


# Mentalization Based Therapy for Borderline Personality Disorder: turning theory into practice

Attachment, Mentalization and  
Psychoanalytic and  
Psychodynamic Therapies  
Seattle October 2007  
Prof Anthony W Bateman



# Mentalizing



In order to adaptively predict and justify each others' actions

- We have to understand that we have
  - **SEPARATE MINDS** that (often) contain
  - **DIFFERENT MENTAL MODELS** of reality that cause our Actions;
- We have to be able to infer and represent both
  - the **MENTAL MODELS** of the other's **MIND** and
  - the **MENTAL MODELS** of our *own* **MIND**



## Approaches to mentalisation

---

- Understanding others from the inside and oneself from the outside
- Having mind in mind
- Mindfulness of minds
- Understanding misunderstanding

## Characteristics of mentalising

- Central concept is that internal states (emotions, thoughts, etc) are opaque
- We make inferences about them
- But inferences are prone to error
- Overarching principal is to take the “inquisitive stance”

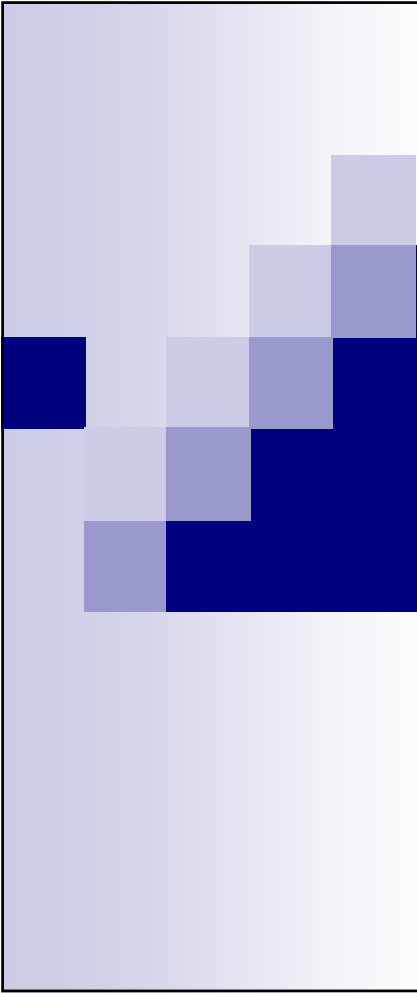
=

*Interpersonal behaviour characterised by an expectation that one's mind may be influenced, surprised, changed and enlightened by learning about another's mind*



## 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



# Mentalizing and Borderline Personality Disorder



## Assumed cause of mentalisation deficit in BPD

- Current model:
  - Constitutional vulnerability
  - Mentalisation deficit can be secondary to the abnormal functioning of the attachment system
    - developmentally early dysfunctions of the attachment system
    - in combination with later traumatic experiences in an attachment context
  - The hyper-responsiveness of the attachment system has negative impact upon mentalising.
  - Even greater in individuals with insecure attachment histories who are already limited in their capacity to maintain mentalisation in the context of attachment relationships
  - Fragile mentalizing leads to return of earlier psychological modes of function – teleological, psychic equivalence and pretend mode.



## The implication of the temporary loss of mentalising

1. Psychic Equivalence
2. Pretend Mode
3. Teleological Stance



## 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

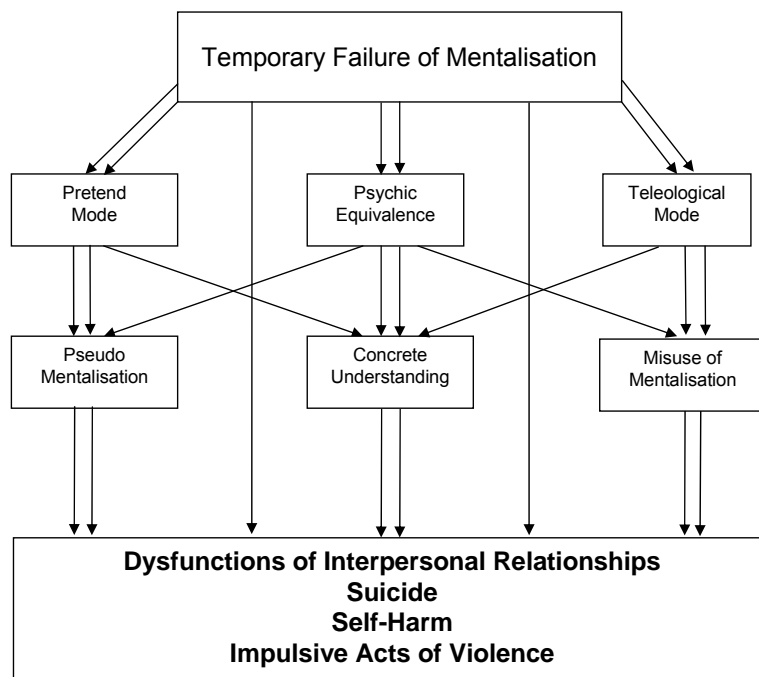


## The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

### ■ Teleological stance:

- Expectations concerning the agency of the other are present but these are formulated in terms restricted to the physical world
- A focus on understanding actions in terms of their physical as opposed to mental outcomes
- Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Only action that has physical impact is felt to be able to alter mental state in both self and other
  - Physical acts (self-harm)
  - Demand for acts of demonstration (of affection) by others

# Understanding suicide and self-harm in terms of the temporary loss of mentalisation



*loss → attachment needs → failure of mentalisation → intensification of unbearable experience →  
→ dissociation → teleological solutions to crisis of agentive self*



