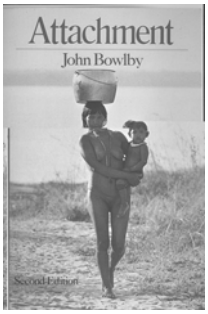
Psychotherapy for Borderline Personality Disorder

Workshop on Mentalisation Based Treatment

Anthony Bateman & Peter Fonagy

Some basic theory

The Role of Early Attachments



- *Attachment confers a selective advantage to humans by the opportunity it affords for the development of neurocognitive social capacities*
- *Evolution has charged attachment relationships to ensure the full development of the social brain*

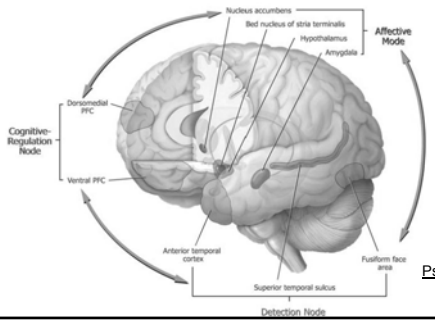
A working definition of mentalization

Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).

The Theory: Three Assumptions Related to Self Development

- that the agentive, mentalizing, psychological sense of *self is rooted in the attribution of mental states*
- that this capacity emerges through interaction with the caregiver, in the context of an attachment relationship, via *a process of contingent mirroring*
- that this capacity *may be inhibited* (decoupled) temporarily or more extensively in response to relational (interpersonal) conflicts, acute stress or trauma in vulnerable individuals➔reemergence of non-mentalizing forms of cognition

Schematic depiction of the interaction of the 3 nodes of the social information processing network (SIPN)*



*Nelson et al Psychol Med 35: 163-174, 2005

Brain structures directly relevant to mentalizing

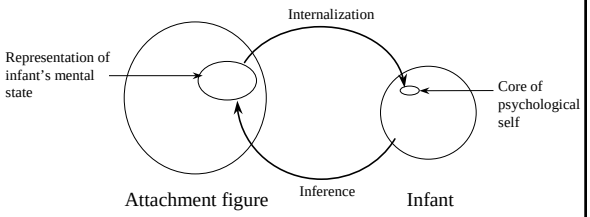
- Reasoning about false beliefs
  - medial prefrontal cortex (anterior to the ACC)
- Attributions of desires & goals
  - the medial prefrontal cortex & posterior superior temporal sulcus
- Inhibitory controls
  - the anterior cingulate cortex (ACC)
- Understanding affect
  - amygdala, insula and basal ganglia
- A shared sub-personal neural mapping between what is acted and what is perceived
  - Mirror neurons in parietal and premotor cortical networks

Mentalizing and Emotional Life

- Mentalization is procedural and mostly non-conscious
- Central to understanding and regulating emotions
- Mentalization is by definition inexact
  - Have to share internal experiences with others to make it meaningful
- Mentalization is developmental, increasingly complex and only gradually achieved fully

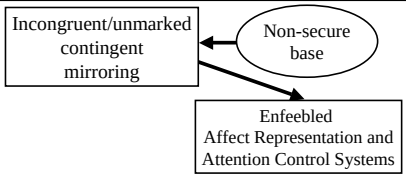
Theory: Birth of the Agentive Self

Attachment figure "discovers" infant's mind (subjectivity)

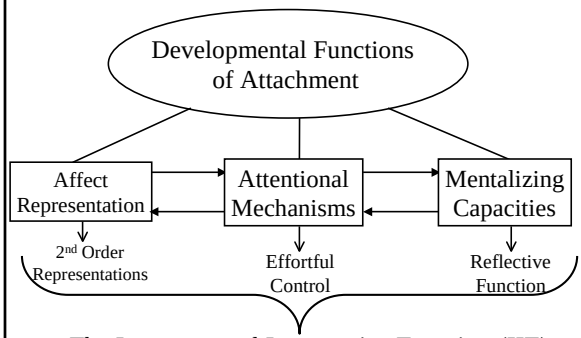


Infant internalizes caregiver's representation to form psychological self
Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality → mentalization

A Model of Borderline Pathology

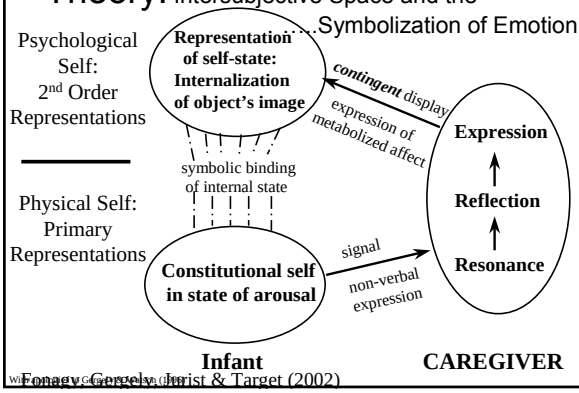


Theory: Revision of Attachment Theory



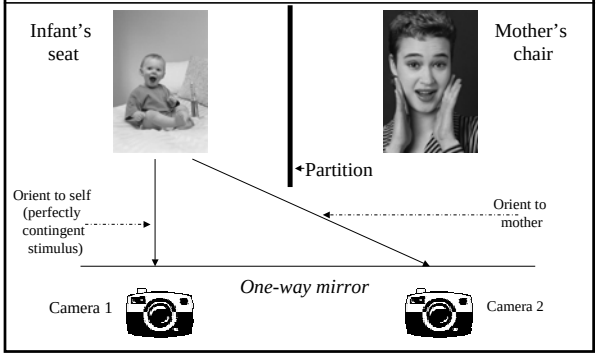
The Interpersonal Interpretive Function (IIF)

Theory: Intersubjective Space and the Symbolization of Emotion



Fonagy, Gergely, Jurist & Target (2002)

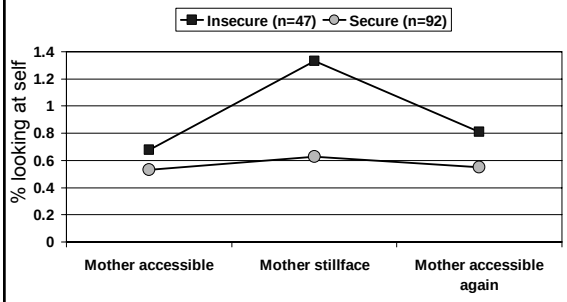
Experimental Arrangements for the Contingency Performance Modified Still Face Study (Koos et al, 2000)



High contingent parent

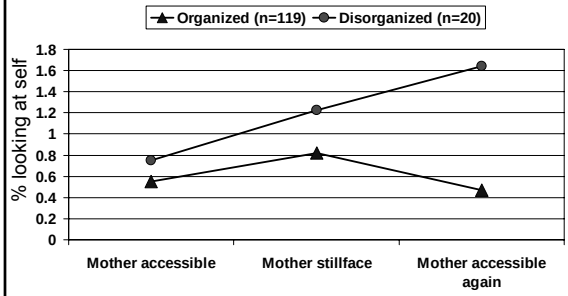
Low contingent parent

Duration of Looking at Self During Three Phases of Modified Still Face Procedure



(Gergely, Fonagy, Koos, et al., 2004) F(interaction)=6.90, df=2,137, p<.0001

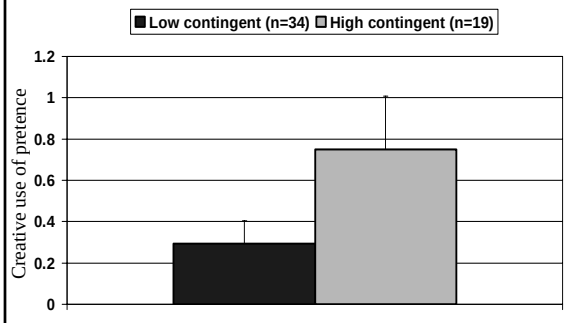
Duration of Looking at Self During Three Phases of Modified Still Face Procedure



