Mentalization Based Treatment

Clinical Training Slides
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?
Structure of Mentalization Based Treatment
Trajectory of Treatment

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

MBT-I
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
<table>
<thead>
<tr>
<th>Information for me:</th>
<th>Information for healthcare professionals:</th>
<th>Things I would like professionals to do which may help me when I am in a crisis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive things I can do when I am in a crisis:</td>
<td>My difficulties as I see them now:</td>
<td>Things which professionals have said or done which have not been helpful in the past:</td>
</tr>
<tr>
<td>Things which have not been helpful when I have been faced with crises in the past:</td>
<td>I am addicted to cannabis, I often go out of my way to get it (which puts me in danger); I have several worries about family and thinking about them can make me feel very depressed; attempting to deal with the problems in my life can lead to thoughts of suicide</td>
<td>Practical Help in a Crisis:</td>
</tr>
<tr>
<td>Staying up all night; admitted to hospital; increasing the dosage of my medication as this prolongs my stay in hospital; health professionals concentrating on my past history instead of current problems</td>
<td>Details of any current treatment / support from health professionals:</td>
<td>Agencies or people that I would like to have copies of this Joint Crisis Plan:</td>
</tr>
<tr>
<td>Specific refusals regarding treatment during a crisis:</td>
<td>Physical illnesses &amp; medication:</td>
<td>✓ Myself</td>
</tr>
<tr>
<td>I do not want to be hospitalised unless it is absolutely necessary; please don’t make decisions about my treatment without including me in the discussion first</td>
<td>Situations which can lead to a crisis:</td>
<td>✓ My GP, Dr. X</td>
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<td>✓ My Community Drug Project worker</td>
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<td>✓ My CPN</td>
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<td></td>
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<td>✓ My partner</td>
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</table>
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: Executive Summary

- Attachment Strategies and Interpersonal Problems
  - Vulnerability factors from past experience
  - Current use of alcohol and drugs
  - Dependent, anxious with others, avoidant and devaluing
  - Defers to others and vulnerable to exploitation
- Impulsivity and emotional problems
  - Self-destructive behaviour, high risk of self harm
  - Anxiety
- Mentalizing process
  - Concrete, anti-reflective, sensitive
Mentalizing Team

- United mind with a commonality of purpose
- Respect for themselves and others
- Ability to develop and adhere to coherent clinical plans
- Good team morale
- Effective leadership
Structure of Team Meeting

- Identifying and marking the task
- Stating the focus for discussion
- Discussing the teams perspectives on the focus
- Returning to task to link the discussion with the focus
- Defining practical and clinical action
Goals of Final Phase

- Increase patient responsibility and independent functioning
- Facilitate patient negotiation about future eg with outside organisations
- Consolidate and enhance social stability
- Collaboratively develop a follow-up treatment plan
- Enhance patient understanding of meaning of ending treatment
- Focus on affective states associated with loss
Goals in Follow-up Phase

- Maintain gains in mentalizing that have been made
- Stimulate further rehabilitative changes
- Support for return to education or employment
- Negotiation of further interpersonal and social problems
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
Summary and orientation to MBT
Some General Principles - MBT

- Primary aim is to increase capacity to mentalize self and others
- Maintain or Regain mentalizing of clinician
- Monitor patient mentalizing capacity
- Manage arousal levels
- Focus on patient’s mind
- Seek out moment of mentalizing vulnerability
- Address current events and immediate states of mind
- Step-wise intervention process starting with empathic validation
Core Summary for new clinicians (1)

1. Collaborative process
2. Formulation of patient problems early in treatment and a focus in each session
   - Trajectory of overall treatment and in each session
3. Identification of non-mentalizing process
4. General Attitude
   - Not-knowing stance
Principles for clinician
   - Aim to re-store or maintain mentalizing
   - Interventions consistent with the patient’s mentalizing capacity
   - Identification of mentalizing poles
6. Principles for clinician (cont’d)
   - Focus on maintaining clinician mentalizing
   - Authentic and open-minded clinician
   - Alert to breaks in mentalizing
   - Monitoring of the state of affective arousal
   - Focus on contingency and marking of interventions

