

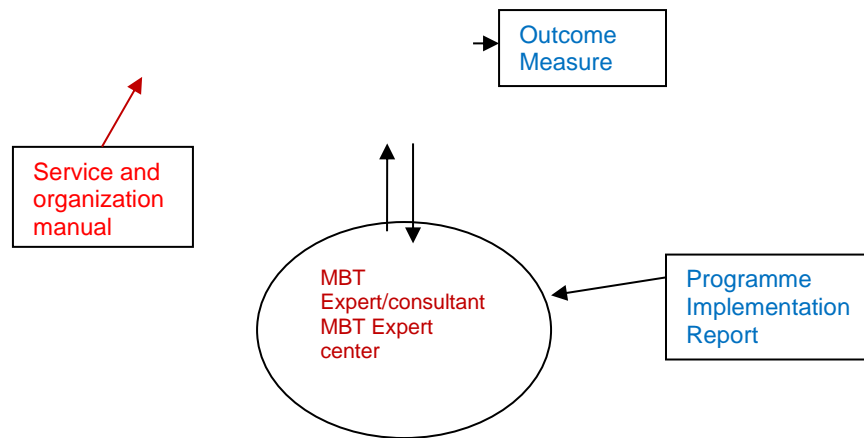
Quality monitoring then – briefly – refers to the efforts being made to provide adherence to the treatment principles, thought to be responsible for making the treatment maximally effective. What is meant by adherence is 1. the efforts of the therapist to stay 'on model'; 2. being continuously aware of the aim of helping the patient to mentalize; 3. the efforts of other team members to help each other keeping a mentalizing stance; 4. the efforts of a supervisor to help the therapist reflect upon difficult cases and restore a mentalizing process; 5. the efforts of an organization to enable a team to do its difficult and challenging job, and so on.

As has been evident from the examples above, quality monitoring is more than a therapist doing his or her job. Adherence and competence of the therapist is only one component of treatment integrity. We assume that the more complex a treatment is (mainly because of its multidisciplinary nature) and the more complex and challenging the population to be treated is (because of their sensitivity to crises and inconsistencies), the more important it becomes to expand the concept of treatment integrity to include also adherence and competence at team and organizational level. This is what we called the multi-level approach to treatment integrity. In other words, not only therapists, but also teams and organizations should be sufficiently competent and adherent to the treatment principles in order to offer the best possible treatment. On a team level, this includes the efforts, ability and willingness to overcome splitting processes and the competence and ability to offer a consistent, reliable and mutually integrated treatment.

Now, what the quality system offers, is through continuous monitoring, a warning of (a lack of) adherence to the model. It also offers clear guidelines on where the problems are and how they could be resolved in order to keep the programme on track. The quality system therefore consists of different components: on the one hand the manuals (describing interventions in line with the model) and on the other hand the monitoring instruments, checking whether therapists, teams and organizations are keeping to the model. These components are mutually related as is evident from this graph:

Graph: Quality assessment system MBT





How to understand this graph?

In the treatment design, there are five involved parties (in circles, one could also include the stakeholders):

- Patient
- Therapist
- Supervisor
- Expert from MBT Expert center
- Organization

The quality system involves **three manuals** (in red):

- Treatment manual: this manual describes the therapy at micro-level: what the therapist has to do to improve the patient's mentalizing. It involves the therapist-patient relationship / interventions (see practical guide and in this manual chapter 2).
- Supervisory manual: this manual describes how the supervisor can help the therapist to stay adherent to the principles outlined in the treatment manual and how (s)he can help the team to keep on mentalizing. It involves the supervisor-team relationship. It also describes which components are necessary to become a supervisor (see chapter 3).
- Organizational manual: this manual describes the embedding of the programme and the organizational requirements to develop a successful programme (see chapter 5).

The quality system involves **two levels of consultation** (in dark red):

- Supervisor: an experienced MBT-therapist supervises the team and therapists
- Expert: an experienced and assigned MBT-expert can be consulted by the supervisor(s)

These are the quality assurance strategies. By elaborating treatment, supervisory and organizational principles in manuals and by establishing a strategy for consultation and supervision, maximal adherence at clinical level is established. However, this might not be a guarantee. Therefore, the quality system also involves **four types of monitoring** (in blue). The adherence is monitored, as is the patient's improvement through therapy. Therefore, there are four types of monitoring:

- Outcome measure: this measure refers to a regular (at least every three-six months) monitoring of outcome at commitment, symptom (psychiatric symptoms, (self)destructive behavior), personality functioning (interpersonal relations), social-vocational, and quality of life level. Feedback should be given to the team and supervisor and to the expert center.
- Therapist Adherence Measure: this measure monitors the adherence of the therapist and team to the treatment manual. This is fed back to the therapist/team, but also goes to the supervisor, enabling him to follow the quality of the therapist and team and to assess needs for further development of the programme.

- Supervisory Adherence Measure: this measure monitors the adherence of the supervisor to the supervisory manual.
- Programme implementation report: this measure monitors the organizational embedding of the programme. It could include a team functioning report (including measures of team dysfunction) as well as a check if the programme requirements are still being met by the organization. The supervisor develops (in collaboration with the team manager) this report and feedback goes to the expert center.

