

Mentalization Based Treatment (MBT) for Borderline Personality Disorder: introduction to clinical practice

American Psychiatric Association Meeting 2011

Financial Disclosures

- NONE



Slides

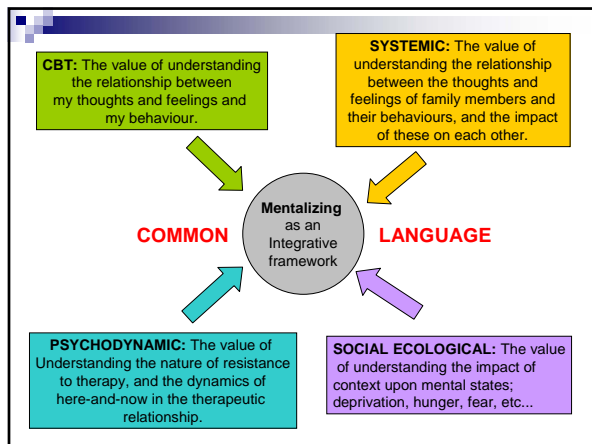
<http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>

MBT Training

- UCLA Los Angeles
 - 17-19th November 2011
 - Contact Robin Kissell MD
 - rkissell@ucla.edu
- Mclean Hospital Boston
 - 12-14th January 2012
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Forewarning

In advocating mentalization-based treatment we claim no innovation. On the contrary, mentalization-based treatment is the least novel therapeutic approach imaginable: it addresses the bedrock human capacity to apprehend mind as such. Holding mind in mind is as ancient as human relatedness and self-awareness.



Exercise – mentalization or mentalizing?

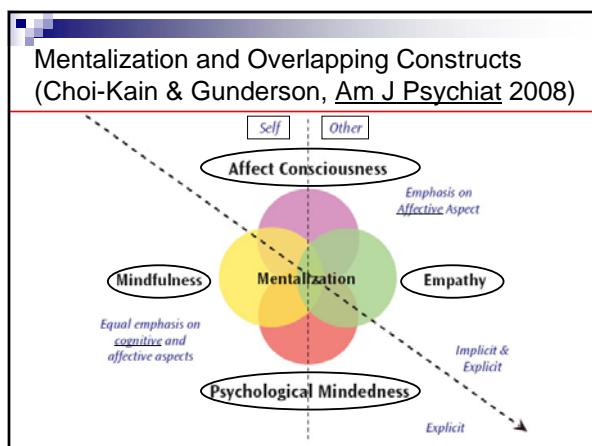
- What is mentalization or mentalizing?
 - Give 3 key aspects of the psychological processes that the concept tries to encapsulate
 - Should we use mentalization or mentalizing?

Mentalizing:
A new word for an ancient concept

Implicitly and explicitly interpreting the actions of oneself and other as meaningful on the basis of intentional mental states
(e.g., desires, needs, feelings, beliefs, & reasons)

Mentalizing: further definitions and scope

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



Mentalisation and conceptual cousins

Component	Mindfulness	Psychological Mindedness	Empathy	Affect consciousness
Implicit	No	No	Yes	No
Explicit	yes	Yes	Yes	Yes
Self-orientated	Yes	Yes	Minimal	Yes
Other orientated	No	Minimal	Yes	Yes
Cognitive/Affect	Cog=Affect	Cog=Affect	Affect>Cog	Affect>Cog

Multiple dimensions of mentalizing in psychodynamic psychotherapy

- Differentiating **self and other** in psychotherapy
 - Adopting the perspective of the other to the self
 - Reducing the impact of the other on the self
- 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)

Treatment vectors in re-establishing mentalizing in borderline personality disorder

Dimensions of mentalization: implicit/automatic vs explicit/controlled in Othello

Why, how now, hol from whence ariseth this?
 Are we turn'd Turks, and to ourselves do that
 Which heaven hath forbid the Ottomites?
 For Christian shame, put by this barbarous brawl:

Dimensions of mentalization: implicit/automatic vs explicit/controlled


Psychological understanding drops and is rapidly replaced by confusion about mental states under high arousal

Dimensions of mentalization: implicit/automatic vs explicit/controlled

Psychotherapist's **demand to explore** issues that trigger intense emotional reactions involving conscious reflection and explicit mentalization are inconsistent with the patient's ability to perform these tasks when arousal is high

Mayes' (2001) Adaptation of Arnsten's Dual Arousal Systems Model: Implication of the Hyper-activation of Attachment