(Gergely, Fonagy, Koos, et al., 2004) F(interaction)=12.00, df=2,137, p<.0001

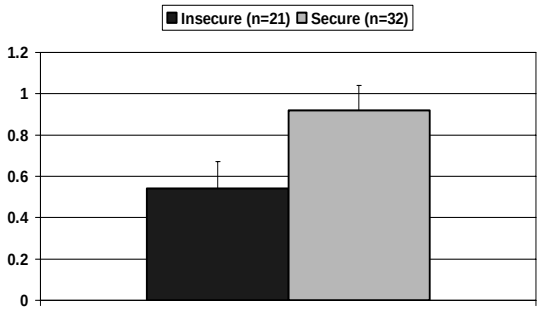
Pretence task at 3 years

High and low contingent mothers in the MIS predicting the creative use of pretence



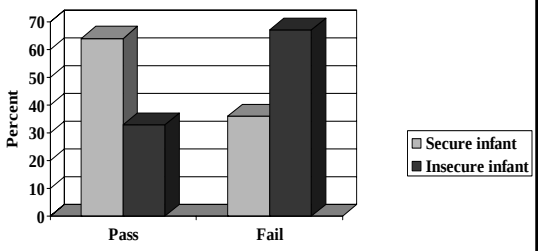
(Gergely, Koos, Fonagy et al., 2004) Mann-Whitney=196, z=2.4, p<.006

Total pretence competence score in relation to attachment security



(Gergely, Koos, Fonagy et al., 2004) F=4.55, df=1,46, p<.01

Infant Security with Mother at One Year Predicts Belief-Desire Reasoning Task Performance (Fonagy, Steele, Steele & Holder, 1997)



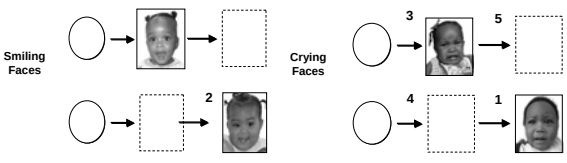
Children's Performance in Theory of Mind Task at 5.5 Years

Attachment history partially determines the strength of mentalizing capacity of individuals

Secure individuals, who had a mentalizing carer, have more robust capacities to represent the states of their own and other people's minds and this can serve to protect them from psychosocial adversity

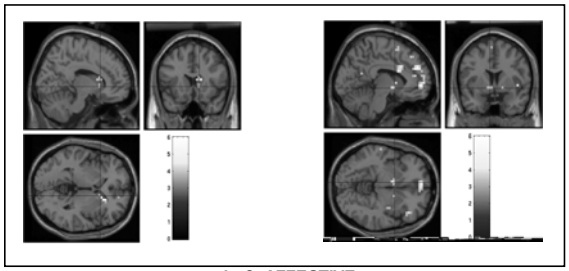
Theory: Maternal Brain Responses to Infant Facial Cues: Exploring the Neurobiology of Attachment

Strathearn, Li, Lanzi, Guest, McClure, Friedlander& Montague (2003)



1 - 2: AFFECTIVE CONTRAST
Crying – Smiling

In the affective contrast between the unexpected delivery of crying vs. smiling faces the control women showed activation of the medial prefrontal cortex (mPFC) and cingulate cortex, areas involved in emotion recognition and processing. However, with the teen mothers, activation was limited to the caudate/ventral striatum



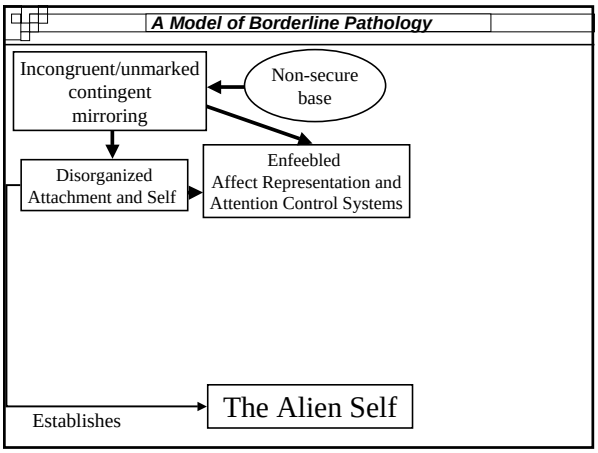
Teenage mothers

1 - 2: AFFECTIVE CONTRAST
Crying – Smiling

Control females

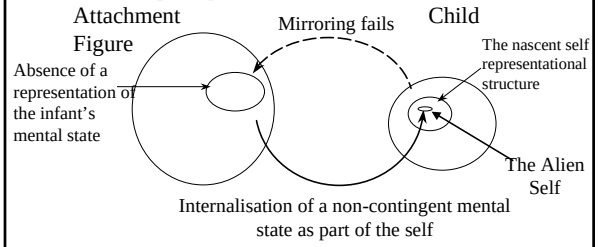
Theory: Conditions for Robust Establishment of Representations of Internal States (Gergely & Watson, 1996)

- Contingency of Mirroring
  - The caregiver accurately matches the infant's mental state
- Markedness of Mirroring
  - The caregiver mirrors while indicating that she is not expressing her own feelings
- Incongruent mirroring → representation of internal state corresponds to nothing real → pretend mode
- Un-marked mirroring → caregiver's expression seen as externalisation of experience → psychic equivalent mode

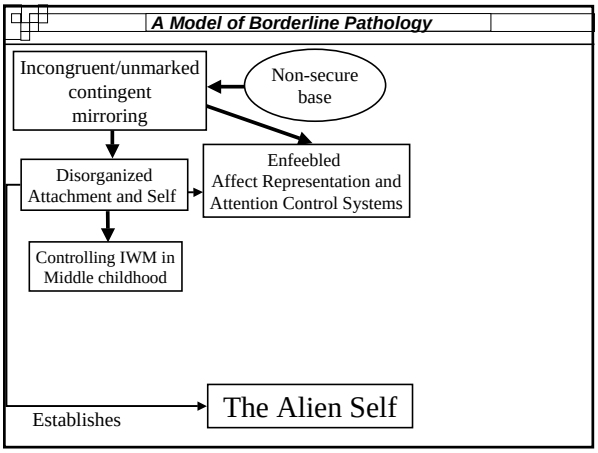


Theory: Birth of the "Alien" Self in Disorganized Attachment

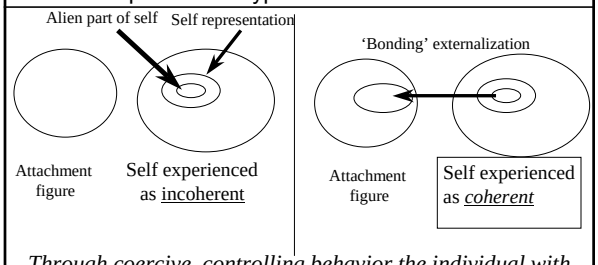
The caregiver's perception is inaccurate or unmarked or both



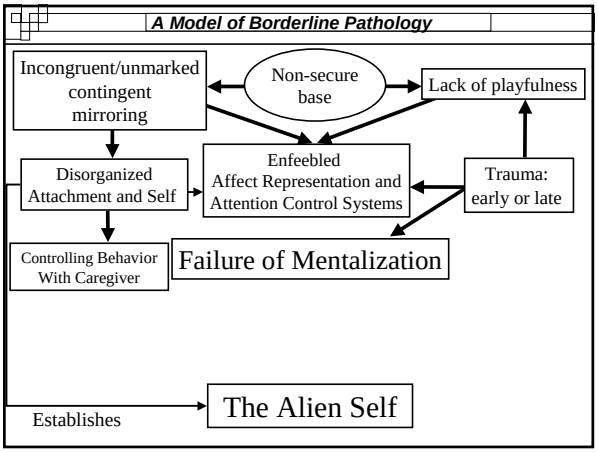
The child, unable to "find" himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics



Creating a Coherent Self-representation by Controlling and Manipulation – Hyper-activation of Attachment



Through coercive, controlling behavior the individual with disorganized attachment history achieves a measure of coherence within the self representation and a controlling and ***hyperactivity of the connection*** *to the attachment figure*



Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

surprised

sure about something

joking

happy

Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

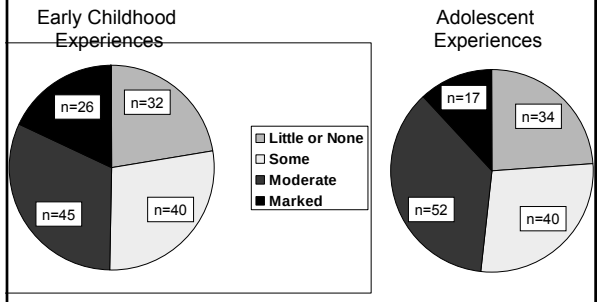
friendly

sad

surprised

worried

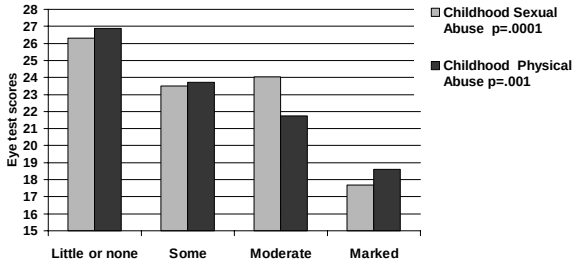
Participant's (N=143) Childhood Experiences of Care and Abuse



(Fonagy & Stein, 2005)

Agreement with contemporary Court or SRS records: Kendal's tau-b = .47, t = 5.81, p =.00001

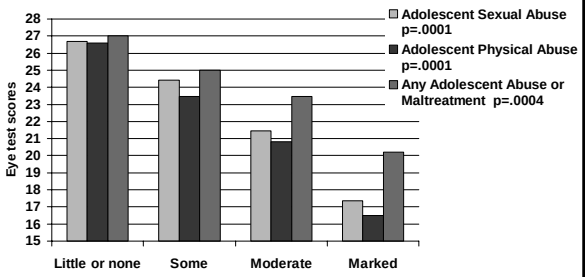
Performance on Eyes Test and Early Physical, Sexual and Psychological Abuse



(Fonagy & Stein, 2005)

R^2 (all CECA subscales)= .35, p<.005

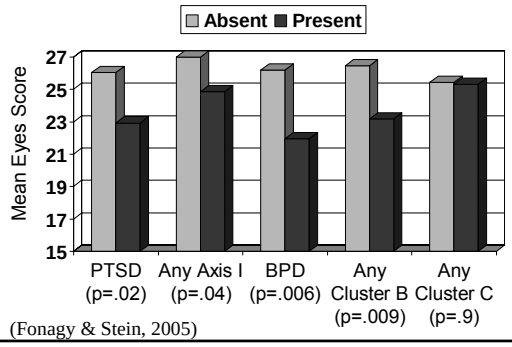
Performance on Eyes Test and Adolescent Physical, Sexual and Psychological Abuse



(Fonagy & Stein, 2005)

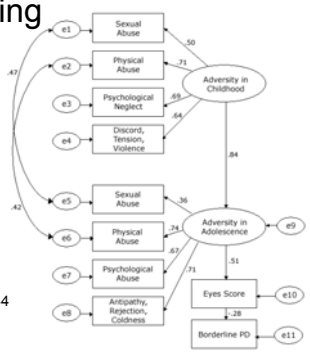
R^2 (all CECA subscales)= .43, p<.005

Performance on Eyes Test and Early Physical, Sexual and Psychological Abuse



(Fonagy & Stein, 2005)

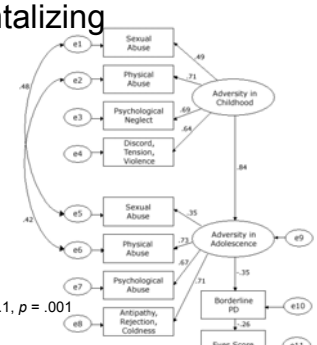
Structural Equation Model for BPD and Mentalizing



$\chi 2$ (32, N = 147) = 40.5, p = .144
CFI = .978
NNFI = .962
RMSEA = .043

(Fonagy & Stein, 2005)

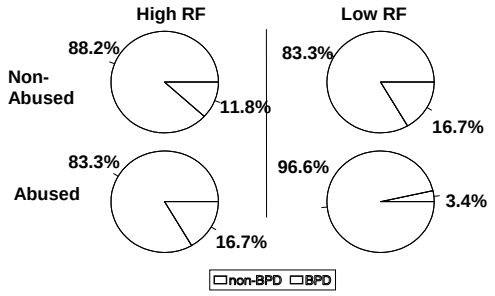
Structural Equation Model for BPD and Mentalizing



$\chi 2$ (32, N = 147) = 61.1, p = .001
CFI = .925
NNFI = .871
RMSEA = .079

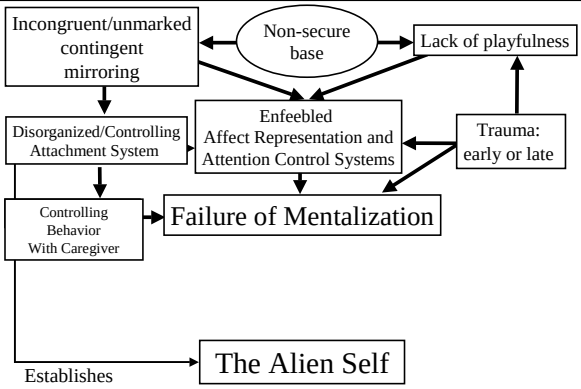
(Fonagy & Stein, 2005)

Interaction of Abuse, Reflective function and BPD (Fonagy et al., 1998 J.Cons Clin)



Likelihood ratio: Chi-squared=8.67, df=1, p<.004

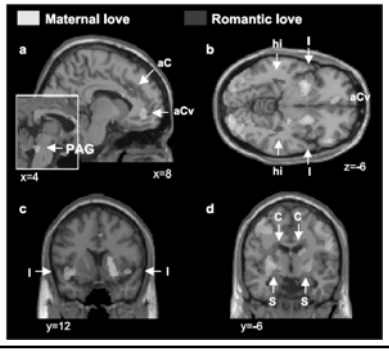
A Model of Borderline Pathology



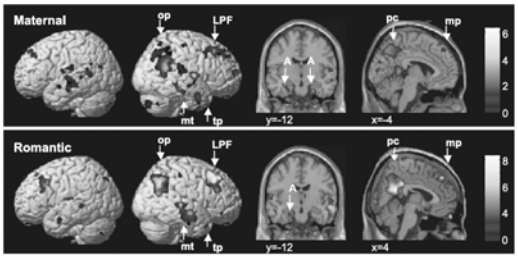
The Neural System Underpinning Attachment: From Rodents and Humans (Insel, 2003)

- Mesocorticolimbic dopamine
  - an important candidate in addiction,
  - also critical for maternal behavior in rats
  - and pair bonding in voles
- A circuit linking the anterior hypothalamus (MPOA) to the VTA and the nucleus accumbens shell may be especially important for mediating the rewarding properties of social interaction
- The neuropeptides OT and AVP are released by socio-sexual experience in rodents and humans ➔
- Can activate this reward circuit ➔ change attachment behaviour (at least in voles)
- fMRI studies indicate activation of same pathways in relation stimuli relating to own infant and partner

The Bartels & Zeki (2004) study of overlap implying neural correlates of attachment



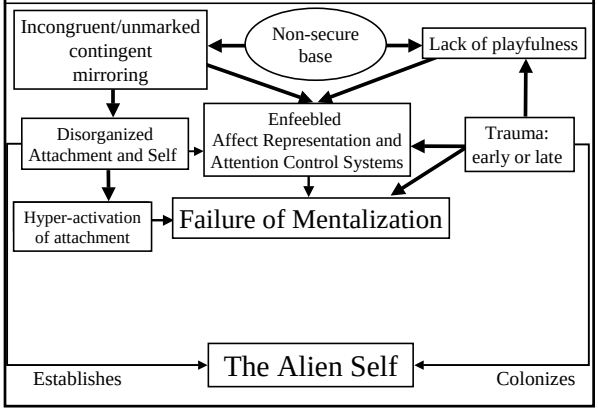
Common regions of deactivation with maternal and romantic love (Bartels & Zeki, 2004)