# Clinical Implications



## Dysregulation of attentional capacities

- With individuals whose attachment relationships have been disorganized we may anticipate quite severe problems in affect regulation and attentional control along with profound dysfunctions of attachment relationships
- Exploratory psychotherapy techniques are likely to dysregulate the patient's affect
- It is wise to anticipate difficulties in effortful control

## Disorganisation of self

- Loss of mentalizing leads to subjective experiences indicating discontinuities in self structure (e.g. a sense of having a wish/belief/feeling which does not 'feel like their own'.)
- Do not see states of minds as if they were manifestations of a dynamic unconscious or as indications of the 'true' but 'disguised' or 'repressed' wish/belief/feeling of the patient  
→ more a panic of survival
- The discontinuity in the self will have an aversive aspect to most patients leading to a sense of discontinuity in identity (identity diffusion)



## Projection of alien self

- Patients will try to deal with discontinuous aspects of their experience by externalisation and structuring relationships (in part by generating the feeling within the therapist)
- The tendency to do this had been established early in childhood
- It is not going to be reversed simply by bringing conscious attention to the process – therefore interpretation of it early in treatment is mostly ineffective



## Psychic equivalence

- Characterised by conviction of being right that makes entering into Socratic debates mostly unhelpful
- Patients commonly assume that they know what the therapist is thinking - claiming primacy for introspection (i.e. saying that one knows one's own mind better than the patient) will lead to fruitless debate
- The rigid character of the patient's thoughts often undermine the therapists sense of self leading to tendency to respond teleologically
- Therapist may make ill advised attempt to 'defend' position
- Grandiosity and idealization are also expectable consequences of an unquestioning mind



## Psychic equivalence and self harm

- It is not the action itself that carries most meaning in this mode but deviation from action that is contingent with the patient's wishes
- Self-harm, suicide attempts and other dramatic actions tend to bring about contingent change in the behaviour of most people - patient experiences a sense of being cared about



## Psychic Equivalence and Fantasy development

---

- Stimulating fantasy about the therapist is likely to be experienced as fact
- Confirms the patient's beliefs or assumptions
- When operating in psychic equivalence does not retain 'as if' quality of 'observing ego'



## Pretend Mode/Pseudomentalizing

- Challenging pseudo-mentalisation in the pretend mode can provoke extreme reactions because of the vacuum it reveals
- Pretend mode pseudo-mentalisation denies the therapist's own sense of reality and the therapist can be left feeling excluded and trying harder to connect to the patient's discourse
- The patient's experience of lack of meaningful connection to reality can be the prompt and drive behind the search for connection but the connections found are often random, complex, unstable and confusing – exploration is unproductive

## Mentalizing and Self-disclosure

### ■ Careful self-disclosure

- Explanation of the reasons for your reaction is useful especially when challenged by the patient
- Answer appropriate questions prior to exploration in order not to use fantasy development as part of therapy
- Verifies a patient's accurate perception
- Underscores the reality that you are made to feel things by him which is an essential aspect of treatment
- Used to consolidate countertransference experience



## Validation as a technique

- Observing and reflection are common to every therapy and are an essential aspect to MBT
- Used to confirm the patient's experience and contingent response as being understandable in a specific context
- Focus is on exploration and on elaborating a multi-faceted representation based on current experience particularly with the therapist to identify distortions if present
- Move towards mentalizing the transference

## Iatrogenesis

- Therapeutic interventions run the risk of exacerbating rather than reducing the reasons for temporary failures of mentalising
- Non-mentalising interventions tend to place the therapist in the expert role declaring what is on the patients' mind which can be dealt with only by denial or uncritical acceptance
- To enhance mentalising the therapist should state clearly how he has arrived at a conclusion about what the patient is thinking or feeling
- Exploring the antecedents of mentalisation failure is sometimes but by no means invariably helpful in restoring the patient's ability to think



# Aims and Structure of Mentalization Based Treatment



## Summary

The aims of treatment are

- To promote mentalizing about oneself
- To promote mentalizing about others
- To promote mentalizing of relationships
  - By being alert to non-mentalizing processes in yourself and the patient
  - By exploration of patient-therapist relationship