7. Trajectory of sessions: interventions structured from empathic validation to exploration, clarification, and challenge through affect identification and affect focus to mentalizing the relationship itself

8. Explicit identification of clinician feelings related to the patient’s mental processing
## Linking theory with practice

<table>
<thead>
<tr>
<th>Problem</th>
<th>Therapist</th>
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</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Alliance. Avoid overcompensating</td>
</tr>
<tr>
<td>Social Scripts</td>
<td>Follow social script</td>
</tr>
<tr>
<td>Taking on others state of mind/Pretend</td>
<td>Explore/Challenge/differentiate</td>
</tr>
<tr>
<td>Contingent</td>
<td>Empathic validation</td>
</tr>
<tr>
<td>Self/other</td>
<td>Marking</td>
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<tr>
<td>Hyperactive attachment</td>
<td>Therapist stance</td>
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</tbody>
</table>
# 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>
</tr>
<tr>
<td>Self- reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
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<tr>
<td>Cognitive</td>
<td>Affective</td>
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<tr>
<td>Explicit</td>
<td>Implicit</td>
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<tr>
<td>Certainty</td>
<td>Doubt</td>
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</tbody>
</table>
Basic Mentalizing: Process
Mentalizing Process - trajectory

- Narrative of event
- Experience at time
- Reflection on events
- Experience talking about it in therapy
- Current feeling about events
- Alternative perspective
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>Too Much</th>
<th>Too Little</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Affective ➔ Cognitive</td>
<td>Cognitive ➔ Affective</td>
</tr>
<tr>
<td>Focus</td>
<td>Re-direct</td>
<td>Emphasise</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Process</td>
<td>Go with the flow</td>
<td>Resist/challenge</td>
</tr>
<tr>
<td>Interpersonal Interaction</td>
<td>Decrease</td>
<td>Increase</td>
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</tbody>
</table>
Managing arousal for optimal mentalizing

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

- Demonstrate support, reassurance and empathy as you explore the patient's 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.
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
Therapist stance
THERAPY STIMULATES ATTACHMENT SYSTEM

EXPLORATION

DISCONTINUITY OF SELF

ATTEMPT TO STRUCTURE by EFFORT TO CONTROL SELF &/OR OTHER
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
  - Eschew your need to understand – do not feel under obligation to understand the non-understandable.

- **Monitor you own misunderstandings**
  - Model honesty and courage to accept mentalizing errors via acknowledgement of your own misunderstanding
    - Current
    - Future
  - Suggest that misunderstandings 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**
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 he 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
  - Stimulate alternative perspectives
  - Demonstrate humility - not knowing
  - Monitor for non-mentalizing and try to Intervene to move patient to mentalizing
Video

Therapist Stance
The mentalizing focus
Clinical Process - summary

- Narrative to alternative perspective
- Intervention spectrum from ‘surface to depth’
- Intervention choice determined by arousal level
- External events to current treatment process to patient-clinician interaction
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)
Clinical summary of momentary session intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- Intervention according to mentalizing problem
- Explore current emotional context in session by identifying the momentary affective state between patient and therapist
- Identify your contribution to the break in mentalizing
- Seek to mentalize the relationship if mentalizing remains robust
# Modes of non-mentalizing

<table>
<thead>
<tr>
<th>PSYCHIC EQUIVALENCE</th>
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<tbody>
<tr>
<td><strong>Clinical form</strong></td>
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<tr>
<td><strong>Therapist experience</strong></td>
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<tr>
<td><strong>Intervention</strong></td>
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<tr>
<td><strong>Iatrogenic</strong></td>
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</table>
## Modes of non-mentalizing

<table>
<thead>
<tr>
<th>PRETEND MODE</th>
</tr>
</thead>
</table>
| **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.  
Counter-intuitive  
Challenge |
| **Iatrogenic** | Non-recognition  
Joining it with acceptance as real  
Insight orientated/skill acquisition intervention |
# Modes of non-mentalizing