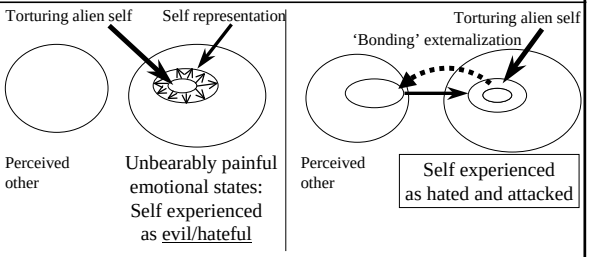
Attachment and the deactivation of mentalizing

- Both maternal and romantic love elicit an overlapping set of deactivations
  - ➢ temporal poles, parietotemporal junction and mesial prefrontal cortex ➔
    - o social trustworthiness, moral judgements, 'theory of mind' tasks, solely negative emotions, attention to own emotions
      - **underpin capacity for determining other people's emotions and intentions**

A Model of Borderline Pathology

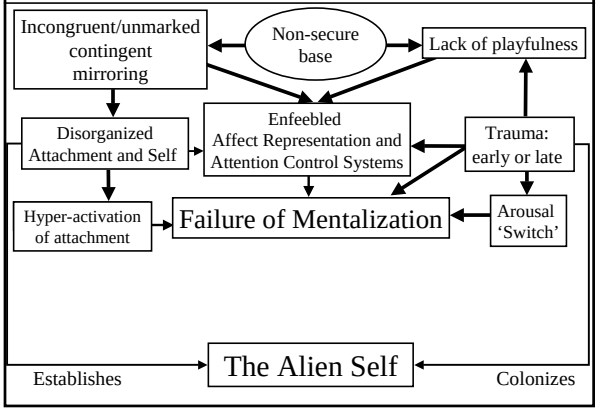


Self-destructiveness, Attachment and Externalisation Following Trauma in Vulnerable Individuals

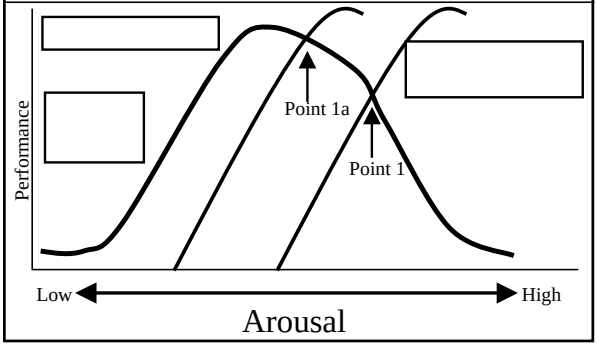


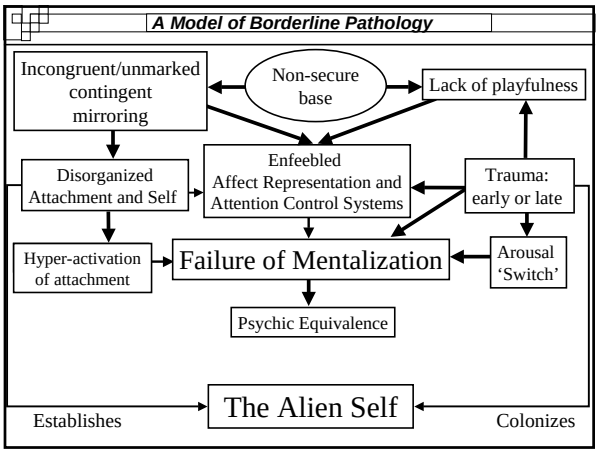
Coercive, controlling behavior is used to reduce the experience of unbearably painful emotional state of attack from within – hyperactivation of the attachment system and externalisation becomes a matter of life and death

A Model of Borderline Pathology



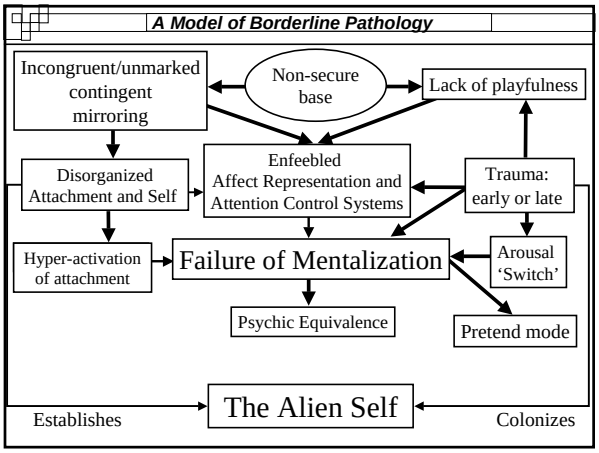
Mayes' (2001) Adaptation of Arnsten's Dual Arousal Systems Model: Implication of the Hyper-activation of Attachment





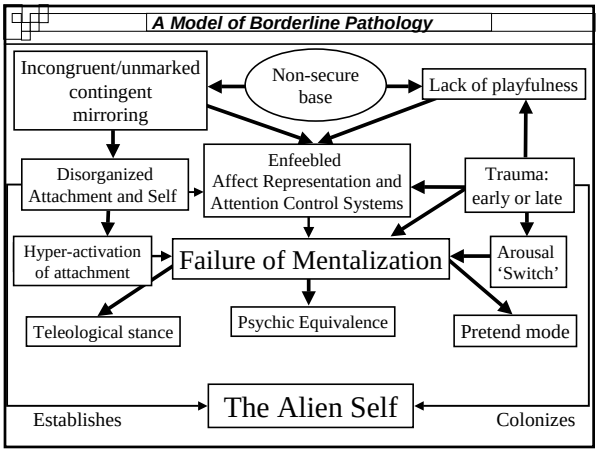
Theory: The Modes of Psychic Reality That Antedate Mentalisation and Characterize Trauma

- Psychic equivalence:
  - Mind-world isomorphism; mental reality = outer reality; internal has power of external
  - Associated with insufficiently marked mirroring
  - Experience of mind can be terrifying (flashbacks)
  - Intolerance of alternative perspectives ("if I think you had your door shut because you want to reject me, then you want to reject me")
  - Self-related negative cognitions are TOO REAL!



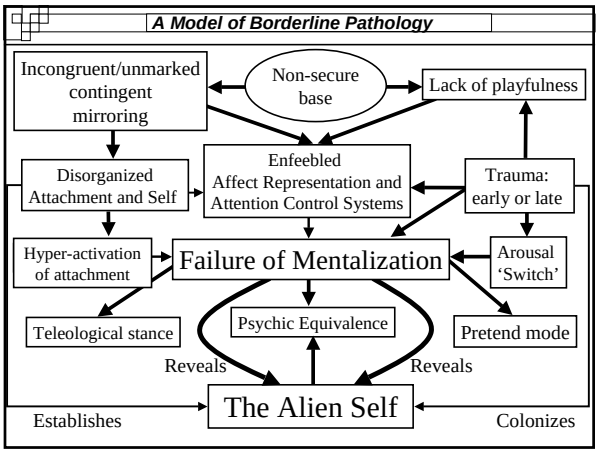
Theory: The Modes of Psychic Reality That Antedate Mentalisation and Characterize Trauma

- Pretend mode:
  - Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
  - Associated with non-contingent mirroring
  - Linked with emptiness, meaninglessness and dissociation in the wake of trauma
  - In therapy endless inconsequential talk of thoughts and feelings
    - Simultaneously held contradictory beliefs
    - Affects that do not acompany thoughts



Theory: The Modes of Psychic Reality That Antedate Mentalisation and Can Characterize Trauma

- 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
    - How a rapist can feel loved in the act of rape
  - Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
    - The therapist's benign disposition, her motivation to be helpful, has to be demonstrated by increasingly heroic acts,
    - Availability on the telephone → extra sessions at weekends → physical touching → holding → serious violations of therapeutic boundaries.



Introduction to Mentalization

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?

