Mentalization Based Treatment

Clinical Training Slides
Structure of Mentalization Based Treatment
Trajectory of Treatment

1. Assessment and assessment of mentalizing
2. Giving Diagnosis
3. Formulation
4. Crisis Plan and risk assessment
5. Contracting including barriers to treatment
6. Outcome monitoring
7. MBT-I
8. MBT

MBT - I Trajectory of Treatment
Goals of initial phase

- Engagement in treatment
- Motivation
- Stabilise factors undermining treatment
- Target high risk behaviours
- Identify long term goals – relationships and constructive activity
- Finalise formulation
Establishing a Diagnosis

- How would you describe yourself as a person?
- What makes you an individual?
- How would someone else describe you?
- What sort of person are you in close relationships?
- What are your best features as a person?
Crisis Plans

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

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

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

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

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

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

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

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

Manual available in Practical Guide
Handouts:

Introduction pathway

- A psycho-educational perspective runs through the entire treatment philosophy of MBT
  - Joint formulation
  - Crisis plans
  - Family involvement
  - Leaflets
  - Importance of therapists mental state
Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

- a pattern of unstable intense relationships,
- inappropriate, intense anger
- frantic efforts to avoid abandonment
- affective instability,
- impulsive actions
- recurrent self-harm & suicidality,
- chronic feelings of emptiness or boredom (dysphoria),
- transient, stress-related paranoid thoughts
- identity disturbance severe dissociative symptoms

unstable relationships
affective dysregulation
impulsivity
aggression
MBT-I Structure

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

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

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

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

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

- Session 7 What is personality disorder with focus on BPD
- Session 8 Mentalization Based Treatment
- Sessions 9 Mentalization Based Treatment
- Session 10 Anxiety, attachment and mentalizing
- Session 11 Depression, attachment and mentalizing
- Session 12 Summary and Conclusion
Overview of the MBT model: Key Domains
## Domains of MBT

### General Domains

- Can be evaluated by viewing a whole session
- Two general core domains
  
  1. Not-Knowing Stance
  2. Sessional Structure

  - Both general domains provide the basis for delivering MBT
  - Impossible to focus work on mentalizing without the two core elements

### Major Component Domains

- Can be evaluated on the basis of the therapist’s interventions
- Four major component domains
  
  3. Mentalizing Process
  4. Non-Mentalizing Modes
  5. Mentalizing Affective Narrative
  6. Relational Mentalizing

- A typical MBT session involves interventions within these 4 domains
- MBT therapist will train on skills to deliver each type of intervention
Domains of MBT

Not-Knowing Stance
- Mentalizing Process
- Mentalizing Affective Narrative

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

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

Safe in Low Anxiety

High Anxiety
Interventions: Spectrum

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

Not knowing/inquisitive/Mentalizing stance
(1) Not Knowing Stance

Core Domain
Therapist/Patient Problem

ATTEMPT TO STRUCTURE
by
EFFORT TO CONTROL SELF &/OR OTHER

RIGID SCHEMATIC REPRESENTATION
NON-MENTALIZING
CONCRETE MENTALIZING (PSYCHIC EQUIVALENCE)
PSEUDO MENTALIZING (PRETEND)
MISUSE OF MENTALIZING
Therapist Stance

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

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

- Using questioning comments to promote exploration
  - What do you make of what has happened?
  - Describe your experience to me in more detail. Where in your body did you first feel that?
  - I wonder (beware of wondering too often!) if that was related to the group yesterday?
  - Perhaps you felt that I was judging you?