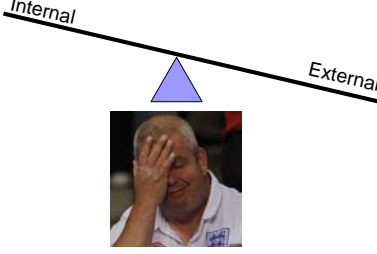
Dimensions of mentalization: internally vs externally focused (mental interiors vs visible clues)

Internal	External
<p>I wonder if he feels his mother loved him?</p> 	<p>He looks tired; perhaps he slept badly</p>

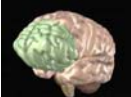

With selective loss of sense of mental interiors, external features are given inappropriate weight and misinterpreted as indicating dispositional states

Internal External

You're covering your eyes; you can hardly bear to look at me



Dimensions of mentalization: Cognitive vs affective mentalization

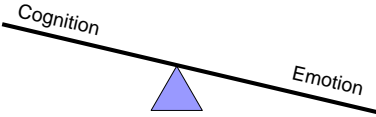
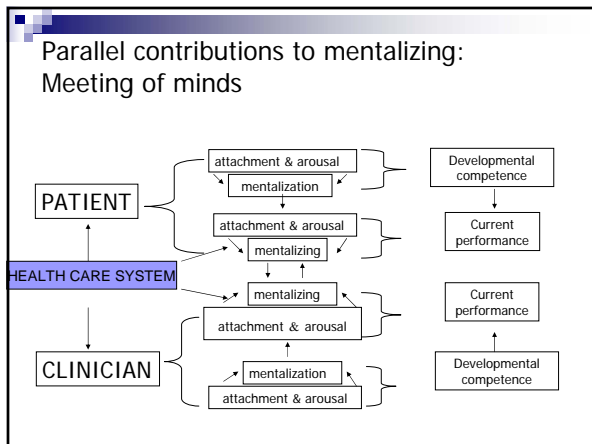
Cognition	Emotion
<p>■ Agent attitude propositions</p> <p>'I think he thought that Charlie ate his chocolate'</p> <p>Associated with several areas of prefrontal cortex</p> 	<p>■ Self affect state propositions</p> <p>'I feel upset about it'</p> <p>Associated with inferior prefrontal gyrus</p> 

Dimensions of mentalization: Cognitive vs affective mentalization

- With diminution of cognitive mentalization the logic of emotional mentalization (self-affect state proposition) comes to be inappropriately extended to cognitions.

Cognition Emotion

"I feel sad, you must have hurt me"

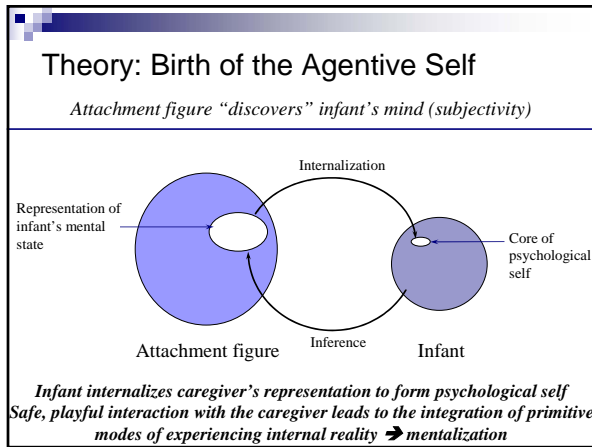



Being misunderstood

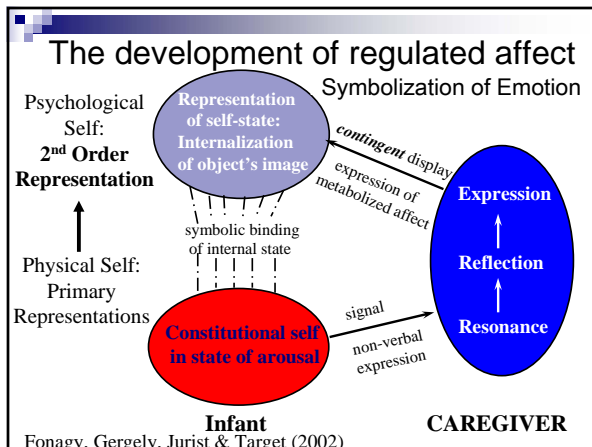
- Although skill in reading minds is important, recognising the limits of one's skill is essential
- First, acting on false assumptions causes confusion
- Second, being misunderstood is highly aversive
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection

Some developmental theory

- ## Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)
- a pattern of unstable intense relationships,
 - inappropiate **unstable relationships**
 - frantic efforts to avoid abandonment
 - affective dysregulation
 - 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