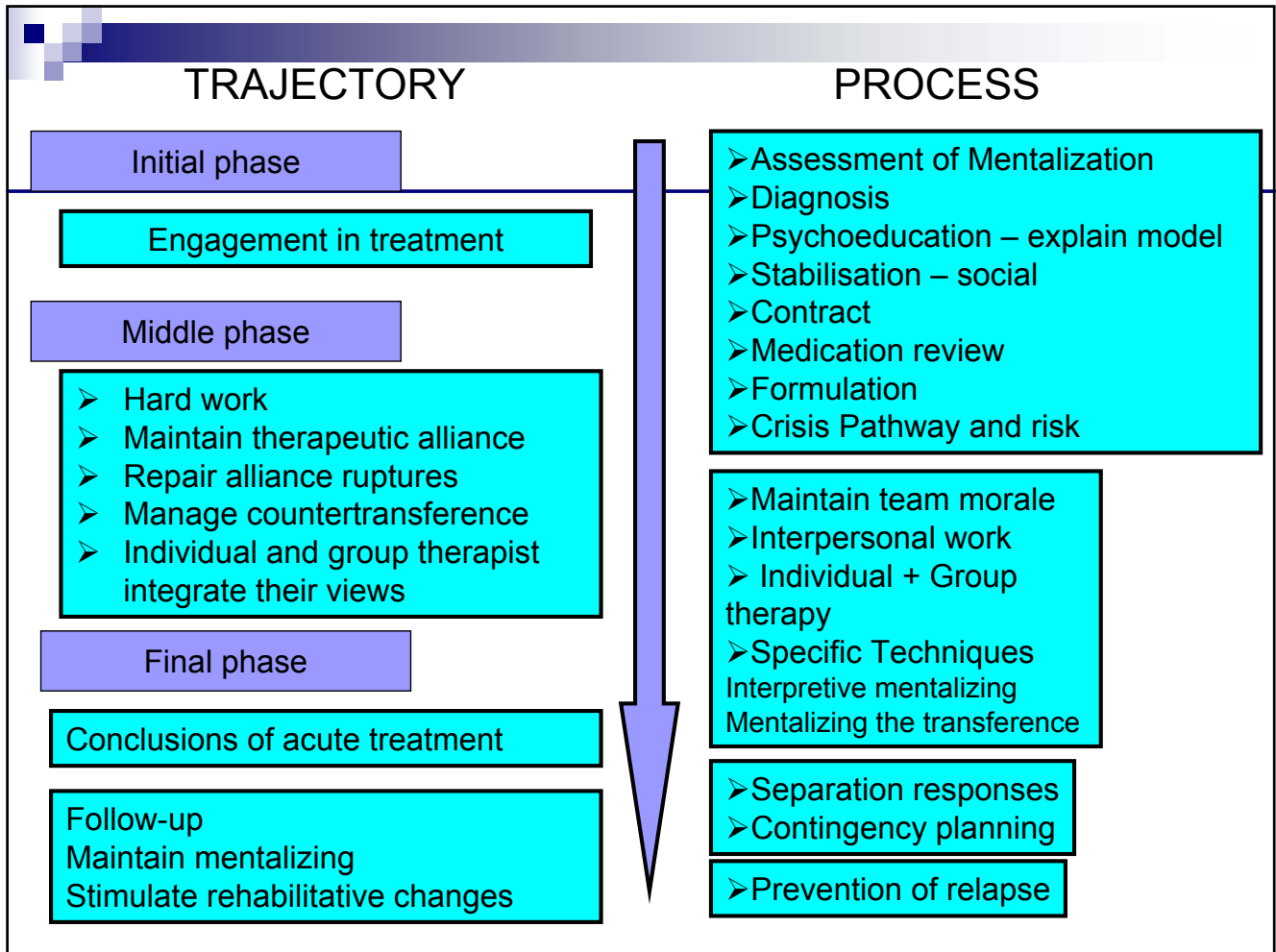
So gradually you and the patient will increasingly respect the privacy of minds and become surprised about what you find.



## Standard MBT Modes

---

- Individual psychotherapy
- Group Psychotherapy
- Crisis Planning
- Team Supervision
- Integrated psychiatric care

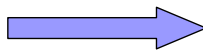




# Therapist stance

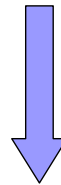
# Therapist/Patient Problem

THERAPY STIMULATES  
ATTACHMENT SYSTEM



DISCONTINUITY  
OF  
SELF

EXPLORATION



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

## ■ Monitor you own errors

- Model honesty and courage via acknowledgement of your own errors
  - Current
  - Future
- Suggest that errors offer opportunities to re-visit to learn more about contexts, experiences, and feelings



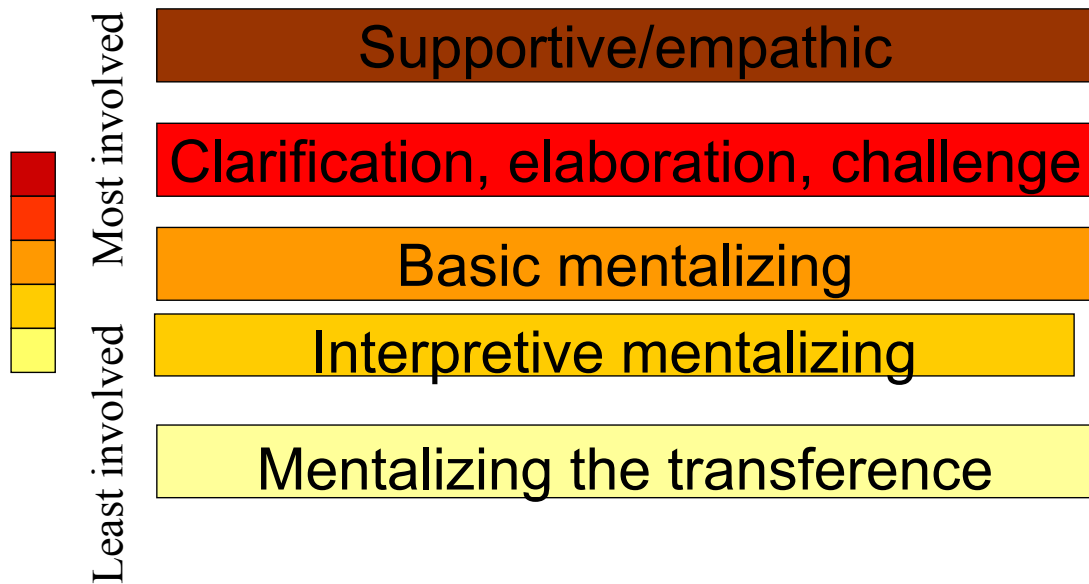
# Guidance on which intervention when



## Clinical summary of intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- 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 transference

# Interventions: Spectrum





## Which Intervention to use when?

- Type of intervention is inversely related to emotional intensity
- Support and empathy given when the patient is overwhelmed with emotion; mentalizing transference when the patient can continue mentalizing whilst 'holding' the emotion
- Intervention must be in keeping with patients mentalizing capacity at the time at which it is given
- The danger is assuming that borderline patients have a greater capacity than they actually have when they are struggling with feelings.



