

Mentalization-Based Treatment

Adherence and Competence Scale

This adherence scale was developed in conjunction with the new MBT Manual – Bateman, A. and Fonagy, P. (2016) *Mentalization-Based Treatment for Personality Disorders: A practical guide*. Oxford: Oxford University Press.

Data related to the development of the scale are being published. The scale has been used in recent research trials of MBT. Training is required to become a reliable rater.

The scale is presented here for clinicians and supervisors to use in their clinical work to support learning and clinical skill acquisition. It may be used

- a) as a focus for discussion of sessions;
- b) to decide on clinician adherence to the model;
- c) to identify domains of MBT that are skilfully delivered and those that are not.

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Introduction to the Scale

Summary of Scale – Instructions for Rater

The scale is divided into:

- a) **Not-knowing stance – rated across the session**
- b) **1 meta-domain – ‘sessional structure’ rated across the whole session**
- c) **4 major domains – in session**

The rater initially assesses the not-knowing stance across the session. The core MBT mentalizing stance, the not-knowing stance, transcends all domains.

The rater then scores the meta-domain (Sessional Structure) and the four component major domains.

The final score is a total of the meta-domain score + the major domain scores + the score for the not-knowing stance.

Items/interventions listed within domains are not scored but are used as evidence justifying the domain score. They are noted for **frequency (F) and extensiveness (E)**.

Frequency for the items in each domain is primarily the number of times the clinician engages in that intervention.

Extensiveness relates to range of the work in that domain judged by the number of items rated. The clinician probes, using **a range of the items** associated with the domain. This links to assessment of quality of MBT.

In the domain of the not-knowing stance – a singular attitude rather than itemised – frequency refers to the number of times the rater identifies the stance is being used; extensiveness refers to the extent that the clinician uses the stance when exploration is necessary and maintains the stance even when the patient closes down the dialogue.

Not-Knowing Stance

The use of the not-knowing stance is a core element of MBT. In the adherence scale the not-knowing stance is scored as a domain in itself across the whole session and is used as a major component of assessing whether the model is being delivered.

Is the primary stance of the clinician throughout the session rooted in a not-knowing stance?

Does the clinician move away from the not-knowing stance sensitively when appropriate, e.g. when being asked a reasonable question by the patient?

Can the clinician return to a not-knowing stance when it is lost?

To what extent does the clinician maintain the not-knowing stance over the whole session?

The clinician's mentalizing therapeutic stance includes: (a) humility deriving from a sense of 'not-knowing', (b) patience in taking time to identify differences in perspectives, (c) legitimizing and accepting different perspectives, (d) actively questioning the patient about their experience – asking for detailed descriptions of experience ('what' questions) rather than explanations ('why' questions), and (e) careful eschewing of the need to understand what makes no sense (i.e. being able to say explicitly that something is unclear rather than 'filling in' in an attempt to understand and explain. The aim is to 'exercise/stimulate' the patient's mentalizing muscle rather than to use your own to make up for their gaps and imbalances in mentalizing).

The aim of the clinician through the use of the not-knowing stance is to create a process in which the patient engages in more reflective discourse about what is happening within themselves, both about themselves and about others. This establishes mentalizing process as a way of retaining autonomy as a person, through an experience of not being taken over by a fixed state of mind or overly influenced by others' states of mind.

Extensiveness is rated according to the sensitivity of the clinician in using the not-knowing attitude appropriately and maintaining it sensitively when the patient closes the dialogue or begins to use ineffective mentalizing.

To what extent does the clinician

Develop and maintain a not-knowing stance **throughout the session?**

FREQUENCY

Not at all (1) A Little (2) Infrequently (3) Somewhat (4) Quite a Bit (5)
Considerably (6) Extensively (7)

EXTENSIVENESS:

Not at all (1) A Little (2) Infrequently (3) Somewhat (4) Quite a Bit (5)
Considerably (6) Extensively (7)

Skill Level Rating Guidelines

Low Quality

The clinician lacks direction in the question; questioning is for the sake of asking questions with no purpose; questioning is focused on fact-finding – when did something happen, who was there, what time was it? It is directive and gives mental states to the patient. ‘Why’ questions are frequent.

Clinician: You did not attend the group last week. Can you tell me why?

Patient: I couldn’t make it and it is not useful.

Clinician: You need to attend the group though. It is part of your programme.

Patient: But I don’t think I want to. It is not useful for me.

Clinician: If you don’t attend the group we will have to talk about stopping therapy.

Patient: I want to carry on with my individual sessions.

Clinician: What is it about the individual session that is helpful contrasted with the group?

Patient: I don’t know.

Clinician: Well, we will expect you back at the group next week and we can talk more about it later.

Adequate Quality

The clinician asks about mental states and uses an authentic attitude to uncertainty about the patient’s experience. The questioning is purposeful and conversational. It is not an interrogation or a fact-finding mission. Open questions are used: ‘Tell me more about your experience’. ‘What did you make of it all?’ Contrasting perspectives are considered: ‘Is that how you see it. I can’t quite see that – help me understand it better.’ ‘Quite a contrast with how we see that – let’s think about how we came to seeing it differently.’ ‘I see that better now.’

Essentially, any statement oriented towards expanding the patient’s reflection on their own and others’ mental states is part of the not-knowing stance. Asking the patient to consider the present or future, in either the cognitive or emotional realm, in terms of their mental states may represent part of the not-knowing stance. This generates more ‘I’ personal statements on the part of the patient as opposed to ‘they’ or ‘he’ statements about others (often seen as distancing talk), which encourages reflective process.

Clinician: What is it like for you that you keep using drugs? Tell me about what it does to you and how you see things over time if you keep using?

Patient: I think that it is getting a bit out of hand.

Clinician: What makes you say that?

Patient: I have started using in the morning now and I never did before.

Clinician: What has changed in you that makes you have to take the drugs in the morning?

Meta-domain – Mentalizing Sessional Structure

This refers to the structure, management and style of the session across the whole session. It contrasts with clinician interventions in a specific domain. The rater is looking for:

a) Opening of session with:

- Engagement of individual patient or patients in a group in terms of developing an alliance
- Continuity with past sessions, e.g. summary of previous group, introduction from clinician about what he/she has thought about from the last session, asking the patient(s) if they have had any thoughts about the previous session.
- Identification of priorities for mentalizing (hierarchy of content) with the individual or the group members
- Identification of the focus for mentalizing (specific content from the hierarchy of content) agreed between the patient and clinician, or between group members themselves and clinicians as a synthesis of problems. This is more reliably implemented in MBT-G but will occur in individual sessions as the session becomes more focal on more specific problems

b) Movement across the individual or group session from the level of validation, to synthesis and focus, to exploration, to affect and contextual work, to relational mentalizing, to closure of the session.

Four Major Component Domains

(Mentalizing Process; Identification of Non-Mentalizing Modes; Mentalizing Affective Narrative; Relational Mentalizing).

Each domain is accompanied by a series of items (interventions) to guide the rater towards the domain being assessed:

- Mentalizing Process

Empathic validation
Identification and acknowledgement of good mentalizing
Managing the flow of exploration
Managing arousal
Contrary moves

- Non-Mentalizing Modes

Psychic equivalence
Pretend mode
Hypermentalizing
Teleological function

- Mentalizing Affective Narrative

Clarification and exploration of narrative
Affect identification
Affect focus
Affect and interpersonal and/or significant events

- Relational Mentalizing

Mentalizing the relationship
Mentalizing the counter-relationship

Rating a Session

1. The rater watches/reads/listens to the whole session to rate:

a) Not-Knowing Stance - assessing the extent that the not knowing stance is established throughout the session

b) Mentalizing Sessional Structure – meta domain.

2. The session is then reviewed in detail, taking a top-down approach.

The rater initially decides what domain is being addressed at a given time in the session. He/she looks at the interventions being used to address the mentalizing in that domain. These provide information for the overall score of that domain.

Raters may find it helpful to think of a series of sequences within a session, defined by content or by a series of intervention items that initially seem to rate in a single domain.

- The rater needs to establish beginning and closing sequences, on the basis of their respective items
- Once this is done the first sequence follows the beginning sequence
- When unclear to which domain the sequence belongs, default to process (Domain 3) and rate there
- If a sequence is a clear miss of non-mentalizing by the clinician, then rate domain of Non-Mentalizing (Domain 4)
- Exploration and clarification need to address affect and relational narrative to belong to domain 5. Otherwise belongs to domain 4.
- Brief relational mentalizing is rated in domain 5, however brief (that is because it is more rare), for example a single intervention and can constitute a kind to nested domain within domain 5.

In a transcript each statement from the clinician is ‘tagged’ as an item.

Items are listed in the scale under the domains to which they primarily contribute – that is, they are more commonly used when working in that domain and are recommended for use within the domain in the manual. However, some interventions may be used appropriately and contextually when working in another domain. In that case they contribute to the assessment of that domain and NOT the domain under which they are listed.

What is an item?

An item refers to an intervention in the MBT manual (2016). It is represented by an observable behaviour or utterance of the clinician. This may be a single statement or a series of statements developing an interaction between patient and clinician

All items listed in each domain do not have to be present in a session to score on the domain. But see point 3 below.

The rater may note the frequency and extensiveness of use of an item. But this assessment is used only to give the rater evidence for his/her judgement of the unadjusted or 'raw' score for the domain. This is a score that does not take into account any judgement of quality. It is based on the frequency and appropriateness of the interventions underpinning the domain. The unadjusted domain score is an overall judgement of the work in the domain over the session and not a simple aggregate of the item assessments. If the clinician works in a domain on a number of occasions in a session, each occasion contributes to a single, final overall unadjusted domain score.

Each item is accompanied by a series of questions to the rater, which represent the common and/or recommended clinical interventions to address the item. These are provided to guide the rater as he/she assesses the domain.

The rater will note the frequency (F) and extensiveness (E) of the use of items when the clinician is working within a domain.

The **frequency of an intervention/item** is the amount of time and attention devoted by the clinician to a particular technical or stylistic intervention. This refers to video rating but is possible on transcript rating. In general style is tone and bodily expression and non-verbal interventions – some clinicians use them a lot. This is part of the ostensive cue system and can be rated within Process (Domain 3) with a rating of frequency, for example of 'firm' intervention, compassionate tone etc.

Engagement and warmth have a lot of stylistic elements and may be delivered across a session with frequent moves and vocalisation and expression.

Extensiveness is represented in this scale most commonly by variance in use of the range of items identified under each domain. So, for example, in the Affective domain the clinician may identify affects but then also work to link the affects to significant interpersonal events. This is defined as increasing extensiveness, and informs the quality rating.

The **highest ratings** for a domain will involve clinician behaviours that are high on both frequency on certain items and extensiveness in terms of the number of items classified within the domain, whereas **middle-range scores** may reflect interventions that were used less frequently when they could have been used more often, or interventions delivered with less depth in terms of linking with a range of interventions within the domain.

