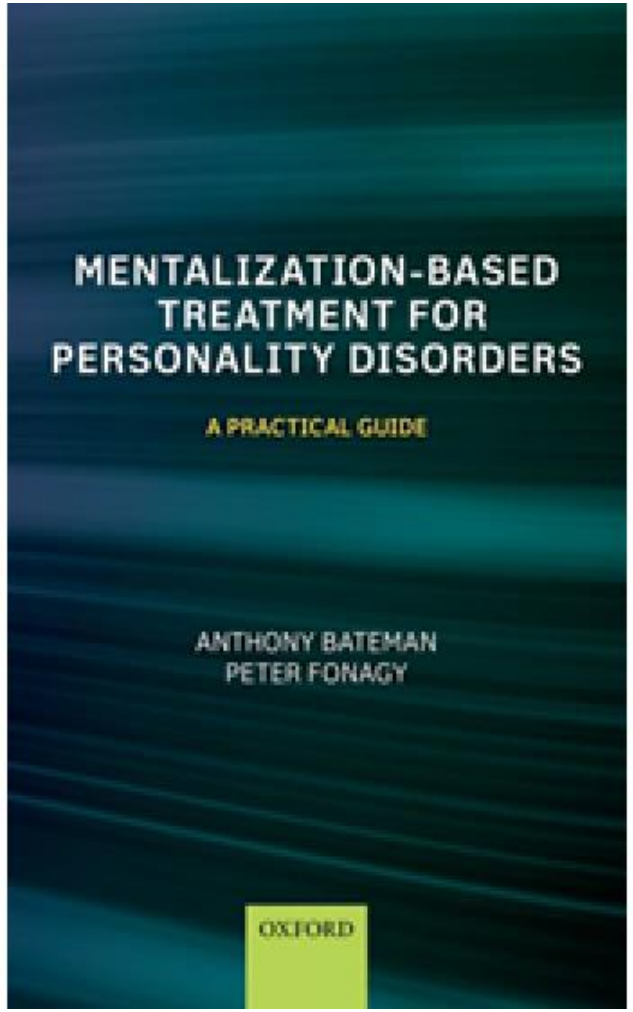
Mentalization Based Treatment

Training Workshop



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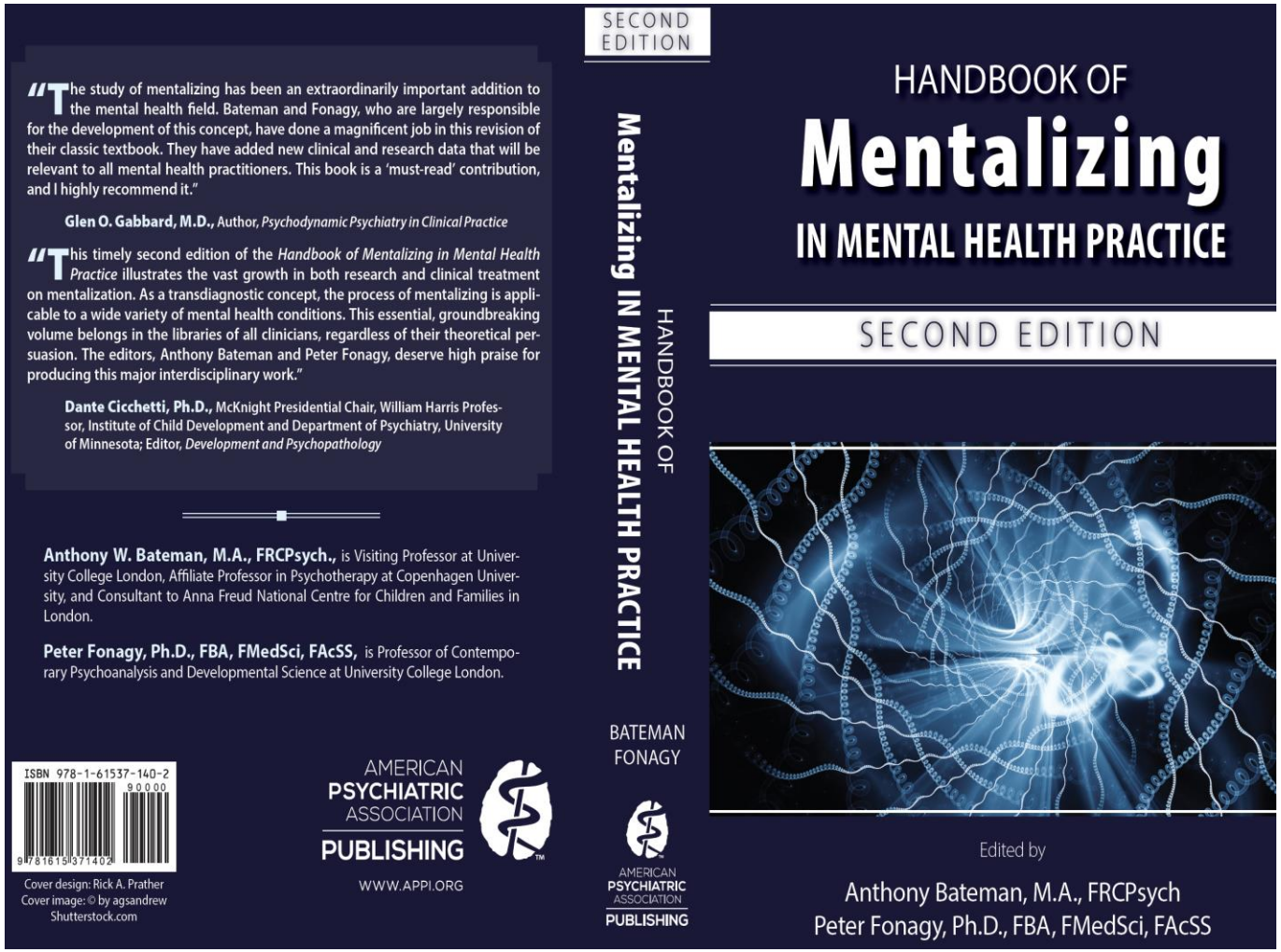
"The study of mentalizing has been an extraordinarily important addition to the mental health field. Bateman and Fonagy, who are largely responsible for the development of this concept, have done a magnificent job in this revision of their classic textbook. They have added new clinical and research data that will be relevant to all mental health practitioners. This book is a 'must-read' contribution, and I highly recommend it."
Glen O. Gabbard, M.D., Author, Psychodynamic Psychiatry in Clinical Practice
"This timely second edition of the Handbook of Mentalizing in Mental Health Practice illustrates the vast growth in both research and clinical treatment on mentalization. As a transdiagnostic concept, the process of mentalizing is applicable to a wide variety of mental health conditions. This essential, groundbreaking volume belongs in the libraries of all clinicians, regardless of their theoretical persuasion. The editors, Anthony Bateman and Peter Fonagy, deserve high praise for producing this major interdisciplinary work."
Dante Cicchetti, Ph.D., McKnight Presidential Chair, William Harris Professor, Institute of Child Development and Department of Psychiatry, University of Minnesota; Editor, Development and Psychopathology
Anthony W. Bateman, M.A., FRCPsych., is Visiting Professor at University College London, Affiliate Professor in Psychotherapy at Copenhagen University, and Consultant to Anna Freud National Centre for Children and Families in London.
Peter Fonagy, Ph.D., FBA, FMedSci, FAcSS, is Professor of Contemporary Psychoanalysis and Developmental Science at University College London.
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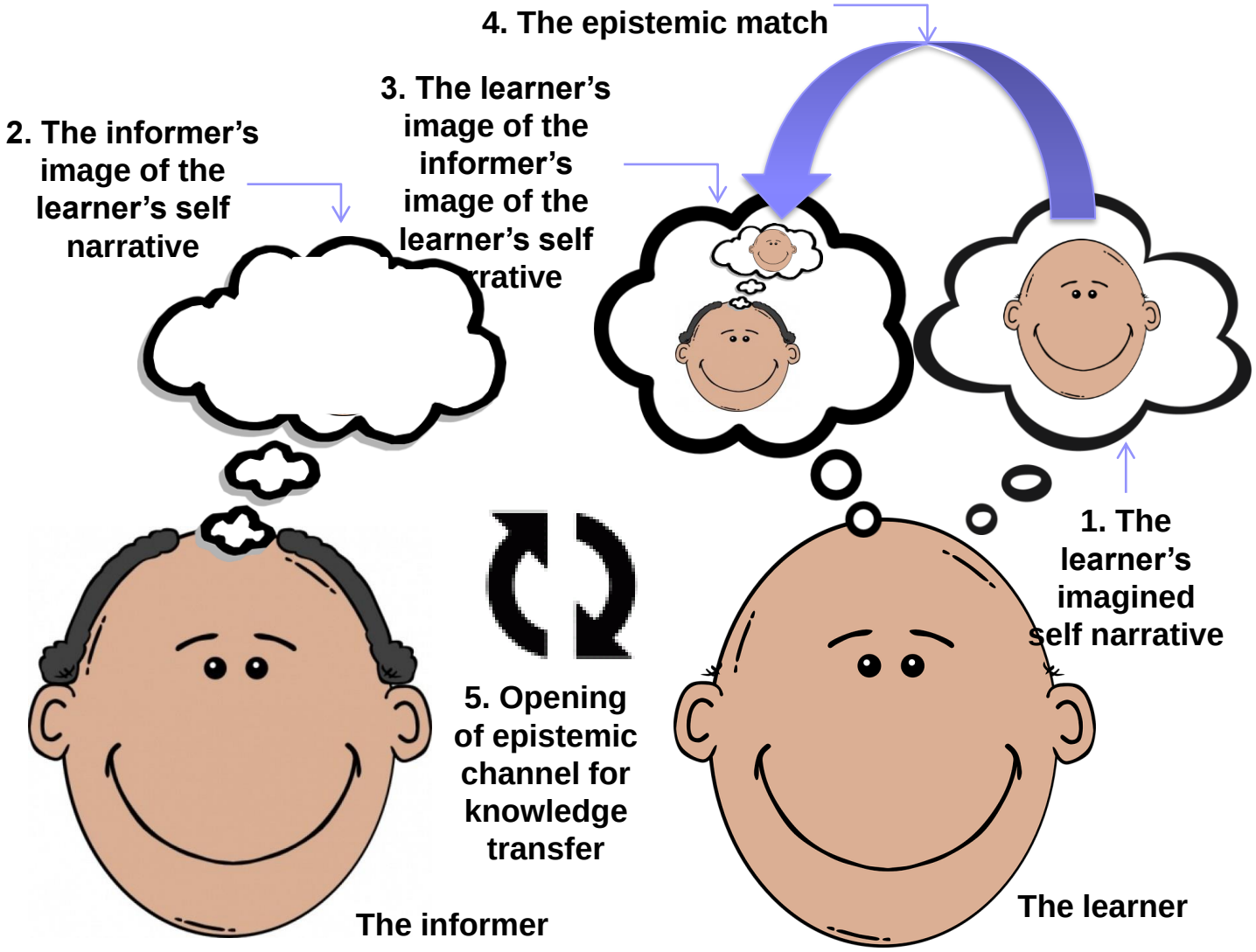
Peter Fonagy, Ph.D., FBA, FMedSci, FAcSS

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?

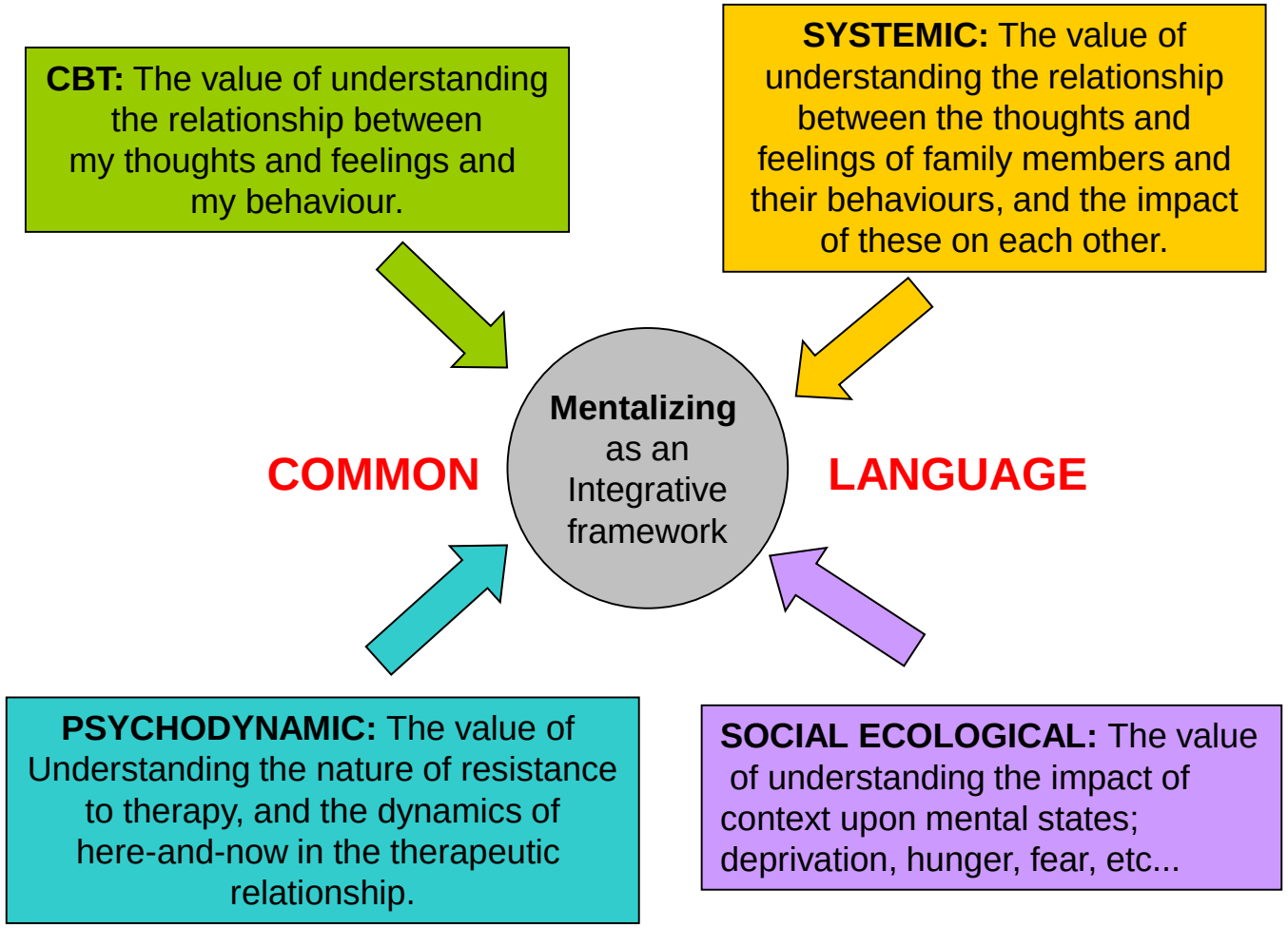
What is mentalizing?

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


4. The epistemic match
3. The learner's image of the informer's image of the learner's self narrative
2. The informer's image of the learner's self narrative
1. The learner's imagined self narrative
5. Opening of epistemic channel for knowledge transfer
The informer
The learner

What I don’t like about mentalizing

- Off-putting jargon for a concept intended to capture the essence of our humanity
- Sounds too cognitive and intellectual, ironic when
  - (a) we are most keen to promote mentalizing of emotion and mentalizing in the midst of emotional states (e.g., “holding heart and mind in heart and mind” captures the spirit better than holding mind in mind)
  - (b) a lot of mentalizing is not conscious, deliberate, and reflective but rather automatic, intuitive, and implicit
- Concept is too broad and all-encompassing such that it can explain virtually anything; we need to focus on different facets of mentalizing


CBT: The value of understanding the relationship between my thoughts and feelings and my behaviour.
SYSTEMIC: The value of understanding the relationship between the thoughts and feelings of family members and their behaviours, and the impact of these on each other.
Mentalizing as an Integrative framework
COMMON
LANGUAGE
PSYCHODYNAMIC: The value of Understanding the nature of resistance to therapy, and the dynamics of here-and-now in the therapeutic relationship.
SOCIAL ECOLOGICAL: The value of understanding the impact of context upon mental states; deprivation, hunger, fear, etc...

Introduction to theory of mentalisation

- The normal ability to ascribe intentions and meaning to human behaviour
- Ideas that shape interpersonal behaviour
- Make reference to emotions, feelings, thoughts, intentions, desires
- Shapes our understanding of others and ourselves
- Central to human communication and relationships
- Underpins clinical understanding, the therapeutic relationship and therapeutic change

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

Successful mentalizing of people and relationships

The person . . .

- Is relaxed and **flexible**, not ‘stuck’ in one point of view
- Can be **playful**, with humour that engages rather than hurting or distancing
- Can solve problems by **give-and-take** between own and others’ perspectives
- Describes their **own experience**, rather than defining other people’s experience or intentions
- Conveys ‘**ownership**’ of their **behaviour** rather than a sense that it ‘happens’ to them
- Is **curious** about other people’s perspectives, and expect to have their own views extended by others’

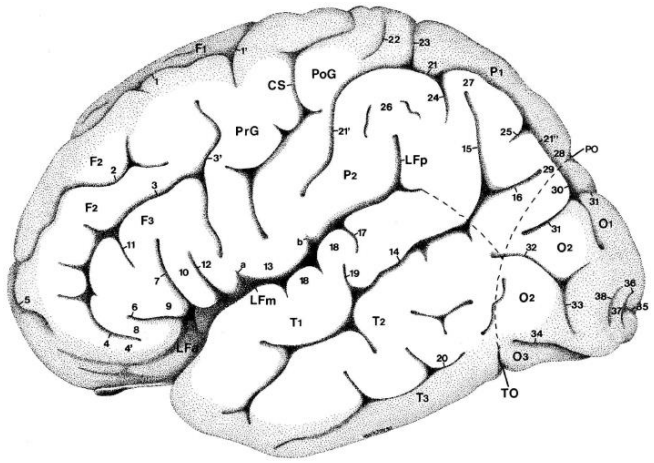
Mentalization: The basics

- Attachment and mentalization are **loosely coupled** systems existing in a state of partial exclusivity.

- **Mentalization** has its **roots in** the sense of being understood by an **attachment** figure,
  - it can be more **challenging to maintain** mentalization **in the context of** an **attachment** relationship (e.g. the relationship with the therapist) (Gunderson, 1996).

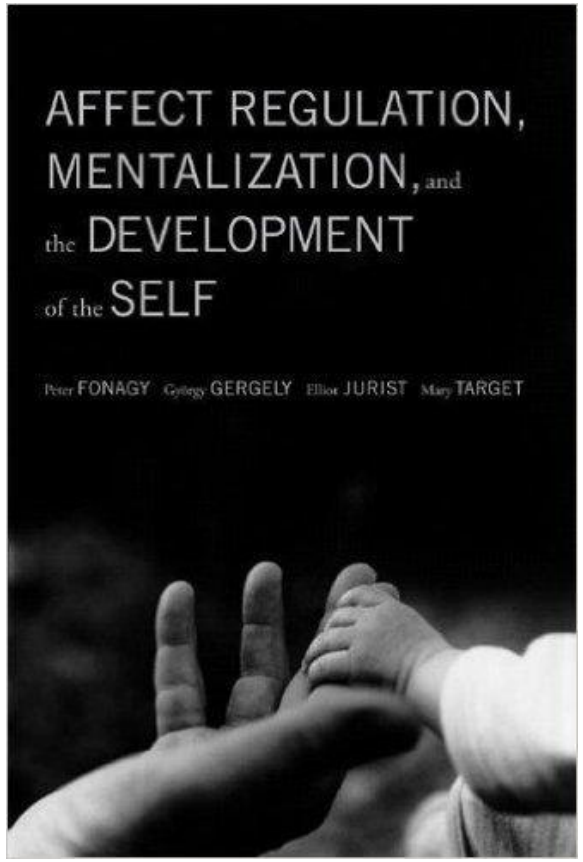
- **BPD** associated with **hyperactive attachment systems** as a result of their **history** and/or **biological** predisposition

- But without **activation** of the attachment system **in therapy** borderline PD patients will never **learn to function** psychologically **in** the context of **interpersonal relationships.**



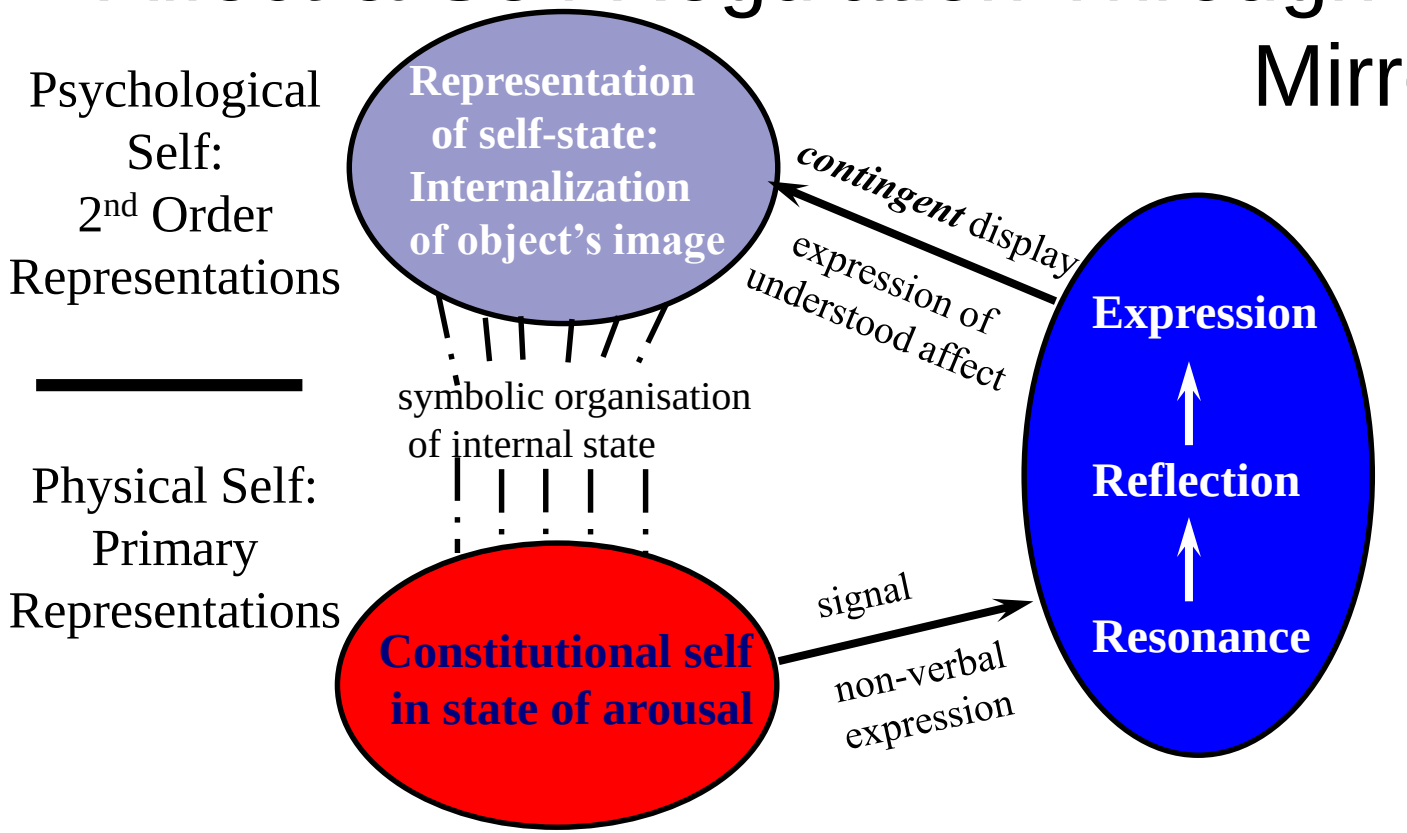
Attachments and the development of social understanding