## Challenge or Stop and Stand

- Aim to kick start mentalising when lost
- Intervention often runs counter to flow of patient discourse
- Listen for assumptions especially about you
- 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...'
- Ensure 'here and now' aspects are included in the challenge



# Mentalizing and transference



## 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



# Mentalising the transference - video

15.30-16.30

18.40-20.00

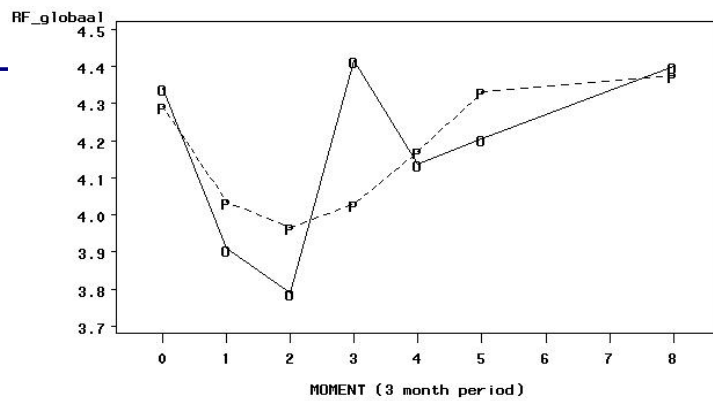


## Mentalizing the Transference

### ■ Dangers of using the transference

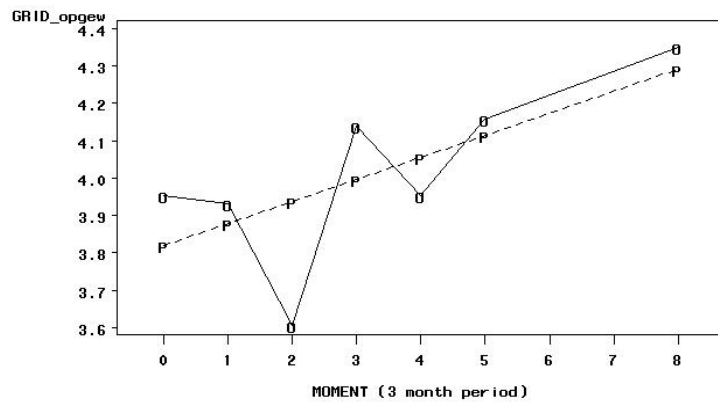
- Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient feel that whatever is happening in therapy is unreal
- Thrown into a pretend mode
- Elaborates a fantasy of understanding with therapist
- Little experiential contact with reality
- No generalization

Change of ORI process measures of 47 pts. during 1 year treatment/1 year follow-up



**Reflective Functioning Scale**

$F(6,255) = 1.97, p = .07$



**Bion Grid Scale**

$F(6,245) = 2.82, p = .01$



## Heterogeneity of borderline personality disorder

- Blatt (1992, 1996) distinguished in his reanalysis of the Menninger study
  - introjective group: paranoid, schizoid, narcissistic group of patients : greater pre-occupation with issues of self-definition
  - anaclitic group: dependent, avoidant, borderline showing greater pre-occupation with issues of relatedness.
- The introjective group profits most from explorative psychoanalytic treatment, the anaclitic group from supportive-expressive treatment.



## Conclusions of Vermote Trial

- Outcome results corroborate the results of the Bateman-Fonagy RCT study on psychoanalytically informed hospitalization based treatment and other effectiveness studies ( Leichsenring, 2003,2005)
- Improvement in the post-treatment phase is an argument for structural change.
- The trajectory analysis shows that severe patients need a very long period before they start to change, but then change can be quite dramatic. Treatment shows the best results with introjective/pre-occupied borderline patients. 25% of patients clearly need a longer supportive approach
- The patient characteristics of this group can be identified from the outset.
- Treatment process revealed an important regression in the first 3-6 months and with an improvement after this period



## 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 of the source of negativity or excessive concern etc.



# Some research evidence



**Trial I:  
RCT of Psychoanalytic Partial  
Hospital Treatment (18 months)  
(Bateman & Fonagy, 1999, 2001,  
2003)**

Attempted Suicide:	NNT (18 months)= <b>2.1</b> NNT (36 months)= <b>1.9</b>
Self-Mutilating:	NNT (18 months)= <b>2.1</b> NNT (36 months)= <b>2.0</b>
Inpatient Episodes:	ES(18m)= <b>1.4</b> ES(36m)= <b>1.1</b>
Depression:	NNT(36m)= <b>2.1</b>



**Trial 2:  
Cohort of MBT Partial Hospital  
Treatment (18 months)  
(Bales and Verheul, Holland)**

Attempted Suicide: NNT (18 months)= **2.4**

Self-Mutilating: NNT (18 months)= **2.3**

General dysfunction: ES(18m)= **1.9**

Depression: ES (18m)= **2.8**



**Trial 3:**  
8 year follow up of patients  
treated with MBT compared with  
TAU  
(Bateman & Fonagy – submitted)



## Design of MBT Partial Hospital follow-up study

- 41 (22 MBT 'v' 19 TAU) patients followed up 8 years after they started treatment
- Contact was made by letter, via their general practitioner, and by telephone.
- Medical and psychiatric records were obtained for all 41 patients and relevant information extracted.
- Patients interviewed by research psychologists who remained blind to original group allocation.
- 5 patients (2 MBT/3TAU) refused interview
- 1 patient from TAU had died from suicide