However, a clinician may only use one item within a domain and the rater decides that the **single item use** is appropriate and the other items were not necessary. In this case the rater scores adequate or above.

In general, it will be assumed by a rater that the practitioner is ‘adequate’ until proven otherwise. The rater has in his/her mind a picture of the ‘good enough’ clinician. The rater will define why a clinician moves below or above this ‘good enough’ level of skill.

FREQUENCY (of each item):

Not at all (1) A Little (2) Infrequently (3) Somewhat (4) Quite a Bit (5)
Considerably (6) Extensively (7)

EXTENSIVENESS (within the domain):

Not at all (1) A Little (2) Infrequently (3) Somewhat (4) Quite a Bit (5)
Considerably (6) Extensively (7)

The unadjusted domain score is a judgment by the rater, who gives a single composite score using the frequency of use of the items plus the number of different items of the domain that are used, that is, the extensiveness within the domain, as evidence. The **unadjusted domain score** is then adjusted **up or down** according to a **skill/quality** assessment to give a **final domain score**

3. Skill Level and Quality

Quality is assessed by **HOW** the interventions are delivered.

An additional issue is **ABSENCE** of the interventions of a domain, that is a domain is not delivered when expected or there is such a low level of delivery that the domain cannot be rated when the manual/model recommends the use of an intervention. **(see Non-Mentalizing Modes for further discussion of this in that domain only).** **In the non-mentalizing mode domain the four modes are considered as distinct items contributing to the domain. Absence of intervention in one non-mentalizing mode when it should have been done reduces quality of the domain rating even if another non-mentalizing mode has been addressed adequately. So failure to intervene in one non-mentalizing mode reduces the overall score of the domain using the absence scoring template).**

HOW and ABSENCE, both related to quality, are treated differently in the scale.

The HOW score is added or subtracted from the domain score.

The **ABSENCE** score – scored as absent when an intervention should have been used but was not, or was at such a low-level rating was not possible and the intervention should have been used more – **is subtracted** from the **final calculated Domain Total Score** of the adherence scale (with the exception of non-mentalizing modes). In the other domains, the domain cannot be scored because there is no intervention in the domain or inadequate frequency of intervention in the domain. In this case **there is no domain score and it is not used as a denominator in the final calculated adherence.**

Quality – HOW skillful is the work in a domain?

Quality refers to the clinician's demonstration of **how** the interventions are delivered in terms of:

- Expertise, competence and commitment
- Appropriate timing of intervention
- Taking account of the context and content of the session
- Matching the mentalizing state of the patient
- Responding to where the patient appears to be
- Extensiveness component in terms of items used when working in the domain.

A definition of skill/quality is given for each domain.

Skill level is *not* the same as effectiveness of intervention. A clinician may make an intervention at a high level of skill but with little effect.

If a clinician engages in interventions with sufficient frequency or extensiveness to rate the domain but the rater thinks more of the items/interventions should have been used, this is rated here.

The rater:

- a) Notes the failure to deliver a range of items/interventions when working in a domain. Should more of the items appropriate to the domain have been used?
- b) Notes the failure to appropriately stop delivering interventions, for example, due to increasing arousal because of the intervention.
- b) Considers that an item/intervention could have been used more.
- c) Decides whether how the interventions were delivered was neutral, negative or positive.

The HOW delivery of interventions/items is scored as follows:

+1.0 The intervention is used at a level to maintain clinical interaction and therapeutic alliance. Context and content are respected in terms of responding to the patient. Timing is appropriate. Multiple items used flexibly within the domain. Avoidance if necessary of interventions leading to excessive anxiety.

OR Uses active avoidance of intervention – for example, when the patient is manifestly within relational mentalizing process but, because of high emotional intensity, this work is reduced ('Perhaps this is not the time for us to go into that.' The clinician then moves the conversation to reduce anxiety).

+0.5 Timing is appropriate and context respected but hesitant delivery.

OR Uses more than one intervention from the domain, allowing more exploration.

Some items may be missed when they could be used.

0.0 Adequate = Indicators that the intervention is used at a sufficient low level to maintain clinical interaction and therapeutic alliance. Context and content are respected in terms of responding to the patient. Timing is appropriate. May use only one item from the domain.

-0.5 Use of a single intervention in domain, reducing depth of mentalizing exploration but does not distort the process of the session, e.g. supportive work only. Timing is clumsy. Intervention is mechanical and lacks sensitivity to context.

-1.0 Low-frequency use of items/interventions in domain when recommended. Harms and distorts the process of the session and impacts on mentalizing exploration. Poor timing and limited/brief exploration.

Scale

-1.0 ----- -0.5 ----- 0 ----- +0.5 ----- +1.0
Harm/Very Poor Poor Acceptable/Adequate Good/V.Good/Excellent

HOW – High Skill

a) A clinician might work in a focused manner on a domain and use an intervention frequently, extensively, and appropriately and within context, with clear evidence of engaging in a not-knowing stance. No components of the domain are missed out when they could be used. This skill level is taken into account on scoring the Domain Likert scale by **increasing** the domain score to a maximum of +1 (+1 for competence HOW)

OR

b) A clinician might engage in an intervention, for example, mentalizing the relationships only once but with extensiveness. This too is taken into account by **increasing** the rating (+1 for competence HOW)

OR

c) A clinician might work in a focused manner on a domain and use an intervention frequently, extensively, and appropriately and within context, with clear evidence of engaging in a not-knowing stance. However, some of the items relevant to the domain are missed out when they could be used. This shows moderate competence in terms of skill. The Domain score is **increased** by +0.5 for competence HOW.

HOW – Low Skill

a) A clinician might use an intervention relevant to the domain but mistime it, or deliver it clumsily or without context. This does not interfere extensively with the process of the session. This would lead to a **decrease** in the domain score, as it affects quality rating (-0.5 for low competence HOW)

OR

b) A clinician might use more than one intervention relevant to the domain but mistime them, or deliver them clumsily or without context. This interferes with the process of the session, with the patient appearing uncertain/bewildered/confused about what the clinician says and struggling to understand the relevance. This would lead to a **decrease** in the domain score as it affects quality rating (-1 for low competence HOW).

This HOW quality score is added to or subtracted from the unadjusted domain score, giving an adjusted domain score.

ABSENCE: Absence of Expected Intervention

This refers to **absence of use**, or such low use of an item/intervention that the rater cannot rate the domain, **when the item/intervention is expected to be used**. This commonly applies to one domain only in any session. If it applies to more domains it is likely that the session cannot be rated for MBT.

Handy Hint: The domain that most commonly shows low-level use or absence is relational mentalizing.

The rater

- a) Notes the failure to work in a domain when the clinician should have done. Should items for the domain have been used?
- b) Considers that an intervention could have been used more.
- c) Decides whether the lack of intervention was neutral or negative or positive.

The absence of intervention is scored as follows:

- +0.5 Active/deliberate and appropriate avoidance of intervention
- 0.0 Adequate = Indicators that the intervention is avoided or used at a low level to maintain the clinical interaction and therapeutic alliance.
- 0.5 Limited use of work in a domain (not allowing rating), could have been used more, reducing the depth of mentalizing exploration but not harmful, e.g. supportive work only.
- 1.0 Complete absence of intervention when recommended. Some harm to the depth of exploration.

Scale

-1.0----- -0.5 ----- 0 ----- +0.5 -----
Harm/Very Poor/Poor Adequate Good/Excellent

This score is subtracted/added from the final calculated DOMAIN TOTAL score (NOT the adjusted domain score itself, which cannot be assessed – insert 9 in the unadjusted domain score box).

For example, relational mentalizing may be appropriate and yet the clinician does not use any interventions related to this domain when expected, and this prevents the exploration of obvious relational mentalizing process. The session remains supportive but with none of the interpersonal process addressed. There is negative impact on the whole session. This means that the domain is unrateable (9) as intervention was expected but not delivered. -1.0 is deducted from the Calculated Adherence Score (Domain Total Score/No of rateable domains) to give a **FINAL SCORE**

4. Each Domain score is scored on a Likert Scale using whole numbers only (1–7).

The adjusted domain score **also includes** an assessment of **skill level/quality** in terms of **HOW** the interventions were delivered.

Summary of scoring

1. Rate not-knowing stance: 1–7.

2. Each domain has UNADJUSTED SCORE X. This does not take into account quality.

DOMAIN SCALE:

9 = Not done at all

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Very Poor Poor Acceptable Adequate Good Very Good Excellent

3. HOW of quality is rated – this is deducted or added to unadjusted domain score.

DOMAIN SCALE taking into account HOW skill level:

-1.0 ----- -0.5 ----- 0 ----- +0.5 ----- +1.0
 Harm/Poor Poor Acceptable/Adequate Good/V.Good/Excellent

4. Add the final adjusted score of each domain and divide by the number of domains scored (6 if all scored) = Final **calculated** domain score – the **DOMAIN TOTAL SCORE**.

5. Absence – absence or insufficient level of intervention when there should have been more – is then **deducted** from the Adherence Score. (In most cases this applies only to one domain. If it applies to more than one domain, then consider whether the session can be rated for MBT at all.)

-1.5----- -1.0 ----- -0.5 ----- 0 ----- +0.5 -----
Harm/Very Poor Poor Acceptable/Adequate Good/Excellent

= Adherence level (the FINAL SCORE)

An Adherence rating within the range of 3.5 – 4.5 is adherent and competent.

NOTE: If the calculated score is <0 , the Final score = 0

If the calculated score is >7 , the Final score = 7

META-DOMAIN – Mentalizing Sessional Structure

This domain refers to the overall structure and management of the session and the atmosphere created by the clinician.

Individual

MBT follows a trajectory in an individual session. The clinician initially creates a facilitative atmosphere by, for example, showing a welcoming, supportive, interested approach in the patient's mental states and their perspectives. He/she takes a session initially from a patient's perspective unless a specific focus is warranted – for example, risk or major concerns about the viability of therapy. The session then moves to identification of the focus for the patient and agreement between patient and clinician about the focus. Once this is organised, the clinician manages the session, ensuring the focus is maintained and developed in a sensitive and responsive manner. The session moves to increasing contextual development of understanding of the focus and towards relational mentalizing to enhance the immediacy and interpersonal nature of the therapeutic work. Finally, the session moves to a close with a review of the work of the session, if possible.

Group

Essentially the same trajectory is followed in a group, with structuring of the session. A summary is given from the previous group, followed by a 'go-around' of all group members to set out the work of the group for the day. This is followed by a synthesis of the problems if necessary or agreement about turn-taking. The exploration phase then takes place, leading to a closure phase reviewing the work of the group.

Rater attentional areas for domain

Does the clinician focus initially on generating a context for mentalizing early in the session (group or individual)?