The development of the ‘mentalizing self’



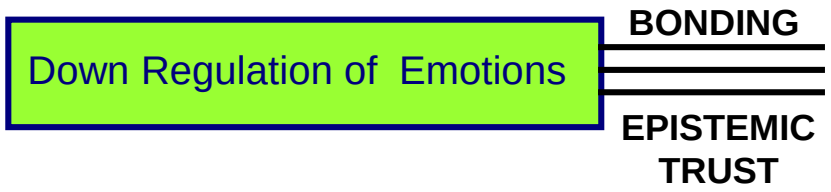
- The capacity to mentalize emerges through interaction with the caregiver:
- The quality of the attachment relationship
  - **If the parent is:**
    - Able to **reflect on infant’s intentions** accurately
    - Does **not overwhelm** the infant
  - **Then** this:
    - Assists in developing **affect regulation**
    - Helps develop child’s sense of a mind and of a **reflective self**

Affect & Self Regulation Through Mirroring



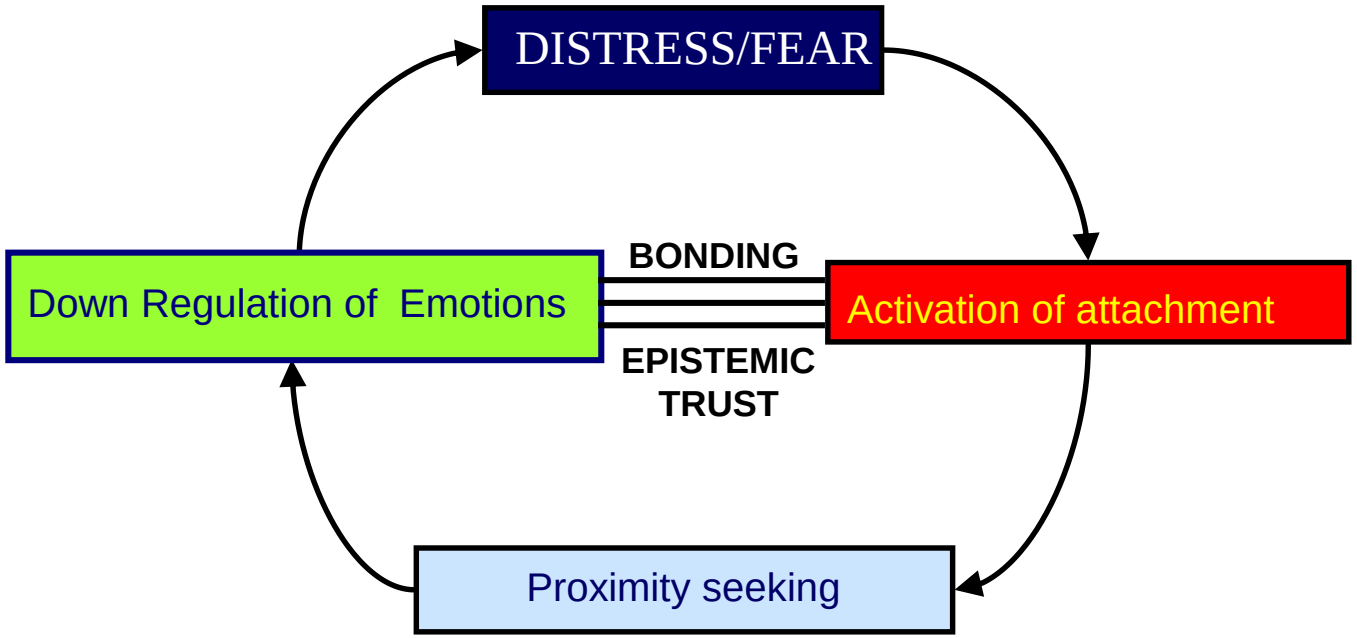
Fonagy, Gergely, Jurist & Target (2002)

How Attachment Links to Affect Regulation



The forming of an attachment bond

How Attachment Links to Affect Regulation



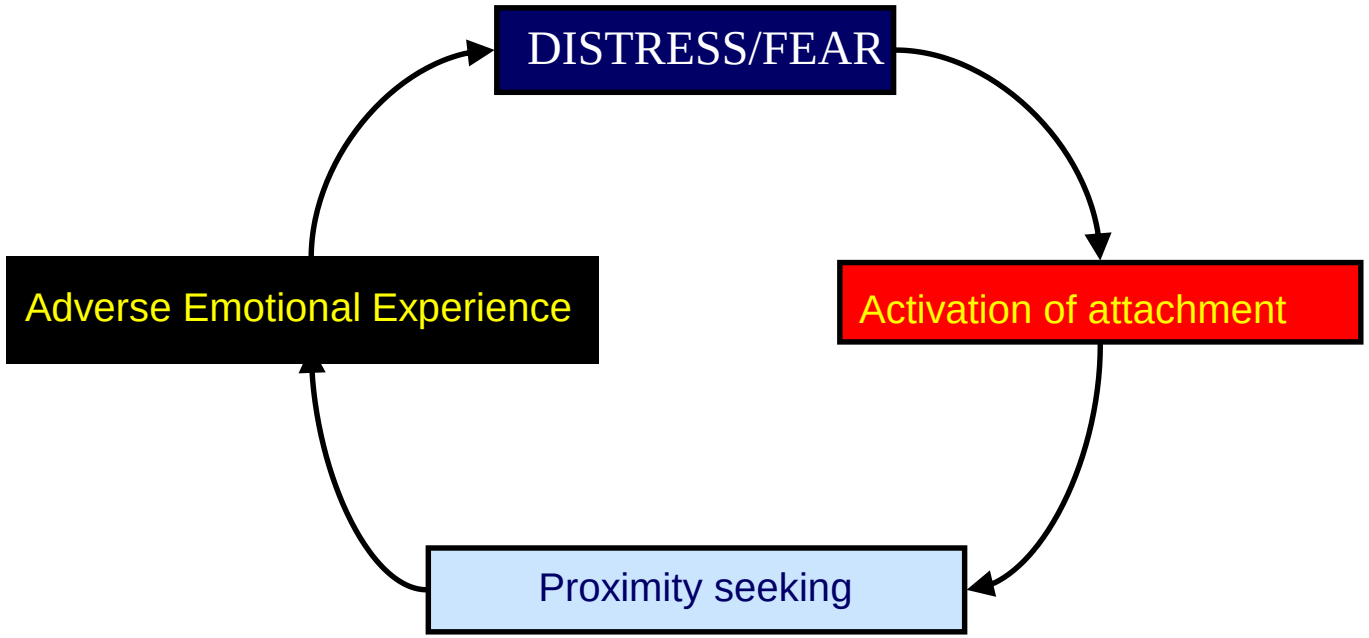
The forming of an attachment bond

Attachment Disorganisation in Disrupted Early Relationships

Adverse Emotional Experience

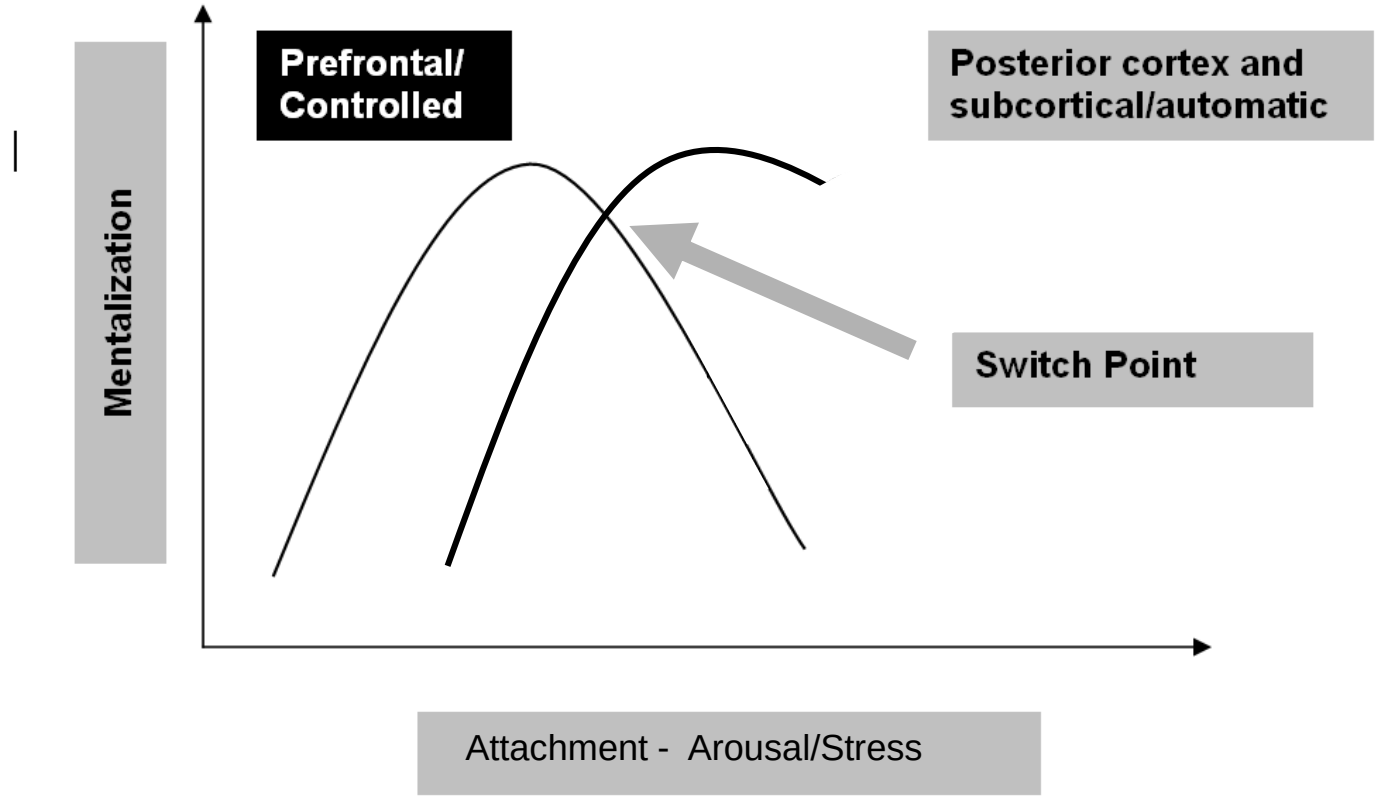
The ‘hyperactivation’ of the attachment system

Attachment Disorganisation in Disrupted Early Relationships

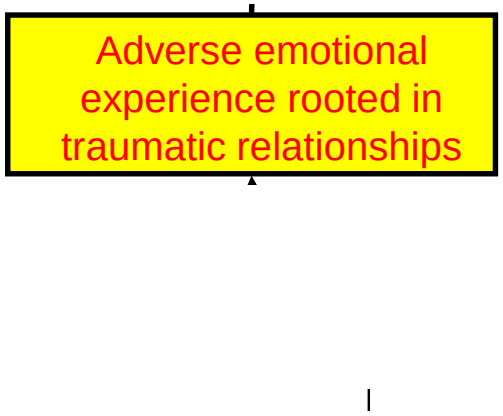


The ‘hyperactivation’ of the attachment system

A biobehavioral switch model of the relationship between stress and controlled versus automatic mentalization (Based on Luyten et al., 2009)



Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse



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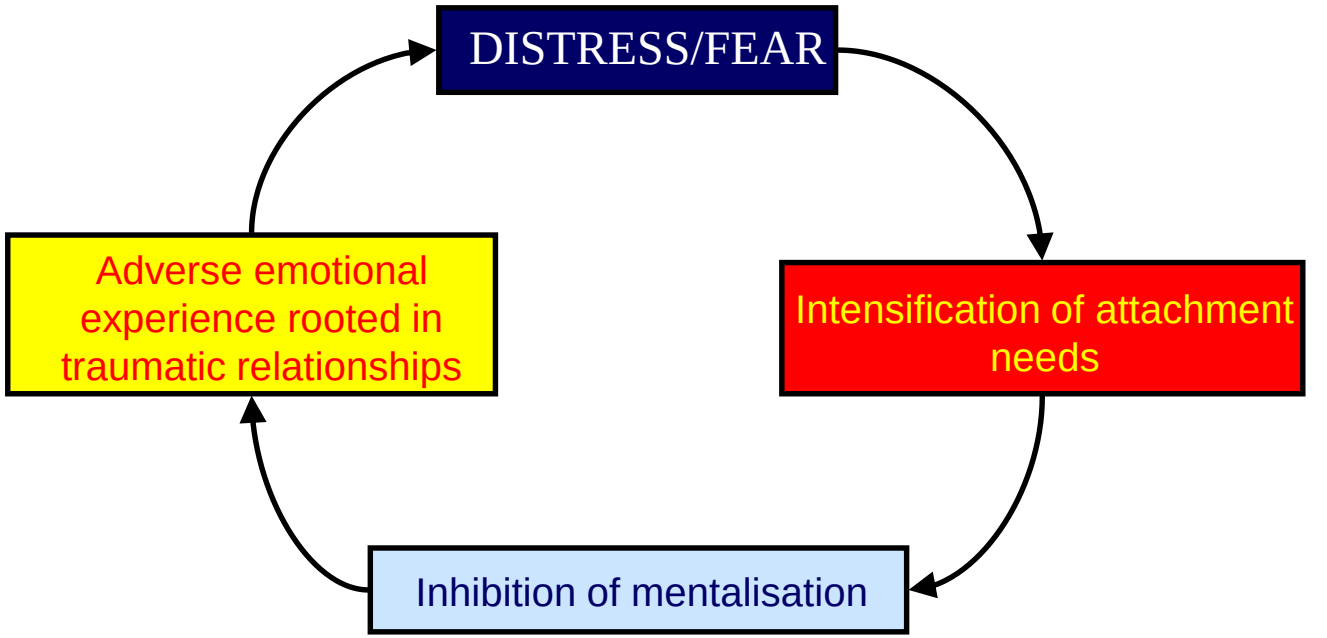


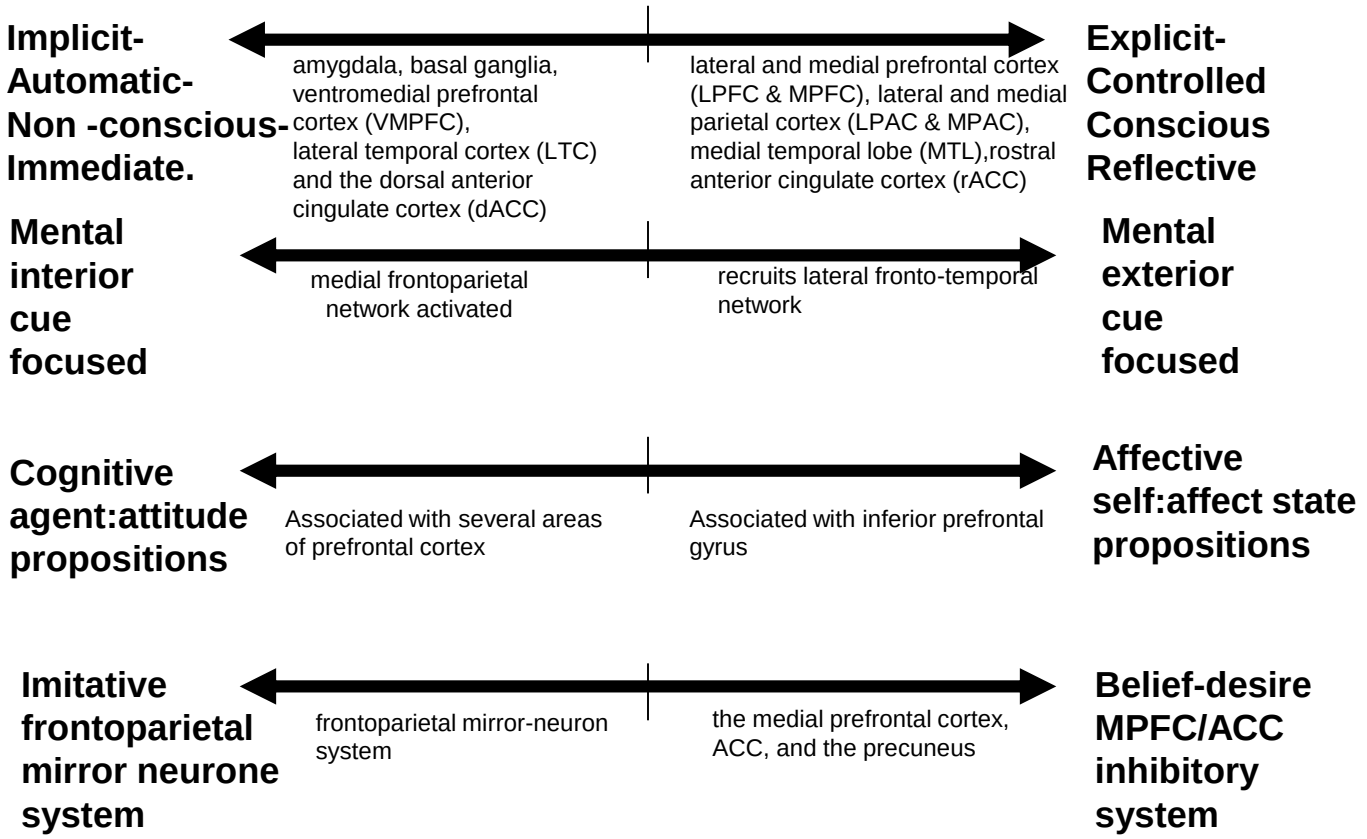
Inaccurate judgements of affect,
Delayed development of mentalization understanding
Failure to understand how emotions relate to situations and behavior

Mentalizing subcomponents

The Dimensions

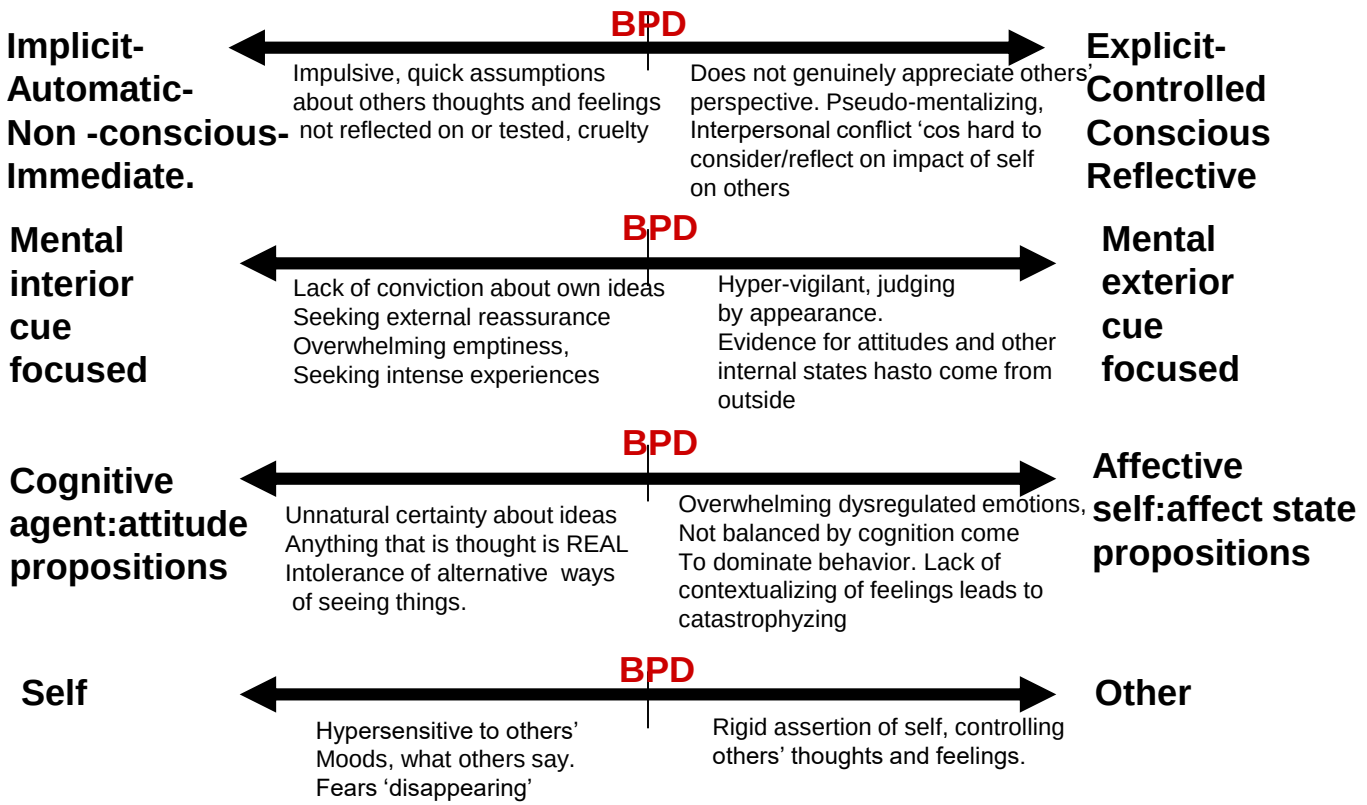
Multifaceted Nature of Mentalization

Fonagy, P., & Luyten, P. (2009). *Development and Psychopathology, 21*, 1355-1381.



Imbalance of mentalization generates problems

Fonagy, P., & Luyten, P. (2009). *Development and Psychopathology, 21*, 1355-1381.