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

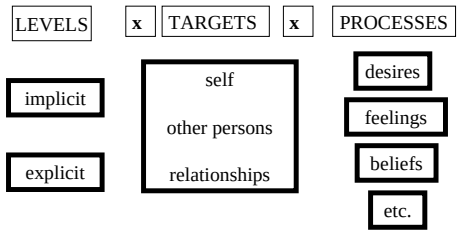
Related/Linked concepts

- empathy
- insight
- psychological mindedness
- observing ego
- potential space
- transitional space
- subjectivity
- mindfulness
- reflection

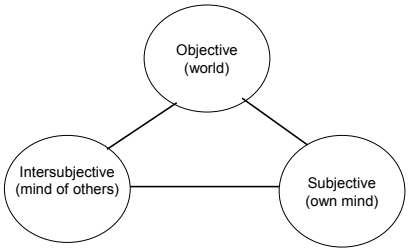
Mentalizing implicitly versus explicitly

- Implicit
  - nonconscious
  - nonverbal
  - procedural
  - unreflective
  - e.g., “mirroring”
- Explicit
  - conscious
  - verbal
  - deliberate
  - reflective
  - e.g., “interpreting”

Broad scope of mentalizing:



Domains of knowledge



Mentalizing interactively and emotionally

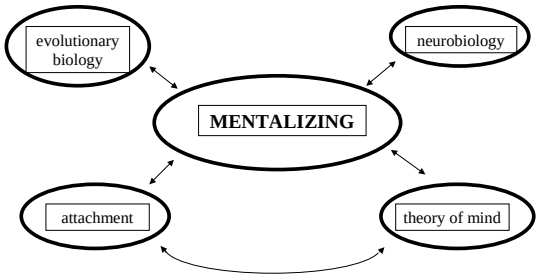
- Mentalizing interactively
  - Each person has the other person’s mind in mind (as well as their own)
  - Self-awareness + other awareness
- Mentalizing emotionally
  - Mentalizing in midst of emotional states
  - Feeling and thinking about feeling (mentalized affectivity)
  - Feeling felt

Example of mentalizing interactively and emotionally

The appetite which we call LUST is a sensual pleasure, but not only that; there is in it also a delight of the mind: for it consisteth of two appetites together, to please, and to be pleased; and the delight (we) take in delighting, is not sensual, but a pleasure of joy of the mind, consisting in the imagination of the power (we) have so much to please.

Thomas Hobbes, quoted in Simon Blackburn (2004) Lust

The concept of mentalizing as a fulcrum for contemporary theory and research



Clinical Applications of Mentalization

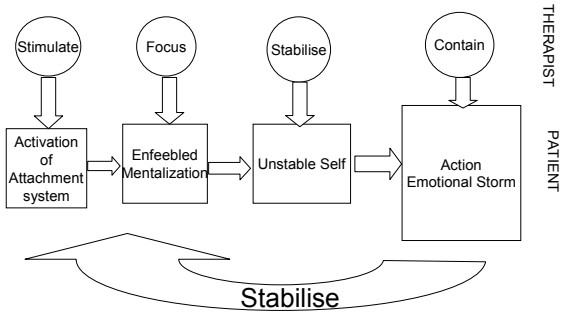
Using Mentalizing in treating patients

- Mentalizing is using "folk psychology" or commonsense understanding to interact and to make sense of the patient and yourself in the therapeutic interaction
- Scientific psychology creates professional knowledge and treatment manuals, but folk psychology is required for their implementation.

Advantages of mentalizing in therapeutic interactions

- Provides a buffer against overwhelming affect for patient and clinician
- Can be consciously targeted
- Can be done outside the heat of the kitchen - 'Lets think about that, now it is not so 'raw''
- Focus on present either within or without therapeutic process
- Develops a transference focus
- Mentalizing fosters mentalizing, through practice, identification, and results
- All therapists mentalize, irrespective of model

MODEL



The challenge of mentalizing interactively

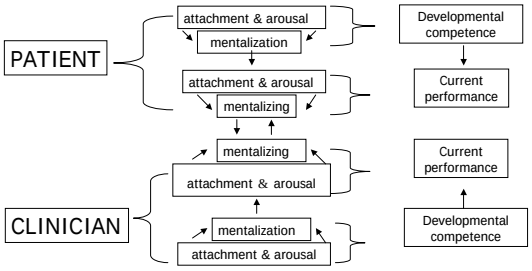
- Mild to moderate arousal is conducive to optimal prefrontal functioning and the employment of flexible mental representations and response strategies
- As task complexity increases, the optimal level of arousal decreases
- Mentalizing interactively (e.g., holding an emotional conversation) is among the most complex cognitive and emotional tasks
- Mentalizing interactively is therefore highly vulnerable to hyperarousal-- in our patients and ourselves

Optimizing Mentalization for the patient

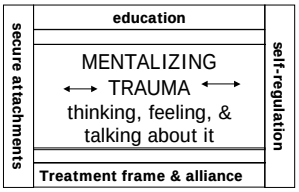
- Therapist requires
  - An attachment history that supports development of the capacity (competence)
  - ability *in the interactive moment* that supports use of the capacity to mentalize (performance)

  Which requires:
  - Optimal level of arousal of attachment system to enable pre-frontal cortex function

Parallel contributions to mentalizing: Meeting of minds



Mentalizing (processing) trauma requires containment



Processing trauma from the perspective of mentalizing

- Goal of processing is to mentalize trauma
- Mentalizing trauma entails being able to have the memory of trauma in mind as meaningful experience
- Goal is *not* to rid the mind of traumatic memories
- Mentalizing is key to the therapeutic *process*, regardless of technique (e.g., exposure, cognitive restructuring, EMDR, psychotherapy)

Mentalisation: a common theme of all therapies for BPD

- All psychotherapies develop an interactional matrix in which the mind becomes a focus
- Therapists consider the patient by representing them in their mind and communicating that representation to them
- experience of patient is of another human having their mind in mind ➔ **Process more important than content**

Mentalisation: a common theme of all therapies for BPD

- Therapy activates an attachment system which is a pre-requisite for mentalisation
- Therapists reconstruct in their own mind the mind of the patient – label feelings, explain cognitions, identify implicit beliefs
- Therapy is a shared attentional process which strengthens interpersonal function and integrative mechanisms
- Content of interventions is mentalistic irrespective of model
- Dyadic nature of therapy fosters capacity to generate multiple perspectives

The nature of BPD therapies

- Many individuals with BPD 'recover' to a significant extent without extensive formal therapeutic intervention
- Many therapies are highly effective for BPD
- Many therapies appear to do harm to individuals with BPD or at least appear to be able to impede a natural process of recovery
- The Fonagy & Bateman Principle:
  - *A therapeutic treatment will be effective to the extent that it is able to enhance the patient's mentalising capacities without generating too many iatrogenic effects.*
  - *Iatrogenic effects are reduced if intensity is carefully titrated to patient capacities and if treatment is coherent and flexible.*

Mentalizing in the pause mode (Stop, Listen, Look)

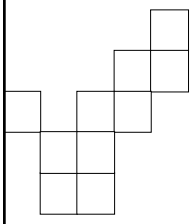
- Awareness of distressed state as a problem
- Identifying feelings
- Feeling and thinking about feeling
- Establishing freedom of movement
- Enabling inquisitiveness
- Getting it out of the head and into the world to facilitate explicit mentalizing
  - Drawing
  - Writing
  - talking

On feelings

- One's own thoughts are central to many therapies (e.g. CBT)
- In Mentalising therapy this is extended to and emphasises
  - the thoughts of others
  - The feelings of others and oneself
  - The process by which thoughts and feelings are communicated
  - The role played by misunderstanding thoughts and feelings
  - The role played by non-mentalising interactions
- In mentalising therapy, feelings are given top priority
- Central to change is recognising and empathising with the feelings of others: breaks inhibitory cycle

Interventions and Change

- Key intervention
  - To model the inquisitive stance – mentalizing stance
  - balance intensity of attachment relationship and complexity of mentalization
- Change occurs
  - when patient learns something new or is reminded of something forgotten about the inner experience of oneself or others
  - when understanding through mentalization is associated with optimally activated attachment system



FAQs about Mentalization Based Treatment

FAQ's about Mentalization Based Treatment: 1

- Is this a new therapy?
  - No! It is a focus for therapy in borderline personality disorder
- Do I have to be an expert therapist?
  - No! We have implemented MBT using generic mental health nurses. However someone well–trained in basic psychotherapy technique and familiar with mentalization needs to provide supervision
  - It is more important that therapists are confident in basic communication with patients and experienced in appraising risk e.g. suicide threats, potential violence, emergency admission

FAQ's about Mentalization Based Treatment: 2

- Can I work alone using MBT?
  - Of course you can BUT for severe borderline patients we recommend that people work together as a team often using split roles but all having a focus of increasing mentalization as the core of the therapeutic interaction
- What is the format of the treatment you are providing, i.e., individual and group, anything else for the patients?
  - Format is 1/7 individual (50mins) + 1/7 group (1.5hrs).
  - Nothing else provided except psychiatric out-patient as and when necessary for medication

FAQ's about Mentalization Based Treatment: 3

- What about format from the perspective of the therapists?
  - Format for therapists is team meetings and group supervisions
- Do other personality disorders show reduced mentalizing?
  - Probably but not in the same way as BPD.

