Mentalizing and Antisocial Personality Disorder

Theoretical summary and clinical perspectives
Multiple dimensions of mentalizing in psychodynamic psychotherapy

- Moving from implicit - automatic mentalization to explicit – controlled mentalization
  - Challenging automatic assumptions

- Elaborating internal representations of mental states of self and others - external and internal mentalizing
  - Challenging superficial judgements based on ‘appearances’

- Connect feelings with thoughts (affect and cognition)
  - Overcoming splitting of affect and cognition (the feeling of feelings)

- Differentiating self and other in psychotherapy
  - Adopting the perspective of the other to the self
  - Reducing the impact of the other on the self
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<th>BPD</th>
<th>ASPD</th>
<th>NPD</th>
<th>Paranoid</th>
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<tr>
<td>Self/Other</td>
<td>+/++++</td>
<td>+/++++</td>
<td>+++/-</td>
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<td>External/Internal</td>
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<td>Implicit/Explicit</td>
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Forest plots for **facial cues** for the six emotions. Dawel et al 2012
Forest plots mean effect sizes vocal cues for the six emotions. Dawel et al 2012.

a) Anger

b) Disgust

c) Fear

d) Happiness

e) Sadness

f) Surprise
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<tr>
<th>What is it?</th>
<th>Psychic Equivalence</th>
<th>Pretend Mode</th>
<th>Teleological</th>
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<td></td>
<td>Exaggeration of internal world. Any negative feeling about self is true, no other perspective possible. Inner experience takes over, over-whelming, terrifying. Feelings too real. Eg I feel bad, I am bad.</td>
<td>Mental states discussed but don't feel real. Mental state dissociated from affect. Inner experience and outer world detached, a sense of emptiness and meaninglessness.</td>
<td>Mental states judged on outcomes in physical world. Forcing something to happen in external world is only avenue to alter a mental state. Exaggeration of external world.</td>
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<th>Common therapist responses</th>
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<td>Puzzled, confused, angry, judgmental of client's experience, (Oh, good god, get a grip!). Overwhelmed, anxious, wanting to try to convince client it's really not that bad, tempted to talk client out of their experience, add other (less limiting) perspectives.</td>
<td>Bored, disengaged, no affect. Something felt to be missing, not “moved” by the client. Limited subjective response.</td>
<td>Therapist will feel tempted to DO something; extend the session, loan them money, give them a hug, etc. Anxiety and pressure to act. Eg “have you got children? If you don’t, you won’t be able to understand”. (Therapist will want to answer)</td>
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<th>What to do?</th>
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<td>Accept their experience, seek to understand it fully. Be CURIOUS! What happened before you felt this? e.g. Rewind What effect does it have on you? Reach out emotionally, “I’m so sorry, that sounds really difficult”. Responses more contingent. Take a detour if necessary.</td>
<td>Probe...explore, examine from perspective of wanting to understand it. Determine its level of intractability. Introduce an element of surprise, paradox. Full challenge, Stop it (stop &amp; stand).</td>
<td>Acknowledge what they need you to be, do, and the importance and meaning of it to them WITHOUT doing it. Validate emotional import and meaning with sincerity, while refraining.</td>
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<th>What not to do?</th>
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<td>Don’t tackle it head on and try to change client’s point of view/feeling. Don’t address content.</td>
<td>Don’t allow it to go on and on. Don’t believe that something useful is happening while in this mode.</td>
<td>Don’t do the something demanded. Unless discussed with team Don’t believe that the demand being satisfied will result in any positive growth</td>
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Mentalization based treatment for antisocial personality disorder

Clinical Perspective

Therapist Stance

Not-Knowing
- Neither therapist nor client 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 mistakes
- Model honesty and courage via acknowledgement of your own mistakes
  - Current
  - Future
- Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings
Essential to the Stance

- Keep it current – what the client feels right now
- Start by empathising – finding a way of stating that you genuinely understand distress
- Explore in the relational realm not just the intra-psychic
- Lower arousal by bringing it to the person of the therapist
  - What have I done?
- Stick to mentalizing aim in somewhat dogged manner
- Quickly step back if client seems to lose control
The Mentalizing Stance

Inquisitive: Tentative, curious, Measured enthusiasm for mental states

Holding the Balance Narrative flow Vs. Interventionist

Terminating Inaccurate or non-mentalizing interactions

Reinforcing Positive mentalizing
Interventions: Spectrum

- Supportive & empathic
- Clarification, Challenge, & Exploration
- Mentalising the relationship
- Non-mentalising interpretations – to use with care
Interventions: Spectrum