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

- In keeping with patient mentalizing capacity
- Affect focused (love, desire, hurt, catastrophe, excitement)
- Explicitly interpersonal and affective
- Relate to current event or activity – mental reality (evidence based or in working memory)
- De-emphasise unconscious concerns in favour of near-conscious or conscious content
Spectrum of Interventions

- Empathic validation – including reassurance, support & empathy
- Basic Mentalizing - Clarification, Exploration and Challenge
- Basic Mentalizing – Affect identification and Affect focus
- Mentalizing the relationship
Interventions: Spectrum

- Supportive/empathic
- Clarification, elaboration, challenge
- Basic mentalizing – affect and affect focus
- Mentalizing the relationship
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
Proscribed 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...
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
Clarification and Affect Focus
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 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
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
Process of Exploration

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
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?
Challenge or Stop and Stand
Challenge - aims

- Bring non-mentalizing to an abrupt halt even if only momentarily
- 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
- Steady Resolve
Challenge - indicators

- Persistent non-mentalizing especially in high risk contexts
- Pretend Mode
- Fixed position in one or more dimensions of mentalizing
- Inadequate progress in treatment
Challenge - 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
Challenge - strategies

- Counter-intuitive statements
- Mischievous or Whacky comments
- Therapist emotional expression to re-balance patient emotional expression
- Frank but Fair
Challenge in boundary violation

- Clarify your boundary (should be a repetition of boundary agreed when treatment began)
- When all avenues explored state impasse – ‘As far as I can tell we are going round in circles. When I say something you simply dismiss it as rubbish and whilst I am willing to accept that it sometime is, I cannot accept that it always is.
- State own position – ‘If we can’t get around this I may have to say that treatment has failed and we should finish
- Monitor feelings in clinician to ensure no impulsive action by therapist
Workshop Exercises
Workshop Exercise

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

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

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

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

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

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

- Therapist: transference tracers and mentalizing the relationship
Workshop Exercise

- Therapist feels that the therapy is stuck and cannot see that it is likely to go anywhere and feels that ending therapy should be considered.
  - Patient has not indicated that she feels similarly
  - Raise the subject with the patient and explore.
Guidance on which intervention when
Interventions: Spectrum

- Supportive/empathic
  - Clarification, elaboration, challenge
  - Basic mentalizing, Affect Focus
  - Mentalizing the relationship

Most involved Least involved
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
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.
Clinical Intervention: Self Harm and the 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

The nascent self representational structure

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

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

Self-experienced as evil and hateful

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.

**Self-harm state**

Perceived other

Unbearably painful emotional states: Self experienced as evil/hateful

Addictive bond

Victimized state

Torturing alien self

Externalisation

Container

Self experienced as hated and attacked
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.
Workshop exercise

- Patient describes having cut himself and requiring sutures.
- Therapist
  - Identify feelings
  - Develop context
  - Integrate the relationship with you in the discussion
  - 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
Transference and Countertransference

Mentalizing the Relationship
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
Therapist Affect (Mentalizing the Relationship)

- Focus the patient’s attention on therapist experience when it offers an opportunity to clarify misunderstandings and to develop prototypical representations
  - Highlight patient’s experience of therapist
  - Use alternative perspectives to emphasise different experience which needs exploring
  - Negotiate negative reactions and ruptures in therapeutic alliance by identifying patient and therapist roles in the problem – accept your contribution
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
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
Workshop Exercise

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

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

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

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

Two types of groups

MBT Group

MBT- I
MBT-I: Psychoeducation for BPD
MBT-I

An introduction to mentalising
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
Adaptations

- Mental Health Centres
- Addiction clinics
- Inpatient units
- Mothers with BPD who have children
- Other
Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

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

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

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

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

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

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

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

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

- Discussion of what is in our mind
- What does it involve
- Being aware of thoughts and feelings
- Is it the same as empathy?
- Includes oneself as well as others
- Emotion disrupts mentalising
Group activity