Are there indicators that the clinician tries to get the patient(s) to focus on specific areas when a number of problems are presented by the patient(s)? In the group this will occur in the initial go-around. The clinician attempts to define the problem areas for discussion for each individual in the group.

In the group, once the problems are identified, is a pathway to manage discussion of those problems identified, e.g. synthesis of problems from different patients? This requires work on the part of the clinician to link patients and their problems together, for example by asking a patient who they wish to talk to in the group about their issue and even suggesting who they might talk to initially. This is to start the conversation in the group between people who have more 'skin in the topic' i.e. it is relevant to them. Once the exploration has started the rest of the group are asked to bring in their

perspectives as they may have a less partial view uncoloured by immediate affect and so be able to give a more considered response.

Are there points at which the clinician manifestly demonstrates intervention from supportive empathic work to affective identification or relational mentalizing?

Is the overall trajectory of the session managed by the clinician with a closure phase towards the end of the session?

Does the session show change over time from surface to depth in terms of experience of the patient/clinician interaction and to increasing complexity of understanding?

Adequate with good Quality – Prototype for Domain

The clinician opens the session and establishes a joint process focusing on, for example, a) areas of problem defined by the patient, b) topics from previous sessions, c) information received between sessions, such as an overdose, arrest or violence, d) any process that interferes with therapy– e.g. non-attendance, group problems.

The clinician will then agree to work on one area initially and begin exploration. This is done in a context of engagement through interest in the patients' perspective and development of appropriate warmth and concern about the patient's problems.

If that patient is discursive and circumstantial, the clinician works to focus the session and keep the patient on the topic. Exploration gradually moves from factual narrative to emphasis on mental states and the experience of the patient in terms of him/herself and others. There is a particular focus on affect and the not-knowing stance becomes well established across the session. Clarification summaries are used at strategic points.

Once the session is established, the clinician works within the relationships between all members of the group (which includes the clinician as an equal and equally flawed member) to highlight alternative perspectives about the patient's problem area.

Towards the end of the session the patient and clinician review what has been achieved, balancing increased understanding with acceptance of areas that need more work.

Examples:

The clinician asks the patient if there are areas that he/she would like to discuss, and explores the extent of the problem: 'Are there any areas that you would like to talk about today that are causing you trouble, or even things that have been positive for you over the week?' The clinician asks the patient to expand so that the issue can be identified: 'What is it about XXX that is causing the problem? Can you identify it?' 'It sounds like XXX. Is that right?'

'Are there other areas we might talk about?'

The clinician might inquire about previous problems that they have discussed to see how the patient is managing them, thereby adding continuity to the sessions: ‘I was thinking about our talk about your sensitivity to your partner not contacting you enough and I wondered how you were getting on?’

There are times when the clinician will need to bring up a problem to discuss. This is not forced on the patient but can be highlighted by the clinician as an important topic: ‘From my point of view I thought that it would be a good idea if we talked about the difficulties you have in coming to the group. The group clinician has been in touch with me about it. She is worried that they have done something to put you off coming. Is that right?’

Focus: ‘From what you have said, we could work on what happened that led you to get out of control or how you are now feeling a failure again. But it occurs to me that it might help if we talked about your relationship with your boyfriend more generally. What is it like when it is good?’

“Which of these is the most important for you to talk about today?’ If the patient’s response matches the assessment of the clinician, the session continues: ‘I was thinking that was important too in relation to the goal of...’.

If the patient chooses a topic that does not match the clinician’s rating of importance, the identification of a focus bears more discussion: ‘What made you choose that? I was thinking that XXX was more important because of...’.

Towards the end of the session in either group or individual treatment the clinician reviews the work that has been done or not done. This is agreed with the patient(s) and a closure phase occurs, with reflection on the work done in relation to the clinical agreement made at the beginning of the session and/or in relation to the initial formulation.

Group Example

Summary

Hello, Mary-Ann. I am sorry that you could not get here last week. Last week—Jen, Sarah, Tom, Peter, and Clare—I thought the main topic was about never managing to meet other people’s expectations. We ended up not quite deciding if people expected too much of us or if we tended to expect too much of ourselves and we misread what others want from us. We all thought we could be rather self-punishing when we felt we did not match up. Sarah, you were particularly caught up with this, and it was creating tension between you and your boyfriend. But Peter, although you could see this, you thought that if people expected things from you that the best thing to do was to “fuck off” and not bother with them. This has some sense, as it made you feel better, but it also means that you end relationships quickly. We then brought up what is expected of us all here and if we ask too much or too little of each other. I’m not sure we concluded anything about that. Certainly, I felt sometimes that things were expected of me that I could not deliver, and that was a problem for me. Perhaps we could come back to the whole topic today at some point. Does anyone remember anything else about this? There may be other things?

There was also a discussion about expecting someone else to join the group. Jen, you were anxious about this, as you feel the group is comfortable at the moment and that it would be messed up by having someone else who we all have to get to know. So, we need to keep that in mind as Jonathan starts in 2 weeks' time. Does anyone have any other points?

Patients then indicate if they have problems that they would like to address in the group on that day; following this, balanced turn-taking has been recommended as a possible strategy. This is not individual therapy within the group, but a focus by the group on designated patients and their current intersubjective and emotional problems. Alternatively, the MBT clinician can negotiate a synthesis of problems so that a few patients are identified as the main protagonists to start working on the problem areas and to provide concrete and individualized examples of the problems in order to avoid pseudomentalizing. The patients are asked to talk together to identify shared emotional states, impulsive urges, or interpersonal anxieties, for example. Toward the end of the group there is a closure phase in which the patients consider together what they have achieved and identify any unresolved issues. This helps the patients gain separation from their problems and promotes emotional regulation before leaving the group. In groups for adolescents, examples of constructive mentalizing that occurred in the group session are highlighted at the end of every session, to elaborate on feelings of “we-ness” and group cohesion.

The purpose of these structural elements is to ensure that the clinician retains a level of authority in the group to maintain interpersonal dialogue about the subjective experience of mental states, which is consistent with the primary aim of facilitating mentalizing and preventing collapse into ineffective mentalizing modes. Moreover, this regular structure also imposes structure within the minds of the patients, and provides them with a sense of security that is necessary for them to be able to begin more robust mentalizing. Allowing the trajectory of the group to unfold by following the patients, rather than leading them, is more likely to lead to ineffective mentalizing due to over-stimulation of emotional and attachment processes.

Ideally, MBT-G strives to create a balance between these emerging processes and emphasis on problems specific to the patient group while avoiding the Scylla of uncontrolled process and the Charybdis of over-control. This requires the clinician to manage group structure and processes to maintain a safe level of stimulation of attachment process and to keep arousal at a level that facilitates rather than undermines mentalizing discourse between participants and reduces the likelihood of ineffective mentalizing interactions. The form of the structure is less important than its aim; clinicians need to show they are actively managing the group structure and focus, not primarily or passively following the group. The clinician takes an even more active stance compared to clinician working with an adult group. This active stance also includes being a strong role model for proper mentalizing for the group members and thereby paving the way to mentalizing for the group. Although the MBT-G clinician takes the lead in general, when the group is engaging in mentalizing dialogue, the clinician “withdraws” and allows the group to work.

Low Quality

The interaction is one-sided, with the clinician giving the patient a list of things and asking him/her to choose the focus of the session. The patient leads the session rapidly into a non-mentalizing discourse with the clinician failing to clarify the overall problem. For example the patient talks about an overdose and self-harm, both of which are behaviours, and the clinician does not identify the complexity of what might have happened. No agreement is made on focus – for example the interpersonal stress that led to the overdose. The session lacks coherence and many topics are presented by the patient. The clinician fails to take sensitive authority in controlling the session development. No closure phase occurs with clinician and patient attempting to identify what they have achieved or failed to address.

Items contributing to this meta-domain

Item: Engagement, interest and warmth

This is a general factor common to all therapies and is not specific to MBT. It is expected that this will be developed at the beginning of the session, and there should be evidence for this. However, it will be more or less present throughout the session. Even if the clinician is challenging a patient this will normally be done with compassion and care, and so the warmth is maintained even though the process may be uncomfortable.

In part, engagement and indicators of interest and warmth will be generated by many of the interventions of MBT, e.g. the not-knowing stance, empathic validation. However, the atmosphere in the session over time is the context in which these interventions take place, and this is what is being assessed here. A facilitating atmosphere is created primarily by the attitude of the clinician through a stance of joint engagement in problems, genuine interest, and appropriate warmth. The converse – an atmosphere of retreat from and closure of scrutiny of mental states – is formed through alienation, hostility, or coldness on the part of the clinician. While this might be rare, a lack of interest from the clinician or a detachment, or even an adversarial stance, may be more common.

To what extent does the clinician:

Show clear engagement with the patient(s) in developing a therapeutic process early in the session?

Demonstrate interest in the patient's problems and areas of achievement?

Create an atmosphere in the session of interpersonal warmth throughout the session?

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Identification of priorities for the focus for mentalizing

MBT sessions are focused and coherent whenever possible. It is not expected that the sessions are free associative. Short-term and long-term aims are developed with the patient during the assessment and formulation phase. The clinician and patient make current priorities for mentalizing at the beginning of the session. Technically, these should be linked to the short-term and long-term aims in the formulation.

Development of the focus for mentalizing is a shared process and may include, for example, the work of the patient in the MBT group or individual session, or on his/her recent behaviours (e.g. suicide attempts, self-harm, violence), or on events related to therapy such as non-attendance.

The development of priorities is not the same as the focus for mentalizing. The focus is the outcome of the work on priorities. Of course the two link and therefore combine in the raters' assessment of the structure of the session.

Group

In the go-around the clinician clarifies the range of problems each patient reports and identifies which is the most important for the group to discuss. Some patients bring a list of problems whilst others may deny problems. In the former situation, the clinician works specifically to find commonality across the 'list' the patient brings, for example do many of the complaints relate to emotional regulation or interpersonal problems, and then defines the central core; in the latter situation the clinician asks the patient to consider whether the problems outlined in the formulation could be part of the discussion – have they been resolved? Have they been apparent over the week?

To what extent does the clinician:

Ask the patient(s) to outline problem areas over the past week or difficulties that continue over time?

Develop a list of relevant areas that bear scrutiny to establish a focus for the session?

Link the priorities to the formulation when appropriate?

Item: Identification of focus for mentalizing

Once the priorities are agreed, the clinician and patient identify a current focus in relation to the short-term and long-term aims if possible. This may require the clinician and patient to negotiate the most important topic for scrutiny.

For example: A patient agreed that a short-term aim of therapy was to reduce her sudden reactive outbursts directed at her boyfriend. She arrived at the session stating that she had hit him the evening before the session. She was upset by this and

considered herself a failure. It was agreed that the focus in the session was to consider what sort of relationship she had with her boyfriend, rather than to focus on her sense of failure, how angry she had been with him, or the immediate trigger of the outburst, which was his late arrival home. While all these aspects are linked, the clinician and patient decided that it might be helpful to think more widely about what sort of relationship she wanted and how her current relationship failed to reach her wishes or to what extent it matched her needs.