Supportive/empathic

Clarification, elaboration, challenge

Affect Focus and Basic mentalizing

Mentalizing the Relationship
Components of mentalizing the 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 perspective
- Monitor the client’s reaction
- Explore the client’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 borderline client 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 feelings in the clinician

- 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 client or therapist (initially)
- Aim at achieving an understanding of the source of negativity or excessive concern etc.
Feelings in the clinician and self-disclosure

- Mind states of therapist in relation to mind states of client
  - Marked
  - Part of therapy
  - Openness
  - Neutrality about origins
  - Available for exploration
Components of mentalizing the counter-relationship

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

- Regulation of arousal
- Identification of non-mentalizing mode
- Empathic validation
- Intervention aiming to restore mentalizing
Summary

Process

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

Intervention

- Empathy
- Clarification
- Exploration
- Clarification
- Affect identification
- Affect Focus
- Interpersonal
Principles for Clinician: summary

**DO:**
- Match interventions to mentalizing capacity
- Regain your own mentalizing before trying to rekindle clients – ‘put on your own oxygen mask before helping the person beside you’.
- Re-wind to point of mentalizing when non-mentalizing starts
- Start at empathic position – stand alongside and observe the client perspective

**DO NOT**
- Ask client to do ‘other’ mentalizing when not able to mentalize ‘self’
- Take over client’s mentalizing
- Argue with psychic equivalence
- Argue with pretend mode
- Place responsibility straight back to client - in session emotional dysregulation results from your error
Mentalizing for ASPD
Mentalizing and ASPD - summary

- Unable to develop any real understanding of their own inner world (Self)
- Experts at cognitively reading the inner states of others (Other)
  - misuse this capacity to coerce or manipulate them with no we-mode of empathic understanding
- Lack abilities to read accurately certain emotions (possibly a wide range), an externally based component of mentalizing
- Cannot generate how they would feel in the others situation
- Fail to recognise fearful emotions from facial expressions. This implicates dysfunction in neural structures such as the amygdala that subserve fearful expression processing.
- Marsh and Blair (2008) in a meta-analysis of 20 studies showed a robust link between antisocial behaviour and specific deficits in recognizing fearful expressions. This impairment was not attributed solely to task difficulty.
Non-Mentalizing Disorganized Groups: Teleological Systems

- Expectations concerning the agency of the other are present but these are formulated uniquely in terms restricted to the physical world
  - Only what is material can be meaningful

- Attitudes to ideas and feelings
  - A focus on understanding actions in terms of their physical as opposed to mental outcomes
  - Only a modification in the realm of the physical is regarded as a true index of the intentions of the other.
  - Only action that has physical impact is felt as potentially capable of altering mental state in both self and other
    - Physical acts of harm → aggression is seen as legitimate
    - Demand for physical acts of demonstration of intent by others → payment, acts of subservience, retributive justice
So how to create a mentalizing group?

- Activate attachment by creating an attitude of compassion and wish to understand
- Enhance the curiosity which members of the group have about each others’ thoughts and feelings
- Be careful to identify when mentalizing has turned into pseudomentalizing (pretending to know)
- Focuses on misunderstanding (mentalizing is the understanding of misunderstanding)
- Curiosity coupled with respectful not knowing
Group process

- Agree code of conduct between all clients
  - Money
  - Meeting outside
- Emphasise a focus on self
- Develop an awareness of internal states
- Consider ‘others’ subjective experience
- Build up a capacity of what someone else feels
- Identify hierarchical aspects of relationship
Key mentalizing components in MBT-ASPD

- Understanding emotional cues - external mentalizing and its link to internal states
- Recognition of emotions in others – other/affective mentalizing
- Exploration of sensitivity to hierarchy and authority – self/cognitive
- Generation of an interpersonal process to understand subtleties of others’ experience in relation to ones’ own – self/other mentalizing
- Explication of threats to loss of mentalizing which lead to teleological understanding of motivation – self/other mentalizing and self/affective mentalizing
Treatment Format

- Treatment for 1 year
- Group therapy 1x per week for 75 minutes with initial introductory groups focusing on emotion recognition and understanding of ASPD
- Individual therapy with group therapist 1x per month
- Integrated psychiatric care
- Crisis planning
- Code of Conduct
Group features