FAQ's about Mentalization Based Treatment: 4

- I am a radical behaviourist. Isn't mentalisation a cognitive/behavioural therapy?
  - No. MBT has an emphasis on affective states and 'depth' analysis, intentionality and motivation. It does not focus on behaviour alone. Anyway we are radical analysts!
- Isn't mentalisation just supportive therapy
  - Yes/No. It is supportive but not JUST supportive therapy. Other active techniques are used.

FAQ's about Mentalization Based Treatment: 5

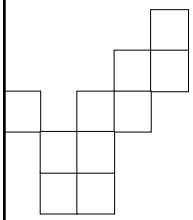
- Is mentalisation an analytic therapy?
  - MBT fits best into the plurality of analytic therapy with its emphasis on patient/therapist relationship, understanding of dynamic processes, and its move in treatment from conscious understanding to unconscious meaning.
- I've been told that transference isn't used
  - Who told you that? Transference is used but in a titrated way. The use of transference differs from TFP.

FAQ's about Mentalization Based Treatment: 6

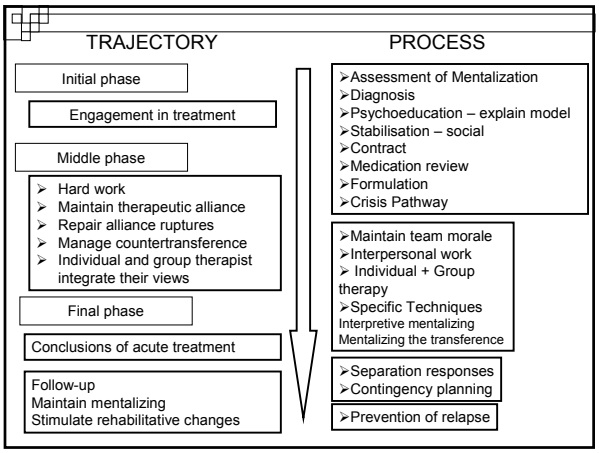
- Mentalisation theory blames the mother
  - Most certainly not! We consider a complex gene-environment interaction as the most likely cause of the reduction on mentalizing capacity in BPD
- Mentalization doesn't seem specific to this therapy. All therapies promote mentalizing so what is so special about this?
  - Perfectly true. The only specific aspect of MBT is placing the enhancement of mentalizing itself as the focus of treatment. All therapies probably increase it indirectly but they are not aware that that is what they are doing!

FAQ's about Mentalization Based Treatment:7

- Do I have to do years of training, loads of supervised videos, be rated by experts overseas and be certified?
  - A very brief training is probably adequate to ensure that you modify your current technique to include a focus on mentalizing
  - Videos may be helpful for learning and discussion but this may be something that you already do
  - No certification is necessary, especially from 'experts' from overseas!
- Does it matter if a patient has mixed therapies? e.g. cognitive interventions, dynamic therapy, and expressive therapy?
  - No! As long as the therapists all meet to integrate their knowledge and understanding from a mentalizing perspective and this provides a coherent focus between all therapies.



Structure of Mentalization Based Treatment



Formulation: Content

- 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
  - 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

Early Issues

- Introducing the approach
- Treatment organisation
- Agreeing on a contract
- Beginning a mentalizing focus
- Containment of family, partners, friends

Treatment Organisation

- Pathway to admission
  - Provision of information
  - Clarification of key problems, as identified by the patient
  - Explanation of the underlying treatment approach and its relevance to the problems
  - Information about individual and group therapy and how it can lead to change
  - An outline of confidentiality
- Clarification of some basic rules
  - Violence
  - Drugs and alcohol
  - Sexual relationships
- Stabilising social aspects of care
- Assuring the possibility of contact with the patient

Provision of Information: Expert Role

- Information – personalised
  - Understanding of BPD
    - Genetics
    - Biological processes – arousal, hormonal pathways
    - Neurobiology – emotional circuitry
    - Developmental
    - Interpersonal inventory
    - Mentalisation – Pause Button/Stop and Search

Treatment Organisation: Agreed Goals

- Initial goals
  - Engagement in therapy
  - Reduction of self-damaging, threatening, or suicidal behaviour
  - Appropriate use of emergency services
  - Stabilising accommodation
  - Rationalisation of medication
  - Development of a psychodynamic formulation with the patient

Treatment Organisation: Agreed Goals

- Long term goals
  - Identification of emotions and their appropriate expression with others
  - Personal integrity
  - Personal responsibility
  - Interpersonal function

Treatment Organisation Formation of working alliance

- Empathy and validation
- Reliability and readiness to listen
- Team morale
- Supervision

Transferable Features

Structure

- Patients and therapists are able to think about aspects of treatment from a shared base, the purpose of therapy and reasons for its components ➔
  - Information/education
  - Shared formulation
  - Therapist can deal with common clinical problems fairly and consistently
  - Structure is framework around therapy which is neither intrusive nor inattentive
- Frames inevitable regressive processes ➔ boundary violations
- Rejection of 'communalism, 'democracy', 'egalitarian principles'
- Rejection of 'authoritarianism, 'controlling attitudes', mindless enforcement of rules

Transferable Features

Consistency, Constancy & Coherence

- Recognition that patients perceive and exploit inconsistency but the problem may also lie within the team itself
- Counteracts reactive, fragmented, unreliable TAU mirroring unstable self
- Treatment must minimise inter- and intra-professional disputes
- When inconsistency (splitting) occurs in treatment team or within clinician it must be recognised, understood and worked through
- The therapeutic frame must be protected, consistency of times, constancy of treaters, coherence of therapeutic messages

Transferable Features

Relationship Focus

- BPD is characterised by problems of forming and maintaining constructive relationships
- It is expected to disrupt treater – patient relationship and this therefore has to be the focus of treatment
- To understand treater – patient relationship all other relationships must become focus of therapy
- Developmentally elaborated dysfunctions (mentalization vs. unintegrated self-object representations) underpinning interpersonal problems are addressed
- Behaviors are not understood in isolation of the mental processes that have led to the enactment (mentalising stance)

Transferable Features

Flexibility

- Instability of lifestyle is inevitably manifested in relation to therapeutic services (e.g. fluctuations of motivation for help, valuing of therapy) and is not be taken as either indication of success or unsuitability for treatment
- Treatment must be flexible and there must be willingness to compromise (e.g. recognise therapy induces panic, temporarily focus on housing)
- The compromise must be recognised by patient and therapist
- the recognition of 'psychic equivalence' in the face of patient's insistence that therapist has a particular state of mind forces the therapist to be (sceptically) accepting of the 'patient's subjective reality'
- Differences in perspective are be explored and not reduced

Transferable Features

Intensity

- Understanding of the pathology indicate that most intensive possible (e.g. 5 times weekly) treatment is not the ideal treatment for trauma
- Trapped by situations that require high levels of interaction
- Comes to be fixed in 'pretend mode' of psychic reality
- Treatment provides balance between need safety and dependency on one hand and autonomy, risk and self reliance on the other
- Adequate time between sessions is provided for patients to reflect, to distract themselves, and not to overwhelm fragile reflective capacities

Transferable Features

Integration of Medication

- Medication is an adjunct to psychotherapy
- Enhances the effectiveness of psychotherapy
- Improves symptoms
- Stabilises mood
- Help patients attend sessions
- Prescription needs to take into account transference and countertransference phenomena
- Integrate into the programme itself.