- Why do you think that he said that?*
- What do you make of her suicidal feeling (in the group)?*
- Why do you think that he behaved towards you as he did?*

*ONLY IF PATIENT NOT IN PSYCHIC EQUIVALENCE
Essential to the Stance

- Keep it current – what the patient feels right now
- Find a way of stating that you genuinely understand their distress – GO ALONGSIDE THE PATIENT
- See the experience through their eyes and mind
- Patient
- Authentic
- Curious
- Thoughtful
- Sensitive
Therapist Stance
Explicit Mentalization

- Not directly concerned with content
- Obtain narrative to focus session
- Beware persistent focus on narrative description
- Exploration draws attention back to implicit representations—feelings for example
  - use language to bolster engagement on the implicit level of mentalization
  - highlight the experience of “feeling felt” (mentalized affectivity)
Basic Mentalizing: Process
(3) Mentalizing Process

Major Component Domain

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Dimension</th>
<th>High arousal</th>
<th>Low arousal</th>
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<tbody>
<tr>
<td></td>
<td>Affective → Cognitive</td>
<td>Cognitive → Affective</td>
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<tr>
<td>Focus</td>
<td>Re-direct</td>
<td>Emphasise</td>
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<td>Patient experience</td>
<td>Validate</td>
<td>Challenge</td>
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<tr>
<td>Responsibility</td>
<td>Clinician accepts</td>
<td>Patient explores</td>
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<tr>
<td>Process</td>
<td>Go with the flow</td>
<td>Resist/challenge</td>
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<tr>
<td>Interpersonal Interaction</td>
<td>Decrease</td>
<td>Increase</td>
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Managing arousal for optimal mentalizing

Over and under arousal are antithetical to robust mentalizing

<table>
<thead>
<tr>
<th>High arousal</th>
<th>Low arousal</th>
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<tbody>
<tr>
<td>Empathic validation of patient perspective</td>
<td>Challenge of patient perspective</td>
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<tr>
<td>Move affective pole to cognitive pole</td>
<td>Move cognitive pole to affective pole</td>
</tr>
<tr>
<td>Move self to other mentalizing</td>
<td>Move other to self mentalizing</td>
</tr>
<tr>
<td>Reduce focus on personal interaction</td>
<td>Increase focus on personal interaction</td>
</tr>
<tr>
<td>Clinician responsibility</td>
<td>Increase patient focus</td>
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</table>
Maintaining Motivation

- Demonstrate support, reassurance and empathy as you explore the patients mind
- Model reflectivity
- Identify the discrepancy between the experience of the self and the ideal self – ‘how you are compared with how you would like to be’
- ‘Go with the flow’ or ‘roll with the resistance’
- Re-appraise gains and identify areas of continuing problem
- Highlight competencies in mentalizing and listen for mentalizing strengths
Imbalance of mentalization generates problems

**Implicit-Automatic-Non-conscious-Immediate.**
- Impulsive, quick assumptions about others thoughts and feelings not reflected on or tested, cruelty
- Lack of conviction about own ideas
- Unnatural certainty about ideas
- Hypersensitive to others’ Moods, what others say. Fears ‘disappearing’

**Explicit-Controlled-Conscious-Reflective**
- Does not genuinely appreciate others’ perspective. Pseudo-mentalizing, Interpersonal conflict ‘cos hard to consider/reflect on impact of self on others
- Hyper-vigilant, judging by appearance. Evidence for attitudes and other internal states hasto come from outside
- Overwhelming dysregulated emotions. Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing
- Rigid assertion of self, controlling others’ thoughts and feelings.

**Mental interior cue focused**
- Mental exterior cue focused

**Cognitive agent:attitude propositions**
- Unnatural certainty about ideas
- Anything that is thought is REAL Intolerance of alternative ways of seeing things.

**Affective self:affect state propositions**
- Unnatural certainty about ideas
- Anything that is thought is REAL Intolerance of alternative ways of seeing things.

**Imitative frontoparietal mirror neurone system**
- Overwhelming emptiness, Seeking intense experiences
- Hypersensitive to others’ Moods, what others say. Fears ‘disappearing’

**Belief-desire MPFC/ACC inhibitory system**
- OVerwhelming dysregulated emotions. Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing
- Rigid assertion of self, controlling others’ thoughts and feelings.
## Theory to Practice: Contrary Moves

<table>
<thead>
<tr>
<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
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<tbody>
<tr>
<td>External focus</td>
<td>Internal focus</td>
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<tr>
<td>Self-reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
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<tr>
<td>Cognitive</td>
<td>Affective</td>
</tr>
<tr>
<td>Explicit</td>
<td>Implicit</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
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Mentalizing Process – affect trajectory