## Assessment at follow-up interview

- Primary outcome
  - Zanarini Rating Scale for DSM-IV BPD (ZAN-BPD)
  - Global Assessment of Function (GAF)
- Secondary outcomes
  - Number of self-harm and suicide attempts
  - Number of emergency room visits
  - Length of hospitalization
  - Continuing out-patient psychiatric care
  - Use of medication, psychological therapies, and community support.
  - Vocational status

## Zan-BPD (22 v 15) Means (SD)

	MBT-PH	TAU	Significance
Positive criteria n (%)	3 (13.6)	13 (86.7)	$\chi^2 = 16.5$ p=.000004
Total mean (SD)	5.5 (5.2)	15.1 (5.3)	$F_{1,35} = 29.7$ p=.000004
Affect mean (SD)	1.6 (2.0)	3.7 (2.0)	$F_{1,35} = 9.7$ p=.004
Cognitive mean (SD)	1.1 (1.4)	2.5 (2.0)	$F_{1,35} = 6.9$ p=.02
Impulsivity mean (SD)	1.6 (1.8)	4.1 (2.3)	$F_{1,35} = 13.9$ p=.001
Interpersonal mean (SD)	1.5 (1.7)	4.7 (2.3)	$F_{1,35} = 23.2$ p=.00003

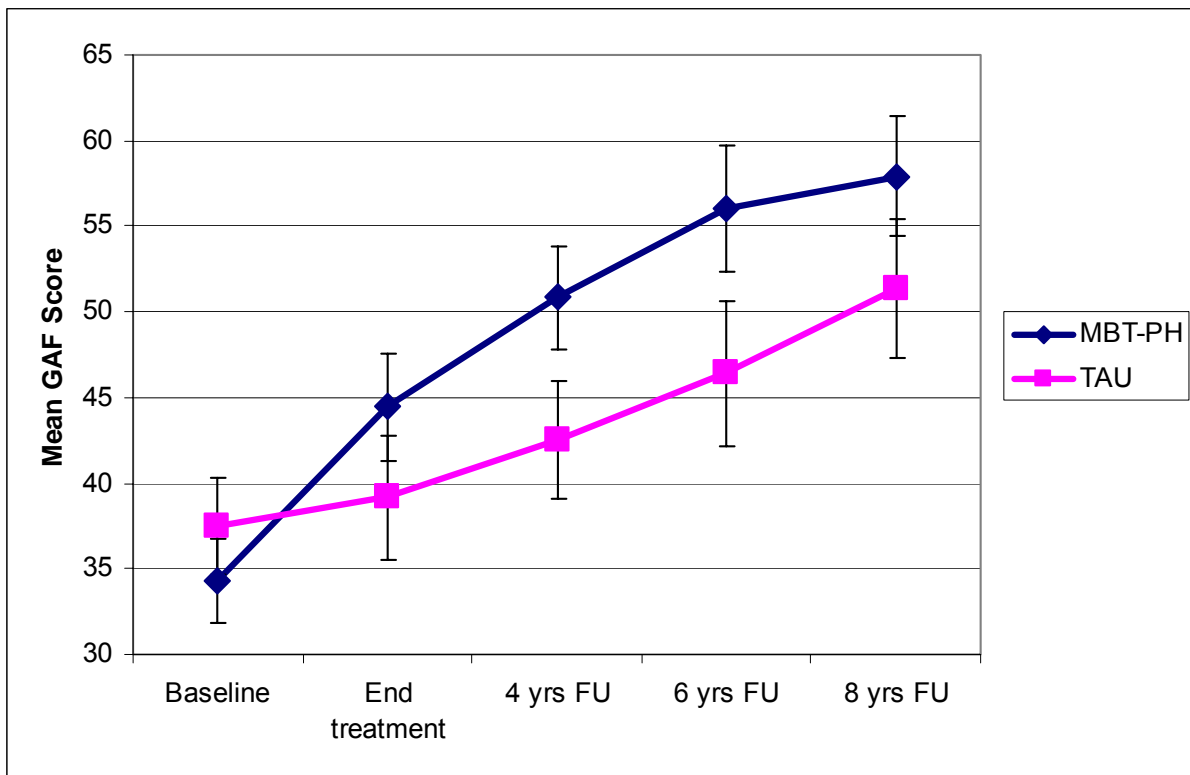
## Suicide attempts (22 'v' 19)

	MBT-PH	TAU	Significance
Total N mean (SD)	.05 (0.9)	0.52 (.48)	U = 73, Z=3.9p = .00004
Any attempt N (%)	5 (23)	14 (74)	$\chi^2 = 8.7, df = 1$ p = .003