To what extent does the clinician:

Seek to engage the patient in defining core problem areas?

Develop an area that both patient and clinician use as the focus of discussion for the session?

FREQUENCY (clear evidence that the clinician is working on this area by steering the discussion back to clarify the topic).

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS (bringing in the formulation and linking current problems to those already identified)

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Group

In the group the go around will indicate the problems that each member of the group wants to discuss. A brief piece of work is done on identifying the element of the problems that will be the focus for each patient (see Identification of priorities for mentalizing). The next step in the group is to combine these between patients to some extent to agree the main themes of the group itself.

A patient stated that he had a lot of things he wanted to talk about – his problems with access visits to his son, his lack of money, and he wanted to talk about an incident he experienced when he went into a store.

The clinician asked him to talk about the incident as exploring ‘incidents with others’ was mentioned in his formulation.

Incident:

The patient described entering a store only to be followed around the store by a security officer. The patient stated that he was being treated like a criminal without evidence. He stated that this was unfair. He tricked the security guard into thinking he had stolen something. When challenged he refused to be searched unless the security guard gave him reasonable evidence to suggest he might have stolen something – ‘Stop and search requires clear evidence. What evidence have you got?’ The security guard called support and the patient was escorted out of the store.

Focusing the problem

The clinician explored this incident to identify what the client had reacted to. Was it being seen as someone he was not that led to his contrary reaction or something more akin to a sense of unfairness? What is unfair in this incident; or was this because he realised that people made unwarranted assumptions based on his appearance and responded to him accordingly?

Synthesis: generalising the individual problem to the group

Involving the other group members in working this out shows high quality in this structural domain. The other group members stated that they understood his reaction to someone making automatic assumptions about him. Gradually the group elaborated a theme about this and the focus for mentalizing was labelled 'being mis-interpreted and 'categorised' by others.

MAJOR DOMAIN: Mentalizing Process

Generating a mentalizing process and controlling the flow of the session is an important aspect of MBT. Mentalizing in any of the other major component domains becomes useful only if it takes place in a context that is focused, contextualised, reflective, and within a controlled level of arousal. The assessment of this domain is done while assessing the other domains. It differs from the meta-domain of Mentalizing Sessional Structure in that it refers to a different level of process. It is the **process** *within* the session in terms of working **within a domain** and not *across* the whole session. At the end of the session the rater scores this domain based on the frequency and extensiveness and quality of the use of the items contributing to the domain.

Adequate with good Quality – prototype for domain

Overall the clinician ensures that the work is reflective and personalised within the component domains. So, for example, if the clinician is working on mentalizing affective narrative, the clarification and exploration, identification of affect, and linking affect to significant interpersonal events will be underpinned by a mentalizing process of empathic validation, recognising good mentalizing or mentalizing effort when it occurs, and facilitating mentalizing movement (contrary moves) while managing arousal levels.

To do this, the clinician engages in **empathic validation**. This involves **contingent responsiveness** on the part of the clinician to the patient's experience. The clinician **marks** his/her comments explicitly and ensures a 'to and fro' interaction in which both the patient's and clinician's mental states are important. The clinician **stops and clarifies or may rewind** the subject to refocus on an area discussed earlier or rewind to mental states elaborated earlier.

The mentalizing process is heightened by **contrary moves** in terms of rebalancing the focus. The patient may be fixed on 'other' and so the clinician moves back and forth

between other and self. A similar process may be necessary for the other mentalizing dimensions.

Mentalizing capacity is related to **arousal levels** and so the clinician maintains an appropriate level of arousal throughout the session, sometimes increasing it and at others decreasing it.

The clinician explores the patient's emotions and overall experience and verbalises the patient's experience, preceding this with an ostensive cue. In addition, the clinician demonstrates that he/she recognises the effect that the emotional state is having on the patient.

'I can see what you are getting at now (marked). You have made it so much clearer; that is really helpful (ostensive cue). You feel so hurt (emotion) that he does not notice how worried you are (context) and seems to ignore it, leaving you thinking there is something wrong with you and you shouldn't be like that (effect).'

'Your sense is that you have tried as hard as you can (positive statement of effort, and ostensive and contingent). You have worked at not taking the drugs and have been really successful for a time. But now that you have taken some you feel depressed (emotion) and think it only proves that you are a weak person and you should have known that it was pointless trying (effect).'

The clinician notes that mentalizing is reduced and actively stops the session and rewinds to the point at which either the clinician or the patient was mentalizing. 'I am not quite sure where we are. Can we go back to XXX. At that point we were talking about...'

'You are going too fast for me. I cannot keep up. Slow down a bit. Let's go back to...'

'Can we think about that a bit more. As I understand it...'

The clinician notes the change in arousal of the patient and intervenes to keep the arousal at a level at which mentalizing is maintained.

'Talking about that seems to make you really anxious. Do you want to rest back for a while, or is it OK to carry on?'

'Sorry about that. I seem to have said something that was insensitive. I didn't quite mean it like that'.

To increase the arousal level, the clinician may have to be more confrontational and focus on the relationship in the session.

'You and I seem to have a problem here. I think we need to talk about what happens when I say XXX. You seem to retreat and fall silent.'

The clinician notes the imbalance in mentalizing processes and acts to restore balance.

‘It does seem that the housing office are really not responding to you at all (other). How is that affecting you (self)?’

You seem to be taking all that on yourself (self). What about him? What on earth is he up to (other)?’

‘When someone looks at you like that (external), what do you make of what is going on in their mind (internal)?’

‘When you are so upset (affect) it is impossible to think, isn’t it. But what if we think about XXX. It does not make any logical sense that XXX (cognitive).’ OR ‘But how did you get to that conclusion? Give me the steps the led you there.’

The clinician shows genuine enthusiasm about the patient, working out his/her experience and using it to address problems. Often this is based on the patient’s report about how an interpersonal interaction that has caused problems in the past unfolds constructively. The clinician emphasises that it is the patient’s ability to understand his/her own internal states and those of others that has been of benefit.

‘You really seem to have worked that out. How did it make you feel?’

‘Well done. Under those circumstances it is quite an achievement to have not “lost it” when you might have done’.

‘I think that is fantastic. How do you feel about it now we are talking about it?’

Items contributing to this domain

Item: Empathic validation

This is operationalised as a contingent/congruent and marked intervention. *Contingency* implies that the responsiveness of the clinician matches the internal state of the patient. *Marking* identifies that it is the patient’s mental state that is being represented, or alternatively that it is the mind of the clinician that is being stated. The patient experiences themselves as the centre of attention as a result of their emotional state being recognised. The intervention makes them feel a ‘person’ who is understood emotionally.

The aim is to establish a shared understanding of an experience that is seen from the patient’s perspective. The clinician demonstrates that he/she accepts the kernel of truth in the patient’s experience. Normalising of experience may occur: anyone in that situation would feel like that’.

Empathic validation is distinct from a sympathetic statement: ‘How awful you must feel’; ‘That is so difficult’; ‘What a terrible thing to happen to you’. These are interpersonally neutral or distancing statements rather than mentally ‘joining’ statements.

To what extent does the clinician:

Identify the current state of mind of the patient?

Accurately reflect the state of mind of the patient?

Demonstrate that he/she understands the effect that it has on the patient?

Creating a full empathic validation after exploration of the patient's current affective state and identifying the effect that it has on the patient indicates a more extensive empathic validation. If this is done in full a number of times in the session the rater will give a 'considerable' or 'extensive' rating to the item.

Group

Empathic validation of any individual in the group follows the outline above. However the clinician will also identify and validate empathically the individual's concerns about himself in relation to the group.

The clinician may also make statements normalising anxiety about talking to others in the group when uncertainty about trusting in others is dominant – 'we all need to accept that talking to each other can be a problem'; 'trusting all of us to be respectful to each other is a big ask'.

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Identification and acknowledgment of good mentalizing

The clinician focuses on the benefits to the patient of good mentalizing. When possible, the positive experience associated with successful mentalizing is emphasised. The MBT clinician is alert to examples of the patient managing his/her emotions constructively, expressing them appropriately and effectively, and when he/she has been able to negotiate a complex interpersonal problem. The clinician explores the effect that this has on self-esteem and relationships. The clinician needs to show positive enthusiasm for the achievements facilitated by good mentalizing. So the key to this intervention is to identify the components of good mentalizing and then to explore the benefits for the patient.

Group

This intervention in the group may be directed to an individual (*adequate quality*) but the rater is also interested to the extent that the clinician highlights and acknowledges good mentalizing *between* participants. This is *high quality group* work.

A patient was concerned about visiting a friend of his in hospital who had a terminal illness. One of the other members of the group asked him about this and in his questioning demonstrated that he was trying to understand the client's reluctance from his perspective rather than his own. It turned out that the client was concerned that he would become emotional during the visit because he thought that his friend was going to die. He did not want to be seen to be a 'wuzz' (slang for weak/emotional person). The clinician identified this process but explicitly working with how each of them experienced the interaction. The 'reluctant' client felt understood and the 'exploring' client described a sense of feeling helpful and that their relationship was more relaxed. At this point the clinician identified the effects of good mentalizing on individuals and on how this supported the positive effects of working in the group.

To what extent does the clinician:

Identify episodes in which mentalizing has been successful?

Explore the benefits that this has for the patient/group?

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Manage arousal

Patients with BPD are vulnerable to loss of mentalizing as arousal levels increase or decrease. It is important to maintain arousal levels in a session within an optimal range – not too high so that mentalizing turns off, and not too low so that mentalizing is severely restricted. The aim is for a patient to manage mentalizing at levels of arousal and in contexts that normally undermine their capacities.

Many different interventions in MBT reduce arousal. However any intervention that is delivered with the primary aim of de-escalating excess affect and/or decreasing anxiety and/or increasing arousal is rated here. This may or may not be an intervention described in the MBT manual. MBT is permissive in its recommendation about how the clinician reduces arousal in a session. Any interventions with the primary aim of decreasing or increasing arousal is acceptable. This may include relaxation/breathing techniques/mindfulness as long as the primary aim is to reduce arousal to facilitate further mentalizing.

There are some interventions in MBT that may reduce arousal as an epiphenomenon. So, for example, if the rater notes a clinician uses a contrary move but this is judged to have an aim to increase flexibility in a dimension of mentalizing e.g. self-other mentalizing or in cognitive-affective processing it is not rated here. However if a contrary move from affective to cognitive processing is primarily to reduce excess anxiety then it is rated here as an intervention to manage arousal.