- Slow open group
- Avoid
  - Time out contracts
  - Discharge due to failure to meet attendance contract
  - Exhortation based on the effect on others of an individual’s absence
  - Challenging a hierarchical relationship early in therapy
MBT-ASPD
Group Principles
Developing code of conduct in group

- Developing shared code of conduct is key task but will be problematic for ASPD
- Highlight and explore their own code of conduct by discussing interactions with others and what leads to violence
- Adopt benign attitude of curiosity and understanding
- Neither condemn nor condone
Group Principles

- Regular attendance
- Commitment to thinking about others as well as themselves
- Openness within group
- Confidentiality outside of group
- Discuss contact with clients outside of the group
- Prohibition of threats and violence
- Avoiding inappropriate and offensive comments
- ‘Advice-free zone’
Communication of group principles

- Discuss principles operating in the group with clients early in treatment
- Explain reasons underlying group principles
- Do not appeal to social generosity/selflessness of individuals or the effects of their actions on others
- Do not inject pressure through inducing shame or guilt
- Emphasise necessity of regular attendance for individuals to address their problems consistently and learn from others
Group challenges

- Engagement and attendance
- Hierarchy and power
- Paranoia and lack of trust
- Risk
- Confidentiality and disclosure
- Boundary violations
Group cohesion

you talkin' to ME?
Establishing a group process

- Lack of engagement and dropout
- Attendance a major issue, difficult to maintain themes which arise from one session to the next
- Slow but general development of solidarity between group members, supportive feel to the group
- Tendency to mentalize their own experiences (albeit not affectively), much more difficult to think about others’ thoughts and feelings
Who is in charge?
Hierarchy and power

- ASPD clients experience relationships in terms of power and control
- Avoid assuming position of power in relation to client too early in treatment, by apologising for perceived errors and accepting criticism
- Therapist’s role is to carry client’s ‘alien self’ – this can only be explored once client feels safe and contained
Developing a collaborative relationship

- Building a therapeutic rapport and collaborative relationship essential for any therapy but particularly difficult for clients with ASPD
- Treatment relationship should be characterized by caring, fairness and trust
- Foster an authoritative, but not authoritarian, style
- Balance flexibility in attitude with modelling consistency and appropriate boundaries
Engaging the clients

- Engaging and maintaining the person with ASPD in treatment is the key challenge.
- ASPD individuals don’t like to think of themselves as clients, associated with shame, stigma and vulnerability.
- May need extended period of engagement or motivational work before engaging in formal treatment programme.
- Address anxieties about diagnosis, group therapy, camera and confidentiality.
Encouraging attendance

- Anticipate difficulties in attendance
- Adopt understanding and flexible attitude
- Avoid rigid rules about discharging after certain number of missed sessions
- Proactively contact clients to remind them of appointments or after missed sessions
- Clarify reasons for non-attendance e.g. depression, anxiety, chaotic lifestyle, lack of money
- Positive reinforcement and emphasis on benefits for individual re regularly regular attendance
Boundary violations
Handling boundary violations

- Adopt flexible stance – firm but fair
- Promote attitude of curiosity, exploration and understanding
- Explain reasons behind principles
- Accept minor boundary violations e.g. cigarette with each other for 15 minutes outside after group
- May explore boundary violations in individual sessions to enhance reinforcement of group principles
Confidentiality

- Clarify the limits of confidentiality and disclosure for both agencies (NHS and NPS) at outset
- ‘Team confidentiality’ – all information shared within clinical team
- Clients encouraged to talk about violent/aggressive incidents in group to mentalize and identify points of mentalizing change
- However, may be reluctant to talk about current offences for fear of disclosure
- May talk about previous offences if do not reveal too much detail to warrant disclosure
Risk and disclosure

- Clinician needs to differentiate an acute risk from chronic baseline risk
- Disclosure considered beyond clinical team if current serious risk of harm to others, or past identifiable offences/victims
- Balance risk of acute harm but with risk of disengaging from treatment if disclose vs staying in treatment and long term risk reducing if do not disclose
- Do not disclose without full discussion with all involved, including offender if possible
Handling breaks and endings

- Breaks associated with an increased risk of ‘acting out’
- Minimise (but do not eliminate) breaks by therapists covering for each other
- Breaks should be communicated in advance where possible
- Do not collude with clients’ conscious rejection of dependence needs by ignoring effects of breaks but be sensitive to feelings of humiliation when discussing these
- Similarly, difficult feelings regarding end of therapy should be anticipated and discussed to avert premature drop-out
Issuing ultimatums