1. **Narrative of event**
2. **Experience at time**
3. **Reflection on events**
4. **Experience talking about it in therapy**
5. **Current feeling about events**
6. **Alternative perspective**
Process of Rewind and Exploration

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

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

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

Intervention
- Empathy
- Clarification
- Exploration
- Challenge
- Affect identification
- Affect Focus
- Interpersonal
Empathic Validation:
Underpinning mentalizing process
Interventions:
Supportive & empathic

- **Provoke curiosity about motivations**
  - Highlight own interest in mental states
  - Qualify own understanding and inferences – ‘I can’t be sure but’; ‘may be you’; ‘I guess that you’
  - Guide others’ focus towards experience and away from “factual fillers”
  - Demonstrate how subjective information could help to make sense of things
Empathic Validation – Affect and Effect

- Interest in and Reflection on **Affect**
- Identification of feelings
- Normalising when possible in context of present and past
- Seeing it through their eyes
- What **effect** does this experience have on them
Interventions:
Supportive & empathic

- Respectful of their narrative and expression
- Positive/hopeful but questioning
- Unknowing stance – you cannot know their position
- Demonstrate a desire to know and to understand
- Constantly check-back your understanding – ‘as I have understood what you have been saying is…
- Spell out emotional impact of narrative based on common sense psychology and personal experience
- For the patient but not acting for them – retains patient responsibility
Interventions: Supportive & empathic

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

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

Major Component Domain
Use and Misuse of Mentalizing / Psychic Equivalence / Teleology / Pretend Mode
What does mentalizing look like in clinical practice?
What does good mentalizing look like?

- Mentalizing on a spectrum from non-mentalizing in which non-mentalizing modes dominate to full mentalizing in which:
- In relation to other peoples thoughts and feelings
  - Acknowledgement of opaqueness
  - Absence of paranoia
  - Contemplation and reflection
  - Perspective taking
  - Genuine interest
  - Openness to discovery
  - Forgiveness
  - Predictability
What does good mentalizing look like?

- Perception of own mental functioning
  - Appreciation of changeability
  - Developmental perspective
  - Realistic scepticism
  - Acknowledgement of pre-conscious function
  - Awareness of impact of affect

- Self-presentation e.g. autobiographical continuity

- General values and attitudes e.g. tentativeness and moderation
Understanding behaviours in terms of the temporary loss of mentalisation

Temporary Failure of Mentalisation

- Pretend Mode
- Psychic Equivalence
- Teleological Mode
- Pseudo Mentalisation
- Concrete Understanding
- Misuse of Mentalisation

Unstable Interpersonal Relationships
Affective Dysregulation
Impulsive Acts of Violence, Suicide, Self-Harm
Psychotic Symptoms
Questions that can reveal quality of mentalisation

- Why did your parents behave as they did during your childhood?
- Do you think your childhood experiences have an influence on who you are today?
- Any setbacks?
- Did you ever feel rejected as a child?
- In relation to losses, abuse or other trauma, how did you feel at the time and how have your feelings changed over time?
- Have there been changes in your relationship with your parents since childhood?
Elaboration of interpersonal event

- Thoughts and feelings in relation to the event
- Ideas about the other person’s mental state at turning points in narrative
  - Elaborate on actual experience
  - Reflecting on reconstructed past
- Understanding own actions (actual past and reflection on past)
- Counter-factual follow-up questions
What does extremely poor mentalizing look like?

- Anti-reflective
  - hostility
  - active evasion
  - non-verbal reactions

- Failure of adequate elaboration
  - Lack of integration of topics
  - Lack of explanation – things just are

- Inappropriate
  - Complete non-sequiturs
  - Gross assumptions about the interviewer
  - Literal meaning of words – mentalizing means you are ‘mental’
Non-mentalizing: Psychic Equivalence