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

- People interpret the same event in different ways
- Some interpretations are more plausible than others
- Some statements about the object is mentalizing (e.g. “I believe that he is confused”), while others are not (e.g. “he comes from a foreign country”)
  - Emphasis is on distinction between mentalizing and non-mentalizing
Danger signs – in life and in group

- Absolutes
- Words
  - Just
  - Clearly
  - Everyone
  - All
- Certainty
- Attributing motives to others
- Defensiveness
Group activity

- Two patients are invited to role play
  - The one will be interviewing the other. The task is to find out what is in the mind of another person in context of them mentioning a problem using a mentalising stance.

- ‘I could not sleep last night’.
Final summary Session 1

- Mentalising is important to:
  - understand what is taking place between people.
  - understand yourself, who you are, your preferences, your own values, etc.
  - communicate well with your close friends.
  - regulate your own feelings.
  - regulate other people’s feelings.
  - avoid misunderstandings.
  - see the connection between emotions and actions more easily, so that you can escape destructive patterns of thoughts and feelings more easily.
Homework – not-knowing stance

- Practice using a mentalising stance
- Encouraged patients to find a friend or someone in their family to interview using a mentalizing stance, i.e. about how the other person was earlier in the day or yesterday.
- Patients are encouraged to ask questions in a curious, non-knowing and non-judgmental way:
  - Identify moods, thoughts and emotions
  - Note how it makes them feel and also ask their interviewees how it makes them feel.
MBT-I Session 2

Problems with mentalizing
Session 2 Problems with mentalizing

- It is Sarah’s birthday. She is planning to celebrate with Mike, her boyfriend, and has invited him home for dinner. She has purchased wine to go with the food, and is looking forward to him coming after work. When Mike arrives, he does not have a gift with him, and he says to her “wow, what a dinner you have made, and on a Tuesday”. During dinner Sarah is quiet and drinks most of the wine herself.

  - What happened? Why do you think Sarah behaves the way she does?
Discussion and identification of non-mentalizing

- Feeling certain about other people’s motives
- Thinking in black-white terms (i.e. without nuances)
- Poor acknowledgement of accompanying feelings (reduced empathy)
- Overlooking the fact that people influence each other
- Interpretation of others without careful consideration may be irrelevant, be off the point, or even be very concrete (i.e. that first this happened then that happened, etc)
- Little curiosity about mental states
- Lots of words are spoken with limited content
- Speech is filled with clichés and fancy words that do not seem to have been digested and that tend to alienate the discussion partner
- External factors are emphasised at the expense of mental states, for example that it rained, or that one had a headache, or the situation is described as being “just how it was”, without any more explanation.
MBT-I Session 3

Emotions
What are the basic emotions?

- Fear
- Anger
- Sexual lust
- Interest and curiosity, exploratory behaviour
- Separation anxiety/sadness
- Love/caring
- Play/joy
- (Craving)
What are socialised or secondary emotions?

- Reactions/responses to primary emotions
  - Shame
  - Guilt
  - Envy
  - Gratitude
  - Jealousy
  - Cheerfulness
  - Astonishment
Attachment and How do I know who I am?
Theory: How do I know who I am?

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
Attachment theory

- Separation anxiety
- Annihilation
- Paranoid anxiety
- Protest
- Despair
- Detachment
- Autonomous
- Dismissive/detached
- Pre-occupied
- Enmeshed
- Incoherent
Bowlby’s Attachment Theory

- Need of human infant to seek protection and security through physical contact with the caregiver

- Attachment system ↔ Caregiving system

- Attachment behaviours
  - proximity seeking
  - clinging
  - smiling

- Caregiving behaviours
  - touching
  - holding
  - soothing

- Affectional bond: expectation of being offered care
Attachment Classification: Secure

- Parenting behaviour
  - co-ordinated
  - sensitive
  - stabilised emotional response