Prementalizing Modes of Subjectivity

- Psychic equivalence:
  - Mind-world **isomorphism**; **mental** reality **=** outer **reality**; internal has power of external
  - **Intolerance** of alternative perspectives ➔concrete understanding
  - Reflects domination of **self:affect state** thinking with **limited internal focus**
- Pretend mode:
  - Ideas form no bridge between inner and outer reality; **mental** world **decoupled** from external reality
  - "**dissociation**" of thought, **hyper-mentalizing** or **pseudo-mentalizing**
  - Reflects explicit mentalizing being dominated by **implicit**, **inadequate internal** focus, **poor belief-desire reasoning** and vulnerabilty to **fusion with others**
- Teleological stance:
  - A focus on understanding actions in terms of their **physical** as opposed to mental **constraints**
  - Cannot accept anything other than a modification in the realm of the **physical** as a true index of the intentions of the other.
  - Extreme **exterior focus**, momentary **loss of controlled** mentalizing
  - **Misuse** of mentalization for teleological ends (harming others) becomes possible because of lack of **implicit as well as explicit** mentalizing

Non- mentalizing: Psychic Equivalence

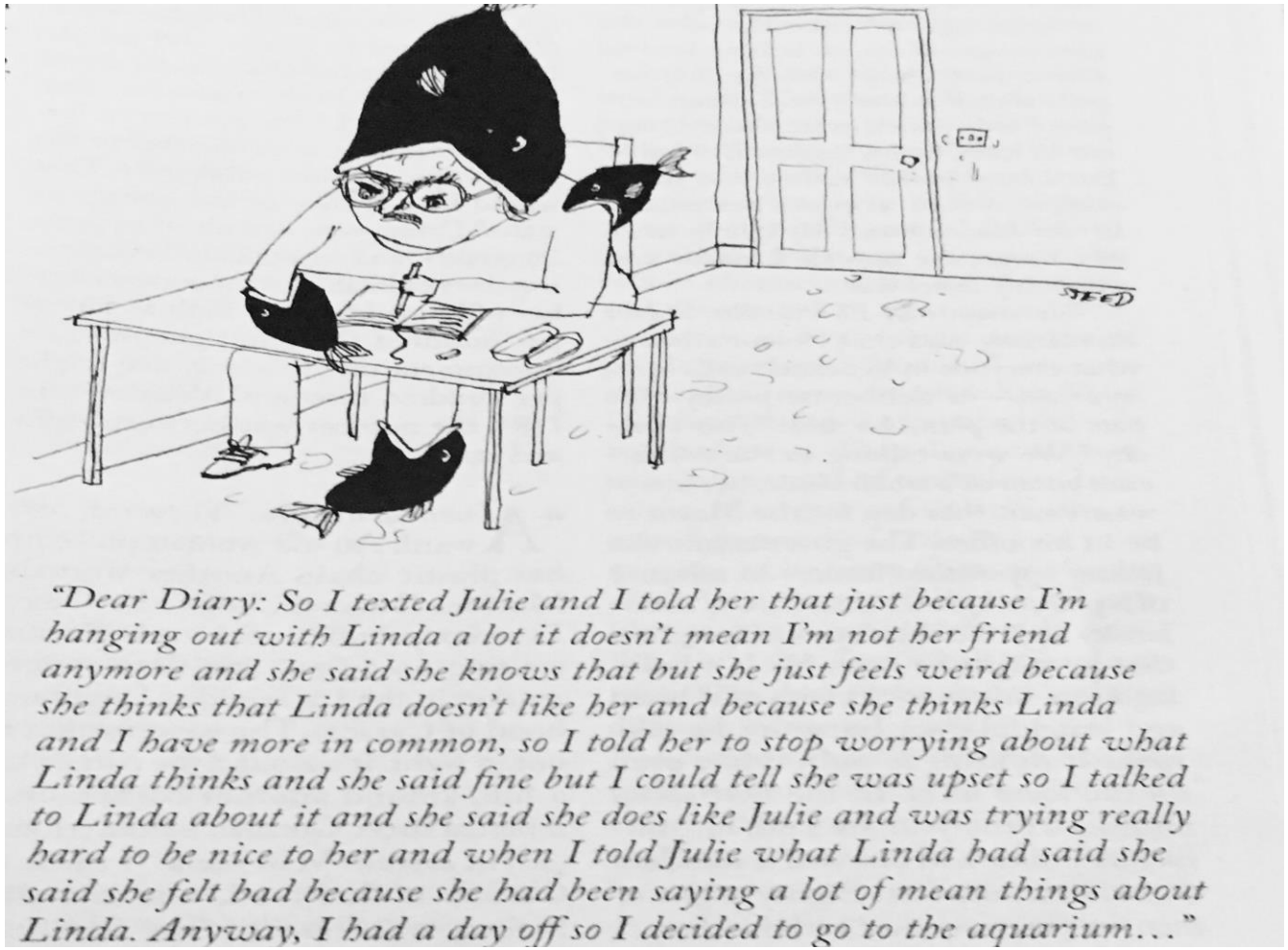
- Mind-world **isomorphism**; **mental** reality **=** outer **reality**; internal has power of external
- **Intolerance** of alternative perspectives ➔concrete understanding
- Reflects domination of **self:affect state** thinking with **limited internal focus**
- Managed by **avoiding being drawn into** non-mentalizing discourse

Non-mentalizing: Teleological stance

- *Teleological* (Greek root *tele-*, *telos*, meaning "end or purpose")
- Entered English in the 18th century, followed by *teleologist* in the 19th century.
- *Teleology* is "the study of ends or purposes."
- A teleologist attempts to understand the purpose of something by looking at its results.
  - A teleological philosopher might argue that we should judge whether an act is good or bad by seeing if it produces a good or bad result
  - teleological explanation of evolutionary changes claims that all such changes occur for a definite purpose
  - Part of philosophy of Immanuel Kant and George Hegel

Non-mentalizing: Teleological stance

- In mentalizing terms a person using telelogical mental process:
  - focuses on understanding actions in terms of their **physical** as opposed to mental **constraints**
  - Cannot accept anything other than a modification in the realm of the **physical** as a true index of the intentions of the other.
  - Extreme **exterior focus**, momentary **loss of controlled** mentalizing
  - **Misuse** of mentalization for teleological ends (e.g. controlling others) becomes possible because of lack of **implicit as well as explicit** mentalizing



"Dear Diary: So I texted Julie and I told her that just because I'm hanging out with Linda a lot it doesn't mean I'm not her friend anymore and she said she knows that but she just feels weird because she thinks that Linda doesn't like her and because she thinks Linda and I have more in common, so I told her to stop worrying about what Linda thinks and she said fine but I could tell she was upset so I talked to Linda about it and she said she does like Julie and was trying really hard to be nice to her and when I told Julie what Linda had said she said she felt bad because she had been saying a lot of mean things about Linda. Anyway, I had a day off so I decided to go to the aquarium..."

Principles

- Manage anxiety and especially attachment anxiety
  - Titrate closeness
  - Affect/Cognitive. Relational/Practical/Functional
- Take care to be contingent and marked in response
- Do not join with non-mentalizing
- Do not take over patient mentalizing
- Do not mentalize non-mentalizing
- Do not meet low mentalizing with your high mentalizing
- Only follow the affect if mentalizing is stable – otherwise contrary move
- Roll with the reaction.
- Do not respond to patient as if he was mentalizing

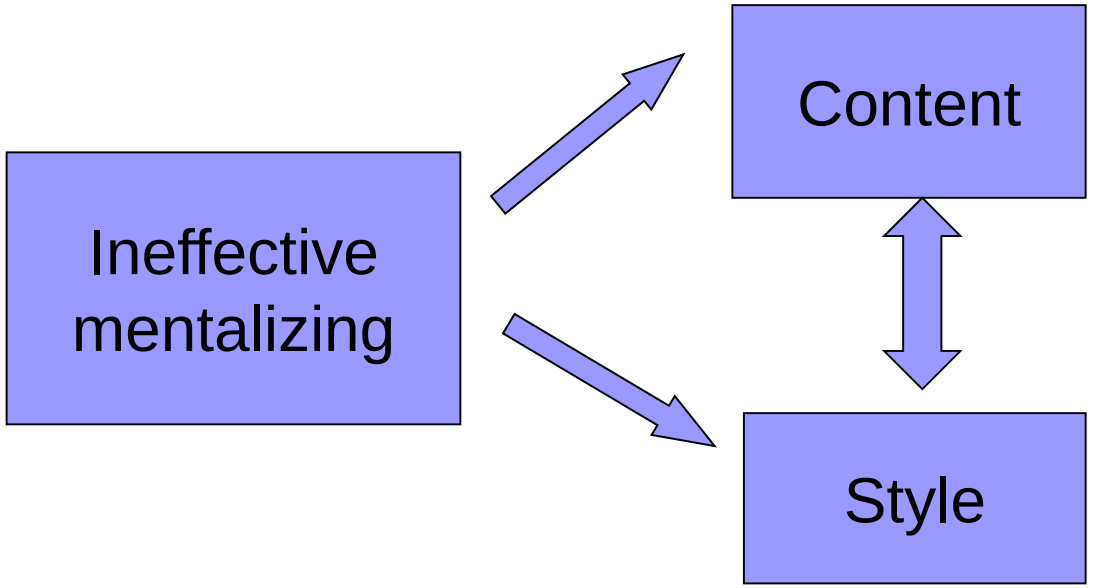
Additional Slides

Further information

Ineffective mentalizing – definition and results

- Ineffective mentalizing = poor outcomes of attempts to mentalize due to restrictions in components of mentalizing
  - **No** ability to consider **complexity** of mental states of self and other
  - Constructive and progressive **interpersonal and social involvement reduced**
  - Unable to **calibrate self states** of mind **through others**
  - No ability to **identify and manage own emotions**
  - Poorer recognition and acceptance **of alternative perspectives**
  - Failure to **negotiate shared positions/viewpoints**

Indicators of ineffective mentalizing



Indicators of ineffective mentalizing – **content**

- Focus on **external** social **factors**, such as the school, the council, the neighbours
- Focus on **physical or structural** labels (tired, lazy, clever, self-destructive, depressed, short-fuse)
- **Labelling** others - stereotypes
- **Absence of content** – paucity of thought in depression

Indicators of ineffective mentalizing – **content**

- **Preoccupation with rules**, responsibilities, ‘shoulds’ and ‘should nots’
- **Denial** of **responsibility**, involvement in problem
- **Blaming** or fault-finding

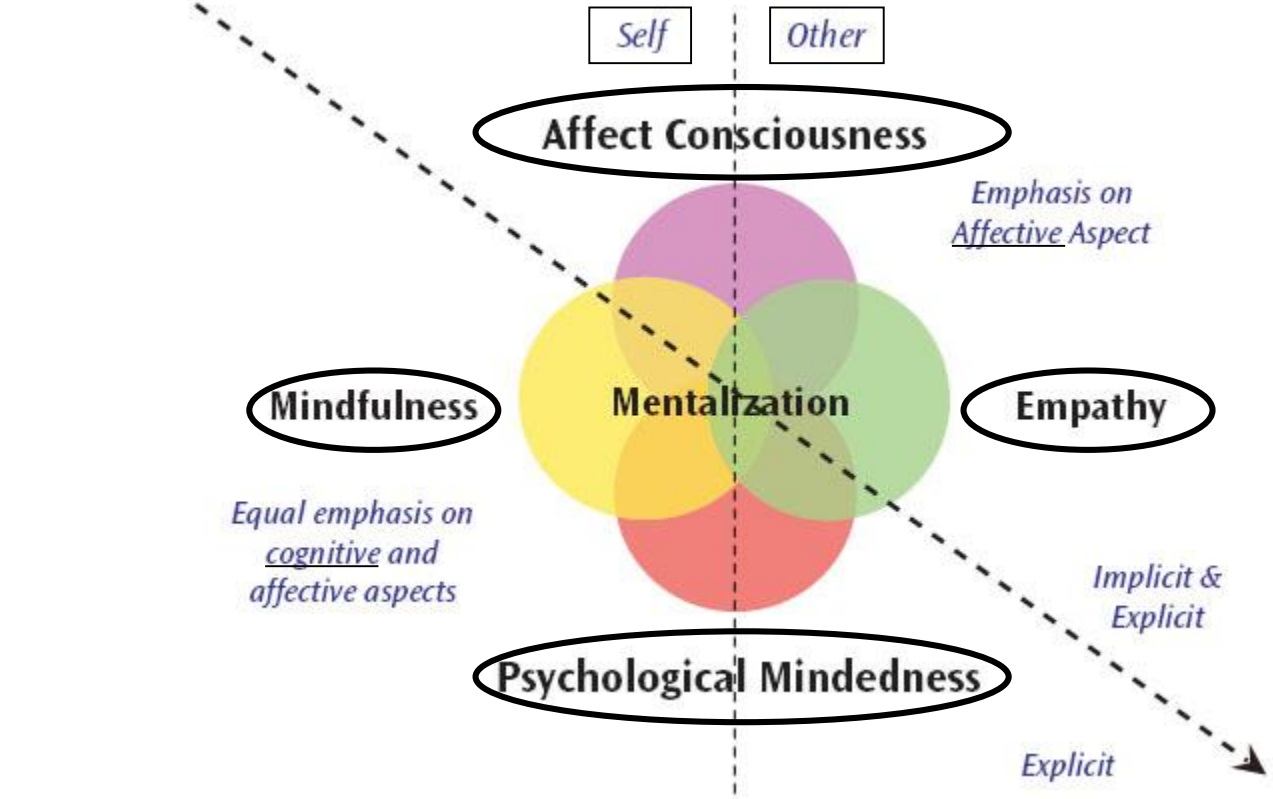
Indicators of ineffective mentalizing – **style**

- **Excessive detail** to the exclusion of motivations, feelings or thoughts
- States of **mind missing** from the narrative
- **Assumptions** of mental states
- **Lack of appropriate emphasis** on important areas
- How something is thought about
  - Expressions of **certainty** about thoughts or feelings of others
  - **Rigidity**
  - **Fixed** perspective with **no** consideration of **alternative viewpoints**

Indicators of ineffective mentalizing – **style**

- Conversation is **unquestioning**
  - **Categorical**
  - **No ordered progression** in development of content
  - **Assumptions** of mental states
  - **Words restrict complexity**
    - Just
    - Clearly
    - Obviously
    - All

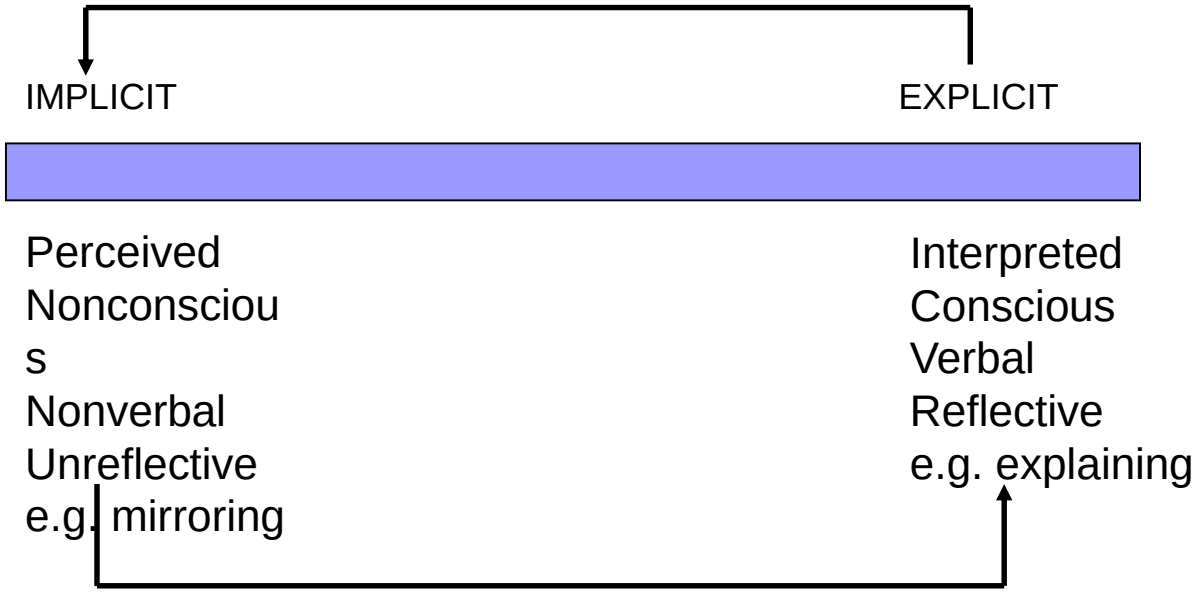
Mentalization and Overlapping Constructs (Choi-Kain & Gunderson, Am J Psychiat 2008)



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

Mentalizing: Implicit ‘v’ Explicit

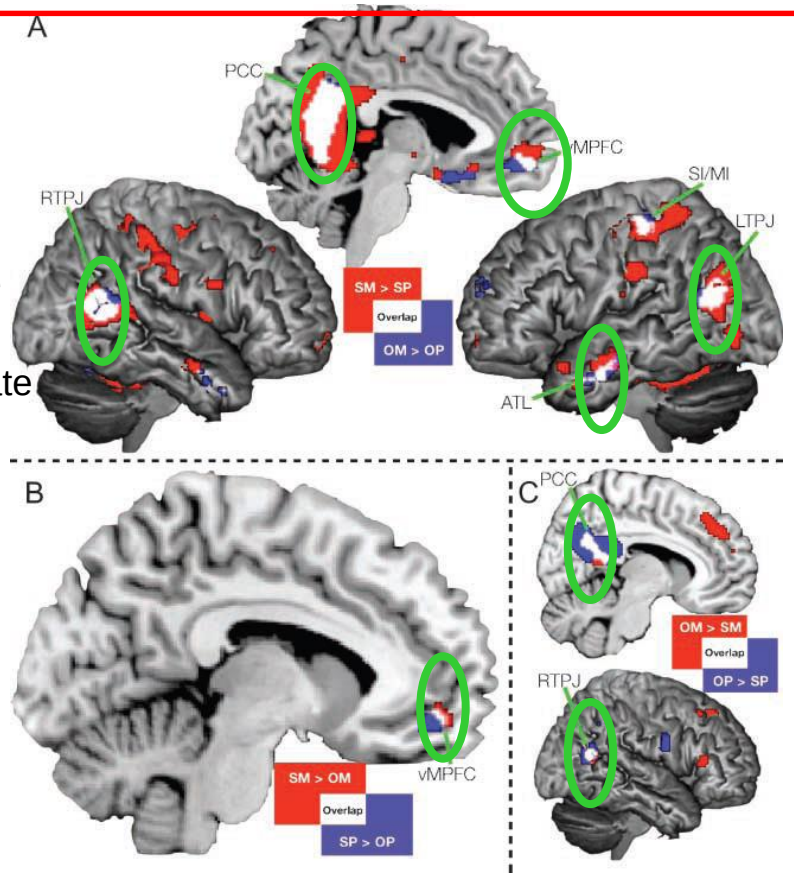


Shared neural circuits for mentalizing about the self and others (Lombardo et al., 2009; J. Cog. Neurosc.)

Self mental state

Other mental state

Overlapping for Self and Other

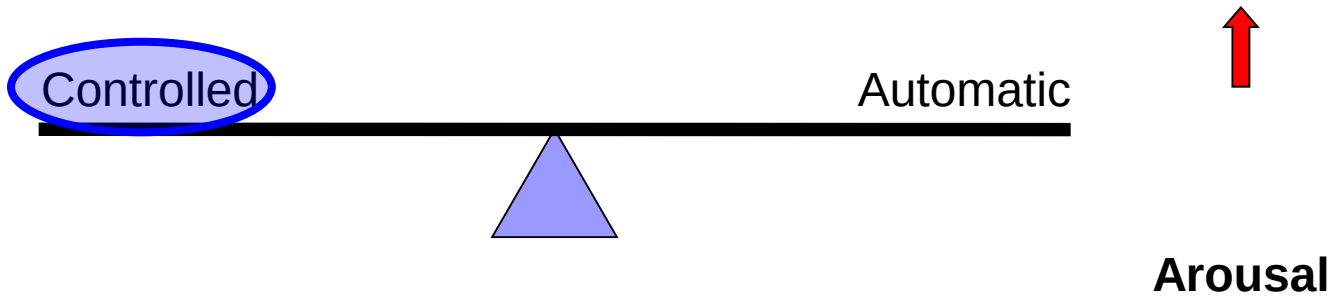


Relational Aspects of Mentalization

- Overlap between neural locations of mentalizing self and other may be linked to **intersubjective origin of sense of self**
  - We **find our mind** initially in the minds of our parents and later other attachment figures thinking about us
  - The parent's capacity to **mirror effectively** her child's internal state is at the heart of affect regulation
  - Infant is **dependent on contingent response** of caregiver which in turn depends on her capacity to be reflective about her child as a psychological being
  - **Failure to find the constitutional self** in the other has potential to profoundly distort the self representation (**exaggerated mirroring** of child's anxiety➔ aggravates anxiety rather than soothe)
  - The same applies to child with inadequate sense of independent self within **therapeutic relationship**

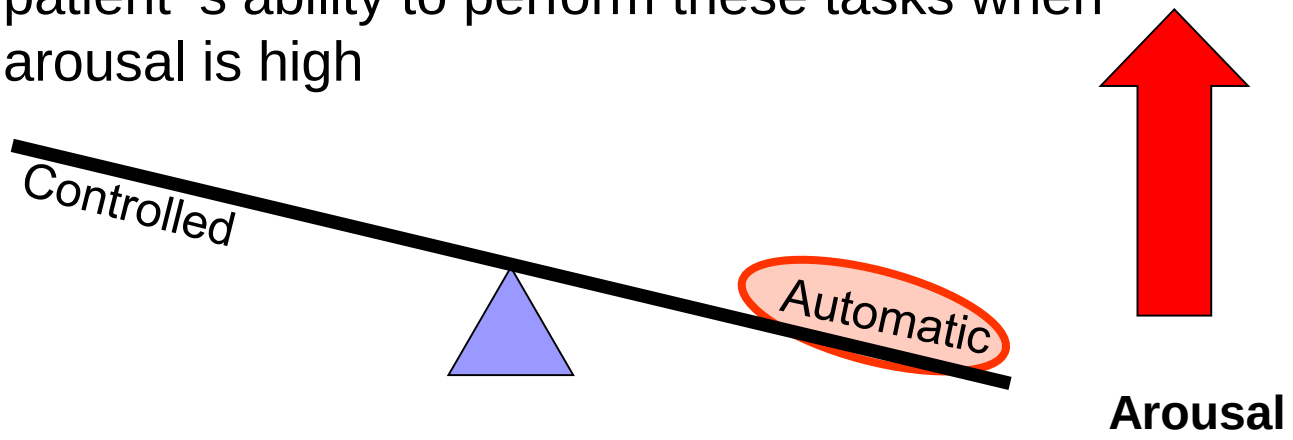
Dimensions of mentalization: implicit/automatic vs explicit/controlled

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



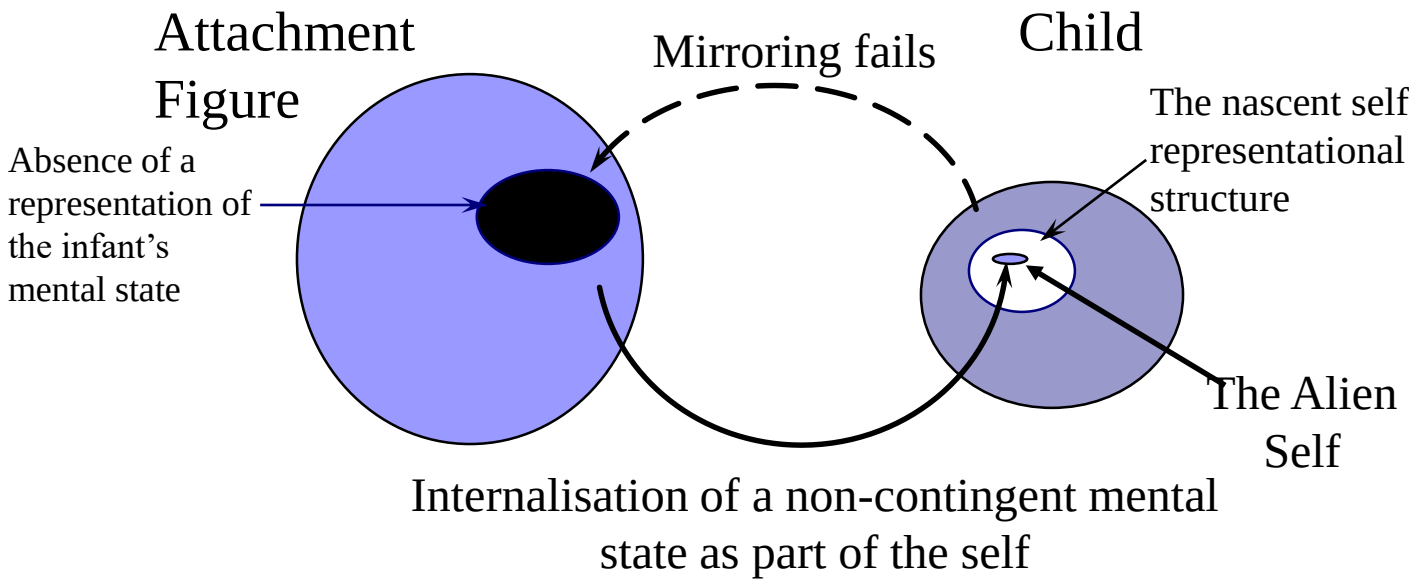
Dimensions of mentalization: implicit/automatic vs explicit/controlled