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

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

- In mentalizing terms a person using teleological mental process:
  - focuses on understanding actions in terms of their **physical** as opposed to mental **constraints**
  - Cannot accept anything other than a modification in the realm of the **physical** as a true index of the intentions of the other.
  - Extreme **exterior focus**, momentary **loss of controlled** mentalizing
  - **Misuse** of mentalization for teleological ends (e.g. controlling others) becomes possible because of lack of **implicit as well as explicit** mentalizing
| Clinical form       | Certainty/suspension of doubt  
|                    | Absolute  
|                    | Reality defined by self-experience  
|                    | Finality – It just is.  
|                    | Internal = external  
| Therapist experience | Puzzled  
|                     | Wish to refute  
|                    | Statement appears logical but obviously over-generalised  
|                    | Not sure what to say  
|                    | Angry or fed up and hopeless  
| Intervention       | Empathic Validation with subjective experience  
|                    | Curious – how did you reach that conclusion  
|                    | Presentation of clinician puzzlement (marked)  
|                    | Linked topic (diversion) to trigger mentalizing then return to psychic equivalent area  
| Iatrogenic         | Argue with patient  
|                    | Excessive focus on content  
|                    | Cognitive challenge  

## Modes of non-mentalizing

### TELEOLOGICAL MODE

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

### PRETEND MODE

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

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

- Counter-intuitive statements – low level

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

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

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

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

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

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

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

Labelling feelings

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

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

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

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

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

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

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

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

Major Component Domain

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

A precursor of relational mentalizing
Challenge and relational process

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

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

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

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

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

**Reasons for working in the Transference/Relationship**

- Poor long term outcome
  - Spontaneous improvements (recovery)
  - Relationship problems and life goals

- Attachment as the root to personality disorder
  - Nature of disorganized attachment
  - Avoidance as long term outcome

- Thinking about relationships: Internal working model
  - Self
  - Object
  - Affect
Therapist Stance

Reflective enactment

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

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

- **Working with the relationship (MUST be mentalizing)**
  - Emphasis on current
  - Demonstrate alternative perspectives
  - Contrast patient’s perception of the therapist to self-perception or perception of others in the group
  - Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
  - Highlight underlying motivation as evidenced in therapy
Components of mentalizing the therapeutic relationship

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

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

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

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

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

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

- **Psychic equivalence**
  - Puzzlement, confused, unclear, excessive nodding
  - Not sure what to say, just going
  - Anger with the patient
Guidance on which intervention when
Guidance on WHICH intervention WHEN
Clinical Intervention: Self Harm and the Alien Self
CLINICAL INTERVENTION:
Self Harm and Alien Self
Theory: Birth of the Agentive Self

Attachment figure “discovers” infant’s mind (subjectivity)

Infant internalizes caregiver’s representation to form psychological self.
Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality ➔ mentalization.
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

Attachment

Figure

Absence of a representation of the infant’s mental state

Mirroring fails

Child

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

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

Torturing alien self  

Self representation

Perceived other

Unbearably painful emotional states: Self experienced as evil/hateful

Self-harm state

Attack from within is turned against body and/or mind.
**Theory:** Self-destructiveness and Externalisation Following Trauma

- **Perceived other:**
- **Unbearably painful emotional states:**
  - Self experienced as evil/hateful

**Self-harm state**

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

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

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

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

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

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

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

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

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

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

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

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

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

For now that is the only reason why you are not, at this moment trying to do it.
Interventions: Spectrum

- Supportive/empathic validation
- Clarification, elaboration, challenge
- Basic mentalizing, Affect Focus
- Relational Mentalizing
Which intervention to use when?

- If in doubt start at the surface empathic validation.
- Move to ‘deeper’ levels only after you have performed earlier steps.
- If emotions are in danger of becoming overwhelming take a step towards the surface.
- Type of intervention is inversely related to emotional intensity – empathic validation being given when the patient is overwhelmed with emotion; mentalizing relationship when the patient can continue mentalizing whilst ‘holding’ the emotion.
- Intervention must be in keeping with patients mentalizing capacity. Danger is assuming that people with BPD have a greater capacity than they actually have when they are struggling with feelings.
Self-harm

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

- **Intervention**
  - Explore reasons for destabilisation of self-structure
  - ‘Tell me when you first began to feel anxious that you might do something?’