- Developmental impact
  - organised in stress
  - negative emotions feel less frightening (meaningful, communicative)
Attachment Classification: Anxious-avoidant

- Parenting behaviour
  - emotional arousal not re-established
  - over-aroused through intrusive parenting
  - caregiver unresponsive or intolerant

- Developmental impact
  - over-regulate affect
  - avoid distressing situations
  - seeking proximity is futile
  - avoid disclosing dependence
  - attachment behaviours are deactivated
Attachment Classification: Anxious-resistant

- Parenting behaviour
  - inconsistent responsiveness

- Developmental impact
  - under-regulate, heightening expression of distress in order to elicit caregiving responses
  - low threshold for threat
  - preoccupied with contact with caregiver
  - vigilant for presence or loss of caregiver
  - proximity not soothing but results in persistent anxiety
Attachment Classification: Disorganised

- Parenting behaviour
  - attachment figure simultaneously source of reassurance and fear
  - prolonged separation
  - intense marital conflict
  - neglect
  - physical or sexual abuse

- Developmental impact
  - capacity to respond to stress most compromised
  - disorganisation
  - disorientation
  - dissociation
  - bizarre repetitive movements
  - self-harm, self-mutilation
  - extreme controlling behaviour
Tom and his girlfriend, Sara, meet again after the university holidays. During the holidays, Tom has not called Sara and when she called or sent an SMS he did not answer. Sara did very little during her holidays, but when Tom asked her about it she answered: "I had a fantastic holiday with plenty to do. I wish the holiday had lasted longer."

Discuss this episode in light of attachment strategies for Tom and Sara.

Why does Sara answer as she does?
Group Activity

- Think about a relationship with an important person in your life (girlfriend, boyfriend, family member, friend) and whether it is secure, ambivalent or distanced
  - Provide examples and think about how that pattern of relationship developed
Examples of Tasks

- Be aware of changes in your mood and what might be causing them
- Monitor own attachment behaviour
- Monitor own reading of others’ behaviour
- Monitor others’ reactions to us
Addictions: Session 2

- What kind of mentalizing problems do you believe may predispose for excessive alcohol/drug consumption?
- What kind of mentalizing problems may arise as a consequence of excessive alcohol/drug consumption?
Addictions: Session 3

- Add ‘craving’ to basic emotions
- Describe your craving for states of intoxication. Is it one or many feelings? Where is it located? How can it be put into words?
- What kind of feelings have been most important for you to regulate with psychoactive substances?
Addictions
Session 6/7 Attachment and mentalizing

- If somebody in the family abused substances, make some notes on what kind of consequences you believe that would have for the culture or ways of relating in the family.
- Make some notes on your own personality traits that might have been augmented by substance abuse.
- Make some notes on how you believe your own behaviour when intoxicated may have affected other people.
MBT - Group

- Problems resulting from failure to mentalize arise:
  - Outside the group (in lives of patients)
  - Within the group (between the patients in group sessions)
  - Patients encouraged to consider both the above using a mentalizing framework
Why a change in emphasis 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.
Mentalizing Group: Generic Techniques
MBT Group

- *Primary task of the group is to provide a training ground for mentalization*
- Closer to (American) psychodynamic group psychotherapy than group analysis.
- More individually oriented.
- Therapists do not wait to see how “the group deals with it”
MBT Group

- Clinician maintains authority
- 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!
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
MBT-G: Clinician Stance

- Authority without being authoritarian
- Maintain clinician mentalizing
- Maintain focus and do not allow persistent non-mentalizing dialogue
- Monitor arousal levels and non-mentalizing modes, beware hypermentalizing
- Work in current mental reality when possible
- Model mentalizing
MBT-G: Clinician Authority

- 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 – Therapist Authority

- Structure the group work by
  - Round at beginning of group and summary of previous group
  - Not allowing aggressive outbursts 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.
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
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
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
Culture of Enquiry: exploration of stories

- 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?
Culture of Enquiry: 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
Culture of Enquiry: 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
- Beware of defining problem based in physical reality and development of teleological solutions
Clarification of 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
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 interpersonal process