Throughout this continuous monitoring, information is being gathered about different levels of adherence and about outcome. This information can be used to detect specific shortcomings and to make improvements. Information can inform the expert and supervisor about necessary training to improve therapist and team functioning. In the next section, each of these monitoring instruments will be discussed more in detail.

6.2. Designing an outcome monitoring system

Helping patients to reduce symptoms, maintain better and more stable relationships, function better socially and in their profession or at school and to experience a better quality of life, is at the core of each treatment for BPD. In the MBT treatment plan, this is made concrete in five general treatment goals: commitment to the therapy, symptom improvement, reducing of (self)destructive symptoms, improvement of interpersonal functioning, and enabling patients to make better use of services (including reducing the number of crisis interventions) (see chapter 4). Changes in social and vocational functioning occur slowly so initially improvement in symptoms and reduction in self-destructive acts are given more attention in the monitoring process. Continuous outcome monitoring is therefore necessary to follow-up the individual outcome of each patient. In a more general sense, the outcome of the patients involved in the programme is the ultimate standard for funders to evaluate their financial investment. It is therefore also the ultimate argument to defend an expensive treatment programme. Outcome results of a larger group of patients can also be used in the evaluation of the programme itself. For the expert center outcome results can serve as a benchmark to compare the quality of different MBT-programs.

Appendix X offers a list of possible instruments and a schedule of measurements, as agreed by the Dutch MBT-research consortium in 2010. These instruments have been chosen for their suitability to measure BPD-related and MBT-related outcomes. However, for routine outcome measurements, a more reduced list could serve well too. For this minimal purpose, we recommend BSI (or OQ-45) and Euroqol-5D (EQ-5D). Measures should take place at the start and after every six months. Finally, if real monitoring is preferred and possible, one could also use the PHQ-9 for a weekly monitoring.

Data can be obtained and be processed by independent research assistants. Feedback to patients can be given in a joint consultation by the research assistant and the principal therapist. Data can deliver input for discussing progress and evaluate treatment obstacles.

6.3. Monitoring the adherence and competence of the therapist and team

Two types of adherence monitoring can be distinguished:

- Adherence to the treatment principles: this refers to the fact that the therapist should adhere to the central treatment principles to maximize the working of MBT, specifically (s)he should be continuously using interventions to enhance the mentalizing process while keeping mentally close to the patient.
- Adherence to the clinical processes: this refers to the fact that the therapeutic process is embedded within a series of clinical processes (as described in chapter 4) that the therapist should adhere to.

Monitoring adherence to the treatment principles

A new (2017) adherence and competence scale has been developed based on MBT for Personality Disorders: a practical guide (2016). The scale can be found at: <https://www.annafreud.org/>

This scale was developed to assess MBT delivered in research trials. It requires training to ensure reliability but it is now being used as a focus for training of MBT therapists and in supervision.

However, a team is not only a collection of individual therapists. Well known in the treatment of Borderline patients are the many splits in the team, creating unreliability and inconsistencies in approach. These mechanisms underlie a flaw in quality of treatment for BPD patients. Therefore, adherence should not only be monitored at individual level, but also at team level. Team adherence refers to the competence and ability of the team to work in an integrated way within a MBT sensitive environment ('one team model'). The different components of the treatment programme should be combined into a coherent treatment and imminent splits should be integrated before being discussed with patients. The team should act in a consistent and reliable way: recurrent issues should be dealt with in a similar way by different team members. The theoretical framework should be shared by all team members, providing them with a unified perspective on team and patient processes. These can be monitored with five additional 'team principles':

1. Consistency in team functioning
2. Effective communication among team members
3. Integration of different treatment components
4. Reliability of the team
5. Maintaining a mentalizing stance within the team

There are two perspectives from which this kind of adherence can be measured: from the 'expert'-perspective: is the therapist 'on model' while doing interventions in therapy? And from the 'patient'-perspective: does the patient him- or herself experience the working of the supposed treatment principles (for example Does (s)he experience the therapist as helping him/her to identify and verbalize affects better?)? One could assume that both should be related: if a therapist stays on model, (s)he will perform the interventions that make the treatment work for the patient in the intended way.

Therapist Adherence Measure from expert perspective

The 2017 MBT Adherence and Competence Scale should be scored clinically by the supervisor, based upon a recorded session. The instrument will identify the interventions and domains that the therapist uses most and least. This may give information on the strengths and weaknesses of every therapist and can be used for gaining extra skills in supervision. The MBT Adherence and Competence Scale can be complemented with the five items referring to team adherence. The supervisor could score the team items based upon his/her observations once every two months.

Monitoring of the clinical processes

The clinical process is the series of successive processes that constitute MBT-treatment (see chapter 4). Besides monitoring whether a therapist is adherent to the treatment principles, it is also relevant to monitor whether a therapist is adherent to the clinical processes. For example, a therapist might be superb in contact with the patient, but in the same time neglecting important processes, like designing a treatment plan, forgetting to talk about ending etcetera. Therefore, a checklist can be developed for therapists to check whether they are also adhering to the clinical processes. These can include formal requirements, like signing a treatment contract, and MBT-specific processes, like making a crisis plan. Below, we suggest specific check points for each of the clinical processes. It is suggested that a supervisor can regularly check this list. The checklist below is probably not exhaustive.