Mentalizing functional analysis
Understanding suicide and self-harm in terms of the temporary loss of mentalization

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

- **Failure of mentalization ➔**
  - *Psychic equivalence ➔ intensification of unbearable experience ➔*
  - *Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔*
  - *Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting*
Step-wise Intervention

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

Self-Harm/Suicide

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

Psychic Equivalence

Restore mentalizing
Mentalizing Functional Analysis

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

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

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

- DO NOT
  - mentalize the relationship in the immediacy of a suicide attempt or self-harm
  - Interpret the patient’s actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the ‘heat’ of the moment. It will alienate the patient.
Workshop Exercises
Role Plays

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

- **Patient**
  - Be a moderate and not the extreme person with BPD
  - Respond as you think your patient would
  - Monitor how the clinician makes you feel – misunderstood, secure, s/he is interested, makes you think etc
  - What was it that made you feel like that or altered your mind state?
A patient calls you to say that he has had enough. He feels that no one cares about him. He doesn’t know what to do.

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

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

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

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

- Patient reports that she has got into an argument at work and suspended pending an inquiry.

- Therapist
  - Inquisitive stance
  - Therapist to focus patient attention on current situation
  - Explore the incident
  - Elaborate mental states of protagonists
  - Demonstrate humility - not knowing
  - Monitor for non-mentalizing and try to Intervene to move patient to mentalizing
Workshop Exercise

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

Therapist

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

- Patient has been shouting at staff and/or complains about another member of staff. Therapist has to address what has been happening.

- Therapist
  - Empathic validation
  - Clarification
  - Elaboration and affect focus
  - Rewind and Explore
  - Stop and stand if necessary
  - (Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.)
Workshop Exercise to use Basic Mentalizing and mentalizing the relationship

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

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

- Therapist: transference tracers and mentalizing the relationship
Therapist feels that the therapy is stuck and cannot see that it is likely to go anywhere and feels that ending therapy should be considered.

- Patient has not indicated that she feels similarly
- Raise the subject with the patient and explore.
Workshop exercise

- Patient describes having cut himself and requiring sutures.

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

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

- Therapist
  - Affect focused clarification
  - Elaboration in context of current relationship
  - Work within the relationship
  - Mentalize the relationship
Patient tells a story about how she was angry and shouted at her 4 year old child. Then she states that she knows that you are appalled by her.

Therapist

- Affect focused clarification
- Elaboration in context of current relationship
- Work within the relationship
- Mentalize the relationship
Mentalizing and Group Psychotherapy
Mentalizing and Groups

Two types of groups

MBT Group

MBT- I
MBT Group

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

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

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

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

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

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

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

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

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

Clinical stance and managing process
MBT-G: Clinician Authority

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

- Attention to implicit-explicit dimension of mentalizing
- Intervene when there is an opportunity for, or need for, mentalizing work.
- Actively promote group interaction
- Principle of ‘No Advice Given’ – Explain carefully!
MBT Group – Clinician Authority

Manage process:

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

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

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

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

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

1. Statement of current emotional state of self or other
2. Identify emotion and explore its 'granularity'
3. Identify how self or other picked up the feeling
4. Check out if their external focus and description is congruent with patient internal feeling
5. Jointly contextualize the feeling in patient
6. Alternative perspective
Vicious Cycles of Non-Mentalizing Within a Dysfunctional Interaction – the MBT Group

- Powerful emotion
- Poor mentalising
- Inability to understand or even pay attention to feelings of others
- Others seem incomprehensible
- Frightening, undermining, frustrating, distressing or coercive interactions
- Try to control or change others or oneself

Person 1

Person 2
The MBT Loop

Notice and Name Interpersonal interaction

Checking

Generalise (and Consider Change)

Checking

Mentalize The Moment Between patients

Checking
Noticing and naming: exploration of stories

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

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

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

- Identify the problems within the story
- Stimulate alternative perspectives from patients
- Facilitate discussion of managing mental states as the problem
Cautions

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

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

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

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

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

- Adolescent Mentalization Based Integrative Treatment

http://www.annafreud.org/pages/ambit.html

Slides available at:
http://www.ucl.ac.uk/psychoanalysis/people/bateman
RFQ web address

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

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