- ## The Development of Affect Regulation
- Closeness of the infant to another human being who via **contingent marked mirroring** actions facilitates the emergence of a symbolic representational system of affective states and assists in developing affect regulation (and selective attention) → secure attachment
 - For normal development the child needs to experience a mind that has his mind in mind
 - Able to reflect on his intentions accurately
 - Does not overwhelm him
 - Not accessible to neglected children



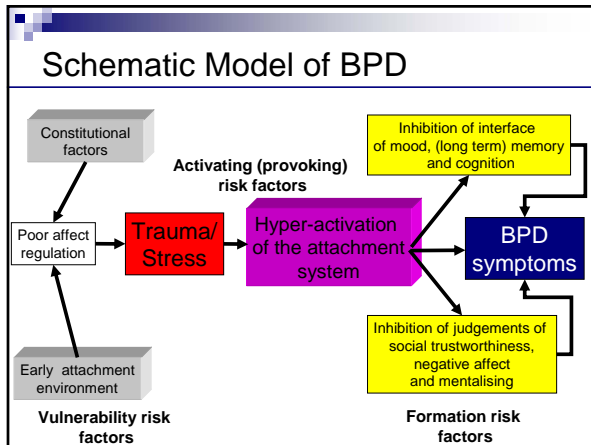
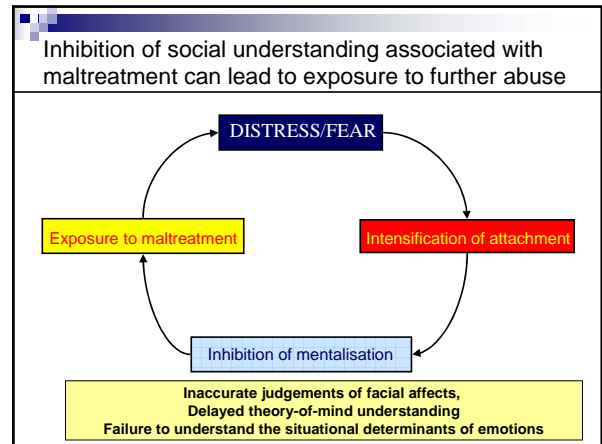
Attachment Disorganisation in Maltreatment

Exposure to maltreatment

The 'hyperactivation' of the attachment system

The hyperactivation of attachment in BPD

- We assume that **the attachment system in BPD is “hypersensitive”** (triggered too readily)
- Indications of attachment hyperactivity in **core symptoms** of BPD
 - Frantic efforts to avoid abandonment
 - Pattern of unstable and intense interpersonal relationships
 - Rapidly **escalating tempo** moving from acquaintance to great intimacy



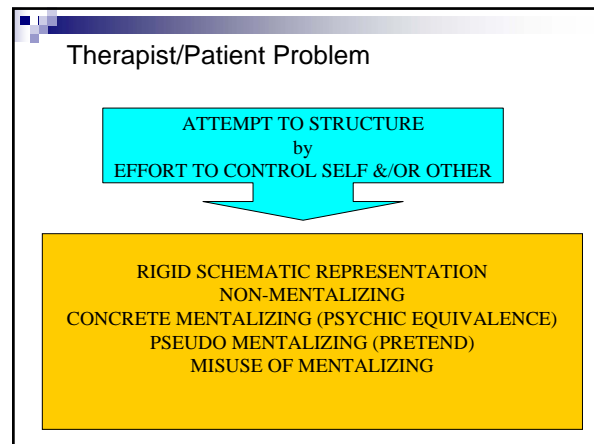
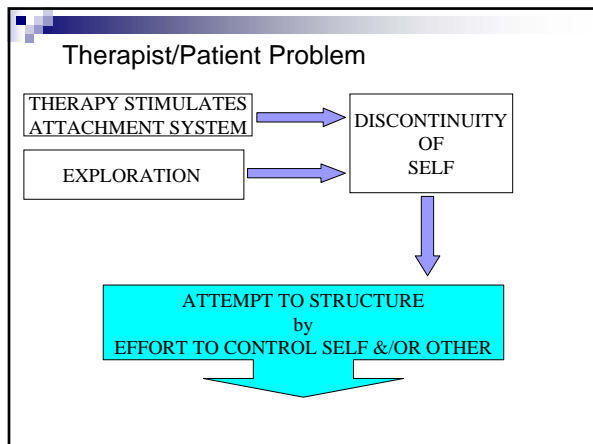
The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

- **Psychic equivalence:**
 - Mind-world isomorphism; mental reality = outer reality; internal has power of external
 - Experience of mind can be terrifying (flashbacks)
 - Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise”)
 - Self-related negative cognitions are **TOO REAL!** (feeling of badness felt with unbearable intensity)