Pre-treatment and initial phase:

- Does the patient fulfil the selection criteria? Has a formal diagnosis of BPD (or ASPD,...) been established?
- Has the patient received the necessary information on the treatment?
- Has the patient signed the treatment contract?
- Has a home visit taken place?
- Have the baseline measurements been administered?

- Has the diagnosis been discussed with the patient / has the patient been given specific psycho-education on developmental theory, aims, link with presenting problems?
- Has there been a thorough assessment of suicide risks and possible commitment problems?
- Has the ability to mentalize been investigated in the context of the patient's actual and past interpersonal relations?
- Have transference tracers been investigated?
- Has there been a medication review?
- Is there a crisis plan?
- Has a dynamic formulation been made and discussed with the patient?
- Is there a treatment plan that is agreed upon by staff and patients? Is there a practical treatment plan?
- Has there been started with designing a signal plan?

Middle and final phase:

- Have there been regular evaluations?
- Has the treatment plan been adjusted in the face of termination?
- Has there been made an individually tailored after treatment plan, including booster sessions and reintegration issues

6.4. Monitoring organizational adherence

The last level at which adherence should be monitored, is the organizational level. As discussed in chapter 3, it is necessary that the programme is embedded in a whole organization. The organization should fulfill necessary criteria in order to organize a successful MBT-programme. This includes the functioning of the team as a whole and embedding the team in the institution. Every 6 months / year a Programme Implementation Report should be made, based upon the checklist of programme requirements. Stakeholders could be included in (parts of) the evaluation. For example, if there is an increase of inappropriate referrals from within the institution, the referral process should be discussed to detect possible causes.

The PIR could give an overview of:

- Are the programme requirements still fulfilled?
- Overview of indicators for problematic adherence (see appendix)
- Overview of cases being treated, cases dropped out, expected case load on annual base, number of cases on waiting list, % finished treatments and their average duration.
- Overview of adherence scores of therapists and detection of recurring problems in team
- Overview of outcome indicators, including number of suicide attempts, number of violent incidents on the ward,...
- Suggestions for improvement for the organization/team.

Chapter 7: Accreditation and Development

This document summarizes training requirements and the competences that need to be achieved by individuals wishing to develop their skills in MBT and by those wanting to become practitioners or supervisors. In sum individuals need to:

- Demonstrate an appropriate knowledge about mentalizing and MBT.
- Acquire and maintain skills and competences of MBT.
- Become familiar with the MBT adherence scale and its use in supervision.
- Be able to convey to others knowledge about mentalizing and the clinical skills of MBT.
- Be able to compare MBT with other evidence-based interventions for personality disorder

Level A – MBT Interest/Skills

- Available for all health care professionals and others who are interested in MBT.
- Undertake an introductory basic training course or MBT Skills training for mental health professionals both of which provide an overview of the theory and practice of MBT.

Level B – Basic Training as MBT Therapist (Practitioner level)

MBT practitioner trainees must have an existing qualification in a mental health profession, good knowledge of mental disorders, particularly personality disorder, and previous experience of conducting psychological therapy with individuals and/or groups.

In the absence of recordable professional registration (core profession), applications for the MBT Practitioner training may be considered from people with suitable clinical experience, employed in NHS or other mental health services in a substantive clinical post at band 5 or equivalent or above. They must have clinical responsibility for patient care as part of their job role which is identified in their contract. They will need to supply evidence of the governance that is in place to support them i.e., clinical and managerial supervision and evidence that MBT training and delivery of MBT is part of their current job plan. On receiving a positive supervisor report, they will be recorded on the Anna Freud register as 'MBT Practitioner without core profession'.

- MBT practitioner trainees must read the MBT manual and have attended a 3 day basic introductory course.
- Attended a recognised 2-day practitioner certificate course (formerly advanced course)
- Four individual patients or two groups or two individual patients + one group must be treated using MBT as the primary intervention for a minimum of 24 sessions (as part of an MBT treatment of 12 - 18 months duration)
- Participation in or working knowledge of MBT-Introductory group or Socialisation to MBT model in individual sessions.
- Patients (minimum of 2 or 1 group) should have a primary diagnosis of Borderline Personality Disorder.
- Supervision of the cases with a Level D qualified MBT supervisor is required.
- Some sessions of each treatment must be recorded (video). If video is impractical audio recording is acceptable if agreed with supervisor. A minimum of three 15-minute sections from different sessions from each treatment selected by the trainee will be submitted for formal review with reference to MBT competencies (see below).
- Supervision should be conducted either individually or in a group format. Each trainee must receive at least 4 hours supervision for each case.
- A reflective written statement must be produced on completion of each case.
- A satisfactory supervisor's report must also be provided.

Level C – CPD for MBT Therapists

- MBT therapists should carry an MBT caseload - at least 2 MBT cases per year.
- MBT therapists should receive ongoing supervision, at least monthly. This may be individual, peer group.
- MBT therapists should attend at least one MBT CPD event per year e.g. national/international conferences, workshop or course.

Level D – Eligibility for MBT Supervisor

MBT Supervisor: Requirements, evaluation and maintenance

Essential Application Criteria

Mental health professional registered with professional organisation (country specific)

Meet criteria for practitioner MBT practitioner level therapist (or on country specific MBT register) – achieved Level A and B and fulfilling requirements for Level C for a minimum of 3 years (Application to become a supervisor may be made by highly experienced clinicians (e.g., other therapy trained and a supervisor role in current job plan) after 2 years practitioner status (normally 3 years post-practitioner status)).