Clinicians may have to stimulate anxiety in patients who have either deactivated attachment process to manage anxiety or closed down their minds to address overwhelming anxiety. In the former situation the clinician uses interventions that stimulate the attachment process e.g. heightens the focus on the relationship between patient and therapist in the here and now; in the latter context it might be appropriate to alter the frame of the session e.g. may go for a walk with the patient; create a context in which the patient can talk for example playing a computer game whilst talking.

Group

Managing the mentalizing process is essential in group work. Group work makes participants overly anxious. They commonly feel exposed and judged and to counter this the clinician has to demonstrate authority in developing and maintaining a compassionate atmosphere in the group. Managing arousal, empathically seeing things from the client perspective, and actively intervening when strong emotions are expressed in conversations reduces the likelihood of non-mentalizing process dominating the group. Intervening to manage arousal is the most important of these.

The rater will consider high arousal levels of the group and note if the clinician intervenes to reduce this when necessary.

Low arousal may be of equal clinical importance and the clinician is expected to stimulate arousal. The rater will note how the clinician does this which is usually done by increasing the focus on the 'here and now' perhaps by explicit mentalizing around the difficulty of the deadening effect of low arousal or by increasing the interpersonal work between patients.

Parking and arousal of individual in group

Problems with attentional control are frequent in patients with BPD and other personality disorders. Patients often find it hard to suppress a dominant desire in order to attend to a sub-dominant process. This means they may not be able to easily focus on a topic of relevance and importance to another person if they, themselves, have a strong desire to talk about something affecting them. They will try to do so but sooner or later their dominant wish to talk about a topic relevant to them will burst out, usually following signs of increasing tension or even desperation. Yet, constructive interaction with others requires good attentional control. All of us have to suppress a pressing wish to talk about something if there is a need to discuss something else or if we are to focus on another person. If people with BPD are to improve their personal relationships it is important that they increase their capacity for attentional control because this is the 'bread and butter' of the to-and-fro of conversations. They need to learn to inhibit their impulse to demand attention or, alternatively, gradually but

sensitively divert attention to themselves in a socially constructive way. The aim of the clinician ‘parking’ a patient is to help them generate this capacity and manage pressure to demand immediate expression. This process is facilitated by the use of a positive therapeutic alliance.

As soon as the clinician recognizes that a patient is becoming agitated, parking him/her may become necessary if the group process is not to be suddenly disrupted by that one patient’s excessive anxiety. The patient may show his/her agitation by shaking a foot, moving around excessively or trying to interrupt; alternatively, he/she may be withdrawn, looking down, furtively glancing or appear preoccupied. The clinician quietly notes this and asks the patient if he/she can wait for a short time so that the group can conclude the current focus before attending to him/her. Often, this is best done slightly conspiratorially as this will make the patient feel special and attended to by the clinician. But, equally, it can be stated openly – *‘Rachel, can you hang on a short time so that we can finish off this with Peter. We will be back to you in a minute’*. The point here is that the patient must feel they are seen as a person with a need and that their urgent demand has been recognized. This allows them to temporarily inhibit the urge to talk about their own problem and possibly attend briefly to the problem being discussed.

A patient, Emma, was clearly agitated as soon as she arrived at the group. During the go-around she said that she had to talk about her boyfriend, who she thought was seeing another woman. She had challenged him about this but he had denied it and said that she was being ‘borderline paranoid’. This had enraged her. At the end of the go-around she was asked if she wanted to go first but she suggested the group started with another patient, who had taken an overdose. The discussion started focusing on the suicide risk of this patient, but it was obvious to the clinician that Emma was becoming increasingly unable to focus on the difficulties of the patient who had self-harmed. Her foot was gyrating back and forth and she was impatient. Quietly, he turned to her, for he was sitting next to her, and said ‘It is really hard listening to other stuff when you want to talk about your own problems. If you can, can you hang on and I will make sure that we get round to you soon.’ Emma calmed. As the group continued, her tension returned, so each time this became apparent the clinician turned to her and quietly said that it would not be long. This, again, reduced her tension.

The skill of the clinician is to know how long a patient can be ‘parked’ or placed in the queue. If it becomes necessary to allow a patient to take over the focus of the group, to ‘un-park’ him/her, the clinician needs to state this explicitly and to ‘park’ the active patient and his/her current topic for a time – *‘Mark, can you hang on to that for the moment so that we can come back to it. I think Emma needs to come in now and talk about her problems as she can’t concentrate on your issues at the moment. We will definitely come back to yours though.’*

It will be apparent that parking is a way in which the clinician takes some authority in the group. He ensures that arousal levels and patient imperatives are recognized and managed. In addition, the ‘parked’ patient feels that they are recognized as an individual and that their needs are recognized. Parking serves as an *ostensive cue* making the patient feel recognized as an ‘agent’, a person who has needs. This

ostensive cue signals to the patient that the clinician has a communicative intention addressed to his/her needs but asks that he/she waits for a short time while other concerns are dealt with. This encourages the patient to manage his/her internal pressure to dominate the discourse and to make demands on others.

To what extent does the clinician:

Recognise and intervene to maintain an optimal range of arousal?

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Managing the form of the session

MBT sessions increase the mentalizing process around a focus through clarification and exploration. The process is not free-ranging in the sense of allowing the patient to cursorily state things without thinking about them, especially if the subject is manifestly complex. In addition, the clinician is alert to breaks in mentalizing and is advised to intervene: ‘What happened then? We were talking about your friend and now we are suddenly talking about the failure of the social services.’ The clinician controls the overall flow of the session. To do this, a number of process/flow interventions are recommended to create coherence to the form of the session.

- a) ‘Stop and explore’
- b) ‘Stop and rewind’

When the patient and clinician identify an area of emotional and personal importance, the clinician manages the moment by holding the session and exploring detail. The patient is prevented from jumping to another topic. Pressure is applied to increase the scrutiny of the patient on the detail of what is being discussed.

Rewind occurs at those times when patient and clinician find themselves lost. The clinician re-winds to a point at which either the clinician was mentalizing or the patient was mentalizing. Alternatively, the clinician notes a dysjunction in the discussion and so asks the patient to attend to this.

Group (see also parking)

Stopping the non-mentalizing dialogue by managing process using stop and explore/rewind is the key to good group work. The clinician makes attempts to stop and rewind whenever the interactional process is uncontrolled. Patients may be talking but without reflection, simply confirming each others’ non-mentalized accounts of themselves or others, engaging in ‘banter’. The clinician sensitively edges

the dialogue back to a point when mentalizing was present in at least one of the members of the group. To do so the clinician might involve the individual who they think is mentalizing – ‘you look like you are thinking about this John – what were you thinking when they were talking about.... (rewind to a point in the interaction)’.

To what extent does the clinician:

Control the flow of the domain work through stopping and exploring?

Control the flow of the domain work through rewinding relevant material?

Follow a trajectory of initially focusing on the patient’s perspective and then moving towards alternative perspectives?

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Contrary moves

Increasing concurrent components of mentalizing reduces restricted mentalizing and increases the scope and complexity of mentalizing. Mentalizing is considered restricted if a) there is excessive focus on self or other, b) it is primarily cognitive with affect split off or absent, c) it is excessively affective with no cognitive coherence and representation, d) it is solely internally or externally directed without each informing the other, or e) it relies mainly on implicit experience without explicit mentalizing to buffer the assumptions and reactivity apparent in excessive implicit mentalizing.

If a patient is focused only on his/her own perspective, for example, to the neglect of other perspectives, this is also likely to indicate restricted mentalizing; the clinician should try to stimulate balance in the mentalizing process by adding the perspective of the other.

Taking another example, if the patient is showing restricted mentalizing in terms of excessive affective process, this can be balanced by cognitive process. Good mentalizing requires the integration of both affective and cognitive process, with cognitive coherence bringing representation to affect and affective experience informing cognitive content.

Contrary moves may influence arousal levels as suggested above. The raters understanding of the intention of the clinician will dictate where it is rated. But it can be rated both under Item Managing Arousal Levels and Item Contrary Move if both apply.

Group Triangulation

Triangulation is an intervention addressing the collapse or imminent collapse of self–other interaction into self–self interaction. It is a special form of contrary move. It also incorporates interpersonal exploration. So it may be rated both here and in relational mentalizing if the focus of different perspective between members of the group is more extensive.

When interaction between two patients, or between a clinician and patient, becomes inaccessible to the rest of the group, the isolation of the interaction from the rest of the group suggests that mentalizing has begun to shift from self–other to self–self, to the extent that the two protagonists are creating a shared representation which excludes alternative scrutiny. Often this is a collusion of sameness and agreement – *‘I am just the same. I know exactly how you feel. You are right and no one should think differently.’* In this context MBT-G triangulates by actively inserting ‘other’ mentalizing into the dialogue to prevent collapse into non-mentalizing process.

Of particular significance is ensuring that triangulation takes place when two clinicians become involved with one patient. In this context the clinicians are viewed as one person; that is, the interaction is psychologically dyadic even though there are three people involved. Involvement of both clinicians tends to occur when one patient is identified as being at serious risk or has been involved in an important personal event. It interferes with the overall mentalizing in the group just as much as two patients joining together to the exclusion of others. The problem is exacerbated because both clinicians may be unaware of the rest of the group for considerable time. To reduce the risk of this happening, in MBT-G the clinicians have an explicit agreement when working together that if one of them focuses on a patient, the other clinician thinks about triangulation and intervenes either by talking to his/her colleague, directly bringing in an alternative perspective, or by actively bringing in other members of the group. When clinicians talk to each other it draws the mind of the patient away from a focus on ‘self’ to possible interest in ‘other’. Once this is achieved, the clinicians can facilitate group interaction around the focus of the problem.

Who to triangulate to?

In MBT-G the clinician triangulates to a specific person. Rarely does he/she triangulate to the group as a whole by saying, for example, *‘What do others think?’* *‘Has anyone else any thoughts about this?’* Specifying an individual forces the interactive process and does not allow the group to easily sink into ineffectual silence. In contrast, asking the whole group to comment would enable group members to avoid the question and to remain detached from the problems being discussed. To prevent this, the clinician moves the dialogue to a member whom he knows may have some interest in the problem or may recognize the difficulties the other person is presenting. At this point the clinician has two choices. He/she can ask the chosen person to comment on the dialogue between the two other patients – *‘What is your view about their discussion?’*; *‘Can you help them with this problem?’* Alternatively, he/she can ask the person to talk about his/her experience of the dialogue – *‘What is your feeling in listening to this?’*; *‘What does it make you think about in yourself?’*;

'Does it trigger any ideas about your own life?'. This intervention would be rated here. If there was then exploration of the patient's experience in relation to the other patients then the rater considers also rating in the relational mentalizing domain.