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



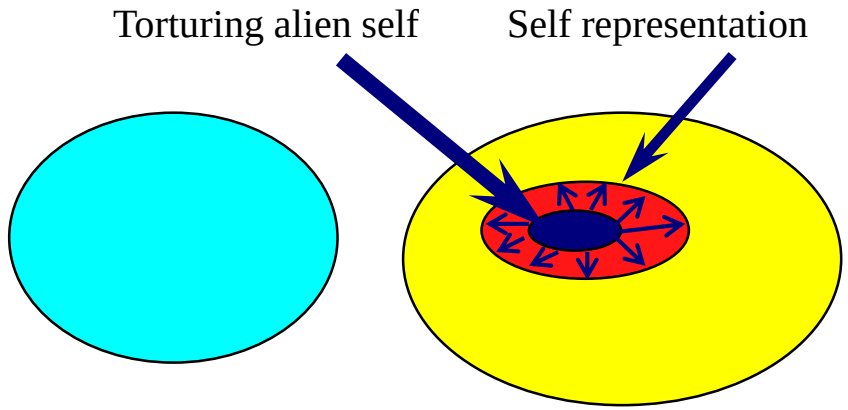
Theory: Birth of the "Alien" Self in Disorganized Attachment

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 which disorganizes the self creating splits within the self structure

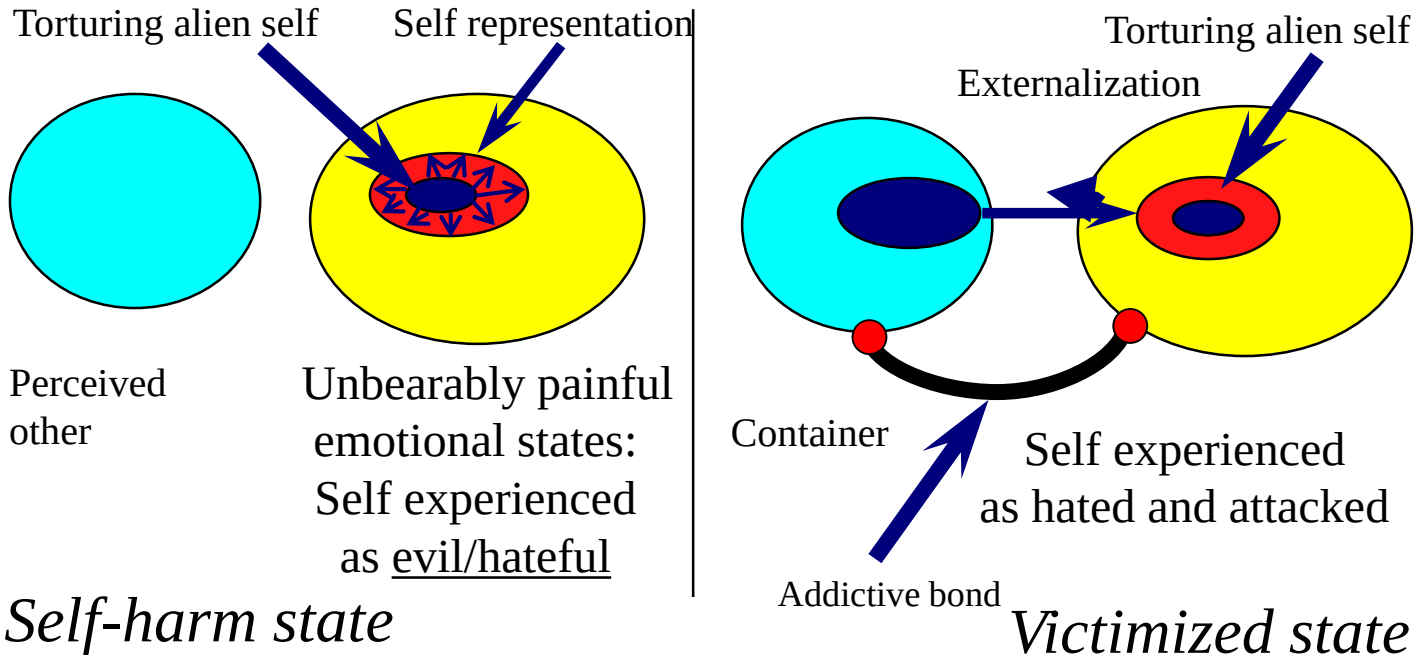
Theory: Self-destructiveness and Externalisation Following Adversity



Self-harm state

Attack from within is turned against body and/or mind.

Theory: Self-destructiveness and Self-destructive relationships



Self-harm state

Victimized state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops

If someone was causing you pain or simply tormenting you, perhaps not everyday for the whole day, parts of a day, or for days and weeks on end,

You could if you were brave or desperate enough, defend yourself, by perhaps attacking (and eliminating) your persecutor.

But what if this thing you hate, was inhabiting your head?

You can’t exactly say please leave my body, you can’t do anything to get it to just pack up and leave because technically, physically that isn’t possible.

You can say fuck you. I hate you. You can self-harm with the hugest force your body can withstand, with all you can muster.

You can do that. You can be very very angry and show them who's boss, you won't stand for it, you won't take it lying down. You want to be heard, you want to say right, you think you can hurt me? I'll show you, I'll show you how much I can hurt you!

But you and this thing, you are inhabiting one body. You attack this thing you attack yourself. You don't have a choice though. That's a sacrifice you make over and over.

Eventually, you realise the only way to get rid of this thing, once and for all is getting rid of yourself. What choice do you really have?

No doctor can specify the problem. No medication can fix the problem that can’t be specified.

You fail to understand yourself. You can’t explain to your family and docs, they can’t help you because you do not talk.

You doubt yourself “do I even have a problem?”

People in real life often treat you like you don’t have a real problem. They talk to you stupidly, you complain that they don’t understand, you look a fool. Perhaps that is why you don’t talk to them anymore.

Maybe you don’t have a problem anyway.

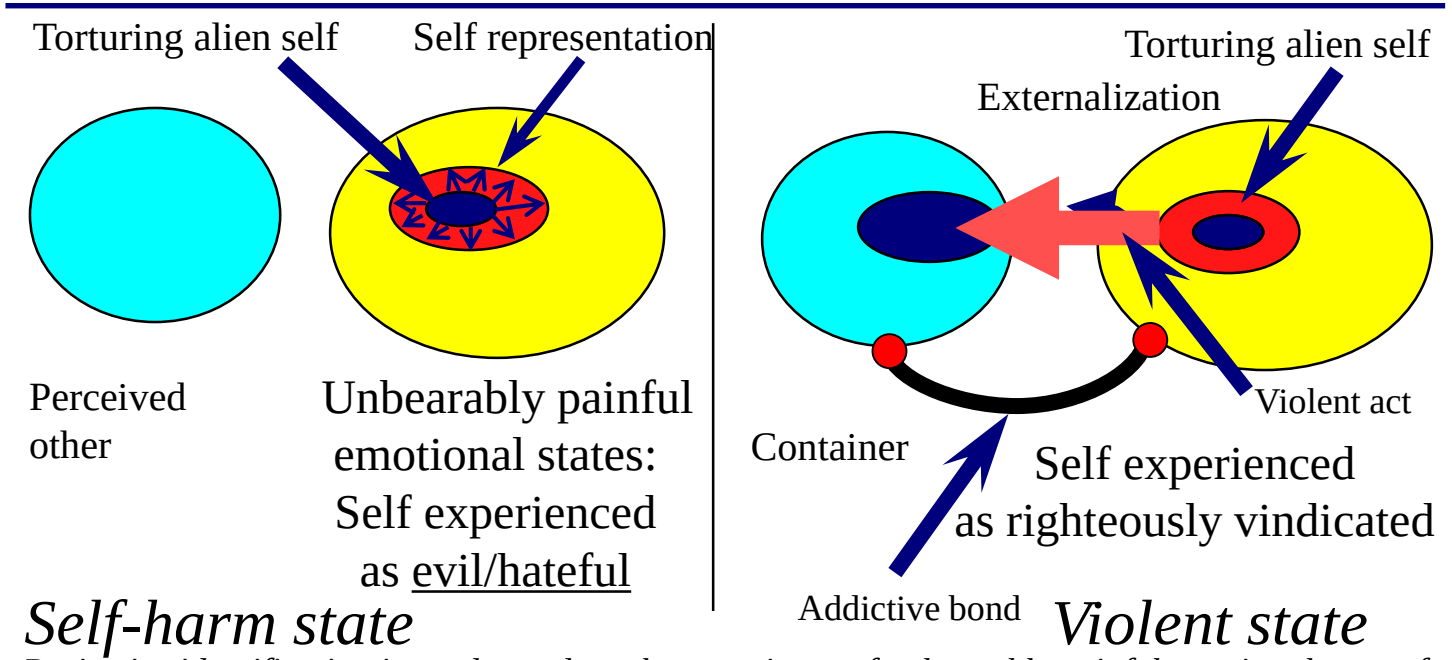
You are a child, quite possibly you are just making this up for some attention, finding an excuse for why you can't stay in college or get a job. Maybe you don't have an excuse, you are just a stubborn little child.

From what everyone tells you perhaps that is true.

You have doubt. You are willing to listen to someone else.

For now that is the only reason why you are not, at this moment trying to do it.

Externalisation & Violence Following Trauma



Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death, the violent act protects against experience of intrusion and addictive bond and terror of loss of abused object can develop

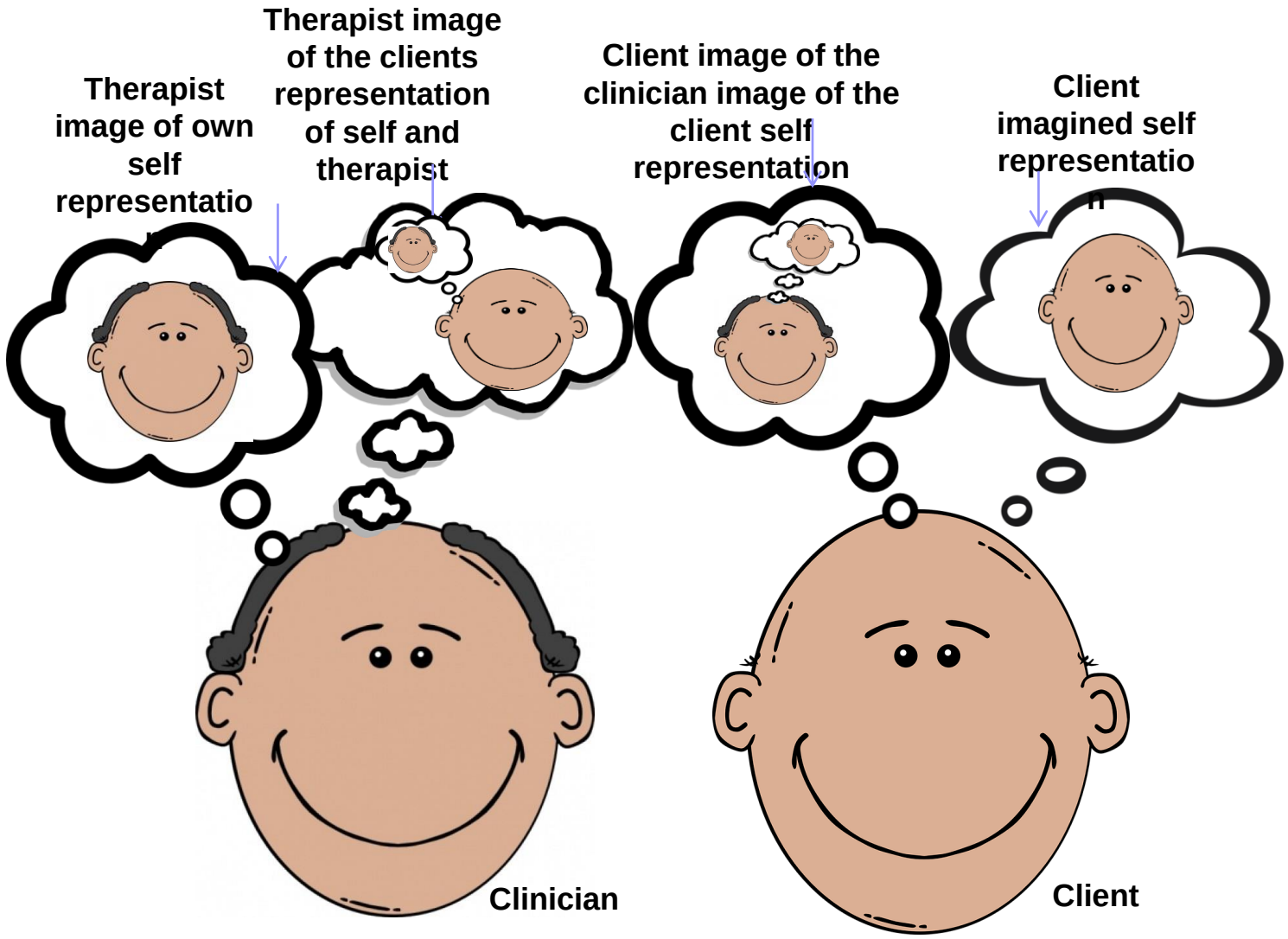
Understanding suicide and self-harm in terms of the temporary loss of mentalization

- Loss ➔
  - *Increase attachment needs ➔ triggering of attachment system ➔*
- Failure of mentalization ➔
  - *Psychic equivalence ➔ intensification of unbearable experience ➔*
  - *Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔*
  - *Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting*

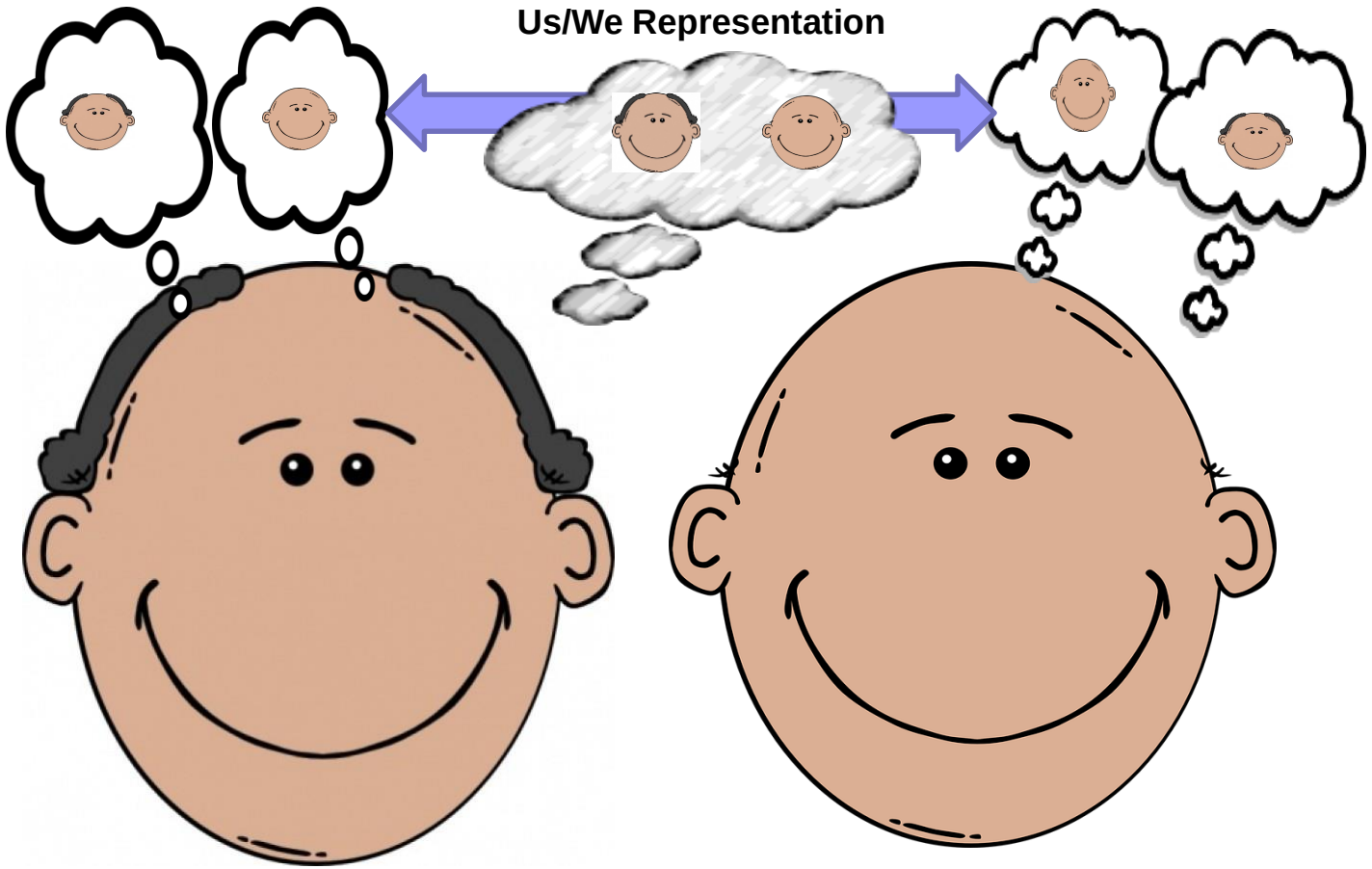
Mentalization Based Treatment

Clinical Training Slides

Overview of the MBT model: Key Domains


Therapist image of own self representatio
Therapist image of the clients representation of self and therapist
Client image of the clinician image of the client self representation
Client imagined self representatio n
Clinician
Client

Higher Order Representation



Domains of MBT

General Domains

- Can be evaluated by viewing a whole session
- Two general core domains

1- Sessional Structure
2- Not-Knowing Stance

- Both general domains provide the basis for delivering MBT
- Impossible to focus work on mentalizing without the two core elements

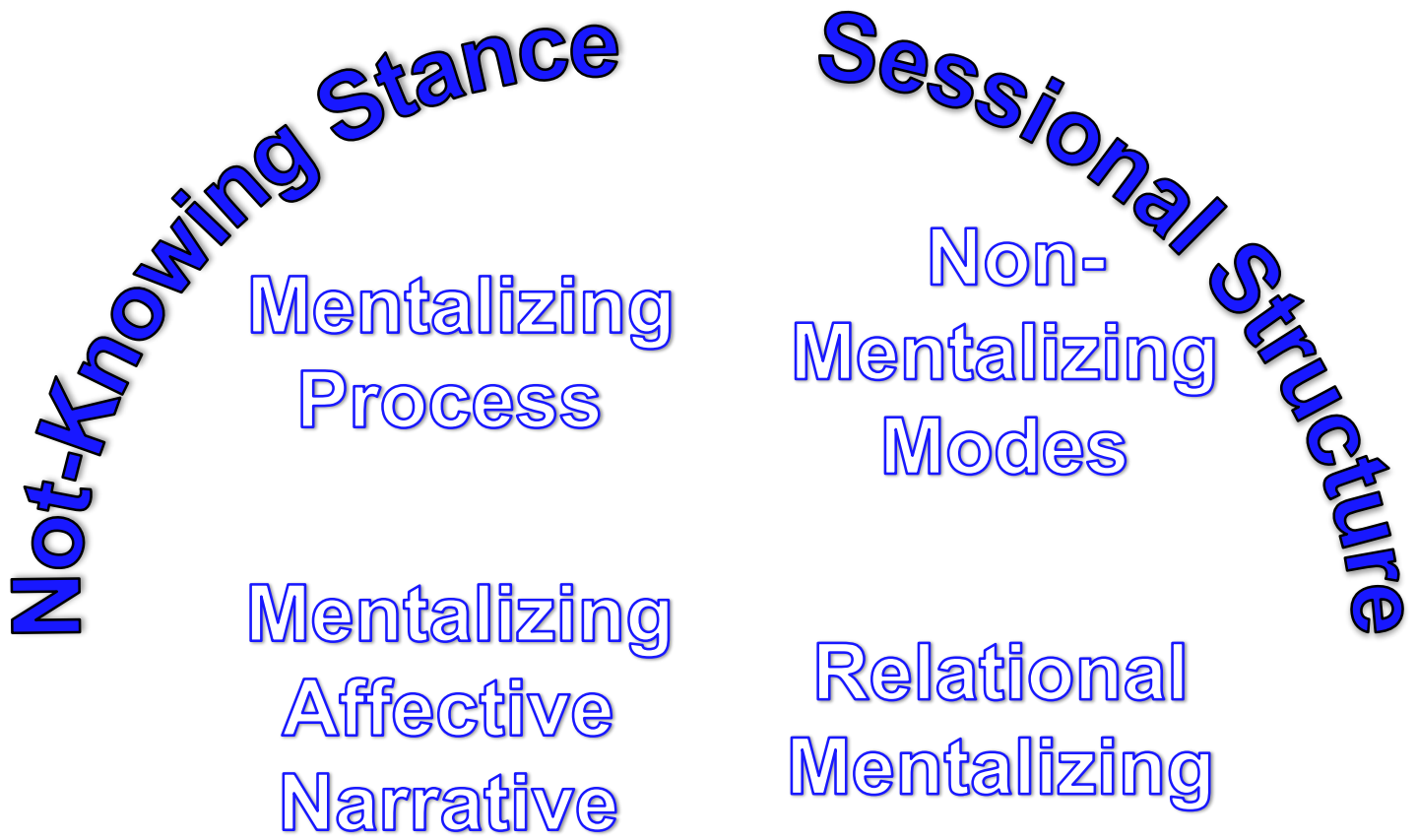
Major Component Domains

- Can be evaluated on the basis of the therapist's interventions
- Four major component domains