Training Requirements may be achieved during the supervision course if agreed with course organiser.

Requirements

To register formally as a certified MBT Supervisor, you will need to evidence the following requirements detailed below:

- Mental health professional registered with professional organisation (country specific).
- Meet criteria for practitioner MBT practitioner level therapist (or on country specific MBT register) – achieved Level A and B and fulfilling requirements for Level C for a minimum of 3 years.
- Evidence the initial agreement to enter the supervisor pathway (see below) following review of at least one video of a treatment session showing MBT clinical interventions (The assessor of the sessions (Anna Freud nominated/and a national expert) will have registered a go/no-go to enter the supervisor pathway).
- You are an experienced MBT therapist with additional expertise and competences on the following domains:
 - Theoretical knowledge
 - Clinical experience
 - Didactical qualities
 - Personal qualities
 - Meta-competencies
- A positive report by a registered supervisor regarding specified competencies must be submitted.
- Course attendance: MBT Basic training and MBT Practitioner Certificate training; MBT Supervisor training course (country specific).
- Evidence of continued MBT Practitioner status.
- Supervision: completed at least 6 supervised MBT cases with **2 or more supervisors** dating from period after having acquired MBT Practitioner registration (supervision individually or in group).
- Supervised at least 2 cases (one individual patient and one group) under direct supervision of an Anna Freud recognised MBT Supervisor. This supervision must comprise of 6 sessions focused on individual therapy and 6 sessions focused on group therapy. This supervision of supervision

should cover the beginning, middle and end phases of MBT treatment that is being delivered as per the original evidence base.

Expertise and competences

The supervisor is an experienced MBT therapist with additional expertise and competences on the following domains:

- Theoretical knowledge
 - Thorough knowledge of the theoretical background of mentalizing theory and therapy
 - Understanding of parallel processes and group processes in teams
- Clinical experience
 - Extensive experience and good skills in performing individual and group therapy in MBT
- Didactical qualities
 - Experience and good skills in teaching, training and clinical supervision in psychotherapy
 - Capacity to establish a framework for mentalizing supervision.
 - Capacity to clarify and explain therapy processes from a mentalizing framework.
 - Ability to compare similarities and differences between MBT and its clinical techniques with those of other therapies.
- Personal qualities
 - Capacity to take an open, transparent and supportive attitude towards supervisees.
 - Capacity to stimulate a mentalizing process among supervisees and teams.
 - Capacity to empower self-confidence of therapists in their therapy sessions.
 - Capacity to support therapists to maintain their mentalizing stance longer in sessions.
- Meta-competences
 - Capacity to take a meta-position towards the team processes in order to detect and manage team processes and parallel processes.
 - Capacity to understand the self-appraisal of therapists regarding their own qualities in relation to a particular client.

Prerequisites

- Positive recommendations by two Anna Freud recognised MBT supervisors regarding specified competencies (guide for supporting statement available via website).
- Submission of a recording of a clinical MBT session accompanied by a self-appraisal of application of MBT.
- The assessor (Anna Freud nominated/and a national expert) give a go/no-go to enter the supervisor pathway.

Training Requirements

- Courses: Anna Freud recognised Basic Training course, Practitioner Certificate Course and MBT Supervisor course (country specific).
- Evidence of continued MBT practitioner status.
- Supervision: completed at least 6 supervised MBT-individual cases and 2 MBT groups dating from period after having acquired MBT therapist practitioner registration (supervision individually or in group)
- Having supervised at least 2 cases under direct supervision of registered MBT supervisor (to be finalised as part of the MBT Supervisor training).

Evaluation

During the supervisor development programme, there will be supplementary live assessment of didactical qualities, personal qualities in supervision and relevant meta-competences. Each potential supervisor receives a written feedback and personal advice for further improvement. In the following period, all potential supervisors enter the supervisor training pathway following the recommendation agreed.

Supervisor training trajectory:

- 10 supervision sessions with Anna Freud nominated and/or national expert on recorded supervision sessions or demonstration of competencies in live supervision session.
- Demonstrating an understanding of scoring of adherence scale (training required)
- Exchange of recorded supervision sessions with other (potential) supervisors at least once per year.

Ending the personal and supervisor trajectory with a positive recommendation will result in formal registration as MBT supervisor.

At the end of the personal and supervisor training trajectory, when the candidate meets the criteria for MBT supervisor he/she will be listed on the Anna Freud (country specific) website as an MBT supervisor.

Maintenance

- Continuous clinical work as a MBT therapist and supervisor
- Evidence of maintenance of knowledge of developments in mentalizing and its applications and in clinical skills of MBT e.g., conferences, reading, case discussion (CPD).
- Exchange video of MBT supervision with other supervisors at least once a year

MBT Associate Trainer: Requirements, evaluation and maintenance

- Application about development to become an associate trainer is made to Anna Freud.
- The applicant as trainer offers some training in mentalizing techniques to mental health professionals in their locality.
- Positive report by registered supervisor regarding specified competencies as a supervisor

Expertise and competences

An MBT Associate Trainer is an experienced MBT Supervisor who has additional teaching qualities and has completed an agreed development programme with Anna Freud (or country specific). Associate Trainers can only offer training courses in agreement with the MBT recognised national training centre.