The slight difference in emphasis between two aspects of triangulation is whether the intervention focuses the patient who is brought in through triangulation on the mind states of the other protagonists or on his/her own state of mind and reactions formed by observing and listening to the dyadic dialogue – 'about them' or 'about me in response to them'. Often the move to stimulate another patient to consider the effect on him/herself as observer of the dialogue stimulates more interactive mentalizing, but this is not necessarily the case, and the clinician can move the dialogue back and forth between the two using both foci, carefully monitoring the outcome on interactional mentalizing. This highlights both the focus of the dialogue between patients in the group and the experiences of the others that can be projected on to the interaction.

To what extent does the clinician:

Rebalance disproportionate focus by the patient on self or other to increase reflection on both perspectives?

Increase the scope of the discussion to integrate cognitive and affective process?

Ensure that over-reliance on external mentalizing is moderated by consideration of internal mentalizing?

Ensure that over-reliance on internal mentalizing is tested against external mentalizing focus?

Address implicit mentalizing processes to make them explicit?

Ensure that assumptions based on external mentalizing are linked to consideration of internal mentalizing?

FREQUENCY & EXTENSIVENESS (of each item):

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

MAJOR DOMAIN: Identification of Non-Mentalizing Modes

The clinician shows evidence of identifying non-mentalizing modes and addressing the problems. Non-mentalizing modes may occur in an intertwined way and are not necessarily discrete phenomena. For example, psychic equivalence may have pretend mode within it; pretend mode may surround teleological understanding of the world. Nevertheless, the clinician is expected to address non-mentalizing modes that either

persist in a session or continually return in the context of increased arousal or specific contexts.

The rater has to assess the non-mentalizing processes in a session and note whether the clinician is specifically addressing the non-mentalizing before trying to focus on the other domains. For example, the patient and clinician may be working on affect but the patient's current mental function is in a non-mentalizing mode. The clinician addresses the non-mentalizing prior to or in parallel to focusing in detail on the affective domain.

Adequate with good Quality – prototype for domain

The clinician is alert to indicators of non-mentalizing and establishes a pathway to reduce the negative effects of non-mentalizing. The clinician prevents the early closure of a topic, questions quasi-explanations, addresses the rigidity of beliefs, and offers counter-factuals or challenge, all with the aim of stopping non-mentalizing process. This is addressing the 'how' of how affect and cognition are held by the patient. Is it rigid and fixed, lacking in complexity, over-elaborated, generalised? The clinician focuses on the non-mentalizing mode that is interfering the most with further mentalizing process (clarification of affective narrative, for example) and engages in interventions to address this.

The clinician notes the occurrence of *psychic equivalence* and acts to try to reduce its effect on mental function. There are a number of strategies possible:

- a) Probe: 'That is quite a conclusion that you have come to. Can you tell me how you got there?'
- b) Linked/allied area but not a focus on the event itself: 'You are certain now that your boyfriend does not love you. What was the relationship like with him before all this happened?'
- c) Diversion to trigger mentalizing stability: 'So things have got really bad there then. What about other things? ... 'Oh so some things are going well. Going back to your boyfriend...'
- d) Contrast perspective: 'I can't make sense of how this has changed so completely. At one moment you felt that he was the only person for you and you were sure that he felt the same for you. Now you are certain it is all over.'

The clinician recognises *pretend mode* and works to reduce its influence on the dialogue and mental process of the patient. There are a number of strategies, on a continuum from stimulating better integration of affect and cognition to presenting the clinician's perplexity, to counterintuitive statements, to making the focus immediate and in current reality, to frank challenge.

- a) 'As you talk about that, I find myself wondering what you feel about it. I cannot quite tell from what you are saying.' (clinician perplexity).

- b) ‘You seem to have great understanding of why these people are doing what they are doing. How is that helping you respond?’ (probe)
- c) ‘Tell me how understanding this has helped you.’(probe)
- d) To a patient who was unable to decide where to start and was weighing up whether to talk about one aspect of the problem or another: ‘I always start with the least important part myself’ (counterintuitive/mischievous challenge).
- e) Full challenge, as defined in the manual.

The clinician recognises hypermentalizing and questions the excessive reliance on complex understanding of mental states. This may be addressed in a number of ways:

- a) Querying how the patient came to their conclusions?
- b) Expressing surprise about the detail from limited evidence
- c) Recognising the vigilance the patient has for others’ motives
- d) Asking how the understanding of others’ motives has helped
- e) Challenge of the excessive cognitive processing

The clinician recognises reliance on the physical world as the primary indicator of mental states and personal meaning of motives. Managing *teleological function* may be addressed in a variety of ways:

- a) Probe the meaning of a demand sensitively without dismissing it, for example, hospital admission: ‘I can see that you want to be in hospital and think that I do not realise how urgent it is (empathic validation) but can you tell me how that shows I understand your current distress? It seems to tell you something that I don’t fully understand.’
- b) Question the teleological demand: ‘I am not quite sure that is right. Does it really show that I understand how desperate you are?’
- c) Challenge the external focus: ‘I could do that and my mind could be thinking something completely different.’ ‘I hadn’t seen you as someone who believes actions speak louder than words. Is that what we are talking about?’

Items contributing to this domain

Item: Psychic equivalence

In the psychic equivalence mode, thoughts and feelings become ‘too real’ to a point where it is extremely difficult for the individual to entertain possible alternative perspectives. When mentalizing gives way to psychic equivalence, what is thought is experienced as being real and true, leading to what clinicians describe as ‘concreteness of thought’ in their patients. There is a suspension of doubt, and the individual increasingly believes that their own perspective is the only one possible.

To what extent does the clinician:

Focus on the extent of the certainty with which the patient holds their thoughts and ideas?

Address the inflexibility and lack of ambiguity through instillation of doubt?

Stimulate mentalizing in related areas to find an alternative perspective from which to address psychic equivalent experience?

Trace the precursors of the rigidity and inflexibility of thought when it is stimulated in the session?

Item: Pretend mode

In the pretend mode, thoughts and feelings become severed from reality. Taken to an extreme, this may lead to feelings of derealisation and dissociation. Patients in pretend mode can discuss experiences without contextualizing them in any kind of physical or material reality, as if they were creating a pretend world. Talk about states of mind occurs but with little true meaning or connection to reality. Attempting psychotherapy with patients who are in this mode can lead to lengthy but inconsequential discussions of internal experience that have no link to genuine experience. A patient who shows considerable cognitive understanding of mentalizing but without any congruent affect may be in pretend mode.

Absence of affect is NOT itself an indicator of pretend mode.

To what extent does the clinician:

Probe separation of affect and cognition?

Explore the evidence the patient has for extensive elaboration of mental state process?

Use challenge/counterintuitive statements to address a lack of progress in the session?

Begin to focus in current reality?

Item: Hypermentalizing

Hypermentalizing is a separate item in the non-mentalizing modes domain because of its known importance in clinical outcomes. Hypermentalizing is a mediator of poor treatment outcomes if it is not addressed.

In hypermentalizing patients show little affective understanding and may often explain relationships and personal interactions by attributing complex mental processes based on inadequate evidence – ‘I know why Jane did not speak to me and ignored what I said., She had spoken to Linda before we went into class. I saw them in the canteen. Linda does not like me and she likes Jane. So she wants Jane to stop

talking to me so that she and Jane can start a friendship. But I know that Jane does not really like Linda because Dave told me when we were playing football....’.

There is an over-recruitment of the cognitive processing system and incongruity of affect if it is present. Often affect is relegated to a secondary role and given little, if any, importance. There is *excessive theory of mind*, commonly defined as a social-cognitive process that involves making assumptions about other people’s mental states that go so far beyond observable data that others may struggle to see how they are justified. There is groundless inferences about mental states.

To what extent does the clinician:

Query the complexity of the motivations given to people?

Express doubt about the reasoning

Challenge the over-attribution of meaning?

Item: Teleological function

In the teleological mode, states of mind are recognised and believed only if their outcomes are physically observable. Hence, the individual can recognise the existence and potential importance of states of mind, but this recognition is limited to very concrete situations. For example, affection is perceived to be true only if it is accompanied by physical contact such as a touch or caress. A patient who experiences mentalizing failure and falls into the teleological mode may express this by ‘acting out’, by carrying out dramatic or inappropriate actions or behaviours in order to generate outcomes from others whose claims of subjective states (e.g. of being concerned about the patient) are not credible to them. For example:

‘Do you really want to support me? You are just being nice to me because you have to be as a professional. If you really wanted to help me you would give me that letter now for the court to say that I am not responsible for what happened’.

‘If you really understood how desperate things are you would admit me to hospital/give me another session.’

The teleological mode shows itself in patients who are imbalanced towards the external pole of the internal–external mentalizing dimension: they are heavily biased towards understanding how people (and they themselves) behave and what their intentions may be in terms of what they physically do.

To what extent does the clinician:

Explore the patient’s insistence that the answer to problems is for the clinician or others to do something?

Probe the reliance the patient has on understanding mental states from evidence relying solely on actions?

Quality of addressing non-mentalizing process

Scoring of this domain

In most sessions the clinician will have to identify and intervene in all areas of non-mentalizing. The rater needs to decide if the clinician has identified and addressed the dominant non-mentalizing modes. If the clinician has intervened in the non-mentalizing modes as they present then this would be rated as adequate or good adherence.

But the rater needs to take into account all non-mentalizing modes when rating this domain.

Does the clinician recognise the non-dominant non-mentalizing mode(s)? If so does he or she address this/them all? If so then a score of adequate or above is merited.

Quality in this domain requires the clinician to recognise and address all the non-mentalizing modes that are active across the session. If the clinician does well in addressing one mode then the score is above adequate. But this is reduced if another mode is not noted or addressed adequately. The rater uses the failure to intervene in a non-mentalizing mode by reducing the score given for the dominant non-mentalizing mode.

So for example the clinician is scored 5 for the work on psychic equivalence but the rater considers that pretend mode is also present across the session. The clinician fails to intervene in pretend mode. So the score is reduced by -1 (pages 9 and 10/11). The domain score is 4.

FREQUENCY:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

EXTENSIVENESS:

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

MAJOR DOMAIN: Mentalizing Affective Narrative

The clinician shows evidence of focusing the patient's narrative, clarifying important areas, moving the narrative from factual disclosure to exploration of mental states, and exploring the detail of the affective experience.

The clinician gradually focuses on affect specifically in relation to significant events and interpersonal interactions. Mentalizing affect in BPD is compromised,

particularly in interpersonal interactions. The key to this domain is, therefore, having worked to clarify the facts and added significance to elements of the events, identifying and elaborating the context of affect within interpersonal interactions in the patient's life and within the interpersonal relationship within the session. In addition, patients need to recognise that managing affect is essential if mentalizing is to flourish, and that mentalizing has to be maintained to manage and process affect. These are mutually interacting systems.