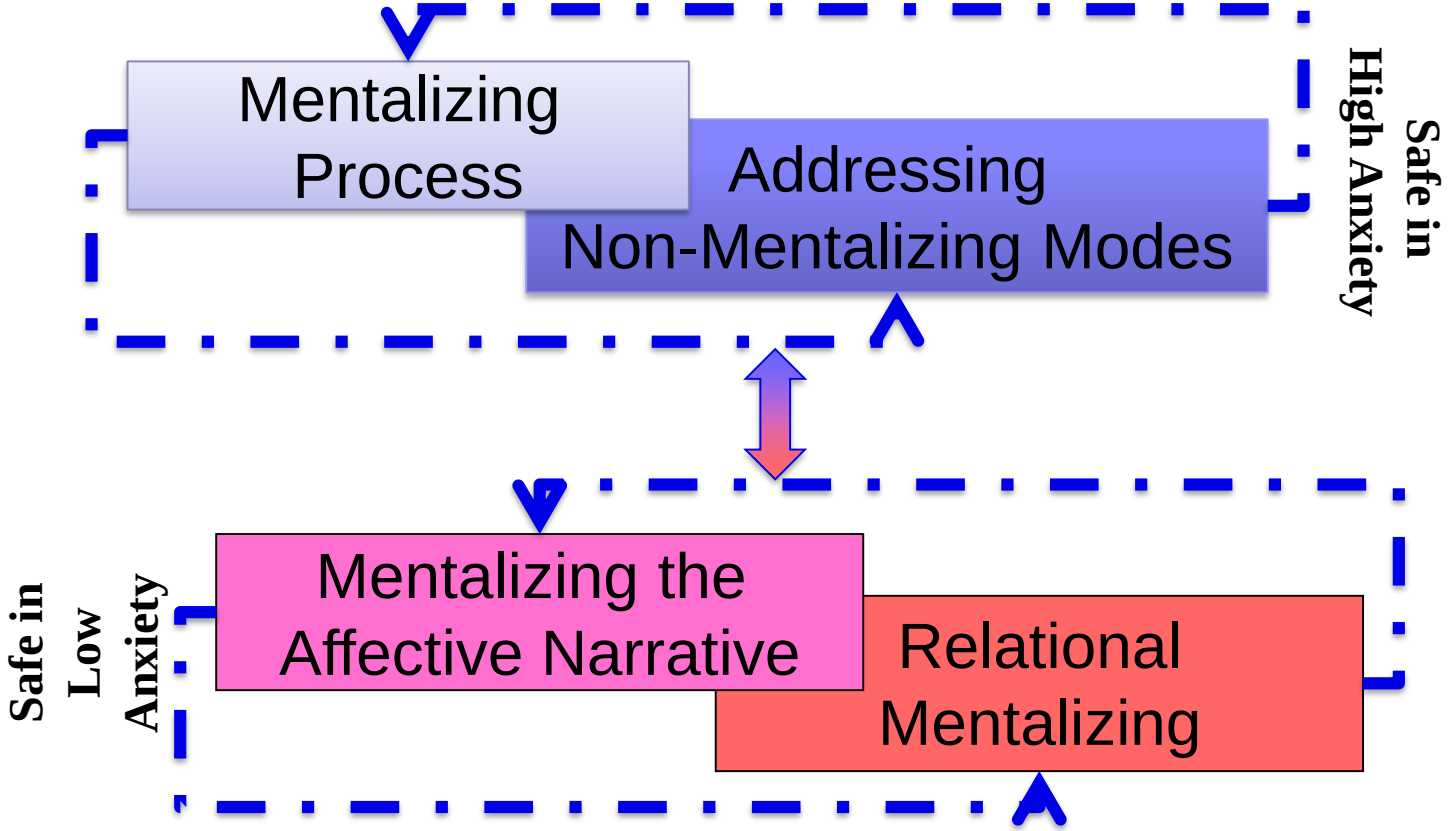
3- Mentalizing Process
4- Non-Mentalizing Modes
5- Mentalizing Affective Narrative
6- Relational Mentalizing

- A typical MBT session involves interventions within these 4 domains
- MBT therapist will train on skills to deliver each type of intervention

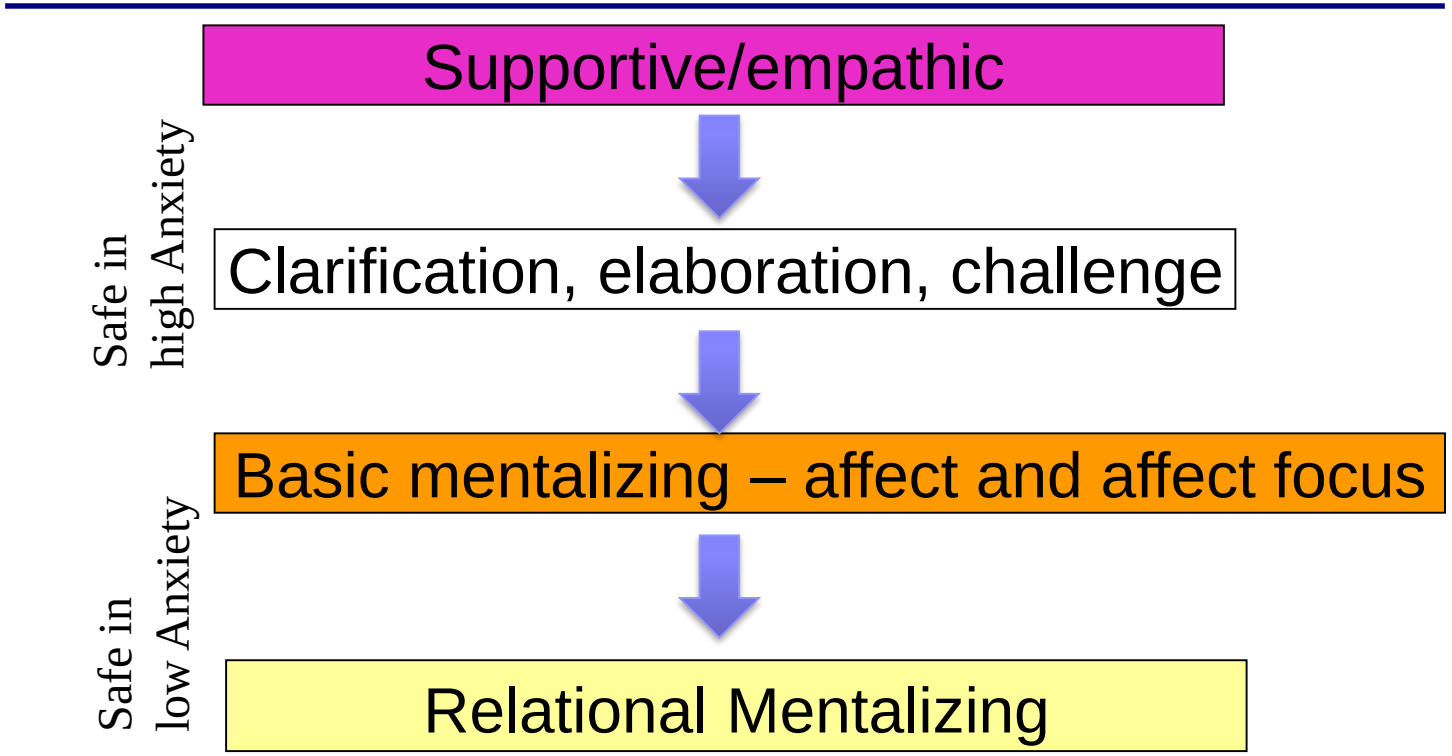
Domains of MBT



Topology: relationships between domains in therapist interventions

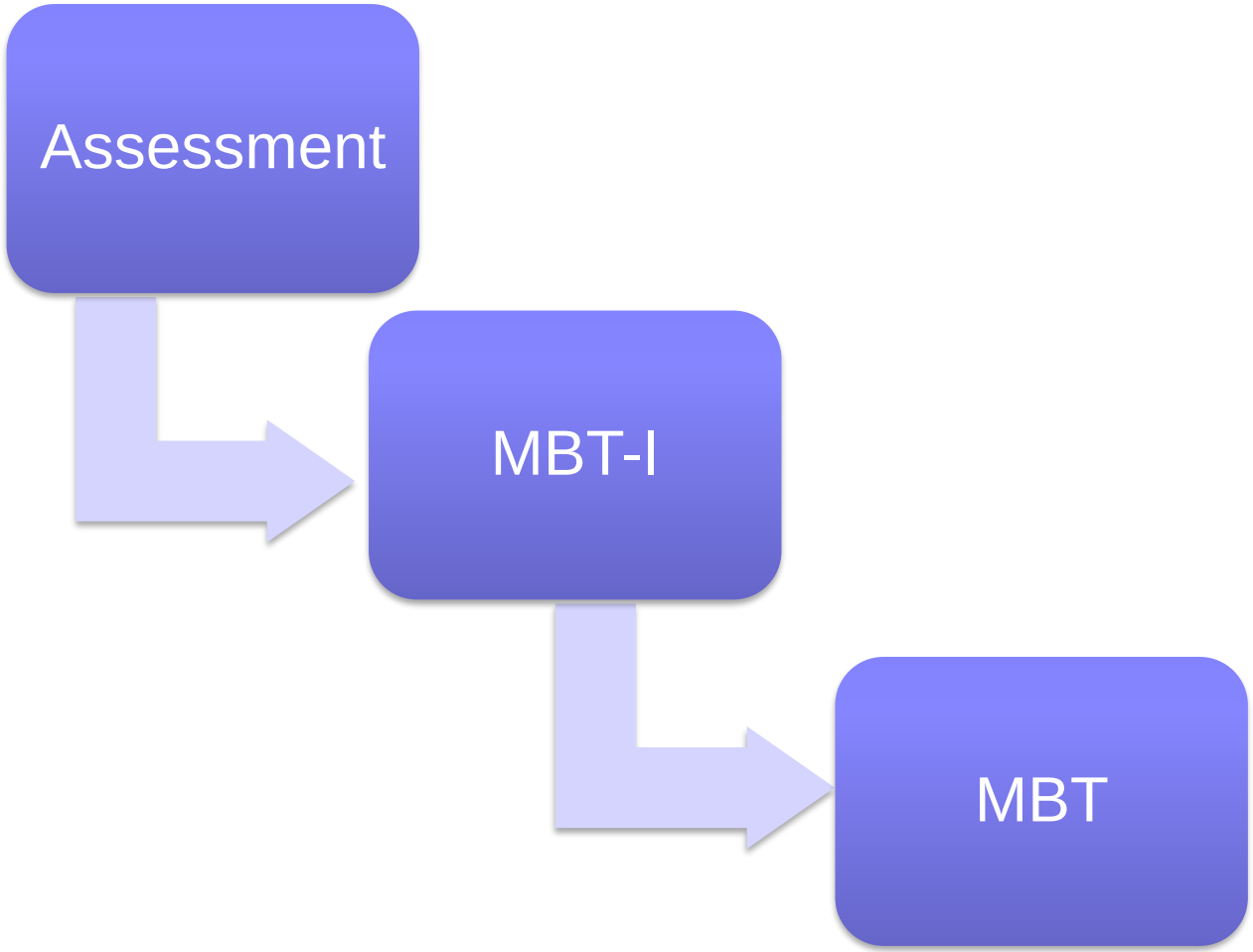


Interventions: Spectrum

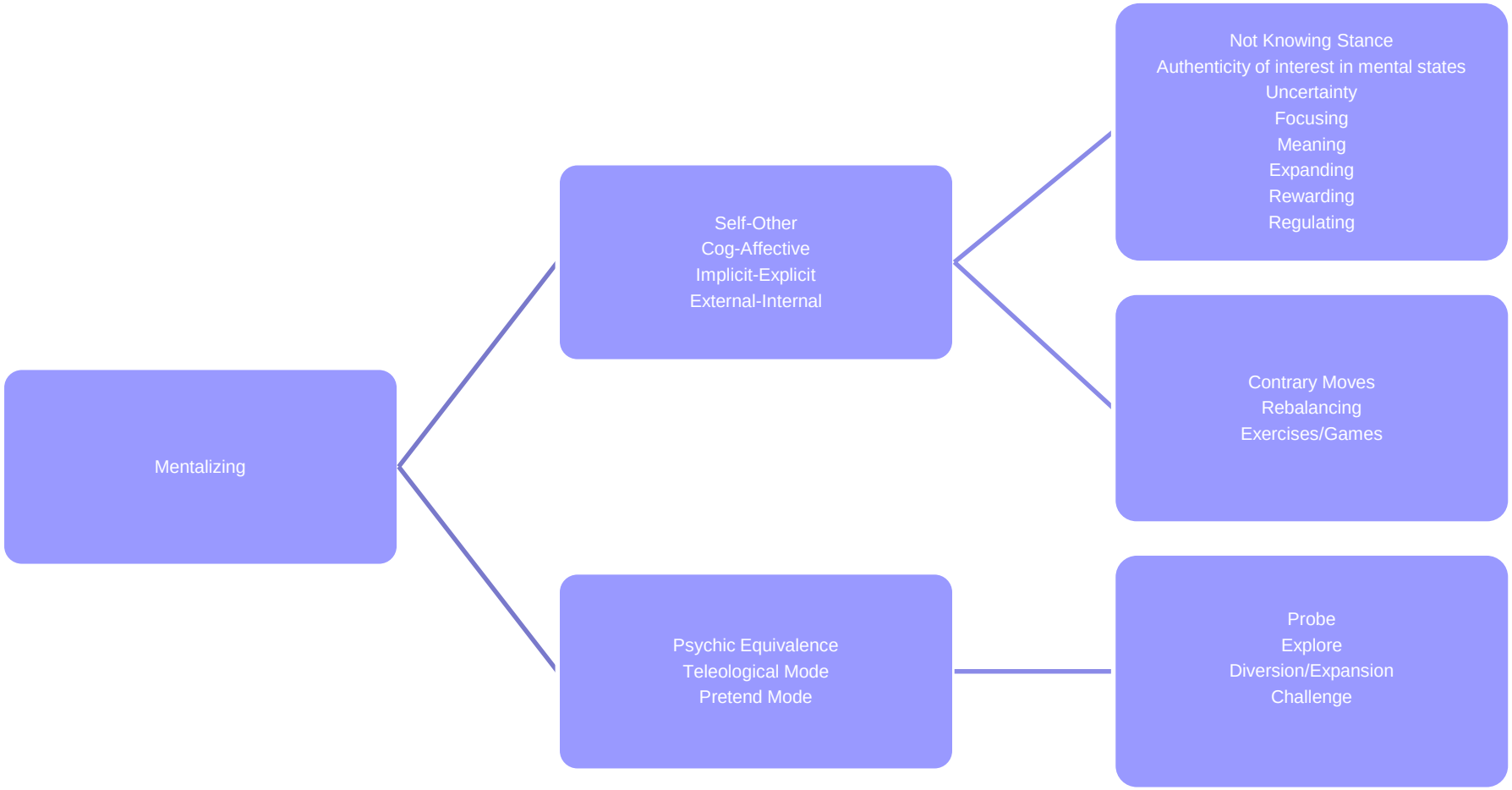


(1) Structure of Mentalization Based Treatment

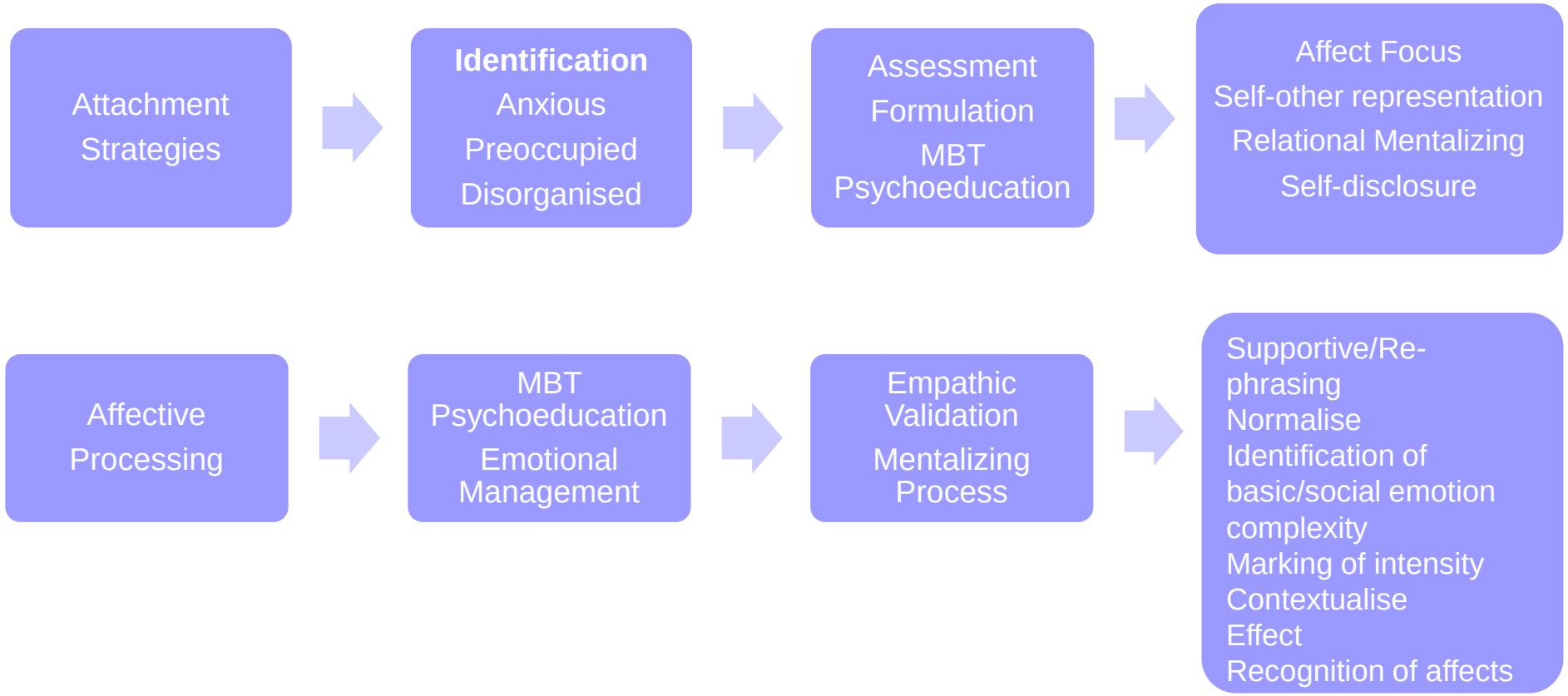
Core Domain


Assessment
MBT-I
MBT

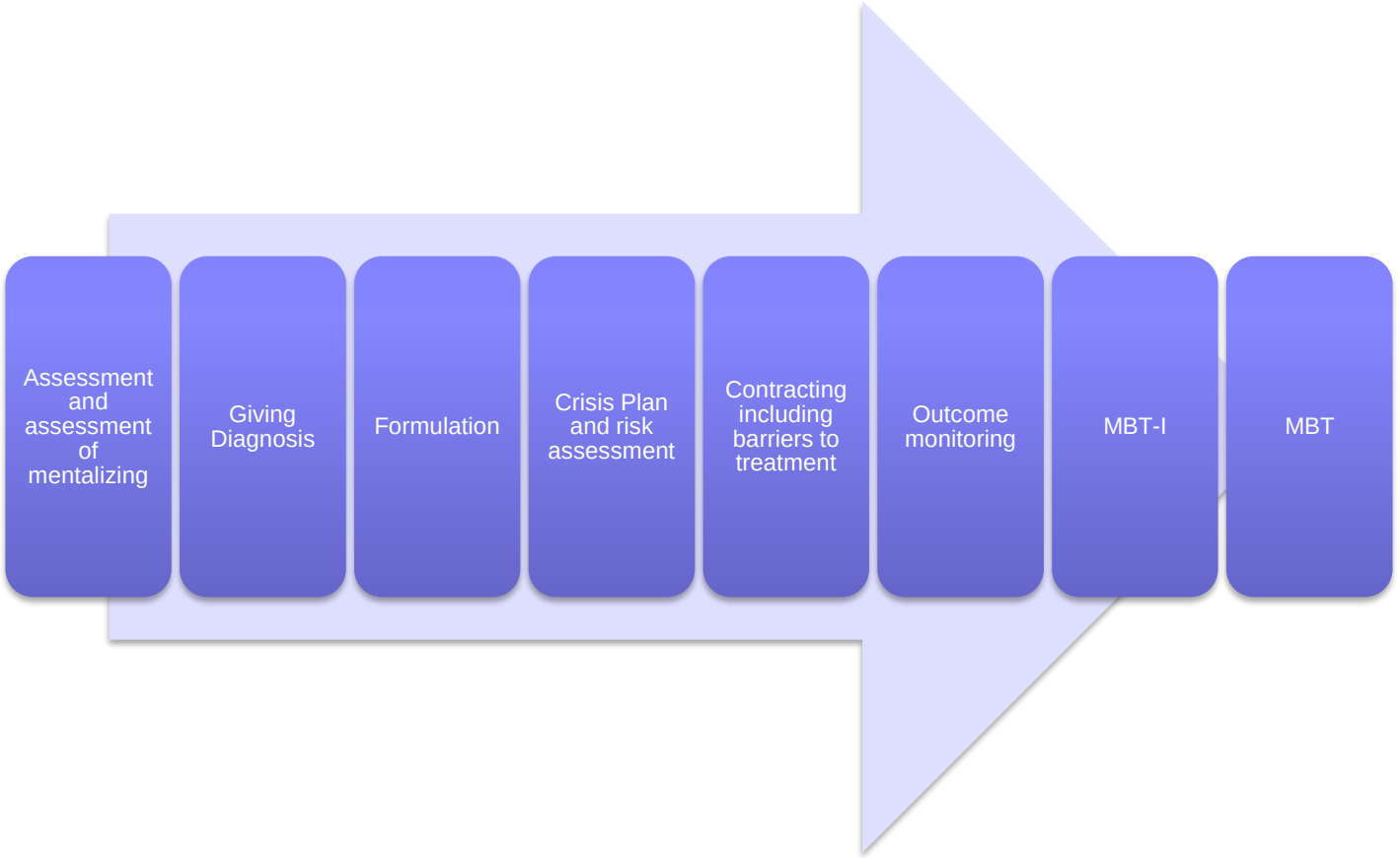
MBT in a Nutshell (1)



MBT in a Nutshell (2)



Trajectory of Treatment



Crisis Plans

- Integrate with normal crisis planning system
- 3 major components
  - Information for patient – what can he do?
  - Information for health care professionals –what can they do?
  - Information for others including what not to do

Aims of Formulation

- Aims
  - Organise thinking for therapist and patient – each sees different minds
  - Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exampled)
  - Modelling humility about nature of truth
- Management of risk
  - Analysis of components of risk in intentional terms
  - Avoid over-stimulation through formulation
- Beliefs about the self
  - Relationship of these to specific (varying) internal states
  - Historical aspects placed into context
- Central current concerns in relational terms
  - Identification of attachment patterns – what is activated
  - Challenges that are entailed
- Positive aspects
  - When mentalisation worked and had effect of improving situation
- Anticipation for the unfolding of treatment
  - Impact of individual and group therapy

Formulation Exercise

- Read the referral letter provided
- Small group
  - Identify important areas for probe questions in the assessment – what questions will you ask
  - What mentalizing problems will you probe for in the assessment
  - Consider a draft mentalizing formulation
  - From this formulation indicate what you predict will occur in treatment

Formulation: Executive Summary

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

Formulation headings to think about

- Current aims
- Vulnerability factors – distal and proximal
- Crisis Plan and Risk – separate from formulation
- Mentalizing profile – common mentalizing modes; dimensional profile
- Relationships – attachment strategies
- Treatment prediction

- I have been picking a few things out of all this as we have been talking.
- People person
  - It seems that you really like other people but find it hard to be on your own. You have to go out and then try really hard to find out if people do like you.
- Being on your own
  - When you have been on your own you said you start to self harm sometimes although it is really good that that has now stopped for quite a long time as has your drug use.
  - Feelings are difficult to describe when this happens
  - When you are with your daughter you feel so much better
- Not being sure

  When you are thinking about your self you seem terribly unsure about what you think – your boyfriend and what he feels for you is a really important example of this
  - When you are not sure about how someone feels about you it makes you really have to find out – you ask and ask. This happened with the father of your daughter until he left you. You then decided not to go back to him and I think we might work out how you managed that as you realized that your instinct was to go back to him even though you 'knew' it was best not to.
- Doing stuff
  - You find that when you try to think about you and what you want and think you end up not being sure and so ask others. Perhaps we can think about your uncertainty about what you think and feel about things especially with your boyfriend.
- Relationships
  - You really want to protect your relationship with your boyfriend
  - Your last relationship which is still going on with the father of your daughter was really difficult for you and he was violent and you felt trapped. You want to make your current relationship different and not get stuck in it.
- Treatment
  - Check that we think you are OK – how might you do that if in between sessions you panic
  - Really want to be helped and worry that it might not work.
- Aims
  - Being alone
  - Not being sure with your boyfriend

Examples of Formulation

Formulation

Current Aims

Your aims are to go out more and stop avoiding other people. Your concern is that you spend too much time alone, you are lonely, and you start thinking that people are against you.

Reduce arguments with other people.

Vulnerability factors

You were unable to trust anyone when you were a child. You experienced abuse and there was no one who cared about you.

By the time you were 12 you started smoking and drinking

Formulation

Crisis Plan

We have developed a way for you to manage your anxiety when you are out in the streets. You focus too much on ‘the look’.