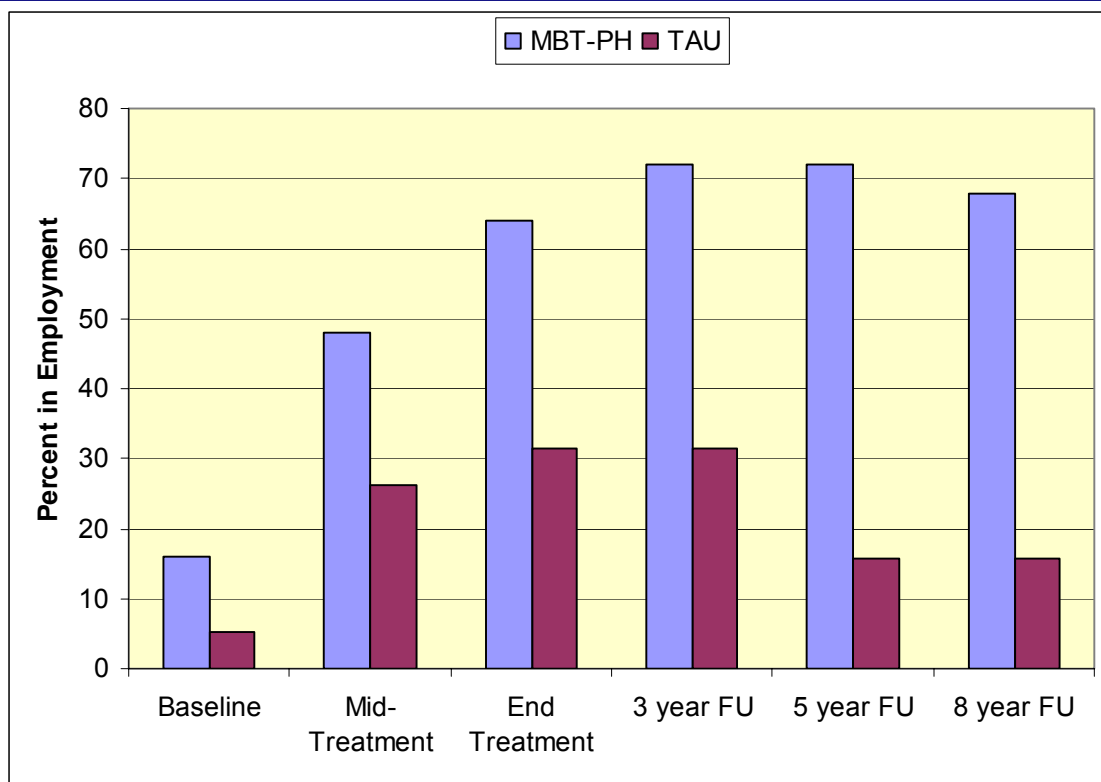
## Global Assessment of Function

	MBT-PH	TAU	Significance
Mean(SD)	58.3 (10.5)	51.8 (5.7)	F1,35 = 5.4 p=.03
Number (%) > 60	10 (45.5)	2 (10.5)	$\chi^2 = 6.5$ , df=1p =.02

# Partial Hospital RCT: GAF Scores




## Partial Hospital RCT: Vocational status



## Conclusions from long term follow-up

- MBT-PH group continued to do well 5 years after all MBT treatment had ceased
- A strong correlate of improvement in the MBT-PH group is vocational status ?cause or consequence
- TAU did badly within services despite significant input.
- TAU is not necessarily ineffective in its components but package or organization is not facilitating possible natural recovery.
- BUT
  - Small sample, allegiance effects (despite attempts being made to blind the data collection) limit the conclusions.
  - GAF scores continue to indicate deficits. Suggests less focus during treatment on symptomatic problems greater concentration on improving general social adaptation.



**Trial 4:  
Implementation of Outpatient  
Mentalization Based Therapy  
for Borderline Personality  
Disorder**

Funded by a research grant from  
the Borderline Personality  
Disorder Research Foundation



## Design of Intensive out-patient MBT randomised controlled trial.

- Referrals (n=70 & n=58 for IOP-MBT and SCM groups respectively)
- Random allocation (minimisation for age, gender, antisocial PD)
- Individual (50 mins) + Group (1.5 hrs) weekly for 18 months
- Assessments at admission, 6 months, 12 months, 18 months
- Medication followed protocol

# Patient Flow

Patients referred  
N = 168

## Enrollment

Interviewed  
N = 154

Did Not Meet Criteria N =	
Reason	N
Did not meet BPD Criteria	5
Substance Dependent	2
Bipolar Disorder	1
Psychotic Disorder	1
Dropped out	3

Met Criteria N = 142  
Offered Randomization  
Minimised for age, gender, antisocial PD