Adequate with good Quality – prototype for domain

The clinician clarifies the 'story' or narrative in terms of facts and events. The clinician asks about emotions and explores their complexity. **This is not simply done by asking the patient 'How do you feel?'** (While this might begin exploration of affect, it should not be the main intervention in relation to affects – asking this question repeatedly is irritating to a patient, even if they know how they feel, or, worse, may be humiliating if they do not know how they feel. Continual questioning of the patient 'How do you feel about that?' is likely **to indicate low-quality work.**)

The clinician asks the patient to describe the effect an event had on them and what experience they had. The patient may need to describe the feeling in bodily terms if he/she cannot name the feeling. When the patient names a feeling, the clinician uses that to explore the feeling: for example, 'I am upset' requires probing so that the patient defines the feeling of 'upset' and then is able to detail the aspects of the context that lead to the 'upset'. Overall, good quality is achieved in this domain if the clinician:

- a) Identifies and explores the affect at the time
- b) Asks the patient to reflect on the affect at the time
- c) Explores the current affect about the event
- d) Considers the affective experience the patient has in talking about the event with the clinician.

Gradually, the clinician builds with the patient a 'dictionary' of problematic and life-enhancing affects specific to the patient and identifies them as they arise in a session.

When possible, the clinician considers the expressed affect in the session rather than only talking about affects in past contexts or those that were experienced in the situation that is being described: 'You seem to find that amusing. Am I right?' 'Can you say what is funny about it?'

Affect is linked to significant events and, when appropriate, to significant interpersonal interactions.

The clinician intervenes to clarify the chain of mental states within the narrative. He/she may explore particular elements in more detail. He/she establishes significance to elements of the narrative. For example:

‘So let’s just stop for a moment and think about what you have been telling us. You came to the session today feeling and thinking that it was going to be a waste of time. It has been difficult so far to work out what it is that makes the sessions unhelpful, but one aspect is that you sense that I do not understand how things are for you. But you have explained that, when you try to tell me things, what I say is not much use to you. Am I right so far?’

‘OK, let me summarise for a moment. When you have an experience that you are a failure, it brings up a whole sense that you have always been a failure and that people who see you as useless are right. Not surprisingly, this makes you desperate and you look to other people to reassure you that you are not a failure.’

The clinician genuinely normalises a feeling when appropriate.

Some patients are unable to name feelings. The clinician helps them to do this irrespective of context: ‘When you get that pain in your chest, can you say what feeling it is?’ ‘That sounds like “hurt” to me. What is it to you?’

The clinician will separate different aspects of feelings, for example, identifying the basic emotional state and a social emotional state or recognising primary and secondary components of affect.

When the patient names a feeling, the clinician questions and clarifies the named feeling by asking for further description: ‘You say that you were angry. Can you describe that a bit more. Where did you feel it? What did it do to you?’

Placing the feeling in context, the clinician might ask ‘What was it about that situation that made you feel that way? Can you identify something in particular?’

The clinician follows a detailed account of interpersonal events in terms of mental states, enquiring about both cognitive and affective process in detail.

Items contributing to this domain

Item: Clarification and exploration of narrative

Clarification is the ‘tidying up’ of non-mentalizing discourse. It involves summarising mental state process rather than only factual clarification. Clarification is not simply repeating or reflecting what the patient has said; this is low-level validation. It is not the re-stating of facts; this confirms a shared narrative: ‘So you cooked dinner and then waited until 9pm for your partner to arrive. When he did not arrive you threw the dinner in the bin.’

Exploration increases the detail of the mentalizing discourse, allowing reflection and questioning and acceptance of ambiguity.

There is continual clarification and exploration of the narrative and movement of the factual narrative to a mentalizing narrative. The clinician generates increasing

complexity of understanding and a richer contextual base around the focus, with emphasis on the affective component.

To what extent does the clinician:

Ask the patient to clarify underlying mental states related to the narrative?

Tidy up disparate mental states through summarising their relationship to each other?

FREQUENCY & EXTENSIVENESS (of each item):

Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

Item: Affect identification

There are a number of interventions which can be identified. These include normalising feelings, identifying and labelling them, differentiating complex feelings, and placing them in context.

Normalising feelings is common as an intervention in terms of the ‘type’ of feeling: ‘It is normal to feel hurt in such a situation’. The problem for many patients is, however, not the type of feeling but the extent and force of the feeling. The clinician tries to differentiate these aspects of feelings with the patient when normalising feelings.

Many patients are unable to differentiate their internal states, and when asked how they feel are unable to describe it. The clinician may build on descriptors from bodily experience to mental representation, coaching the patient to label each feeling and differentiate them.

To what extent does the clinician:

Normalise feelings in terms of the feeling type?

Identify the excessive level of feeling?

Differentiate multi-layered feelings?

Attempt to enable the patient to place feelings in a context?

Item: Affect focus

The intervention of defining the affect focus in the patient–clinician relationship is to some extent, but not solely, a dialectic move to rebalance the therapeutic relationship along the implicit–explicit dimension of mentalizing. The aim is to increase the complexity, depth and intimacy of the relationship while managing the associated interpersonal affect and maintaining mentalizing.

The affect focus indicates that the unspoken can be spoken, that it is safe to share emotional aspects of relationships and check out personal understanding of an element of the relationship. The affect focus is defined as an ‘elephant in the room’ to which both patient and clinician are contributing; it is not something that is created and formed by the patient alone. The clinician identifies an aspect of the patient–clinician interaction with the associated emotion that is influencing the progress of the session.

For example: A patient may be worried about a report to a child protection team and what the clinician will say in his report, while the clinician is similarly worried about what he will write and is listening to the patient to see whether she is managing her children well. For her part, the patient is trying to show that she is a good mother by describing pleasant mother–child interactions. The clinician makes this mutual concern open and explicit.

The clinician is able to identify and explicate both the patient’s and the clinician’s component of the affect that is reciprocally shared between them.

‘When I ask you things about your visits to your children you seem to check me out very carefully. Are you trying to work out what I think? From your part, perhaps you are worried about whether I think you are a good mum. From my part, I think we do have to work out what sort of mum you can be, so I am thinking about it as we talk. It looks like it is something that we should be quite honest with each other about. Otherwise we will both remain anxious.’

‘You look away all the time and say you are not sure when I ask you things. I worry that I am asking you too much and that I should shut up. It looks like you also worry that this might all be too much, and so you shut up. Perhaps we both need to be aware that I might be too pushy and you might feel too pushed.’

‘I appreciate that you don’t want to talk about your overdose now that it is in the past. You want to talk about other things because talking about it makes you feel bad. But that leaves me preoccupied as we talk about other things, concerned about how much at risk you are. So your mind will be on one thing while my mind is partly on something else.’

This is not the same as relational mentalizing. Affect focus may begin relational mentalizing, but relational mentalizing requires more than recognizing the elephant in the room. So, taking the example of the child protection dilemma – the clinician and patient identify it as a factor that interferes with progress. It is not worked on as a component of the patient–clinician relationship but makes an implicit process interfering with treatment explicit. Relational mentalizing indicates a wider meaning in terms of the patient’s relationships overall and requires more development.

Taking another example, in which the affect focus may eventually lead to mentalizing the relationship: a patient, whose presentation in terms of body language and speech suggested a threat to others, created an intimidating atmosphere in the session. The clinician was constantly alert to possible threat. This was made explicit by the clinician so that the elephant in the room was recognised and agreed: ‘I wanted to talk a bit about what happens when we talk about these things. It seems to me that there is

something that I do that makes you feel a bit on edge and wary of me. I say that because I am also rather wary and worry that you might feel really angry with me. Is that going on, do you think?’ This is not relational mentalizing. It would be rated as relational mentalizing if more work is done, but here it is rated as affect focus contributing to the domain Mentalizing Affective Narrative with good quality.

To reiterate: this interactional process was discussed in more detail and accepted as an issue for treatment. No further work was done until the interactional relationship was safe. So this part is rated under affect focus and NOT relational mentalizing.

Further detailed work would be rated as relational mentalizing in terms of the patient’s threatening demeanour, the counter-feelings in the clinician, the interactional process, and its meaning in terms of how the patient managed relationships in the external world.

To what extent does the clinician:

Identify and express factors in the patient–clinician relationship that interfere with the progress of the session?

Item: Affect and interpersonal and/or significant events

Patients describe interpersonal events that have happened to them. Often this is done with little reflection. In MBT it is not enough to clarify the actual events. It is necessary to ask the patient to identify affects in relation to the story – what leads to what? What is the experience and how does it change? Of particular importance in this process is working in detail. The clinician should not accept generalisations about affects, but try to explore the feelings in detail in relation to the changes in an interpersonal interaction described by the patient. It is not enough, for example, to accept that the patient felt hurt during an interaction with their boyfriend. It is necessary for the clinician to explore exactly what it was that led to the patient to have the feeling they describe – was it something about *how* the boyfriend said what he was saying, or was it something about *what* he was saying, for example. The clinician can then move the patient forward ‘frame by frame’, as it were, so that important features are not missed. Overall, this is a mentalizing functional analysis around important interpersonal events and is rated in this domain. However, the control of frame-by-frame process is rated as part of the Mentalizing Process domain.

This item is more than clarification and exploration as mentalizing process. If the clinician makes a summary ‘tidying up’ non-mentalizing into mentalizing process, this is rated under clarification and exploration. This is likely to be a brief intervention. If the clinician spends some time in delineating mental states over time with the patient, which is not a summary but a major interventional process in terms of events, it is rated here.

Good mentalizing capacity means allowing oneself to be influenced and informed by emotional reactions as they occur. The ability to interact authentically and flexibly with other people without ignoring or suppressing one’s own feelings assumes the

capacity to maintain openness with respect to what that interaction might be doing at an emotional level. The clinician therefore asks the patient to link emotional reactions to interpersonal transactions, particularly more recent events. Through this therapeutic discourse the patient is ‘trained’ in understanding and dealing with intersubjective emotional interactions. This is why this intervention takes time in a session.

Not all events that are explored in the treatment of patients with personality disorder are necessarily interpersonal. For example, a serious suicide attempt or episode of self-harm may not occur in the context of immediate interpersonal problems. Nevertheless, in MBT the clinician is asked to explore the affects related to the non-interpersonal event in a similar way to those that are interpersonal. This is not simply looking at emotions in the immediacy of the event itself. It is a mentalizing functional analysis around the precursors of the event. Exploring affect related to significant events requires the clinician to rewind the narrative and the descriptions of mental states to a time prior to the event itself. This control by the clinician would contribute to the rating of the domain Mentalizing Process. Excessive focus on the actual event and the accompanying affects does not trigger reflection on the mental states leading up to a significant event, which might allow the underlying problem(s) to be identified. The event is not the problem; underlying mental states that are unmanageable are.

To what extent does the clinician:

Link emotional states to interpersonal interactions and components of significant events?

Concern him/herself with the *how* and *what* of the interpersonal interaction?

Identify points of vulnerability when the patient might address the cascade into non-mentalizing?