- Ultimatums should rarely be issued.
- Avoid becoming embroiled in arguments with clients about their attendance, attitude, behaviour, and use of offensive statements about others, e.g. comments about race and gender.
- Ultimatum seems unavoidable, should be ‘life’ ultimatums rather than ‘therapy’ ultimatums.
- Issuing ultimatums about discharge from therapy generally unhelpful and rarely increases motivation or stimulates change.
- If potential breakdown of treatment seems imminent, try to identify possible ways of addressing the problem collaboratively by first agreeing with the client what the problem is.
No More Disrespect
MBT-ASPD Introductory sessions

- What is ASPD
- What are emotions?
- Identification of emotions in self
- Consideration of ‘we-mode’
- Attachment patterns – dismissing
- Hierarchical relationships
- Externalising
- Relationships
Personality Disorder

- A person has a personality disorder when a certain number of personality traits, which are persistent ways of thinking, feeling, regulating impulses and relating to other persons, join together in a specific pattern.
- Traits need to have been characteristic of the person since at least late adolescence or early adulthood,
- Behaviours are maladaptive making the person and/or society suffer.
- People with ASPD have had a conduct disorder during adolescence e.g. problems at school and perhaps with peer groups and with the police.
- Traits typically affect self-image and self-esteem, thinking about others, and will usually cause problems in social interaction, work and/or family life (e.g. being overly-assertive, extremely suspicious, controlling of others, uncontrolled temper, dominating others, always avoiding conflicts)
- A personality disorder does not affect the entire personality. One can have many good and positive personality traits and many talents in addition to those that are problematic.
What is ASPD?

- Outline the characteristics of ASPD
  - Tendency to be against authority and engage in persistent unlawful behaviour
  - Sensitivity to others and their motives, often thinking that people do things deliberately to us
  - Feelings of being picked on by authority, for example police, and unfairly treated by systems such as housing, benefits, employment
  - Often finding it necessary to cover things up or not to be fully honest
  - Failure to plan and to find oneself ‘doing things’
  - Blaming others for events and for our own actions
  - Not feeling sorry because the other person was to blame or deserved it
  - Not caring about safety of oneself or others when involved in problematic interactions
  - General aggressive attitude sometimes leading to fights
Group Exercise

- **Group leader**
  - Ask each group member to make a note of or to talk about: 1) his/her own problematic personality traits, and 2) his/her good and positive personality traits and any talents.
  - Or alternatively, ask each member to write down or talk about what ‘makes me me’ (i.e. what are my individual characteristics).
- Make a list of key words on the flip chart to focus the discussion. Prevent the participants talking about other people’s characteristics rather than their own.
- Key areas may include: Anger, sensitivity, distrust, misery, honour, respect, (un)reliability, care/love of others and feeling cared for or loved, traumatic experience.
Personality Disorder and Change

- The group leader talks about change and the difficulties encountered. Focus on each group member for 5 minutes exploring one aspect of his problem.

  - How serious is it to them?
  - Is it other people who are more worried about it and if so why are they concerned?
  - What would be gained by the problem being addressed?
  - What might be lost?
MBT-I Session 2 and 3
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 discussion around event

- People interpret the same event in different ways
- Some interpretations are more plausible than others
- Some statements about the incident are mentalizing (e.g. “I believe that he was ashamed”), while others are not (e.g. “he deserved it”)

  Emphasis is on distinction between mentalizing and non-mentalizing
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.
Danger signs – in life and in group

- Absolutes
- Words
  - Just
  - Clearly
  - Everyone
  - All
- Certainty
- Attributing motives to others
- Defensiveness
Final summary Session 2 and 3

- 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
MBT-I Session 4 and 5

Emotions and how to manage them
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
Managing emotions

- How do we recognise our own emotions?
- How do we recognise emotions in others?
  - The group leaders may wish to consider using the Mind in the Eyes Test at this point.
- How do we control our emotions?
  - Early alert
  - Identification
  - Withdrawal
  - Acceptance
  - Opposite action
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”
- 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 – Therapist Authority

- Therapist openly and repeatedly explains the primary task of the group
- Praise the group by acclaiming mentalizing when it happens
- 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.
Summary of previous group

Problem ‘round’ for all clients

Work towards synthesis

Exploration
MBT Group – Therapist Authority

- The therapist will at times need to take control of the group while still remaining a participant, not an observer.

- Anxiety levels of both group and individuals must be monitored to ensure they become neither too high nor too low.