Refused Randomization  
N = 14

## Allocation

Randomized  
N = 128

## Treatment

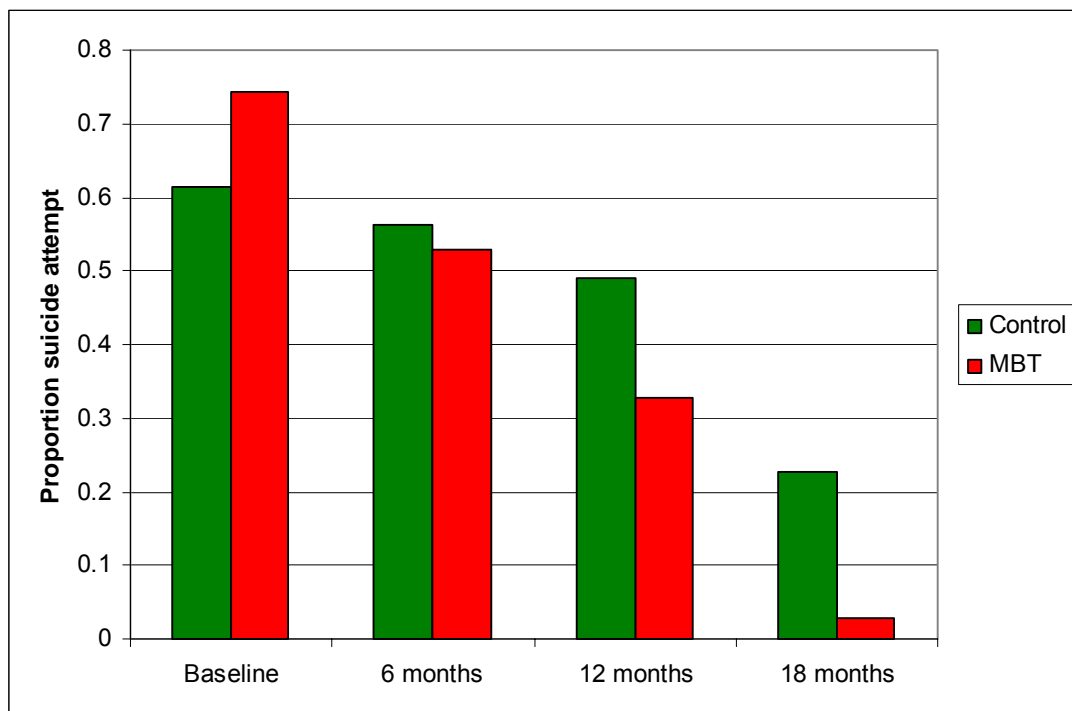
+

## Analysis

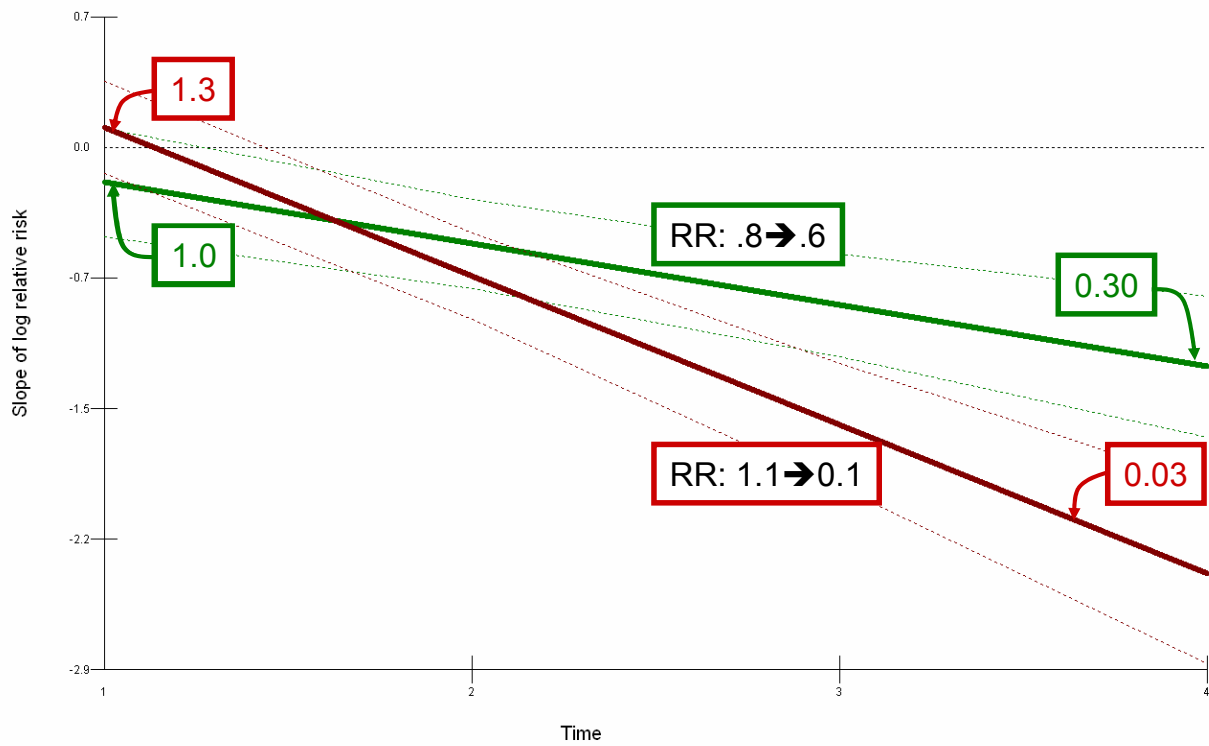
MBT  
N = 70

SCM  
N = 58

# Suicide attempts in 6 month period

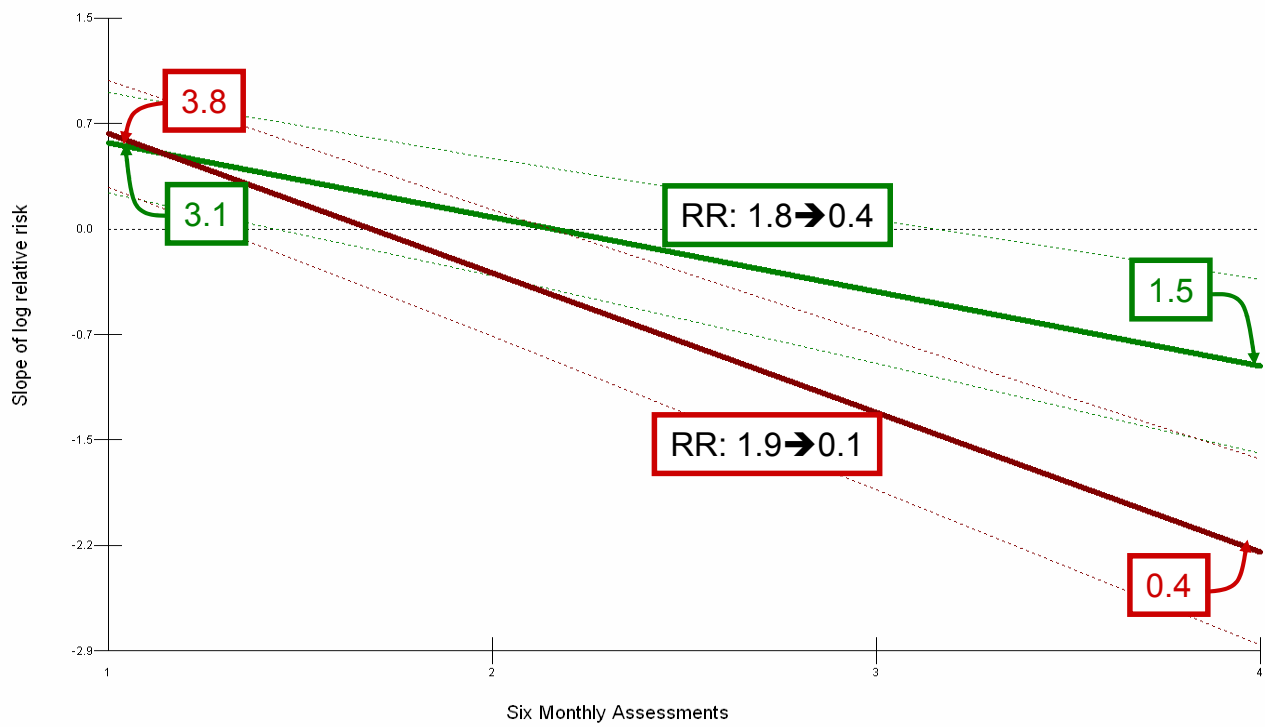


Rate of Decline of Suicide in MBT (red) and Control (green) Treatments



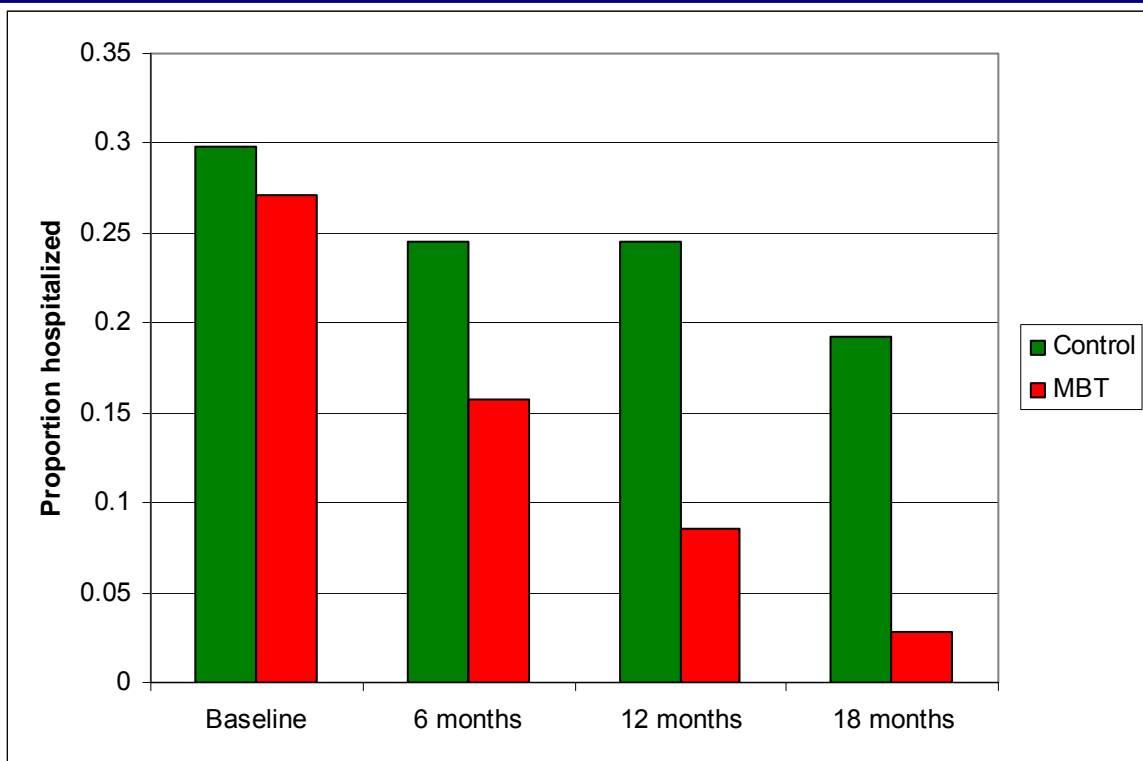
Coefficient of difference between slopes =  $-.081$ ,  $z=3.8$ ,  $p<.00006$ ,  $d=.69$

Rate of Decline in Self-harm in MBT (red) and Control (green) Treatments



Coefficient of difference between slopes=-.065, z=5.0, p<.00002, d=.89

# Proportion of patients hospitalized



## Conclusion

- MBT-OP is surprisingly effective
- The sample was less disturbed than the partial hospital sample
- Most of the MBT subjects but also some of the SCM subjects lost their diagnosis
- Relatively few of the SCM patients improved in terms of subjective measures
- Very few of the MBT patients did not improve in way they were expected to
- Even when improved remains quite high scoring on pathology scales

OXFORD

**Psychotherapy for Borderline  
Personality Disorder**

*mentalization based treatment*

ANTHONY BATEMAN AND PETER FONAGY

2004

MENTALIZATION BASED  
TREATMENT FOR BPD

A PRACTICAL GUIDE

ANTHONY BATEMAN  
PETER FONAGY

2006



**Thank you for  
mentalizing!**

For further information  
[anthony@abate.org.uk](mailto:anthony@abate.org.uk)