Transferable Features

Clinical Guidance on Medication

- Consider the primary symptom complex
  - affect dysregulation
  - Impulsivity
  - cognitive-perceptual disturbance
  - current transference
  - countertransference themes
- Discuss implementation of medication within the treatment team
- Educate the patient about reasons for medication, possible side-effects, expected positive effects

Transferable Features

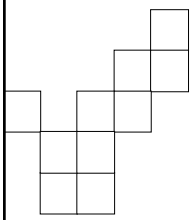
Clinical Guidance on Medication

- Make a clear recommendation but allow the patient to take the decision and do not try to persuade the patient to take the medication
- Agree a length of time for trial of medication (unless intolerable side-effects) and do not prescribe another drug during this time even if the patient stops the drug
- Prescribe within safety limits, for example giving prescriptions weekly
- See the patient at agreed intervals to discuss medication and its effects. Initially this may be every few days to encourage compliance, to monitor effects, and to titrate the dose.
- Do not be afraid to suggest stopping a drug if no benefit is observed and the patient experiences no improvement

Treatment Organisation

Common problems

- Dropouts
  - Barriers to treatment
    - Geography
    - Appointment times
- In-patient care
  - Suicide/homicide risk
  - Comorbidity
  - Anxiety in countertransference
  - Respite for patient and carers
  - Contraindications
    - Emotional crisis
    - Hate in the countertransference
    - Panic

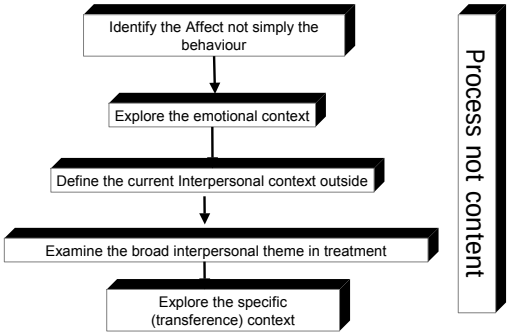


The mentalizing focus

Beginning a mentalizing focus

- Goal is to learn how to find out more about how a person is thinking or feeling
- Therapist task is NOT to become perfect at guessing
- Listen for statements suggesting mentalizing strengths
- Highlight competencies
- Identify context of affects

Clinical Pathway for interventions



Interventions: principles

- Simple sound-bite
- Affect focused (love, desire, hurt, catastrophe, excitement)
- Focus on patients mind (not on behaviour)
- 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

Interventions: Spectrum

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

Interventions: Spectrum (1)

- Supportive & empathic
  - "I can see that you are feeling hurt"
- Clarification & elaboration
  - "I can see that you are feeling hurt, I wonder how come?"
- Basic Mentalising
  - "I can see that you are feeling hurt and that must make it hard for you to come and see me/be with me today" (depending on amount affect arousal that you want to allow)
- Interpretive Mentalising
  - Transference tracers: "I can see that you are feeling hurt and that reminds me of how you often react when you feel someone does not do exactly what you want them to do"

Interventions: Spectrum (2)

- **Mentalising the transference**
  - "I can see how you can end up feeling hurt by what is happening here" (empathy), "and then you are not sure if you want to be here or not" (outcome of feeling - experience near), "In the end I think that the only way you feel you deserve my attention is if you can feel that you are the hurt victim who has a right to treatment (motivation)"
- **Non-mentalising interpretations – to use with care**
  - Dyadic transference interpretation (Kernberg): "You need to create a relationship in which you feel the victim of someone who is cruel and hurtful to you"
  - Triadic transference (Strachey): "You felt victimised as a child and now with me and with other people you feel compelled to recreate relationships where you are the person who is hurt by those who do not care for you enough"
  - Historical (past blaming, trauma focused): "Your feeling of hurt at the moment is because you have been reminded of how you felt rejected by your mother"

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'
  - 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

Interventions: Supportive & empathic

- **Provoke curiosity about motivations**
  - Highlight own interest in 'why'
  - 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 "fillers"
  - Demonstrate how such information could help to make sense of things

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
- Trace action to feeling
- Seek indicators of lack of reading of minds

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?

Intervention: Confrontation and 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

Intervention: Confrontation and Challenge

- **Stop and Stand**
  - Clarify your boundary (should be a repetition of boundary agreed when therapy began) whilst giving your understanding of patients position in relation to it – 'I think that you continue to attend simply so that you can force me to watch you deteriorate but I can't continue to do that. We need to tackle this.
  - 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.
  - Recruit group members to recognise impasses and shift from 'dialogue of the deaf' to a mentalizing discussion
  - State own position – 'If we can't get around this I may have to say that treatment has failed and should finish
  - Monitor countertransference to ensure no acting out by therapist

Interventions: Basic Mentalizing

- '**Stop, Listen, Look'**
  - During a typical non-mentalizing interaction in a group
    - 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
  - 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
- **Recruiting**
  - Gemma is obviously angry. Can anyone help her with this because I wonder if beneath it she is beginning to feel ignored

Interventions: Basic Mentalizing

- **Stop, Re-wind, Explore**
  - Lets go back and see what happened just then. At first you 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** ("I wonder if…" statements)
  - Explore manifest feeling but identify consequential experience – 'Although you are obviously dismissive of them I wonder if that leaves you feeling a bit left out?
  - 'I wonder if there are some resentments that make it hard for you to allow yourself to listen to rules. Lets think about why the rules are there?
  - 'I wonder if you are not sure if it's OK to show your feelings to other people?'

Workshop Exercise to use Basic Mentalizing

- Patient – Discuss an important relationship and allow the story to unfold when prompted
- Therapists: Use empathic statements and basic mentalizing
  - Stop, Look, and Listen and explore important content
  - Stop, rewind, and explore
  - Stop and stand if patient uses non-mentalizing and gross assumptions about you or others

Interventions: Interpretive 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 otherwise.
  - 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 Transference

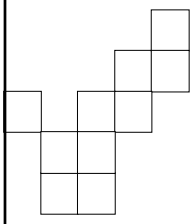
- **Transference Interpretation**
  - Emphasis on current
  - Demonstrate alternative perspectives
  - Contrast patient's perception of the therapist to self-perception or perception of others in the group
  - Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
  - Highlight underlying motivation as evidenced in therapy

Steps in MBT Transference Interpretations

- Validation of transference feeling
  - Feeling is not crazy, it is real and legitimate
- Exploration of transference
  - Use techniques of exploration and elaboration above
- Accept enactment (if any)
  - Being drawn into transference is normal, admit it, draw attention to it
- Collaboration in arriving at interpretation
  - Use inquisitive stance to engage patient in inquiry
- Alternative perspective from therapist
- Follow patient reaction with next interpretation
- *Journey more important than the destination*

Interventions: Mentalizing the Transference

- **Dangers of mentalizing 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



The mentalizing focus in group therapy

Implicit mentalizing group

The aims of the implicit mentalizing group are

- To promote mentalizing about oneself
- To promote mentalizing about others
- To promote mentalizing of relationships

Implicit mentalizing group

- 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

Implicit mentalizing group: ways to explore understanding of each other

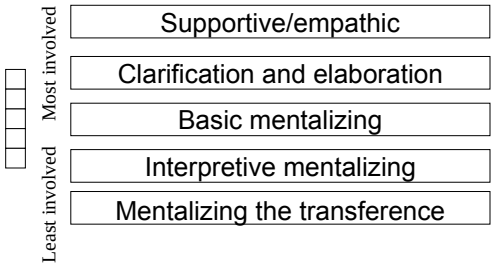
- Focus on what a patient is saying asking him to clarify and expand
- Ask other patients for their understanding of what is being said during moments of uncertainty
- Generalize the problem – 'Has anyone else experienced this?'
- Return to a topic sensitively or if necessary Stop and Stand if the group dismisses something of manifest importance

Implicit mentalizing group: ways to explore understanding of each other

- Generate a group culture of enquiry about motivations
- Insist that patients consider others' perspectives and work to understand someone else's point of view
- Challenge inappropriate certainty and rigid representation
- Therapist should directly express own feelings about something that he believes is interfering with group progress

Guidance on which intervention when

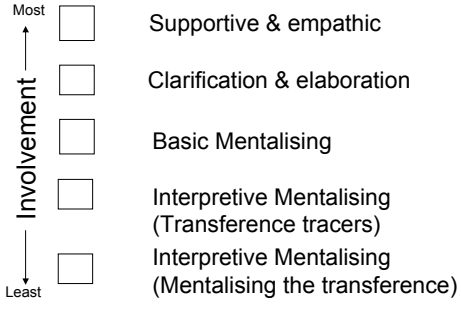
Interventions: Spectrum



Which Intervention to use when?