- Teaching qualities
 - Ability to convey theory in a structured and dynamic way.
 - Ability to demonstrate MBT interventions through role playing.
 - Extensive knowledge of the theoretical base and treatment methods of a wide range of therapies of people with complex emotional and interpersonal problems associated with developmental trauma (traditionally may be diagnoses with borderline personality disorder/ Emotionally Unstable Personality Disorder).

Inflow criteria for Associate Trainer Pathway

1. Recommendation from a senior MBT Supervisor/Trainer
2. Demonstrable competence as an MBT Supervisor
3. Participation in MBT Training

- Attend a minimum of 4 basic training courses led by an approved trainer as role play supervisors with a satisfactory trainers report
- Teach some of the basic training course at an additional course and achieve a satisfactory trainers report

4. Assessment/Evaluation

- Two courses will be led by the trainee trainer with the support of a recognised MBT trainer and in agreement with the national training centre.
- Satisfactory reports about teaching ability from feedback and evidence of skills development in the trainees.

Maintenance

- Continuous work as a MBT supervisor and trainer
- Joint delivery of training with national centre 1x every two years.

MBT Competences

Borderline Personality Disorder

Source:

Bateman, A. & Fonagy, P. (2006) Mentalisation-based Treatment for Borderline Personality Disorder: a practical guide. OUP:Oxford

Bateman, A. & Fonagy, P. (2016) Mentalisation-based Treatment for Personality Disorder: a practical guide. OUP: Oxford

With thanks to Alessandra Lemma who extracted these competences from the manual

Knowledge

General

An ability to draw on knowledge of the psychological and interpersonal difficulties experienced by clients with a diagnosis of BPD
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Knowledge of the developmental model underpinning the understanding of BPD

An ability to draw on knowledge that a mentalisation based approach is grounded in attachment theory
An ability to draw on knowledge that MBT formulates the mental vulnerabilities associated with BPD as resulting from the fragility of mentalisation in the context of attachment relationships
An ability to draw on knowledge of the developmental factors and experiences (e.g. a history of trauma) that are typically associated with a vulnerability to loss of mentalisation

An ability to draw on knowledge that the vulnerability to loss of mentalisation leaves the client exposed to more primitive modes of experiencing internal reality that, in turn, undermines the coherence of self-experience

Knowledge of the aims and focus of the treatment

An ability to draw on knowledge that the treatment aims at increasing the client's capacity to mentalise:
An ability to draw on knowledge of what constitutes 'good' and 'poor' mentalising
An ability to draw on knowledge that the therapy aims to support the recovery of mentalisation, not the acquisition of insight into unconscious dynamics
An ability to draw on knowledge that the treatment systematically focuses on: <ul style="list-style-type: none"> • the client's state of mind, not on their behaviour • the client's affects in the here-and-now of the session or recent past, not on the interpretation of unconscious or distal events

Knowledge of the treatment strategy

An ability to draw on knowledge that the treatment comprises both individual and group therapy in the context of either day hospital provision or intensive out-patient treatment with psychiatric support
An ability to draw on knowledge that the three main phases of the treatment have distinct aims targeting particular processes:
The initial phase aims to assess the client's capacity to mentalise and to engage the client
The middle phase focuses on helping the client to develop a mentalising capacity and to retain it amidst emotional states
The final phase focuses on helping the client to prepare for ending intensive treatment
An ability to draw on knowledge that the treatment makes active use of the client-therapist relationship to explore failures of mentalisation and their consequences

Therapeutic stance

An ability to establish and maintain a supportive, reassuring and empathic relationship with the client
An ability to adopt a stance of 'not knowing' which communicates to the client a genuine attempt to find out about their mental experience
An ability to sustain an active, non-judgemental mentalising stance that prioritises the joint exploration of the client's mental states:
An ability to communicate genuine curiosity about the client's mental states through actively enquiring about interpersonal processes and their connection with the client's mental states
An ability to sustain a positive, supportive stance without undermining the client's autonomy:
An ability to critically consider the appropriateness of supportive interventions that may involve taking concrete action within therapeutic boundaries
An ability to critically reflect on when and how to self-disclose:
An ability to communicate to the client, through relevant questions and observations, the therapist's openness to reflecting on their own 'non-mentalising errors' and how they may have impacted on the client
An ability to model honesty by acknowledging the therapist's own errors

Assessment

General

An ability to assess the client's overall functioning to arrive at a diagnosis of BPD
An ability to assess level of risk to self and other

Model specific

An ability to distinguish mentalisation from: <ul style="list-style-type: none">• pseudo-mentalisation• concrete (psychic equivalent) thinking• misuse of mentalization
An ability to assess the client's capacity to mentalise and factors that undermine mentalisation through an exploration of the client's current and past interpersonal context:
An ability to elicit a detailed picture of the client's significant relationships and their connection with presenting problem behaviours
An ability to elicit interpersonal narratives through asking questions that invite the client to elaborate and reflect on their own mental states and those of others
An ability to assess the quality of the client's current and past interpersonal functioning, including:
Assessment of whether the client's pattern of relationships is 'centralised' (i.e. unstable, self-focused and inflexible) or 'distributed' (i.e. stable, distancing and inflexible)
Assessment of the quality of communication between the client and other people