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

- **Pretend mode:**
 - Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
 - Linked with emptiness, meaninglessness and dissociation in the wake of trauma
 - Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
 - In therapy endless inconsequential talk of thoughts and feelings
 - The constitutional self is absent → feelings do not accompany thoughts



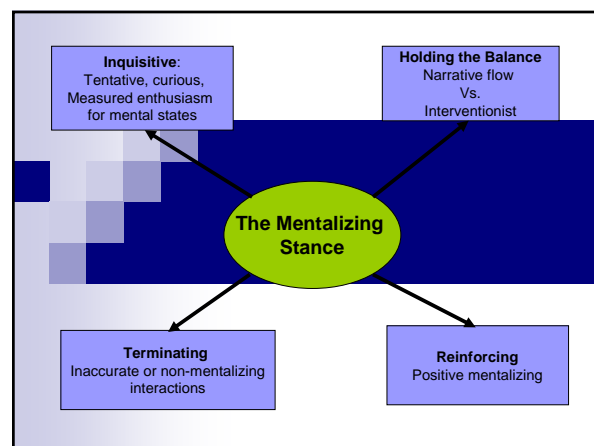


- ### Therapist Stance
- **Not-Knowing**
 - Neither therapist nor patient experiences interactions other than impressionistically
 - Identify difference – 'I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you'.
 - Acceptance of different perspectives
 - Active questioning
 - Eschew your need to understand – do not feel under obligation to understand the non-understandable.
 - **Monitor your 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 patient 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 patient seems to lose control

Contrary Moves

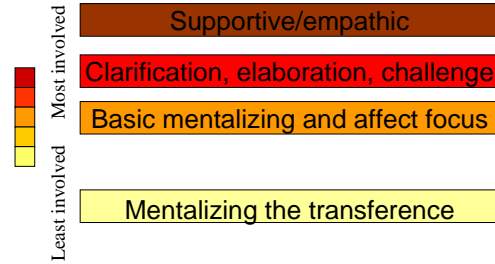
Patient/Therapist	Therapist/Patient
Knowing	Unknowing
Self- reflection	Other reflection
Emotional distance	Emotional closeness
Cognitive	Affective



Interventions: Spectrum

- Supportive & empathic
- Clarification, Challenge, & elaboration
- Basic Mentalising
- Interpretive Mentalising
- Mentalising the transference
- Non-mentalising interpretations – to use with care

Interventions: Spectrum



Challenge

Intervention: Challenge

- Aim is to 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 if they seem to respond
- Intervention should be outside the expected frame
- Use humour when possible

Intervention: Challenge

- **Stop and Stand**
 - Persist and decline to be deflected from exploration - 'Bear with me, I think we need to continue trying to understand what is going on'
 - Steady resolve - 'I can understand that you want me to support what you are doing but I don't think that would be right because...'
 - Convert deceit into frank truth - 'although you feel he has so much that he wouldn't miss it, the fact is that having stolen it you are a thief'
 - Identify affect attached to action - 'I can see that although you tried not to 'con' them, the pleasure and delight of doing it seems to have been stronger'
 - Ensure 'here and now' aspects are included in the challenge

Clarification and Affect Focus

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)
- Reflect on what it must be like to feel like that in that situation
- 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?

Current affective interpersonal experience

- Define the current affective state shared between patient and therapist
- Do this tentatively from your own perspective
- Do not suggest it is the patient's experience
- Link the current affective state to therapeutic work within the session itself

Transference and Countertransference

Components of mentalizing the transference

- 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 patient's reaction
- Explore the patient's reaction to the new understanding

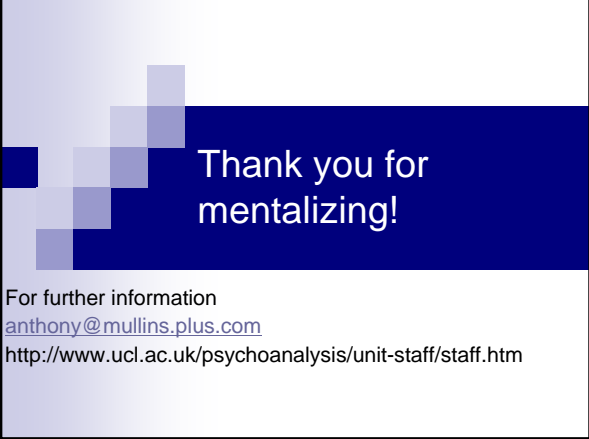
Interventions: Mentalizing the Transference

■ Dangers of using the transference

- Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient 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 countertransference

- 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.



Thank you for
mentalizing!

For further information

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<http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>