- Interventions aiming to increase mentalizing within the group in the immediacy of the moment are key to the group’s constructive development.
MBT Group: Culture of Enquiry

- Encourage clients to be aware of what they are thinking and feeling
- Encourage clients to consider the thinking and feeling of others
- Encourage clients to consider why they/others are thinking/feeling in relational context
  - I heard X saying that he is angry, but I think he is hurt about not being taken seriously in the group
  - What am I feeling, what are they feeling, and why?
MBT Group: Exploration

- Focus on what a client is saying asking him to clarify and expand
- Ask other clients for their understanding of what is being said during moments of uncertainty
- Generalize the problem – ‘Has anyone else experienced this?’
- Return to a topic sensitively or if necessary Stop and Stand if the group dismisses something that leader feels is important
Group MBT Summary

- Active participant therapist adopts not knowing stance and validates clients’ 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 client 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.
“It’s all out there”

1. Problem is located in ‘the system’ e.g. housing, job market, benefits system etc.

Response:

• Recognise the seriousness of the external issue

• Remind group of the task and what’s possible within the group session

• Try and shift emphasis to how they can be helped to manage their own feelings when faced with the system
Sample response…

• “It does sound as if you feel that the housing system can be terribly frustrating; what you describe sounds like a complete nightmare (empathic validation)…but if we remind ourselves of the task in this group (re-orienting to the task) if we can’t change the system itself, what might help is if you can think about what goes on inside you when you are faced with a particular situation that is difficult. Like when you feel ignored, or you’re just made to wait. Mark said he regrets shouting at the receptionist because it stopped him getting what he had gone for (Identifying ineffective expression of affect) so perhaps we can understand a bit more about what went on just before you lost it. It might help you so that you don’t have to respond like that next time? (returning to the affect)”
“You don’t want to do that…”

2. Group members can start giving each other advice or instruction: session becomes didactic

Response:

• Reinforce the fact that the group are trying to be helpful

• Remind them of the task and the advice free zone

• Try and bring them back to the affect – through sharing experiences as a group

• Ask the advisor what it is about the person that he is giving advice to that makes him think he will be able to use it
"It’s really good to see that people want to help Paul with managing his relationship breakup, as it’s clear that many of you have been through something similar (validation of group’s efforts to help). But perhaps there’s an opportunity being missed here…maybe if Paul can understand his feelings a little better, that might help he might be able to work out the best way to manage (reminding group of the task). I wonder whether the group can use their own experiences of breaking up with someone to try and help Paul make sense of what he’s going through. Maybe it’s not just about anger…? (encouraging mentalisation of affect of self and other)"
The Guru’s sermon

- One group member dominates and group collude with this

- Group’s Anxiety mentalisation

  - Difficult technically for therapist as dominant group member likely to feel undermined/silenced/humiliated.

  - Helpful to direct a question at another group member who has had a similar experience – likely to bring in the rest of the group without humiliating the speaker (Triangulation)
“So Mike seems to have quite a lot of experience of going through the family court system (positive reframing), but I’m also aware that Steve has had the experience of trying to negotiate access to his children over many years… (shifting focus to bring in another group member). I’m surprised that you’ve been quiet in this discussion, Steve…I wonder what’s going on for you in listening to Mike talk about his experiences…” (encouraging mentalising about other potentially leading to self/other mentalizing)
The overexcited/chaotic group

- Group members talk over each other, making it hard for the therapist to intervene, mentalization stops
  - Reinforce the group’s ‘enthusiasm…’ (empathic validation of effort)
  - Do not criticise the group’s chaotic style
  - Useful for therapist to share the effect of chaotic process upon therapist’s capacity to mentalize (Marking clinician state of mind)
  - Stop & Rewind to the issue that has stirred up the group and when some mentalizing was occurring
  - Invite the group to think about why this particular issue has caused such an animated discussion (mentalizing explicitly about the group process)
“This is clearly an issue that really stirs people up (acknowledgement of group’s engagement with the problem). I don’t know about you, Claire, but whilst everyone’s talking at the same time, I’m thinking that I’d like to try and help with this, but at the moment I can’t really think. (‘open-mindedness of clinician of effect of the process on therapist’s capacity for mentalization). Can we go back and identify the point at which the group became so animated (Rewind) and try and work out the feelings that have been stirred up…? (resuming the task)”
The animated but excluding pair

- Two group members engage in animated discussion whilst the others look on
  - Point out to the group what seems to be happening (identification of interpersonal process to become the focus of mentalizing)
  - Try and elicit the other group members’ experience of this (triangulation)
“I’ve just realised that Paul and John are really intensely engaged in this discussion, but everyone else seems to have gone quiet! (reflection on what’s happening) And I’m sitting here, thinking…what’s this about? Can anyone help make sense of this? (sharing therapist's own thought process)

I’m struggling to work out what makes it hard for the whole group to relate to this. Paul… you’ve certainly felt up against like Mark and Steve describe – when you were seen by the crisis team last week…?” (actively bringing in other group members through active triangulation)
Video Clip…

- To what extent are Steve and the group mentalising/not mentalising?