Mentalizing profile

You are sensitive to others and their expressions. You make quick decisions about their motives. You often feel you have to protect yourself and you feel better than others much of the time. You tend to work things out rather than feel your way with other people.

Formulation

Relationships

You describe trying to meet with people and get to know them better but quickly you feel that they do not like you and you then feel anxious and avoid seeing them. You tend to assume this without finding out if it is true.

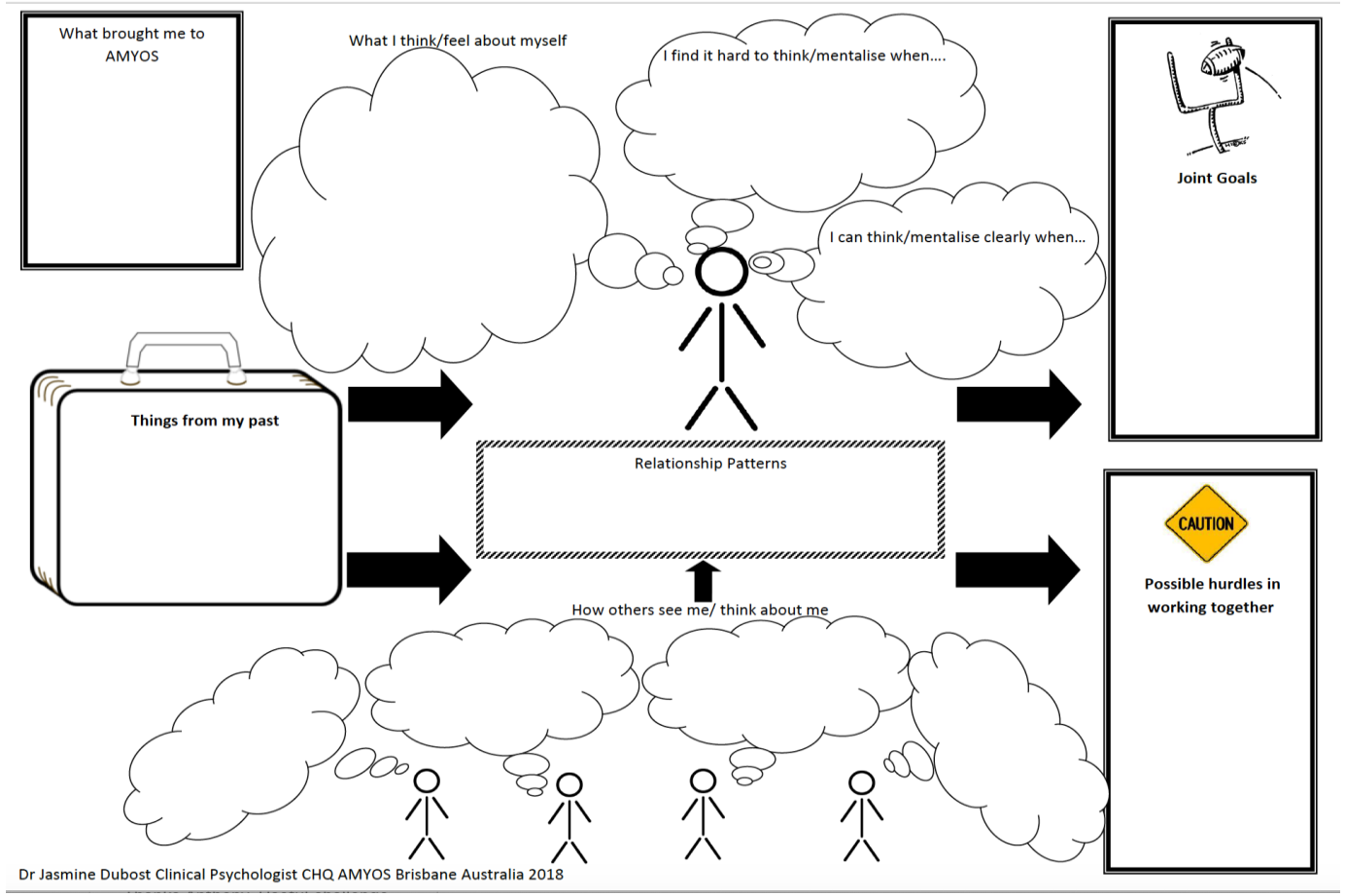
Dave is an exception to this. You see him and can relax. We agreed that we will explore what is different about your relationship with him and other relationships.

Formulation

Treatment

You think that you will come to the group but are naturally anxious that people will not like you. Your tendency will be to avoid this and even not come to the group.

We will explain this to the group when you start.


What brought me to AMYOS
What I think/feel about myself
I find it hard to think/mentalise when....
I can think/mentalise clearly when...
Joint Goals
Things from my past
Relationship Patterns
CAUTION
Possible hurdles in working together
How others see me/ think about me
Dr Jasmine Dubost Clinical Psychologist CHQ AMYOS Brisbane Australia 2018

Story formulation (for a child)

Once there was a little turtle. When he hatched he raced down the beach, excited to get into the water. He thought the waves would treat him gently, but instead they threw him about. He had to hide in his shell because every time he came out, the waves would throw him about again. When he hid, he felt safe. He wished the bigger turtles would protect him and help him to swim better, but they often left him on his own, which he felt sad about. He moved between different turtle families, but none of them helped him learn to swim. And because he hid so often, none of the other sea creatures knew that he struggled so much. The poor turtle learned to survive on his own in his shell.

MBT-Introduction (MBT-I)
Psychoeducation for BPD

Manual available in Practical Guide

Handouts:

- http://www.annafreud.org/training-research/mentalization-based-treatment-training/mbt-i-leaflets/

MBT-I Structure

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

Explicit Mentalizing Group

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

Introductory part of 1st session

- Introductions
- Details of group times, duration, structure etc
- Rules of group (eg confidentiality, alcohol)
- Information sheet provided
- Topics
  - Personality structure
  - Emotions, cognitions, behaviours
  - The interpersonal realm

Structure of each session

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

12 Structured Sessions

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

12 Structured Sessions

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

Therapist stance

Not-knowing

Curiosity around mental states

(2) Not Knowing Stance

Core Domain

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 – open questions, reflective questions - ‘what is it like’; ‘what would make a difference’,’how did you manage that?’
  - Eschew your need to understand – do not feel under obligation to understand the non-understandable.

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

Mentalizing process

- Not directly concerned with content/narrative but with helping the patient ➔

Generate multiple perspectives ➔ to free himself up from being stuck in the “reality” of one view (primary representations and psychic equivalence) ➔ to experience an array of mental states (secondary representations) and ➔ to recognize them as such (meta-representation)

Basic Mentalizing: Process

(3) Mentalizing Process

Major Component Domain

Contrary moves / basic mentalizing (diachrony) / elaboration of narrative / empathic validation

Interventions:
Basic Mentalizing

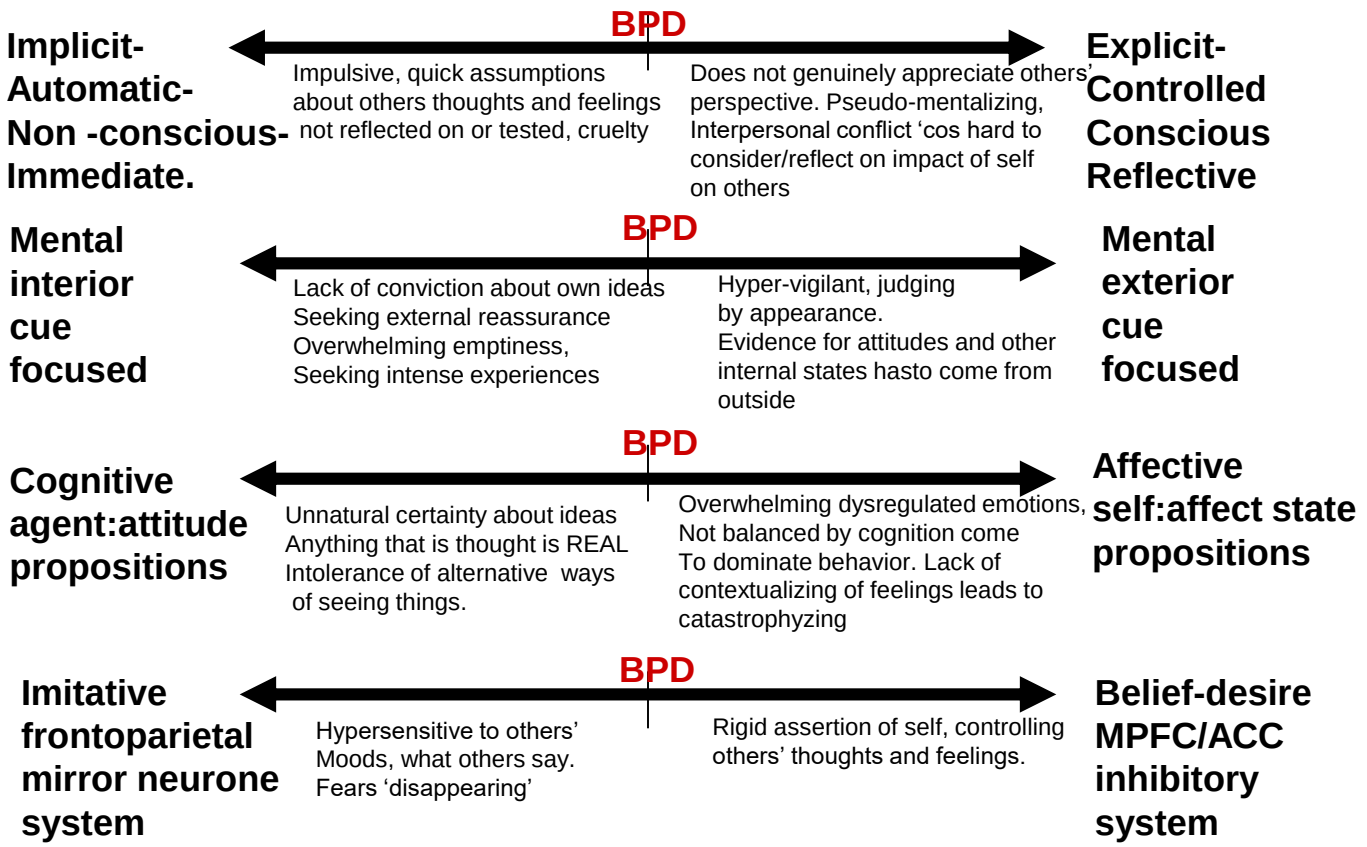
- ‘**Stop, Listen, Look**’
  - During a typical non-mentalizing story
    - stop and investigate
    - Let the interaction slowly unfold – control it/microslice
    - highlight who feels what
    - Identify how each aspect is understood from multiple perspectives
    - Challenge reactive “fillers”
    - Identify how messages feel and are understood, what reactions occur
- **When patient able to mentalize to some degree**
  - What do you think it feels like for X?
  - Can you explain why he did that?
  - Can you think of other ways you might be able to help her really understand what you feel like?
  - How do you explain her distress/overdose
  - If someone else was in that position what would you tell them to do

Interventions:
Basic Mentalizing

- **Stop, Re-wind, Explore**
  - Lets go back and see what happened just then. At first you/I seemed to understand what was going on but then…
  - Lets try to trace exactly how that came about
  - Hang-on, before we move off lets just re-wind and see if we can understand something in all this.
- **Labeling with qualification (beware)** (“I wonder if…” statements)
  - Explore manifest feeling but identify consequential experience – You say you are anxious with others so I wonder if that leaves you feeling a bit left out?
  - ‘I wonder if you are not sure if it’s OK to show your feelings to other people?’

Imbalance of mentalization generates problems

Fonagy, P., & Luyten, P. (2009). *Development and Psychopathology, 21*, 1355-1381.



Theory to Practice: Contrary Moves

Patient/Therapist	Therapist/Patient
External focus	Internal focus
Self- reflection	Other reflection
Emotional distance	Emotional closeness
Cognitive	Affective
Explicit	Implicit
Certainty	Doubt

Process of Rewind and Exploration

- Draw attention to disjunction in topic/dialogue/ tone
  - Let's go back to see what happened just then.
  - At first you seemed to understand what was going on but then…
  - Lets try to trace exactly how that came about
  - Hang on, before we move off, let's just rewind and see if we can understand something in all this.
  - Oh I thought we were talking about your child and now you are suddenly on the gearbox in your car? What happened there to make such a jump?

Beware of anti-process statements!

- What you really feel is…
- I think what you are really telling me is …..
- It strikes me that what you are really saying…
- I think your expectations of this situation are distorted
- What you mean is…

Summary

Process	Intervention
‘Stop, Listen, Look’	Empathy
Stop, Re-wind, Explore	Clarification
Contrary Moves	Exploration
Manage anxiety	Challenge
Affect and Interpersonal regulation in session	Affect identification
	Affect Focus
	Interpersonal

Empathic Validation:

Underpinning mentalizing process

Empathic Validation – Affect and Effect

- Interest in and Reflection on **Affect**
- Identification of feelings
- Normalising when possible in context of present and past
- Seeing it through their eyes
- What **effect** does this experience have on them

Empathic Validation – micro-skills

- Empathic Validation
  - Reflect narrative
  - Recognise and identify the emotion
  - Demonstrate intensity of affect
  - Consequences it has in behavioural and mental terms - the effects.

Empathic Validation - examples

E.g., “I’m asking you to name a feeling that you haven’t got a word for at the moment. You’re doing your best, trying hard, but coming up short, which is embarrassing. And it seems I’m missing that, which is then creating the experience that you’re inferior to me and that I’m rubbing your nose in that, so that it seems like shutting down is the only option left.

E.g. 2, “You’re trying very hard not to do what you usually do, keeping things to yourself. There’s a sense of achievement in that. But then seeing me look at my watch gives you the impression that that I’m bored with you, as though I don’t see or value your effort, and you have to yell at me and force me to take you seriously.”

The most useful empathic validations are those that demonstrate you understand not just how the patient is feeling, but also the present impact and consequence of feeling this way.

Note: The measure of an effective intervention is that it results in a strengthening of the therapeutic alliance

Ineffective mentalizing and low level of mentalizing

(4) Addressing Non-Mentalizing Modes

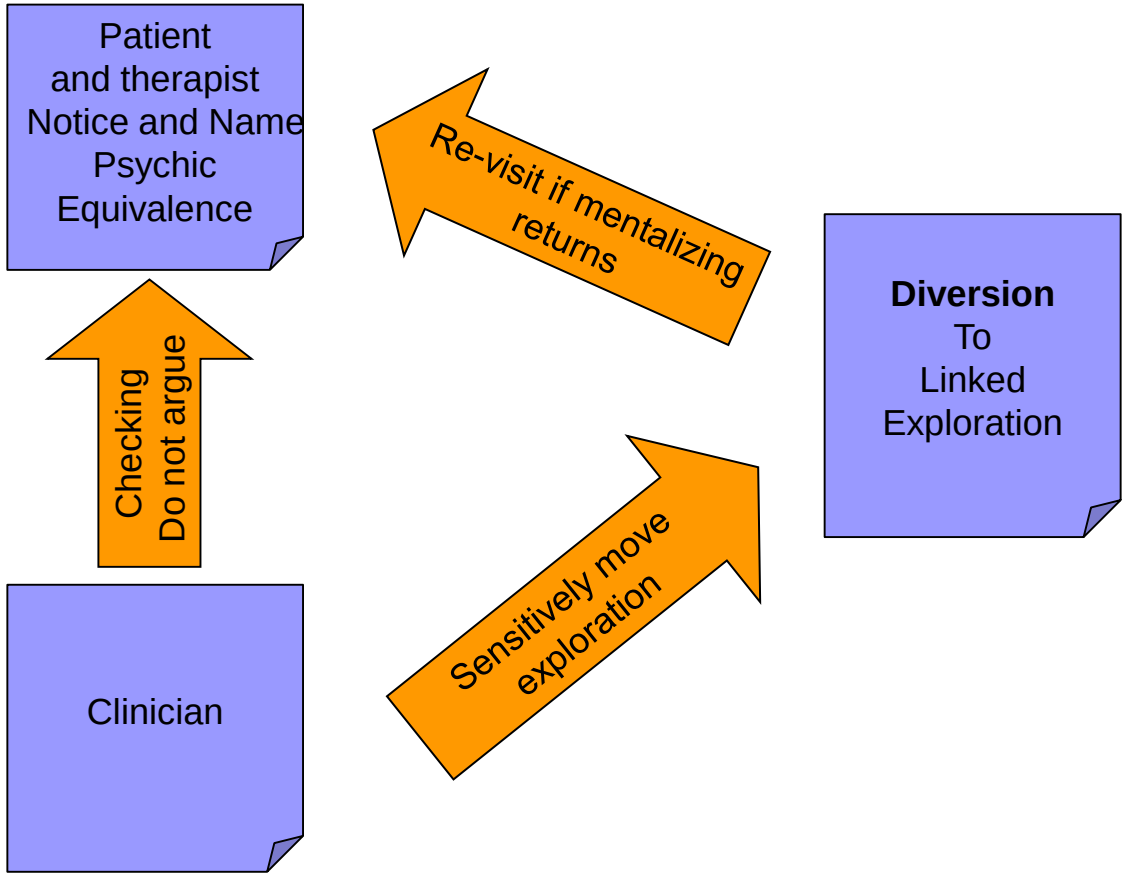
Major Component Domain

Use and Misuse of Mentalizing / Psychic Equivalence / Teleology / Pretend Mode

Modes of non-mentalizing

PSYCHIC EQUIVALENCE	
Clinical form	Certainty/suspension of doubt Absolute Reality defined by self-experience Finality – It just is. Internal = external
Therapist experience	Puzzled Wish to refute Statement appears logical but obviously over-generalised Not sure what to say Angry or fed up and hopeless
Intervention	Empathic Validation with subjective experience Curious – how did you reach that conclusion Presentation of clinician puzzlement (marked) Linked topic (diversion) to trigger mentalizing then return to psychic equivalent area
Iatrogenic	Argue with patient Excessive focus on content Cognitive challenge

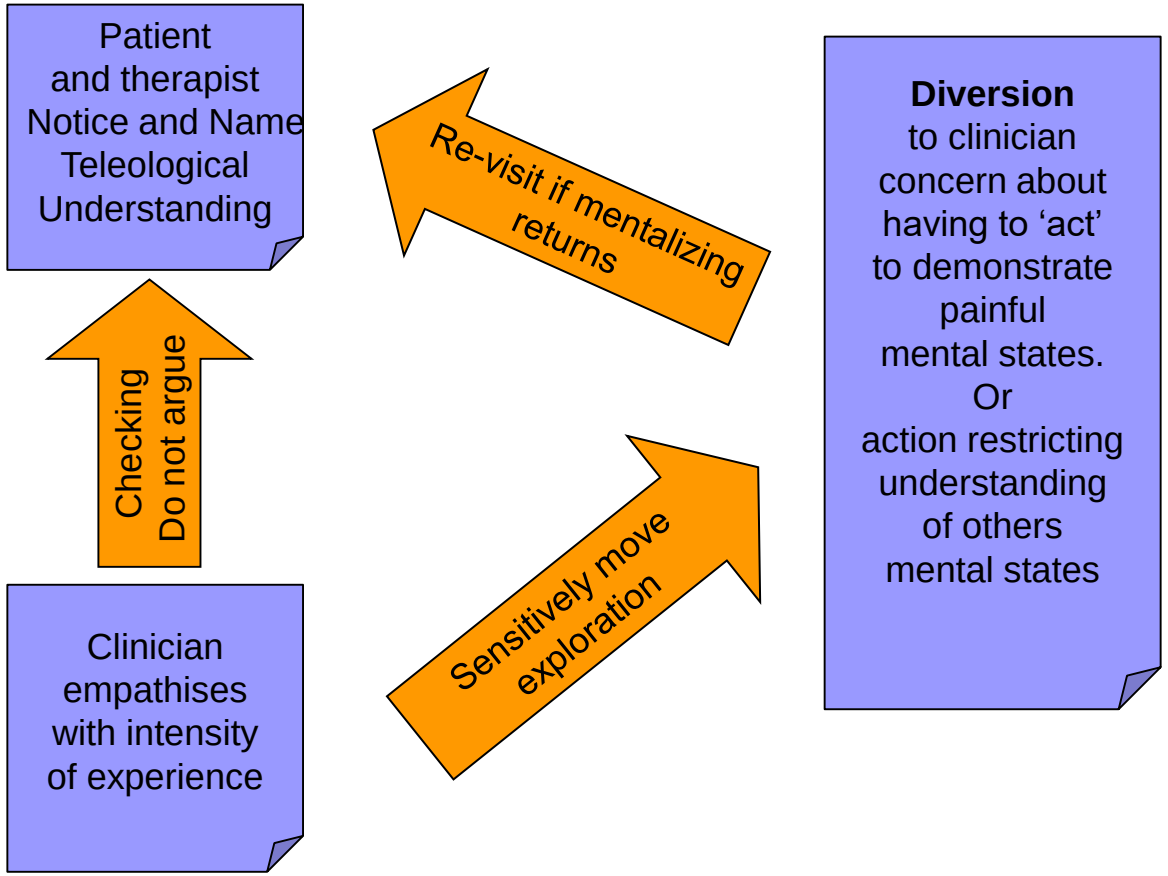
The MBT Loop


Patient
and therapist
Notice and Name
Psychic
Equivalence
Re-visit if mentalizing returns
Diversion
To
Linked
Exploration
Checking
Do not argue
Sensitively move exploration
Clinician

Modes of non-mentalizing

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

The MBT Loop


Patient
and therapist
Notice and Name
Teleological
Understanding
Re-visit if mentalizing returns
Diversion
to clinician
concern about
having to 'act'
to demonstrate
painful
mental states.
Or
action restricting
understanding
of others
mental states
Checking
Do not argue
Sensitively move
exploration
Clinician
empathises
with intensity
of experience

Modes of non-mentalizing

PRETEND MODE	
Clinical form	Inconsequential talk/groundless inferences on mental states Lack of affect. Absence of pleasure Circularity without conclusion – spinning in sand (hypermentalizing) No change Dissociation – self harm to avoid meaninglessness Body-Mind decoupled
Therapist experience	Boredom Detachment Patient agrees with your concepts and ideas Identification with your model Feels progress is made in therapy
Intervention	Probe extent. Current in-session focus Counter-intuitive Challenge
Iatrogenic	Non-recognition Joining it with acceptance as real Insight orientated/skill acquisition intervention

Challenge

A technique for pretend mode

CHALLENGE: A *Technique for Pretend Mode*

Challenge - strategies

- Counter-intuitive statements – low level
- Therapist emotional expression to re-balance patient emotional expression – moderate level
- Mischievous or Whacky comments – high level

Low level challenge for fluctuating pretend mode

- Persistent small challenge in the dialogue
  - Sensitive humour – closest point of two mind states
  - Counter-intuitive remarks
  - Opposites
  - Over or under emphasis in reaction
  - Moderate skepticism

Clarification and Exploration of Affect

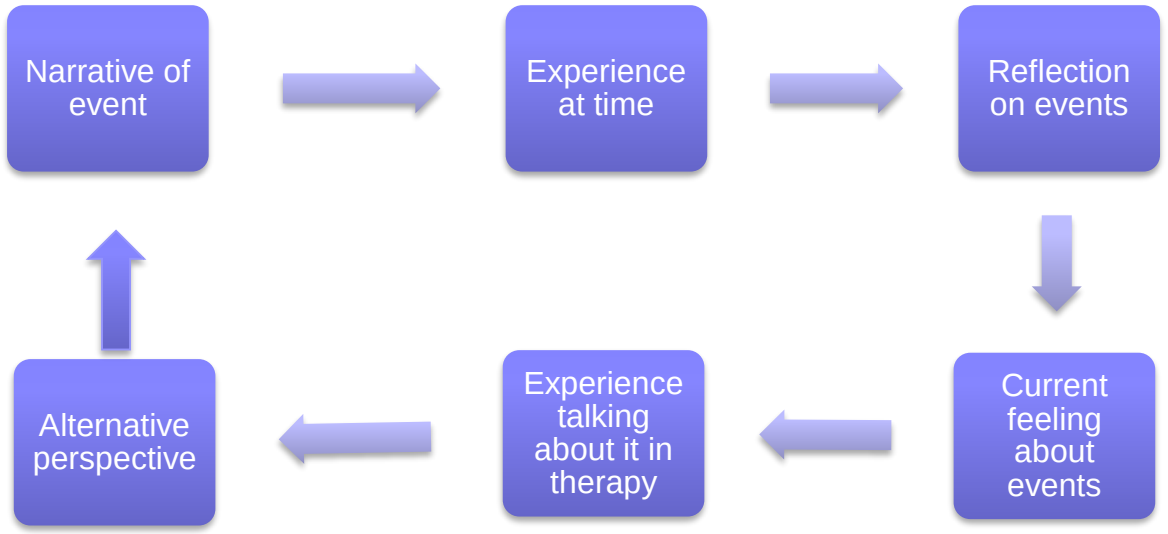
Clarification and Exploration of Affect

(5) Mentalizing the Affective Narrative

Major Component Domain

Affect trajectory / Affect Clarification – Elaboration – Exploration – Focus

Mentalizing Process – affect trajectory



Intervention:
Clarification & Affect elaboration

- Clarification is the ‘tidying up’ of behaviour which has resulted from a failure of mentalization
- Establish important ‘facts’ from patient perspective
- Re-construct the events
- Make behaviour explicit– extensive detail of actions
- Avoid mentalizing the behaviours at this point – only begin promoting mentalizing once facts available
- Trace action to feeling
- Seek indicators of lack of reading of minds

Affect elaboration

- Normalise when possible – ‘given your experience it is not surprising that you feel X’
- Identify, name and give context to emotion - labelling
- Explore absence of motivating emotions – relentless negativity is wearing to others
- Identify mixed emotional states

Intervention:
Clarification & Affect elaboration

- **Labelling feelings**
  - During non-mentalizing interaction therapist firmly tries to elicit feelings states
  - Therapist recognises mixed emotions– probe for other feelings than first, particularly if first emotion is unlikely to provoke sympathy in others or lead to rejection (e.g. frustration, or anger) c.f. basic and social emotions
  - Reflect on what it must be like to feel like that in that situation –' if that was me I would feel X'
  - Try to learn from individual what would need to happen to allow them to feel differently
  - How would you need others to *think about you*, to feel differently?