Engagement

An ability to communicate with the client in a direct, authentic, transparent manner, using simple and unambiguous statements so as to minimise the risk of over-arousing the client
An ability to share the diagnosis of BPD with the client in an open, collaborative manner that stimulates the client's reflection on what this means for them in the context of their experience and reported difficulties
An ability to introduce the client to an attachment-based understanding of BPD:
An ability to pitch the level of explanation according to an assessment of the client's capacity to take in new information which in turn depends on their capacity to mentalize at that moment
An ability to personalise the introduction of the model by linking it to the client's own history and current experiences
An ability to introduce the client to the treatment rationale and goals primarily through using the live process in the session (e.g. by highlighting for the client examples of his mentalising strengths and vulnerabilities as he describes himself and his relationships)
An ability to introduce the client to the ground rules that protect the treatment boundary and to provide a rationale for them in the context of the mentalising focus of the treatment:
An ability to engage the client in exploring his reaction to the rules
An ability to arrive at a formulation and to set this out in writing in a clear, explicit manner, illustrated with examples so that it can be shared with the client
An ability to introduce and discuss the formulation with the client whilst monitoring the impact it has on the client so as to respond sensitively to indicators of emotional arousal. An ability to modify the formulation according to new understanding with the client.

An ability to engage the client in collaboratively identifying how they will access help when in crisis
An ability to identify and agree with the client therapeutic goals

Intervention

Knowledge

An ability to draw on knowledge that interventions are aimed primarily at helping the client discover what they feel and to develop meaning, and not to interpret what the client may be feeling and why they may be feeling it

General characteristics

a) Content of interventions

<p>An ability to make interventions that are:</p> <ul style="list-style-type: none"> • Focussed on the client's mind, not on behaviour. • Affect focussed (primarily in relation to the here-and-now of the session) • Related to current event(s) and near-conscious or conscious content • Simple, short and unambiguous • Qualified (e.g. 'I am not sure if...') so as to model managing uncertainty in relation to the mental states of others • Accurately and succinctly restates and spells out the assumptions behind, neither oversimplifying nor overcomplicating the client's thoughts and feelings about an issue

b) Process of intervention

An ability to respond to requests by the client for clarification in a direct and clear manner that models a self-reflective stance open to correction
An ability to follow shifts and changes in the client's understanding of their own and others' thoughts and feelings
An ability to become aware of and respond sensitively to sudden and dramatic failures of mentalization in the client
An ability to make use of the here-and-now relationship with the therapist to help the client identify failures of mentalisation and explore their consequences
An ability to consider the timing and the type of interventions in the context of an assessment of the client's current emotional state so as to maintain the client's level of arousal at an optimal level that supports mentalizing

Ability to explore mentalising

Knowledge

An ability to draw on knowledge that interpretive mentalising is a gradual, staged process that closely monitors the client's state of emotional arousal so as to ensure that the interpretation maximises the likelihood of mentalisation by not over-arousing the client
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Application

Ability to explore mentalising

An ability to use clarification and elaboration to gather a detailed picture of a behavioural sequence and associated feelings
An ability to clearly restate and elaborate for the client the therapist's understanding of thoughts, feelings, beliefs and other mental states described by the client and to do so in a way that opens discourse about these rather than closing it off.
An ability to help the client make connections between actions and feelings
An ability to help the client develop curiosity about their motivations
An ability to help the client identify the failure to read minds and its consequences
An ability to share the therapist's perspective so as to help the client to consider an alternative experience of the same event
An ability to maintain or to redirect the focus of exploration to the client's felt experience, motivations and current state of mind, pointing out instances of 'non-mentalising fillers' (e.g. rationalisations, dismissive statements)
An ability to help the client shift the focus from non-mentalising interaction with the therapist towards an exploration of the current feelings and thoughts, as manifest in the client-therapist interaction, or in recent experiences outside the therapy room
An ability to judiciously praise the client when the client uses mentalising with a positive outcome so as to encourage and support change

Ability to re-establish mentalising

An ability to identify breaches in mentalising, as they occur in the patient, the therapist or both so as to redirect the focus on understanding the rupture or impasse and re-establish mentalizing
An ability to draw the client's/group's attention to the rupture or impasse so as to explore what has happened, focusing on the felt experience of each participant
An ability to challenge the client's perspective whilst exploring their underlying emotional state
An ability to communicate to the client/group the affective process that inhibits the capacity to mentalise
An ability to sensitively, yet firmly persist with the focus on exploration of the client's state of mind in the face of resistance to reinstating mentalising

Ability to mentalise the transference

Knowledge

An ability to draw on knowledge that the treatment focuses on encouraging the client to reflect on what is happening <i>currently</i> in the therapeutic relationship
An ability to draw on knowledge of the treatment rationale for focusing on the therapeutic relationship (i.e. so as to help the client consider alternative perspectives of the same event, not to provide insight)
An ability to draw on knowledge that mentalising the transference is only indicated when the client is considered able to reflect on their own mental states and those of the therapist in the context of heightened affect