- If in doubt start at the surface – support and empathy
- Move to 'deeper' levels only after you have performed the 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 - support and empathy being 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 bordeline patients have a greater capacity than they actually have when they are struggling with feelings.

Titration of intervention to involvement



How do I….?

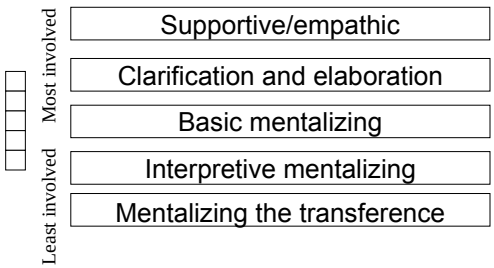
How do I deal with? (1)

- **Function**
  - What is the function of this behaviour – it is commonly to restabilise instability (not primarily aggressive)
- **Context**
  - What is the context of the problem and how does it relate to interpersonal interaction
- **Affect**
  - What is the overt feeling and covert feeling 'It is obvious that you were angry but it sounds like you were really hurt'
- **Motivation**
  - What conscious motivation does the patient report?

How do I deal with? (2)

- **Mentalise (basic/interpretive)**
  - the conscious motivation, the feeling, and the context - 'you say that you cut yourself so that you can feel alive because when your partner leaves the house you begin to feel dead'. 'When someone is not there you get frightened that you don't exist'.
- **Mentalise (transference) (later)**
  - 'You will feel like cutting yourself after the session because not being here is likely to bring out that dead feeling. Perhaps you believe that I will forget about you between sessions and out of sight for you is out of mind and out of mind means you become terrified that you are dead'.

Interventions: Spectrum



How do I deal with? Self-harm

- **Function**
  - To maintain the self-structure
  - Explore reasons for destabilisation of self-structure
    - Tell me when you first began to feel anxious that you might do something?'
  - Make a systematic attempt to place responsibility for actions back with the patient to re-establish self-control
    - 'I can't stop you harming yourself or even killing yourself but I might be able to help you understand what makes you do it and to find other ways of managing things'.

How do I deal with? Self-harm

- **Context**
  - Investigate external and internal interpersonal context
    - Seek obvious external interpersonal precipitants
    - Explore repetitive relational fantasy, often of rejection or abandonment
    - Consider recent treatment history within individual and group therapy

How do I deal with? Self-harm

- **Affect**
  - Feeling of badness = I am bad (psychic equivalence) = Self-harm
  - Explore rejection, loss, hurt, abandonment, and panic
  - Emptiness and experience of a void or 'black hole'
  - Link to context

How do I deal with? Self-harm

- **Motivation**
  - Re-stabilise
    - Predictable, mentalisable schematic relationships
    - Rigid understandable motivations – 'He didn't turn up because he wanted me to suffer'.
    - Formulaic explanations – 'He deserves to suffer because he is bad'. 'I won't come because they don't want me there'.
  - Reduce panic
  - Establish existence
    - Support for body existence through seeing blood
    - When mental existence is in doubt reinforce existence through your body
    - Emptiness becomes partially filled
  - Rarely to control/attack other

How do I deal with? Self-harm

- Intervention
  - Empathy and support
    - You must not have known what to do?
    - Oh dear! That must be disappointing after all this time.
  - Define interpersonal context
    - Detailed account of days or hours leading up to self-harm with emphasis on 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 do I deal with? Self-harm

- 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 presents
- DO NOT
  - mentalize the transference 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 Example Self-Harm (1)

- Example: Teacher throws herself down stairs and spends time in hospital where she is highly critical of staff. She can't understand how hospital staff can treat people as they do. She would never treat her pupils so badly.
  - Projected Self-hatred
  - Filling the vacuum by creating
    - Predictable (mentalisable - schematic) relationships
    - Support for body existence (mental existence is in doubt regress reinforcing your existence through your body)

Clinical Example Self-Harm (2)

- Explication of patient understanding of motives of nurses
  - 'how do you explain their attitudes to you'
- Identify other contexts in which these feelings have occurred
- Link to earlier feelings before the self-harm episode
- Interpretive mentalizing
  - 'you seem to have to experience them as wicked and seeing you as horrible so that you yourself don't have to consider how horrible it is that you keep trying to harm yourself in this way.

How do I deal with? Suicide attempt

- Example:

Patient e-mails to state that she is going to kill herself by taking an overdose: 'I know that you have tried but there is nothing more to do. So I am writing to say goodbye. Don't blame yourself because I know that you have tried'.

How do I deal with? Suicide attempt (1)

- **Function**
  - Re-stabilise herself by destabilising the therapist. She was frightened and now has you frightened so she may be more stable but how long that lasts will be dependent partly on your reaction.
  - Note the positive aspect of her letting you know about her intention
- **Context -** What is the context of the problem and how does it relate to interpersonal interaction
  - Therapist thinks about recent events in patients life and in treatment. He is aware that patient feels that she never manages to complete tasks and is currently struggling with a sense of inadequacy.
  - Therapist e-mails back asking if anything has happened that might have made her feel so bad about herself and suggests a time that he is available to talk to her on the phone – Stop.

How do I deal with? Suicide attempt (2)

- **Affect** What is the overt feeling and covert feeling ?
  - Elicit patients sense of futility and talk about the context of the feelings. Elicit that the patient felt quite pleased with some work that she was doing and went to photocopy some of it. When she got home she realised that she had left the work and the photocopies in the library. This led her to feel that her mind was disintegrating and the only way to manage this is to recreate her mind by disintegrating the mind of the therapist.
- **Motivation -** What conscious motivation does the patient report?
  - Wants to relieve therapist of seeing such a useless patient and to protect him from her badness – 'All that you have done and I can't even manage to photocopy anything without losing it.
  - Continue to explore with her all thoughts and feelings that she has had around it – Rewind and Explore

How do I deal with? Affect Storm

- Example:
- Patient walks into the consulting room and starts shouting whilst marching around the room. She then takes off her sweater revealing her bra and becomes increasingly angry and insulting about everybody including the therapist.

How do I deal with? Affect storm (1)

- **Function**
  - Once again it should be in the realm of trying to re-stabilise herself. If she gets through the affect storm Uncertain and cannot be understood within the immediate context. However it will restabilise
- **Context -** What is the context of the problem and how does it relate to interpersonal interaction
  - There is no clear context initially and so the therapist has to rely on his current understanding of the patient.
  - Therapist attempts to establish a context – 'keep talking'.
  - Maintain calm, verbal, contact with patient.
  - Point out your puzzlement about what is going on – 'Can we just sit down and find out what is going on?'

How do I deal with? Affect storm (2)

- **Affect** What is the overt feeling and covert feeling ?
  - Stop, Rewind, Explore
  - The patient's mother had telephoned the previous evening and asked the patient to come and help her with a party the following weekend and the patient had initially agreed but then felt bullied into it.
- **Motivation -** What conscious motivation does the patient report?
  - Affect storm moves her away from the complex feelings about her mother and everyone becomes distracted from disentangling the feelings about the mother. The removal of the bra is a further distraction and should not be directly interpreted as an act of sexual provocation.
  - Continue to explore with her all thoughts and feelings that she has about her mother.

Workshop Exercise – Self-Harm

- Patient – recently self-harmed. Be unclear or unreasonably clear about why you self-harmed.
- Therapist – Identify and explore
  - Function of behaviour
  - Context
  - Affects
  - Motivation – conscious followed by inquisitive of unconscious motives