Affect and significant/interpersonal events

Process of Exploration of significant interpersonal event

During a typical non-mentalizing interaction in a group or individual session

- Stop and investigate
- Let the interaction slowly unfold – control it
- Highlight who feels what
- Identify how each aspect is understood from multiple perspectives
- Challenge reactive “fillers”
- Identify how messages feel and are understood, what reactions occur

Process of Exploration

- If patient not in psychic equivalence:
  - What do you think it feels like for X
  - Can you explain why he did that?
  - Can you think of other ways you might be able to help her really understand what you feel like?
  - How do you explain her distress/overdose
- If someone else was in that position what would you tell them to do

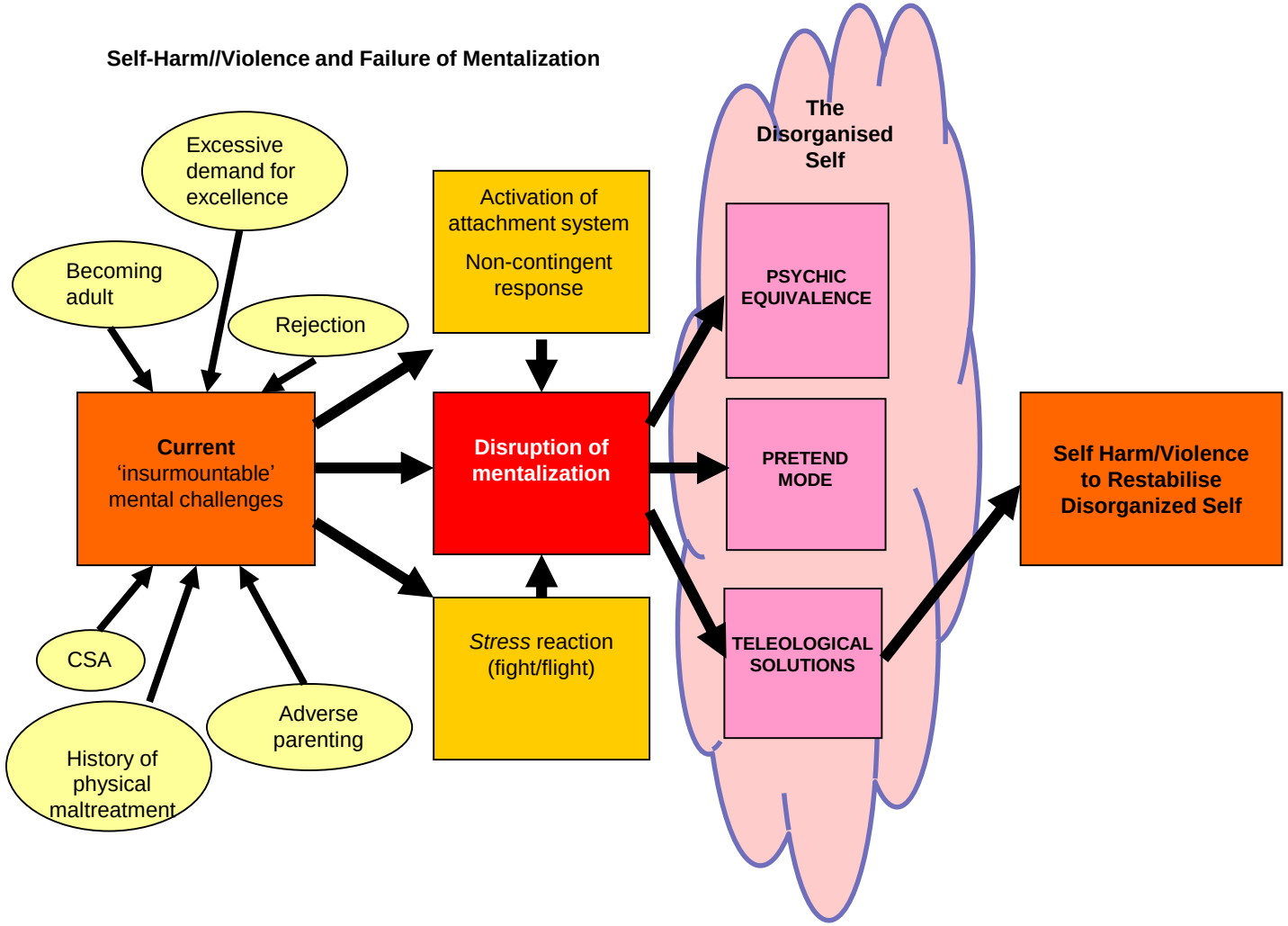
Guidance on intervention for self-harm

Self-harm

- **Function**
  - To re-establish the self-structure following loss of mentalizing
- **Intervention**
  - Explore reasons for destabilisation of self-structure
  - ‘Tell me when you first began to feel anxious that you might do something?’ ➔ Mentalizing functional analysis

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

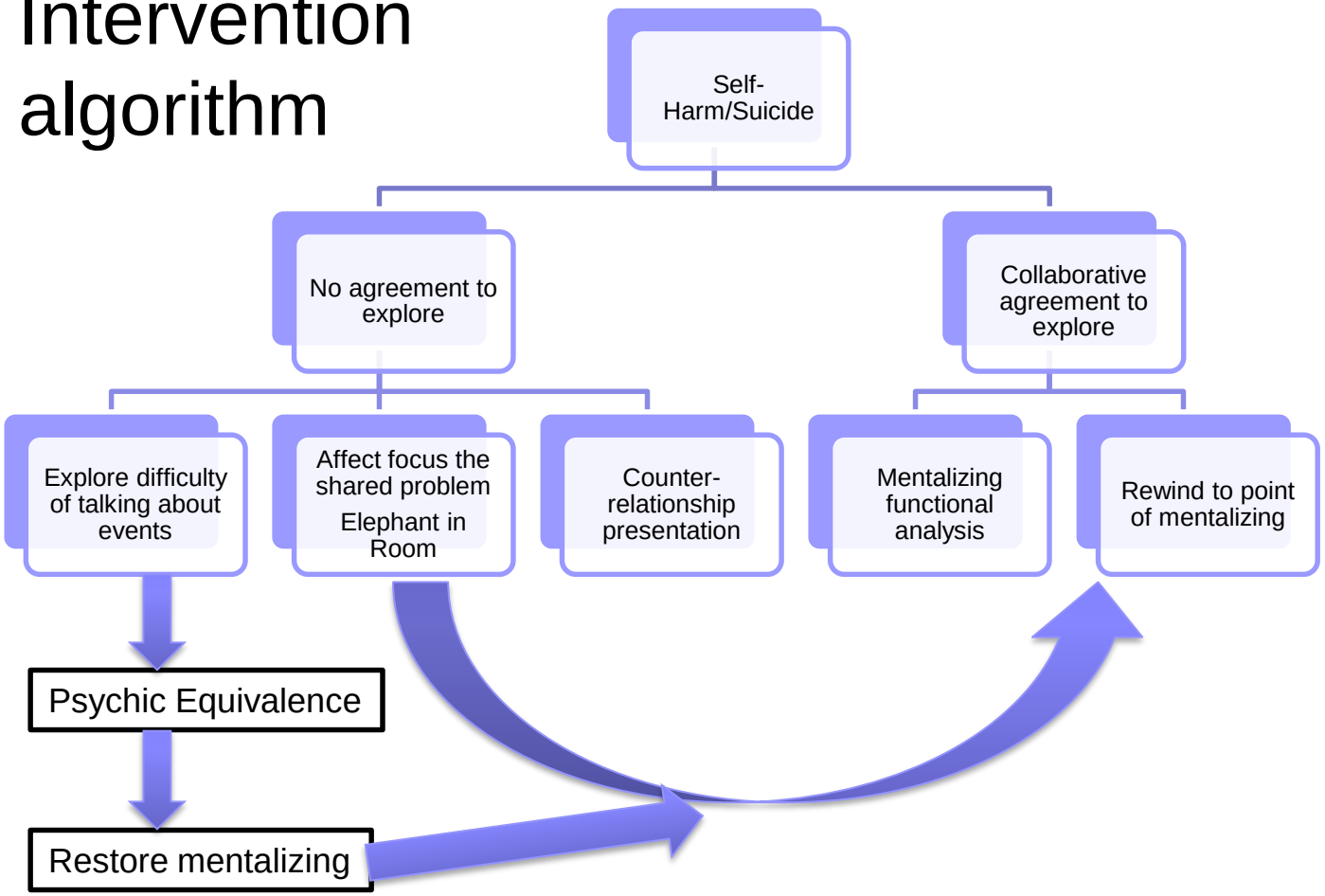
- Loss ➔
  - *Increase attachment needs ➔ triggering of attachment system ➔*
- Failure of mentalization ➔
  - *Psychic equivalence ➔ intensification of unbearable experience ➔*
  - *Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔*
  - *Teleological solutions to crisis of agentive self ➔ suicide attempts, self-cutting*


Self-Harm//Violence and Failure of Mentalization
Excessive demand for excellence
Becoming adult
Rejection
Activation of attachment system
Non-contingent response
Current 'insurmountable' mental challenges
Disruption of mentalization
Stress reaction (fight/flight)
CSA
History of physical maltreatment
Adverse parenting
The Disorganised Self
PSYCHIC EQUIVALENCE
PRETEND MODE
TELEOLOGICAL SOLUTIONS
Self Harm/Violence to Restabilise Disorganized Self

Step-wise Intervention

- Contingent response = empathic validation with current state
- Establish joint reflection on suicide/self-harm/violence
- Affect focus if no joint reflection – presentation of shared dilemma
- Identify moment of ‘loss’, attachment trigger and context
- Work towards recognition/awareness of vulnerability points and context representation

Intervention algorithm



Mentalizing Functional Analysis

- Seek point of vulnerability
- Stop and Rewind to point before mentalizing was lost
- Stop and Explore a point when mentalizing was taking place
- Micro-slice mental states towards the self destructive act
- Continually move around self and other mental states
- Place responsibility for keeping mind on-line back with the patient
- Ask patient to identify when she could have possibly re-established self-control

Mentalizing Functional Analysis

- Empathy validation and support ➔ collaborative stance
  - You must not have known what to do?
- Define interpersonal context
  - Detailed account of days or hours leading up to self-harm with emphasis on mental/feeling states
  - Moment to moment exploration of actual episode
  - Explore communication problems
  - Identify misunderstandings or over-sensitivity
- Identify affect
  - Explore the affective changes since the previous individual session linking them with events within treatment
  - Review any acts thoroughly in a number of contexts including individual and group therapy – how could treatment focus better to prevent this action again? What can we do better?

Mentalizing Functional Analysis

- Explore conscious motive
  - How do you understand what happened?
  - Who was there at the time or who were you thinking about?
  - What did you make of what they said?
  - Challenge the perspective that the patient provides if therapeutic alliance is robust
- DO NOT
  - mentalize the relationship in the immediacy of a suicide attempt or self-harm
  - Interpret the patient’s actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the ‘heat’ of the moment. It will alienate the patient.

Affect

and

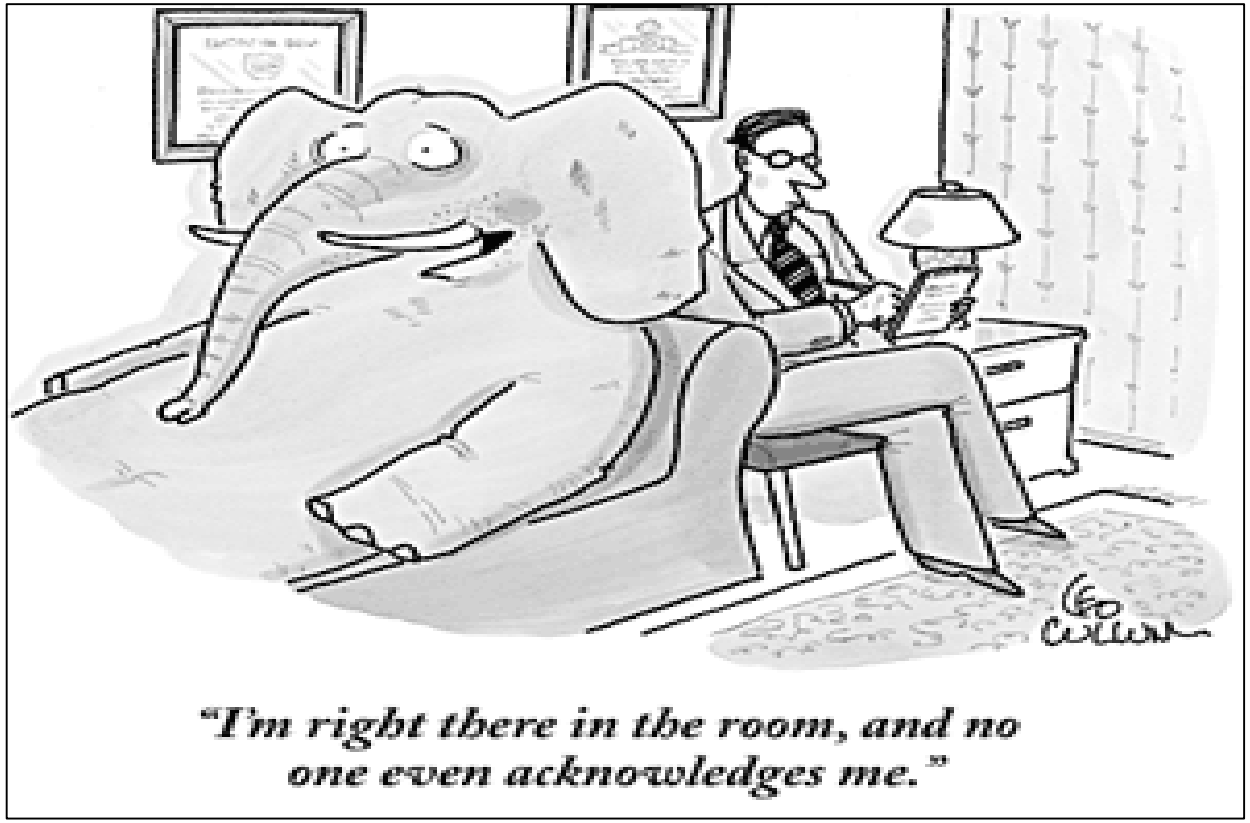
implicit sessional interaction:

Differentiating the dominant and sub-dominant theme

Affect Focus: Making implicit mentalizing explicit

- Not the affect associated with the story or event
- Patient may have different affect related to story
- Affect focus is current affect as experienced in the telling of the story
- Make explicit if important in interpersonal terms in patient/clinician relationship
- Naturally moves towards mentalizing the relationship

Elephant in the room



"I'm right there in the room, and no one even acknowledges me."

Current affective interpersonal experience = affect focus = Sub-dominant theme

- Work on sub-dominant themes
- Define the current affective state **shared** between patient and therapist
- Do this tentatively from your own perspective
- Do not attribute it to the patient’s experience
- Link the current affective state to therapeutic work within the session itself

Relational Mentalizing

(5) Relational Mentalizing

Major Component Domain

Challenge / Relational Mentalizing / Transference markers / Intervention Algorithm for self-harm / Mentalizing Functional Analysis

Challenge

A precursor of relational mentalizing

Challenge and relational process

- Aim
  - Clinician precipitately present in session – from absent to present
  - Bring non-mentalizing to an abrupt halt even if only momentarily
- Process
  - Use relational alliance
  - Surprise the patient's mind; trip their mind back to a more reflective process
  - Grasp the moment – stop and stand - if they seem to respond
  - Stick with it.

Challenge - indicators

- Clinician
  - Not in room
  - Pretend Mode
  - Inadequate progress in treatment
- Patient
  - Pretend mode
  - Persistent non-mentalizing especially in high risk contexts
  - Fixed position in one or more dimensions of mentalizing
  - Inadequate progress in treatment

Challenge – high level

- Characteristics
  - Infused with compassion
  - Non-judgemental
  - Unheralded, left-field, surprise
  - Outside the normal therapy dialogue but within the frame of professional treatment
  - Targets affect using empathic validation more often than cognition
  - Use humour when possible

Relational mentalizing

Interventions:
Relational Mentalizing

- **Reasons for working in the Transference/Relationship**
  - Poor long term outcome
    - Spontaneous improvements (recovery)
    - Relationship problems and life goals
  - Attachment as the root to personality disorder
    - Nature of disorganized attachment
    - Avoidance as long term outcome
  - Thinking about relationships: Internal working model
    - Self
    - Object
    - Affect

Therapist Stance

- **Reflective enactment**
  - Therapist's occasional enactment is acceptable concomitant of therapeutic alliance
  - Own up to enactment to rewind and explore
  - Check-out understanding
  - Joint responsibility to understand over-determined enactments

Interventions:
Relational Mentalizing

- **Transference tracers – always current**
  - Linking statements and generalization
    - ‘That seems to be the same as before and it may be that..
    - ‘So often when something like this happens you begin to feel desperate and that they don’t like you’
  - Identifying patterns
    - It seems that whenever you feel hurt you hit out or shout at people and that gets you into trouble. May be we need to consider what happens.
  - Making transference hints
    - I can see that it might happen here if you feel that something I say is hurtful
  - Indicating relevance to therapy
    - That might interfere with us working together

Components of mentalizing the therapeutic relationship

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist's own distortions)
- Collaboration in arriving at an understanding
- Present an alternative/additional perspective
- Monitor the patient's reaction
- Explore the patient's reaction to the new understanding

Interventions:
Mentalizing the relationship

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

Counter-relational mentalizing

Components of mentalizing the counter-relationship

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.

Components of mentalizing the counter-relationship

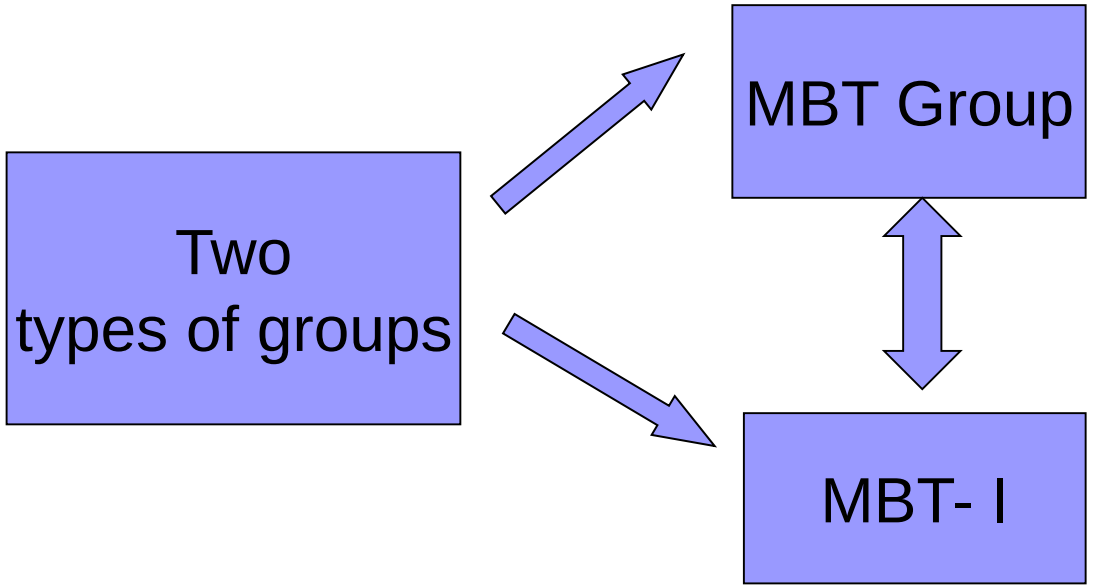
- Anticipation of response/reaction of patient
- Mark your statement
- Do not attribute what you experience to the patient
- Keep in mind your aim
  - Re-instate your own mentalizing
  - Identify important emotional interaction that affects therapy relationship
  - Emphasise that minds influence minds

Typical Counter-relationship emotions

- Pretend mode
  - Boredom, temptation to say something trivial
  - Sounding like being on autopilot, tempting to go along
  - Lack of appropriate affect modulation (feeling flat, rigid, no contact,)
- Teleological
  - Anxiety
  - Wish to DO something (lists, coping strategies)
- Psychic equivalence
  - Puzzlement, confused, unclear, excessive nodding
  - Not sure what to say, just going
  - Anger with the patient

Mentalizing and Group Psychotherapy

Mentalizing and Groups



MBT Group

Why a change in emphasis in groups for severe PD?

- Poor research evidence behind the Foulkesian claim that groups with severe personality disorders can develop productive group culture by the help of a minimally engaged group therapist.
- Literature is full of anecdotes of chaotic situations with borderline and narcissistic patients
- Dropout rates are high
  - most often explained by the patients as painful negative affect states being activated, but not being resolved, by the group (Hummelen et al., 2006).
- Tendency to underestimate the mentalizing deficits of borderline patients and to expose them to group situations far beyond their capacity.