Application

An ability to help the client gradually progress, over the course of treatment, from the least intensely felt reflection to the more intensely felt reflection by staging interventions in the following sequence:
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<ul style="list-style-type: none"> • Exploration of emotional experience in current external relationships • Exploration of emotional experience in relation to interpersonal themes as they emerge in relation to the treatment • Exploration of the transference
An ability to work collaboratively with the client towards an understanding of the transference experience by engaging the client in being curious about what has happened in the room:
An ability to use the techniques of clarification and elaboration to elicit a detailed picture of what has transpired between client and therapist
An ability to monitor countertransference and to work to regain a reflective stance after an enactment
An ability to acknowledge and explore openly with the client an enactment on the part of the therapist:
An ability to communicate the therapist's perspective about the impasse or rupture, focusing on the failure of mentalisation, not on giving insight into underlying unconscious factors.
An ability to monitor and engage with the client's response to an interpretation

Metacompetencies

<p>An ability to apply the core aims and strategies of a mentalising approach to a group context.</p> <p>An ability to apply the core aims and strategies of a mentalizing approach to a systemic context including the patient's family system and the system within which services are provided.</p> <p>An ability to work in a team using the mentalizing approach and assisting others to retain a focus on the approach in their work with their patients – particularly at times of crises and difficulties.</p> <p>An ability to reflect on own work and identify where failures of mentalizing on the part of the therapist interfered with the delivery of good quality care.</p> <p>An ability to monitor the patient's progress in mentalizing over the course of a multi-year treatment.</p>
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Appendix X: What does good mentalisation look like

Poor mentalisation may be readily categorized into one of several types. In contrast good mentalization takes but one form. Here we consider several contexts within which the assessor may note high quality mentalisation. The illustrations are self-descriptions but in actual assessment the therapist would be looking for evidence of these traits rather than statements claiming such attributes. An easy scoring scheme is provided in the Appendix. The assessor is simply asked to reflect on the interview just conducted and note compelling examples of categories of mentalisation, ticking either the strong or weak evidence column as appropriate. Each of the four themes are to be scored.

1. In relation to other people's thoughts and feelings

- a. *opaqueness* -- acknowledgement in commentary that one often does not know what other people are thinking, yet not being completely puzzled by what happens in the minds of others (e.g. "What happened with Chris made me realise that we can often misunderstand even our best friends' reactions")
- b. *the absence of paranoia* -- not considering the thoughts of others as in themselves a significant threat and having in mind the possibility that minds can be changed (e.g. "I don't like it when he feels angry but mostly you can cajole him out of it by talking with him about it")
- c. *contemplation and reflection* -- a desire to reflect on how others think in a relaxed rather than compulsive manner (e.g. during the interview the person actively contemplates the reasons why someone she knows well behaves as they do)
- d. *perspective-taking* -- acceptance that the same thing can look very different from different perspectives based on individual history (e.g. a description of an event that was experienced as a rejection by one person and a genuine attempt made to identify how it came about that they misunderstood it)
- e. *a genuine interest* in other people's thoughts and feelings -- not just for their content but also for their style (e.g. the person appears to enjoy talking about why people do things)
- f. *openness to discovery* -- the person is naturally reluctant to make assumptions about what others think or feel
- g. *forgiveness* -- acceptance of others conditional on understanding their mental states (e.g. the person's anger about something dissipates once they understand why the other person had acted in the way they did)
- h. *predictability* -- a general sense that, on the whole, the reactions of others are predictable given knowledge of what they think and feel

2. perception of own mental functioning

- a. *changeability* -- an appreciation that one's views of and understanding of others can change in line with changes in oneself
- b. *developmental perspective* -- understanding that with development one's views of others deepen and become more sophisticated (e.g. the person acknowledges that as they grew up they began to understand their parents' actions better)
- c. *realistic scepticism* -- a recognition that one's feelings can be confusing
- d. *acknowledgement of preconscious function* -- a recognition that at any one time one may not be aware of all that one feels, particularly in the context of conflict
- e. *conflict* -- awareness of having incompatible ideas and feelings

- f. *self-inquisitive stance* -- a genuine curiosity about one's thoughts and feelings
- g. *an interest in difference* -- an interest in the ways minds unlike the subject's own work such as a genuine interest in children's minds
- h. *awareness of the impact of affect* -- insight into how affects can distort one's understanding of oneself or others

3. self-representation

- a. *advanced pedagogic and listening skills* -- the patient feels that they are able to explain things to others and are experienced by others as being patient and able to listen
- b. *autobiographical continuity* -- a capacity to remember oneself as a child and evidence the experience of a continuity of ideas
- c. *rich internal life* -- the person rarely experiences their mind as empty or contentless

4. general values and attitudes

- a. *tentativeness* -- on the whole a lack of absolute certainty about what is right and what is wrong and a preference for complexity and relativism
- b. *moderation* -- a balanced attitude to most statements about mental states both in regard to oneself and others that comes from accepting the possibility that one is not in a privileged position either in regard to one's own mental state or that of another person and sufficient self monitoring to recognise flaws (e.g. "I have noticed that sometimes I overreact to things")

Appendix 1: List of outcome instruments recommended by the Dutch MBT Research consortium