Link emotions to the related events?

Explore the mental states leading up to the significant event?

Group

Clarification of interpersonal perspective

The clinician works with two or more patients to identify and contrast their personal reactions to significant stories. Once a patient has described an event and identified his feelings associated with the event, other patients will hopefully give their reactions. In groups for people with ASPD there is often no shortage of comments about how an event ‘should’ be seen and what reaction the individual ‘should’ have. Commonly this is confirmation that indignation is warranted. The clinician works to expand any differences of perspectives between the clients who are discussing the problem.

A client talked about his relationship with his 15 year old daughter and the complexity of trying to see in her in the context of his acrimonious interactions with

her mother. He had tried to contact his daughter for Christmas but his former girlfriend had not passed on his message. He thought she deliberately tried to sabotage his relationship with his daughter.

Another patient agreed and said that this was typical of women who always tried to get revenge by using the children. Both clients then concurred that this was what she was doing. The discussion continued in this way with both holding fixed views. The clinician first intervened to reduce the collusive psychic equivalence by doing a diversion and asking them to talk about their relationships with their girlfriends prior to the on-set of acrimony. This allowed both patients to expand their perspective on their relationships.

Returning to the index client's current understanding of his ex-girlfriend's motive in not passing on a message to his daughter, another patient suggested that she had probably 'forgot'. Of course the index client rejected this suggestion but did accept that this is what she had said when he confronted her about it. He then began to talk about how his ex-girlfriend had changed and that he had no understanding about what had triggered her change in attitude to him.

Once these different perspectives are clarified and the 'story' has been expanded the clinician in the group can focus more on the affects associated with the narrative. However in addition the clinician in the group tries to use the group for active 'in vivo' learning about recognising emotions in others and for contrasting those emotions with how one feels oneself – 'if I was in that situation I would feel....

Interpersonal affect recognition

This intervention in the group is how the clinician supports the patients' abilities to recognise underlying affects in each other using their external focus of mentalizing. Once this has been identified the patient's check it out with each other – 'am I right to think that you are not just angry but also feel hurt?'

The key to this intervention is for the clinician to ask one patient to describe his sense of how another patient is feeling. This is affect recognition in others.

(The clinician might ask a client to identify his current feeling as he is talking. This would be rated under affect identification and it would not be rated here. However if the clinician asks another member of the group to talk about his sense of how the patient who is talking is feeling and what he is subjectively picking up from him in terms of his underlying feeling it is rated here. (It would be rated as a contrary move if it was not specifically about affect).

This item is about 'my sense (any patient in the group) of how you (another patient) are feeling'. The clinician also asks the patient who is commenting to discuss how he has come to his view.

MAJOR DOMAIN: Relational Mentalizing

Relational mentalizing is a multi-layered process with ‘transference tracers’ at the surface and exploring alternative perspectives at the more complex end of the interventions. Transference tracers link content, for example, patterns of behaviour, and process of the session either to the patient–clinician relationship (an inward movement) or to the patient’s life outside therapy (an outward movement), but they do not have the depth and complexity of full relational mentalizing.

The aim of relational mentalizing is to create an alternative perspective by focusing the patient’s attention on another mind – that is, the mind of the clinician or the mind of other patients in the group – and to assist the patient in the task of contrasting their own perception of themselves with how that is perceived by another. The emphasis is on using the relationship pattern to show how behaviours and motives may be experienced differently by others.

Individual therapy

For example, an experience of the clinician as persecutory and demanding, destructive and cruelly critical does not equate to his/her actual motive. It may be a valid perception given the patient’s experience of the clinician’s behaviour, but there are likely to be alternative ways of seeing what lies behind the clinician’s behaviour.

Importantly, the aim is not to give insight to the patient as to why they are distorting their perception of the clinician (if they are) in a specific way, but rather to engender curiosity as to why, given the ambiguity of interpersonal situations, they choose to stick to a specific version.

Adequate with good Quality – prototype for domain

An example giving illustration of the sort of things the clinician might say in mentalizing the relationship.

A patient stated that he thought the clinician had a preformed idea of what he was like – ‘You will believe all the bad things that are said about me by the other patients in the group’..

The clinician initially validates the patient’s experience of him and explores the clinician’s contribution to it.

‘Hmm. I can see how you have got the idea that I have already formed an opinion about you based on what other people have said. I agree some of the questions I am asking assume that they are correct.’

The clinician then identifies the effect it is having on the patient in relation to the clinician. In this case, the patient distrusted the clinician and thought that it was not really worth talking to him.

Clinician: Now we have talked about that, I can see that you will be alert to anything I say and may be you feel suspicious of whether I want to see you. What is it like to be seeing someone you can't trust much?

Patient: I am willing to see if it will work, but you are going to have to work hard to see if you can persuade me you are OK.

Clinician: You are right that there is a lot in your notes that describes how angry you are a lot of the time and how that has caused you trouble. Does it make you wonder if it is worth coming here for help?

This was elaborated in terms of the patient being sensitised to people in authority seeing him only as an angry person and not seeing him in a more nuanced way as a person with a range of feelings and attitudes.

Clinician: So it looks like I have fitted into the same pattern as everyone else. Am I the latest authority, then?

Patient: You are establishment. I hate establishment.

Clinician: If it is like that then perhaps you will stop coming, in the same way as you don't talk to all those other people any more.

The alternative perspective that developed related to the patient's sense that relationships of any kind made him anxious, and so he felt better about himself if the other person was at fault. This allowed him to withdraw with dignity rather than as a failure.

Adequate rating with good quality may require the clinician to mentalize the counter-relationship. This work means the clinician first, identifies the counter-feeling itself or, at least, talks about it coherently while working it out. Second, he/she anticipates the reaction of the patient to what he/she is about to express, and openly states this. This is essential if what is going to be said is likely to be difficult for the patient to hear. Third, the clinician marks carefully what he/she is saying, that is, he/she ensures that the patient understands that what the clinician is about to say is non-contingent and is expressing his/her own state of mind and not his/her representation of the patient's state of mind. Finally, the clinician keeps in mind the aim of focusing on his/her feelings, which is primarily to identify emotions that may be affecting the treatment relationship and to show that minds influence minds, or, less often, to maintain his/her own mentalizing, for example, if he/she is frightened.

Item: Mentalizing the relationship

The process of mentalizing the relationship is divided into a number of steps – validation of patient perception, identification and acceptance of the clinician's contribution to the perception, increasing the complexity and ambiguity of the patient-clinician interaction, and seeking alternative perspectives.

To what extent does the clinician:

Explore the patient's close relationships in his/her daily life, identifying interactional patterns?

Use the interactional patterns of the patient's close relationships in life to understand the patient–clinician interaction?

Focus on the way in which the patient relates to the clinician to understand the patient's life relationships?

Validate the patient's experience of the clinician by exploring the clinician's contribution to the experience?

Seek to increase the complexity of understanding of the patient's perspective of the clinician?

Item: Mentalizing the relationships in group

Mentalizing the relationship in group work follows the same principles outlined for individual work except the interactional process under scrutiny is not solely the interaction with the clinician. It is the interactions between all group members including the clinician as a group member. The purpose is to increase the perspectives about interactions, especially current interaction between group members, and to prevent interactions falling into fixed, singular perspective of limited complexity. To do so the clinician presents his own viewpoint and experience whilst eliciting that of others.

The rater will rate interpersonal exploration here. If exploration is primarily about affect in relation to interpersonal process it should be rated in the Affective Domain. Here the rater is concerned with understanding the complexity and meaning of interactions between people either in the group or in their lives in the world.

Example

Taking an interaction in the group:

John told Simon, another patient, that he found him distant and superior and he did not like it. The other patient told him that he didn't think he was and this was his problem if he found him like that.

Clinician: Let's look at that. So John you find Simon distant and a bit superior. Can you say where you get that from and perhaps Simon you can listen with us all to see if there is anything in this.

Simon: I am not listening to him (dismissively).

Clinician: Let's try as that is why we are here – we want to hear what others think so that we can consider if that is helpful to us at all. It may not be but first we have to see.

John: Well he always sits back and comments. Simon, you never talk to us about yourself. It makes me think that you think you are superior to us.

After a few more comments the clinician validated John's experience but at the same time suggested that he thought that Simon was more anxious about talking about himself than being driven by feeling superior to others (presenting other perspective).

John: Well he could be but all he does is comment and usually he puts me down.

Clinician: Simon do you recognise anything in either of these experiences that we have as we see things a bit differently?

The clinician sensitively probed these experiences whilst asking Simon to consider them. The patients began to accept that a personal experience that was aversive might lead to a misunderstanding of the underlying process contributing to someone's attitude. Simon did not realise that he was seen as superior and demeaning; John had no idea that Simon was anxious. Developing this theme further with contribution from the clinician's perspective increases the quality of mentalizing relationships. In addition if other patients can also outline their own experience of Simon's attitude and John can contrast those with his own the quality score for relational mentalizing will increase..

Item: Mentalizing the counter-relationship

The clinician openly communicates what is in his/her mind when it is relevant to the patient-clinician interaction. This is especially the case when something in a session or across sessions interferes with treatment progress. For example, the clinician's mind may be taken up by over-protective wishes for a patient or by fearfulness of or dislike for a patient. Such feelings will occupy his/her mind and prevent a focus on the patient, and may also be of particular relevance to how the patient relates to others. In MBT it is recommended that the clinician quarantines these feelings initially, while they are identified, then talks about them openly but in a way that shows that it is the clinician's mind that is the subject of scrutiny – that is, to what extent he/she is reacting to the context, content and process of treatment. Is this just him/her, or is this relevant to the patient's way of functioning?

Presentation of the counter-responsiveness of the clinician to the group and group members follows the same principles. At times the counter-relationship of the clinician may be about the group itself rather than the individuals in the group. In this context the clinician presents his experience of the group and this may be important when trying to address an impasse involving all group members.

Example: the patients were talking to each other in a lively and jocular manner and yet, to the clinician, they seemed to be talking about nothing in particular. Whenever the clinician tried to intervene he was ignored. Eventually he presented his reaction to all this in terms of being pushed out and his worry that the patients were not really focusing on anything but were socialising. The patients immediately responded by

presenting their own experience of their interactions, reporting the conversation as helpful. This allowed the clinician to ask about how the conversation was helpful and to increase the reflection of the patients on what they had been doing.

To what extent does the clinician:

Identify his/her own feelings in the session to elaborate the relationship with the patient?

Express his/her feelings to address significant factors that interfere with the relationship with the patient?

The following interventions *decrease* the quality of MBT:

Item: Addressing non-mentalizing process through clinician mentalizing

Item: Joining with non-mentalizing modes

Item: Past to present interpretation implying causality

Item: Countertransference interpretation

Item: Free association

Item: Socratic questioning to disconfirm or invalidate beliefs