- What could have been done differently to enhance mentalisation?
Mentalizing Group: specific techniques
Triangulation

- Therapist identifies important interaction between participants
- Notes the observer(s)
- Separates the protagonists
- Actively explores the observer(s) experience of the interaction (not initially about his/her experience of the observed interaction)
Parking

- Clinician notes that a client is unable to maintain attentional control
- Identify the experience of the client rather than the content of the problem
- Actively help the client 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 client – you may have to pause the group if the client becomes excessively anxious.
Siding

- Clinician notes that a client is vulnerable to other clients actions/comments/focus
- Actively take the side of the client
- Co-therapist (if present) takes position of antagonist
- Support the vulnerable client until mentalizing is rekindled in the group
- Switch sides if necessary when the vulnerable client is more stable
Mentalizing common clinical situations

Interventions
Recruitment to cause

- Clients ally with each other against a ‘system’ or organisation e.g. housing, police, hospitals
  - Empathise and find point of validation
  - Allow sharing initially
  - Nudge discussion to emotions triggered e.g. unfairness
  - Question teleological understanding
Defiance

- Contrary attitude in life and in group
  - Argue with client – contraindicated. What do you do if you find yourself opposing the client?
  - Presentation of clinician perspective – needs to be skilfull and infused with not-knowing attitude
  - Validate but nuance twist (subtle challenge)
  - Affect focus on the interaction
Escalating threats – client to client

- client verbally and possibly physically threatens another client
  - De-escalating techniques
  - Take authority but do not become authoritarian
  - Maintain a cognitive position in contrast to the affective position
  - Take a client out of the group for a short time to discuss the problem
  - Co-therapist discusses the problem with the other client in the group.
Escalating threats – client to clinician

- Client threatens clinician
  - De-escalation techniques and primary focus on safety
  - Apologise for creating the difficulty – measured ‘submission’
  - Affect focus the hierarchical relationship if present or interactional process when client calms
  - Address in individual review
Idealisation of themselves as a ‘special’ group of people

- Clients integrate and form cohesive group through paranoid organisation
  - Allow early in treatment
  - Validate the sharing of similar problems
  - Unity allows exploration of difference
  - Change the focus on general advice to more personal specific advice – ‘what is it about Peter that makes you think that your advice will be equally useful for him?’
Emotional expression - self

- Clients find naming and expressing complexity of their current and past feelings uncomfortable or impossible
  - Question the tendency to collapse all feeling into ‘anger’
  - Re-iterate MBT-I information about emotions
  - Work on identifying affects
  - Increase the link between affect and context
  - Link this work with stimulating emotion recognition from self to other
Clients may recognise emotions accurately in others but fail to identify and be compassionate with them – ‘affect and its effect’. They misuse their understanding.

- Ask Peter if he can describe how Paul feels.
- How was that inference made?
- Work on moving external focus to internal focus of mentalizing.
Emotional expression – self/other

- Clients cannot easily engage in a self-other affective mentalizing process. They tend to default to practicality and advice.
  - When a Peter is talking about a problem ask Paul to describe how he thinks Peter is feeling.
  - How was that inference made?
  - Check it out – is that how you feel Paul?
  - If not please describe how you feel?
  - Pass it back to Peter to re-consider
Clients make assumptions from external mentalizing focus.

- Identify and jointly work on the specific aspects of external mentalizing – facial expression (describe), tone of voice (describe), body posture (define)
- Practise move to internal focus – group exercise if necessary
- Identify disparities between external information and internal states
Paranoid reactions to clinician

- Clients may suddenly react without warning to something in the group
  - Identify quickly what the trigger is
  - Overtly consider if their understanding has any merit in terms of clinician contribution
  - Validate how they could have understood a comment in the way they have
  - Explain your own motive whilst not denying their understanding
  - Open the discussion in the group if they had a similar understanding
  - Accept that you will be more thoughtful about how you say something
To be continued!

All sites to log clinical situations and responses.