Instruments			Measure moments						
Name	Items	Period	Baseline	6 months	12 months	18 months	24 months	30 months	36 months
Interview									
▪ SCID-I		5 jaar	X			X			(X)
▪ SCID-II		5 jaar	X			X			(X)
▪ SSHI		6 mnd	X	X	X	X	(X)	(X)	X
Self report									
▪ PAI-BOR	45		X	X	X	X	(X)	(X)	X
▪ BSI	60	1 week	X	X	X	X	(X)	(X)	X
▪ IIP	64	Huidig	X	(X)	(X)	X	(X)	(X)	X
▪ ECR	36		X	(X)	(X)	X	(X)	(X)	X
▪ RFQ	45		X	(X)	(X)	X	(X)	(X)	X
▪ BDI	20		X	(X)	(X)	X	(X)	(X)	X
▪ DAPP-SF	120	Huidig	X			X			X
▪ EQ-5D	5	1 week	X	X	X	X	(X)	(X)	X
▪ TiC-P	15	4 weken	X	X	X	X	(X)	(X)	X
▪ Sheehan	3		X	X	X	X	(X)	(X)	X

¹X=strongly recommended; (X)=desired/high quality data

²SCID-I=Structured Clinical Interview for DSM-IV Axis I disorders; SCID-II= Structured Clinical Interview for DSM-IV Axis II disorders; SSHI=Suicide and Self-Harm Inventory; PAI-BOR=Personality Assessment Inventory – Borderline features; DAPP-SF=Dimensional Assessment of Personality Pathology-Short Form; BSI=Brief Symptom Inventory; EQ-5D=Euroquol 5D; IIP= Inventory of Interpersonal Problems; ECR=Experiences of Close Relationships; RFQ=Reflective Functioning Questionnaire; TiC-P= Trimbos/iMTA questionnaire for Costs associated with Psychiatric Illness (Care Consumption Report); Sheehan=Sheehan Disability Scale

Optionele maten aanbevolen (nader aan te vullen): MPQ=Multi-dimensional Personality Questionnaire; MMPI-RF=Minnesota Multiphasic Personality Inventory-2 Restructured Form; SIPP-118=Severity Indices of Personality Problems-118; RMET=Reading the Mind in the Eyes Test;

Appendix X: Programme requirements and recommendations

Fulfilled	Not fulfilled	Programme requirements:
<input type="checkbox"/>	<input type="checkbox"/>	1. The programme implements quality monitoring system, including logistics for adherence assessment and outcome monitoring
<input type="checkbox"/>	<input type="checkbox"/>	2. The programme is only available for patients meeting the selection criteria
<input type="checkbox"/>	<input type="checkbox"/>	3. Basic training and regular supervision is necessary for every team member (see.... training and supervision requirements)
<input type="checkbox"/>	<input type="checkbox"/>	4. MBT-therapists should have a minimum engagement of 24-28 hours in the programme.. In a 5-day programme at least some therapists should work full time.
<input type="checkbox"/>	<input type="checkbox"/>	5. A MBT team consists of 4 - 9 therapists.
<input type="checkbox"/>	<input type="checkbox"/>	6. The MBT-supervisor works at least half time for the MBT programme.
<input type="checkbox"/>	<input type="checkbox"/>	7. The MBT supervisor delivers weekly supervision to the team and is available for individual consultation in cases of crisis. The supervisor also contact the expert weekly by mail or telephone.
<input type="checkbox"/>	<input type="checkbox"/>	8. The MBT-caseload per therapist should not exceed 18 patients (excluding low frequent follow up patients)
<input type="checkbox"/>	<input type="checkbox"/>	9. A MBT treatment lasts generally between 12-18 months.
<input type="checkbox"/>	<input type="checkbox"/>	10. A psychiatrist is integrated in the team. Medication is prescribed by the psychiatrist but is discussed by the whole team. The prescribing psychiatrist is not the patients therapist.
<input type="checkbox"/>	<input type="checkbox"/>	11. Every MBT therapist makes a treatment plan for each individual patient and monitors the results of treatment in every case, using the electronic file
<input type="checkbox"/>	<input type="checkbox"/>	12. Therapists from the programme should be available during office hours in case of crisis. Outside working hours patients can leave a message; therapists ensure calling back the next working day.
<input type="checkbox"/>	<input type="checkbox"/>	13. The programme should make clear arrangements with local psychiatric services considering crisis admission policy. A protocol for crisis interventions can be obtained from MBT-Netherlands
<input type="checkbox"/>	<input type="checkbox"/>	14. The MBT-therapist should make a crisis plan for each individual patient at the start of treatment. The General PD should be informed about this plan.
<input type="checkbox"/>	<input type="checkbox"/>	15. Follow-up care should be organized by the programme. Mostly no referrals to other intensive treatment programs should be necessary after the MBT-treatment trajectory.
<input type="checkbox"/>	<input type="checkbox"/>	16.
<input type="checkbox"/>	<input type="checkbox"/>	17. MBT supervisors are functionally in lead of the therapists they are supervising.

Fulfilled	Not fulfilled	Programme Recommendations:
<input type="checkbox"/>	<input type="checkbox"/>	1. To enhance treatment adherence, it is recommended that MBT therapist do not work from different theoretical perspectives. Other diagnostical, teaching, coordinating, etc. tasks are not a problem
<input type="checkbox"/>	<input type="checkbox"/>	2. It is recommended that the programme starts with two teams, in order to be able to maintain a reflective stance about the intended actions of the other team
<input type="checkbox"/>	<input type="checkbox"/>	3. It is recommended that the outcome for each individual case is monitored through the outcome monitoring system and that feedback is being given to the therapist and client.
<input type="checkbox"/>	<input type="checkbox"/>	4. It is recommended that therapists are at least partly evaluated based upon the results obtained in their cases and their adherence to the model