MBT Group

- *Primary task of the group is to provide a training ground for mentalization*
- Based on fusion of group process and interpersonal therapy groups
- Interpersonally directed by clinician
- Clinician maintains authority of group process

Differences from other interpersonal focus groups?

- No interpretations made about unconscious processes
- Group matrix is not a feature of MBT-G
- Refrain from making interpretations ‘about the group’
- Therapist = active participant adopting a not knowing, non-expert stance
- Encourage group culture of relational curiosity rather than suggesting complex relational hypotheses
- Therapist makes own thinking explicit, transparent and understandable
- Therapy relies on active therapist maintaining flow and structure of session rather than adopting position secondary to group process

Mentalizing Group:

Structure

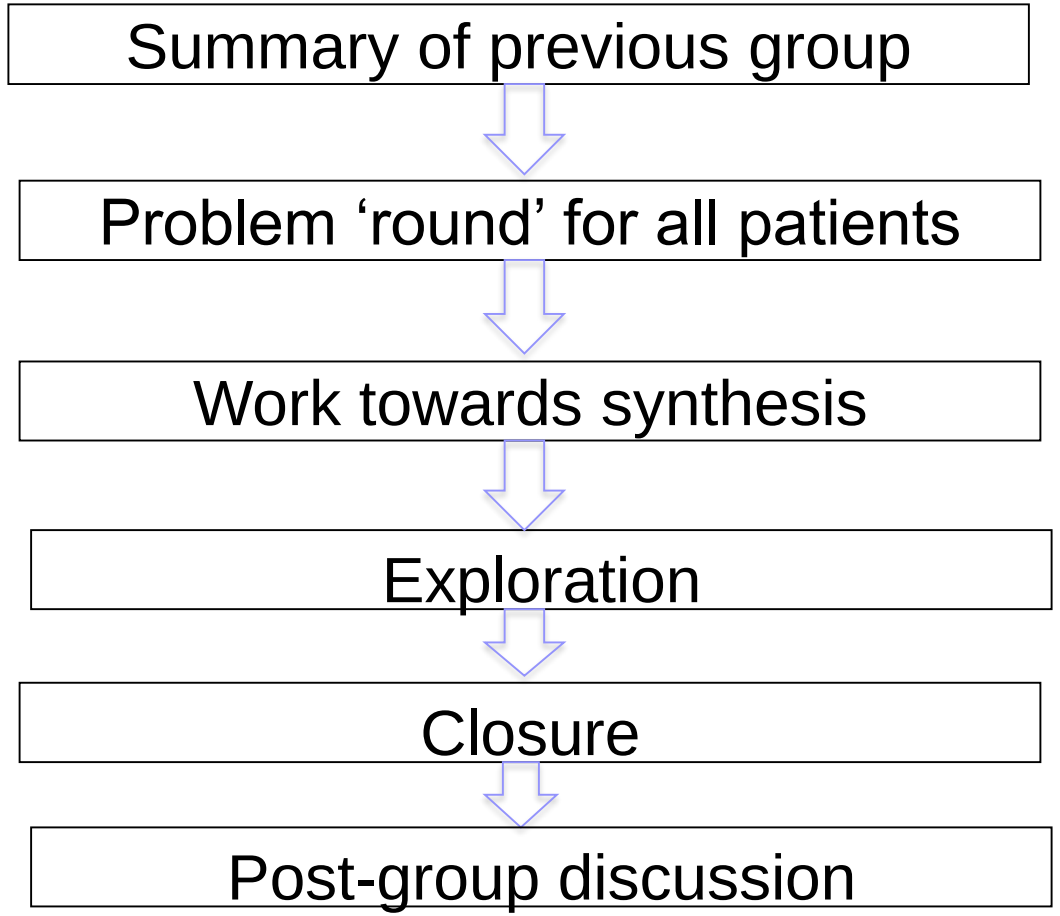
Developing a relational passport: preparation for group

- Psychoeducation
- Explore relational vulnerability from past relationships
- Identify core self and other representations
  - Avatar development between patient and therapist – past and present
- Map attachment strategies in relationships
  - Anticipate unfolding in treatment
- Rehearse prior to group explaining content of relational passport

Format of MBT-G

- Slow open group
- 1-2 clinicians
- 75 minutes
- 6-8 patients
- Agree principles including ‘extra-group’ activity
  - Attendance
  - Drugs and alcohol
  - Attitude
  - Focus
  - Re-iteration at times of MBT-I information
  - Principle of ‘No Advice Given’ –Explain carefully!

Trajectory of Group Session



Problem Round

- Establish individual problems to be discussed
- Ask each patient in turn
  - Explore briefly the core of their problem
  - Collaboratively agree the focus
  - If no problem return to them at the end of the round
  - Suggest a problem for dicussion if clinician is aware of difficulties not resolved in the group

Synthesis

- Specific personal problem to general shared problem e.g. boyfriend problem to relational
- Maximum of 2 themes e.g. being excluded and alone; sensitivity and rejection
- Identify common elements between patients
- Patients describing problem become the main protagonists for the discussion.

Summary of previous group

- Developed by clinicians in post-group discussion
- Develop culture of patient contribution
- Includes examples of successful mentalizing
- Identifies self-other mentalizing problems
- Maintains over-arching themes

Mentalizing Group

Clinical stance and managing process

MBT-G: Clinician Authority

- Authority without being authoritarian
- Therapist openly and repeatedly explains the primary task of the group
- Maintains structure and states group principles
- Active and participating clinician stance
- Praise the group by acclaiming mentalizing when it happens
- Maintain focus and pace the group

MBT-G: Clinician Stance

- Maintain clinician mentalizing
- Maintain focus and do not allow persistent non-mentalizing dialogue
- Monitor arousal levels and non-mentalizing modes, beware hypermentalizing
- Work in current mental reality when possible
- Model mentalizing

Mentalizing Group: Generic techniques

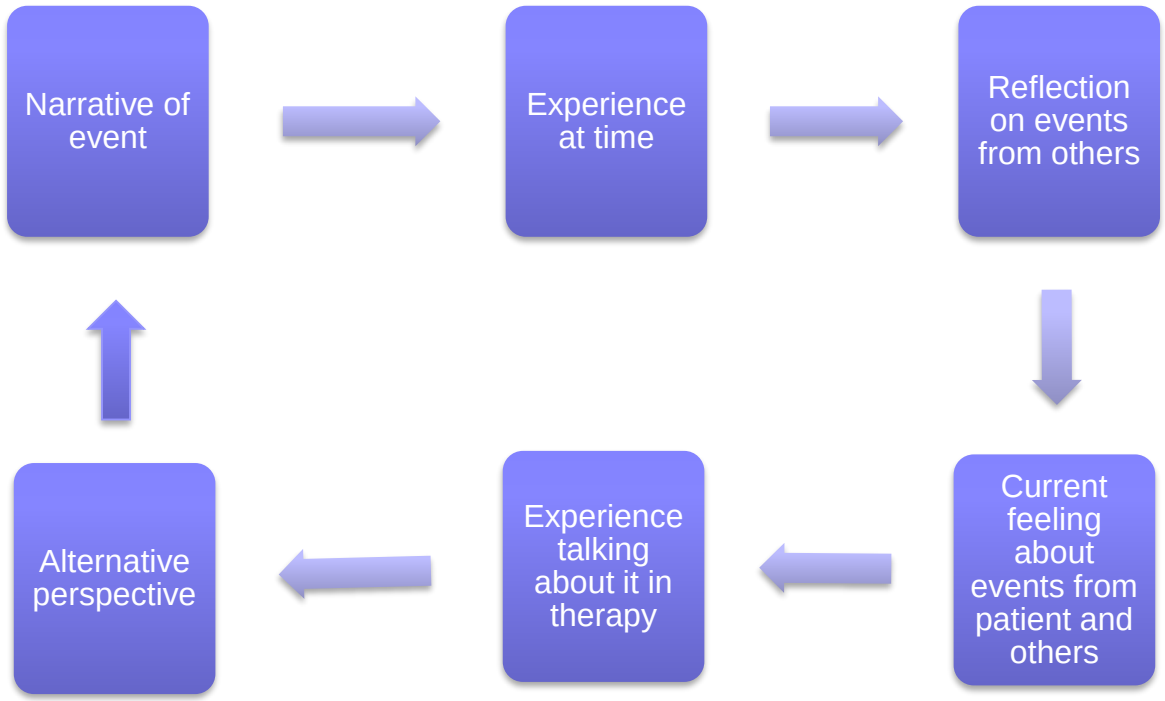
Facilitating epistemic trust in group

- **A**uthentic clinician curiosity
- **C**ulture of enquiry about mental states
- **E**xploration of stories
- Clarification of problems
- Mentalizing the detail of the problem
- Mentalizing interpersonal process in group
- Identification of relational patterns
- Mentalizing relationships in group

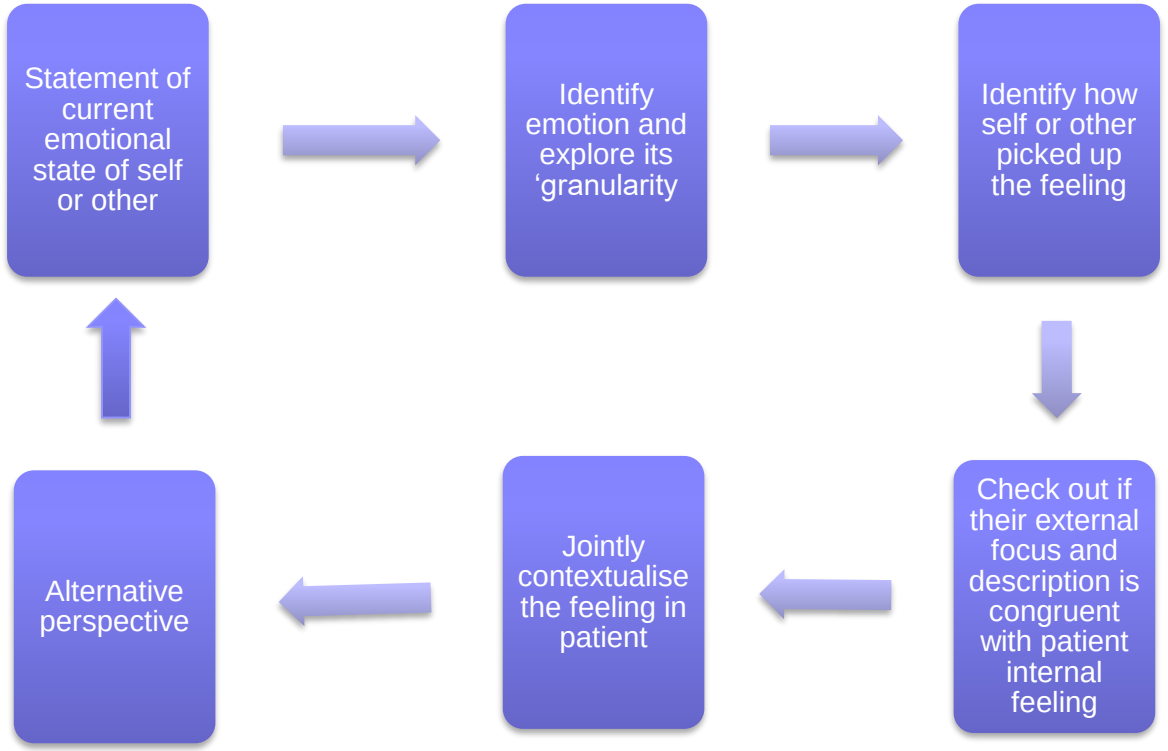
Identification of relational patterns

- Open sharing by all patients of relational aspects of initial formulation
- Focus on attachment processes in group during individual sessions
- Identify and define relational pattern in ‘stories’ given by patient
- Work to delineate benefits and drawbacks of pattern

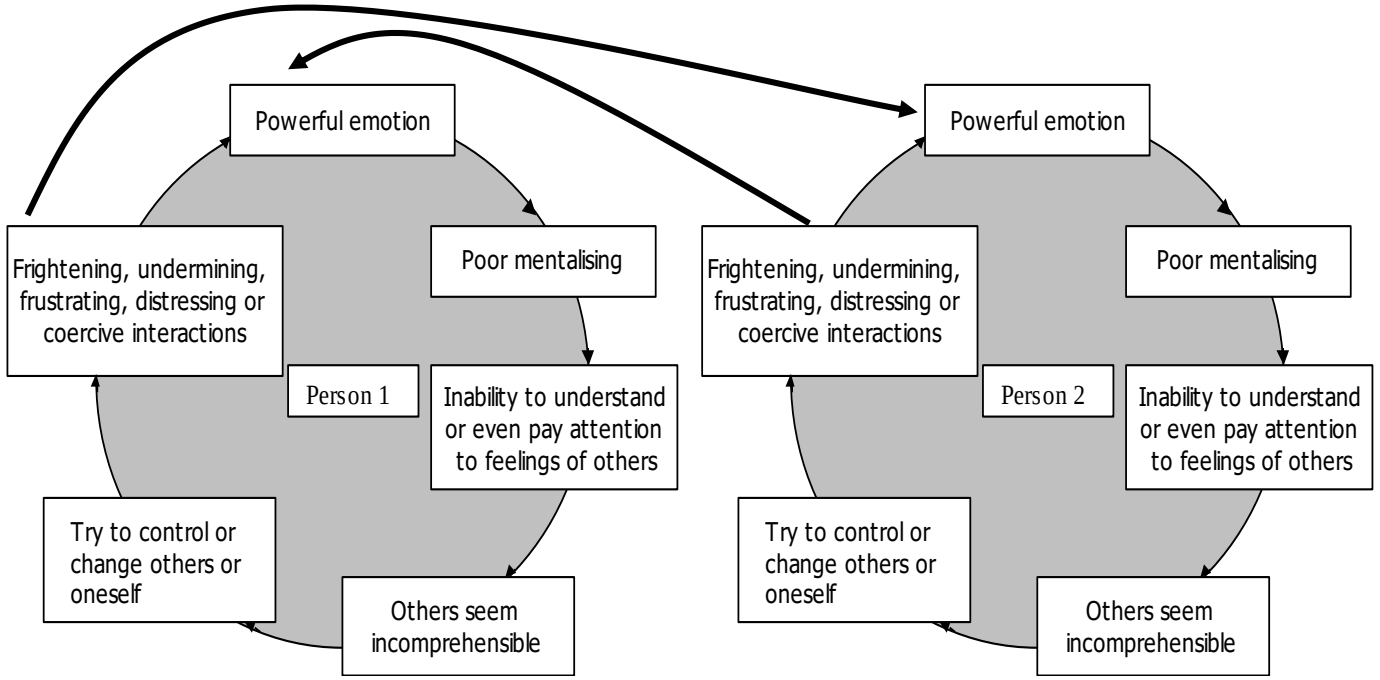
Mentalizing interaction and significant events



Mentalizing interaction and affect



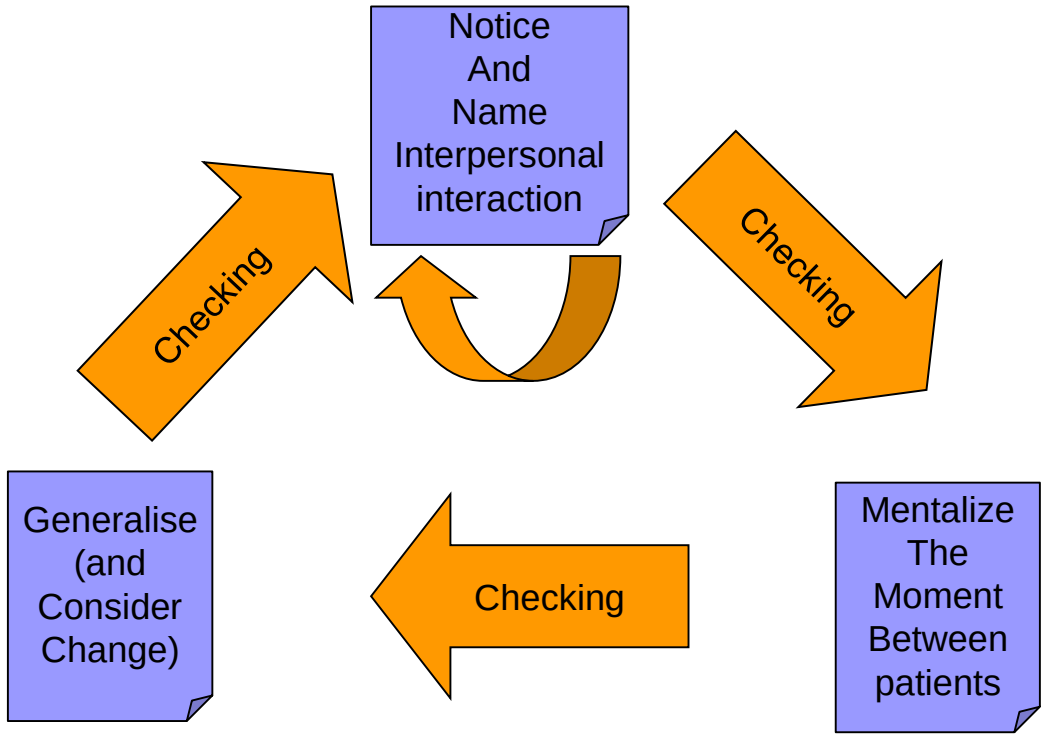
Vicious Cycles of Non- Mentalizing Within a Dysfunctional Interaction – the MBT Group



The

MBT Loop

The MBT Loop


Notice And Name Interpersonal interaction
Checking
Checking
Mentalize The Moment Between patients
Checking
Generalise (and Consider Change)

Clarification of problem

- Identify the problems within the story
- Stimulate alternative perspectives from patients
- Facilitate discussion of managing mental states as the problem

Noticing and naming: exploration of stories

- Encourage patients to articulate explicitly what would otherwise be privately ascertained/assumed about mental states of others
- Support patients to make explicit their working through of story (detail) so that rest of group (clinician and patients) can identify when mentalizing and non-mentalizing has occurred

Mentalizing the moment

- Encourage patient to be aware of what they are thinking and feeling as they tell a story
- Ask other patients to consider the thinking and feeling of themselves and the narrator
- Suggest patients consider why they/others think/feel as they do in the story
  - I heard X saying that he is angry, but I think he is hurt about not being taken seriously
  - What am I feeling, what are they feeling, and why?

Mentalizing the moment: exploration of stories

- Generate a group culture of enquiry about motivations of people in story
- Insist that patients consider others' perspectives and work to understand someone else's point of view
- Therapist should directly express own feelings about something that he believes is interfering with understanding of story

Cautions

- Easy to become trapped in individual therapy in the group
- Excessive use of clinician mentalizing to make sense of story and to assume understanding of problem
- Hypermentalizing and rapid interaction about problem masquerade as interpersonal process
- Beware of defining problem based in physical reality and development of teleological solutions

Mentalizing Group: Specific techniques

Triangulation

- Therapist identifies important interaction between participants
- Notes the observer(s)
- Separates the protagonists
- Actively explores the observer(s) own experience of the interaction (talk about self) or about his/her thoughts about the observed interaction (talk about others).

Parking

- Clinician notes that a patient is unable to maintain attentional control
- Identify the experience of the patient rather than the content of the problem
- Actively help the patient focus on a sub-dominant theme
- Keep a lid on the dominant desire by letting off momentary steam
- Don’t forget you have parked a patient – you may have to pause the group if the patient becomes excessively anxious.

Siding

- Clinician notes that a patient is vulnerable to other patients actions/comments/focus
- Actively take the side of the vulnerable patient
- Other clinician (if present) takes position of antagonist
- Support the vulnerable patient until mentalizing is rekindled in the group
- Switch sides if necessary when the vulnerable patient is more stable

RFQ web address

- https://www.ucl.ac.uk/psychoanalysis/research/rfq

Thank you for mentalizing!

For further information
anthony.bateman@ucl.ac.uk

Slides available at:
https://www.ucl.ac.uk/psychoanalysis/people/bateman

Additional slides

Suggested exercises

and

Further information

Workshop Exercises

Role Plays

- **Clinician**
  - Interview as you normally do
  - Don’t try to do anything original!
  - Try to explain to the patient what you are trying to do at some point
  - Observers to help you out whilst monitoring what is a mentalizing intervention and what is not.

- **Patient**
  - Be a moderate and not the extreme person with BPD
  - Respond as you think your patient would
  - Monitor how the clinician makes you feel – misunderstood, secure, s/he is interested, makes you think etc
  - What was it that made you feel like that or altered your mind state?

Large Group Exercise

- A patient calls you to say that he has had enough. He feels that no one cares about him. He doesn't know what to do.
  - Talk to him on the phone
  - Observers to note mentalizing and non-mentalizing statements of therapist

Large group exercise

- A patient in emotional crisis telephones you to say that she feels useless and nothing can be done. Even her boyfriend doesn't answer the phone and she feels something awful is going to happen.

  - Talk to her on the phone for a few minutes
  - Observers to note mentalizing and non-mentalizing statements of therapist

Workshop Exercise

- Patient to talk about incidents in his/her life
- Therapist
  - **Inquisitive stance – not knowing/humility**
  - **Rebalance the mentalizing problem – self to other or other to self**
  - **Empathic Validation**
  - **Explore the incident with curiosity**
  - **Control the process**
  - Focus on the incident
  - Labelling of Affect
  - Therapist to focus patient attention on current situation

Workshop Exercise

- Patient reports that she has got into an argument at work and suspended pending an inquiry.
- Therapist
  - Inquisitive stance
  - Therapist to focus patient attention on current situation
  - Explore the incident
  - Elaborate mental states of protagonists
  - Demonstrate humility - not knowing
  - Monitor for non-mentalizing and try to Intervene to move patient to mentalizing

Workshop Exercise

- Patient does not feel that you understand and think that it would be better to have another therapist.
- Therapist
  - **Empathic position**
  - **Clarification**
  - **Elaboration and affect focus**
  - **Stop and stand if necessary**
  - **Rewind and explore**
  - Work within the current relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.

Workshop Exercise

- Patient has been shouting at staff and/or complains about another member of staff.. Therapist has to address what has been happening.
- Therapist
  - **Empathic validation**
  - **Clarification**
  - **Elaboration and affect focus**
  - **Rewind and Explore**
  - **Stop and stand if necessary**
  - (Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.)

Workshop Exercise to use Basic Mentalizing and mentalizing the relationship

- Patient – Discuss an important relationship and allow the story to unfold when prompted
- Therapists: Basic mentalizing
  - Stop, Look, and Listen and explore important content
  - Stop, rewind, and explore
  - Stop and stand if patient uses non-mentalizing
- Therapist: transference tracers and mentalizing the relationship

Workshop Exercise

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

Workshop exercise

- Patient describes having cut himself and requiring sutures.
- Therapist
  - Identify feelings
  - Develop context
  - Integrate the relationship with you in the discussion if interfering with exploration
  - Aim to re-instate a continuity of self-structure by kick starting mentalizing
  - If unsuccessful work on what you and patient are to do perhaps by identifying an affect focus

Workshop Exercise

- Patient states that they feel you are a bully because you keep making them talk about things they do not want to talk about.
- Therapist
  - Affect focused clarification
  - Elaboration in context of current relationship
  - Work within the relationship
  - Mentalize the relationship

Workshop Exercise

- Patient tells a story about how she was angry and shouted at her 4 year old child. Then she states that she knows that you are appalled by her.
- Therapist
  - Affect focused clarification
  - Elaboration in context of current relationship
  - Work within the relationship
  - Mentalize the relationship