- Initiate careful step by step explorations of crucial intersubjective transactions (implicit to explicit)
- Stop the group process when it is off task or is missing important opportunities for mentalizing interpersonal process in the here and now
- Challenge inappropriate certainty and rigid representation
- Demonstrate and explain the primacy of the here and now
- Link to attachment patterns identified in formulation
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

- **Active** stance (very active at times!)
- 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
Handy hints for clinician

- Attention to each member of group (not just the one speaking)
- Aim to gauge understanding / mentalizing of each member at all times
- Floor manager/dinner party host-hybrid
Handy hints for clinician

- Whilst being attentive to speaking member of group, another eye is scanning rest of members
- Be alert to concurrent activity in group which may indicate an emotional response to something going on
- Put current group discussion on hold whilst group is invited to attend to concurrent activity before it gathers momentum and becomes unmanageable before returning to ‘paused’ group.
Group MBT Summary

- Active participant therapist adopts not knowing stance and validates patients’ affective experiences.
- Consider experiences brought in from outside and those occurring within the moment in the group.
- Maintain operable affective temperature within group.
- Be prepared to take control.
- Multi-task: do not focus solely on speaking patient but be aware of what is happening with others.
- Don’t forget about the quiet members (not 1:1 with an audience).
- Be prepared to pause group dialogue so group can attend to emotional responses arising elsewhere in group.
- Encourage members to mentalize explicitly and compare to that of others in group.
Summary and Top Tips

- “Not-Knowing”, non-expert, active-participant stance
- Validate the patients’ felt experience
- Use the group to generate alternative perspectives
- Use systemic, circular questioning techniques to generate exploration of each others’ mind states – ‘Outside-In’ and ‘Inside-Out’ interventions
Summary and Top Tips

- Don’t be afraid to take control at times if mentalising completely breaks down and affective arousal becomes too great.
- Be transparent about your own affective and mind states, and mark them as your own – Be part of the group.
- Challenge unwarranted beliefs, certainty and rigid representation.
Summary and Top Tips

- Keep your interventions simple
- Avoid group interpretations OR group explanation/comment
- Use specific techniques when required
  - Triangulation
  - Parking
  - Siding
  - Pick your fight
Thank you for mentalizing!

For further information
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Slides available at:
http://www.ucl.ac.uk/psychoanalysis/people/bateman
Some alternative slides
<table>
<thead>
<tr>
<th></th>
<th>BPD</th>
<th>ASPD</th>
<th>NPD</th>
<th>Paranoid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self/Other</strong></td>
<td>++++</td>
<td>++++</td>
<td>+++-</td>
<td>++++/+</td>
</tr>
<tr>
<td><strong>External/Internal</strong></td>
<td>+++/+</td>
<td>+++/+</td>
<td>++++</td>
<td>++++/+</td>
</tr>
<tr>
<td><strong>Implicit/Explicit</strong></td>
<td>+++/+</td>
<td>+++/-</td>
<td>++/+</td>
<td>++++/+</td>
</tr>
<tr>
<td><strong>Cognitive/Affective</strong></td>
<td>++++</td>
<td>+++/-</td>
<td>++/-</td>
<td>++/++</td>
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Highlighting alternative perspectives

- I saw it as a way to control yourself rather than to attack me (patient explanation), can you think about that for a moment?
- You seem to think that I am not listening and yet I am not sure what makes you think that (or validate if correct!)
- Help me see it like that. I am not aware that you did not do well. It seems that it was a success to me.
Therapist stance

- Empathic is about how they are thinking and feeling, getting them to describe important experience.
- Cannot explore before empathy established.
- Use not knowing what to say as clue that something does not make sense and there is something to be curious about.
- Curiosity about experience, probing about patients experience serves to validate the experience.
- Normalizing is component of moving to detailed work – stating feelings in first person: “I would feel X if I was in that situation too…”
Managing arousal for optimal mentalizing

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