What is mentalization based therapy?

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Understanding borderline behaviour

Mentalizing

In order to adaptively predict and justify each others’ actions

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

Cognitive Prerequisites for Mentalization

- To be able to represent causal mental states of others
  with COUNTERFACTUAL contents (FALSE BELIEFS)
- To be able to represent causal mental states of others
  with FICTIONAL contents (PRETENCE, imagination, fantasy)
- To simultaneously represent and differentiate between
  the MENTAL MODELS of the SELF and of the OTHER
  about reality
- To infer and attribute the mental states of Others from
  visible behavioural cues as mind states are INVISIBLE
- To be able to detect our own perceptible (behavioural,
  physiological, emotional, arousal, etc.) cues in order to
  infer, interpret, and attribute mental states to our Self

Approaches to mentalisation

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

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

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

Mentalizing implicitly versus explicitly

<table>
<thead>
<tr>
<th>IMPLICIT</th>
<th>EXPLICIT</th>
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<tbody>
<tr>
<td>perceived</td>
<td>interpreted</td>
</tr>
<tr>
<td>nonconscious</td>
<td>conscious</td>
</tr>
<tr>
<td>nonverbal</td>
<td>verbal</td>
</tr>
<tr>
<td>unreflective</td>
<td>reflective</td>
</tr>
<tr>
<td>e.g., mirroring</td>
<td>e.g., explaining</td>
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Imagination in mentalizing: A balancing act

<table>
<thead>
<tr>
<th>Search and Destroy</th>
<th>Compartmentalizing</th>
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<tbody>
<tr>
<td>nonmentalizing</td>
<td>mentalizing</td>
</tr>
<tr>
<td>grounded</td>
<td>distorted</td>
</tr>
<tr>
<td>concrete &amp; stimulus-bound</td>
<td>imagination</td>
</tr>
<tr>
<td>imagination</td>
<td>gone wild</td>
</tr>
<tr>
<td>(paranoia)</td>
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Mindblindness

<table>
<thead>
<tr>
<th>Excrementalizing</th>
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<tbody>
<tr>
<td>mentalizing</td>
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<tr>
<td>imagination</td>
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<tr>
<td>imagination</td>
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<td>gone wild</td>
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Being misunderstood

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

Mean Eyes Scores of Self-harming/Suicidal patients (n=25), PD controls (n=25), Axis-I (n=24) and non-Psychiatric Controls (n=25)

(Fonagy, Stein, Allen & Vrouva, 2005)

Mentalizing and Borderline Personality Disorder
Assumed cause of mentalisation deficit in BPD

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

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

<table>
<thead>
<tr>
<th>Non-Abused</th>
<th>High RF</th>
<th>Low RF</th>
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</thead>
<tbody>
<tr>
<td>Abused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Abused</td>
<td>88.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Abused</td>
<td>83.3%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>
| Likelihood ratio: Chi-squared=8.67, df=1, p<.004

Three key aspects of development of mentalizing

1. Congruence
2. Marking
3. Arousal

The Development of Affect Regulation

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

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

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

(Gergely, Fonagy, Koos, et al., 2004) F(interaction)=12.00, df=2,137, p<.0001
Secure individuals, who had an attentive attuned carer, have more robust capacities to symbolically represent emotional states in their own and other people’s minds and this can serve to protect them from future psychosocial adversity.

BPD patients have normal mentalizing capacities except under conditions of arousal and intense attachment.

Mentalizing problems manifest in individuals associated with traumatic experiences perhaps as a defensive manoeuvre?

Vulnerability to trauma is greater in individuals with weaker affect regulation and attentional control.

Limitations in mentalisation brings forth pre-mentalistic ways of representing mind.

BPD patients think less about mental state of person he/she is playing with.

BPD patients noticed when the other person reacted contingently with them (gave more when they gave more, less when they gave less).

BPD patients did not react to what their partner did independently of their actions.

The implication of the temporary loss of mentalising:

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

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

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

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

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

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

Therapist stance

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

Summary
The aims of treatment are
- To promote mentalizing about oneself
- To promote mentalizing about others
- To promote mentalizing of relationships
  - By being alert to non-mentalizing processes in yourself and the patient
So gradually you and the patient will increasingly respect the privacy of minds and become surprised about what you find.

Therapist/Patient Problem

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

Therapist/Patient Problem

Therapist/Patient Problem
Therapist/Patient Problem

ATTEMPT TO STRUCTURE by EFFORT TO CONTROL SELF & OR OTHER

RIGID SCHEMATIC REPRESENTATION
NON-MENTALIZING
CONCRETE MENTALIZING (PSYCHIC EQUIVALENCE)
PSUEDO MENTALIZING (PRETEND)
MISUSE OF MENTALIZING

Therapist Stance

- Not-Knowing
  - Neither therapist nor patient experiences interactions other than impressionistically
  - Identify difference - “I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you”.
  - Acceptance of different perspectives
  - Active questioning

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

Clinical summary of intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- Explore current emotional context in session by identifying the momentary affective state between patient and therapist
- Identify your contribution to the break in mentalizing
- Seek to mentalize the transference

Clinical Implications

Mentalizing and Self-disclosure

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

- Psychic equivalence, Pretend Mode: Validation as a technique
  - Observing and reflection are common to every therapy and are an essential aspect to MBT
  - Used to confirm the patient’s experience and contingent response as being understandable in a specific context
  - Focus is on exploration and on elaborating a multi-faceted representation based on current experience particularly with the therapist to identify distortions if present
  - Move towards mentalizing the transference
Psychic Equivalence and Fantasy development

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

Components of mentalizing the transference

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

Conclusions of Vermote Trial

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

Heterogeneity of borderline personality disorder

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

For further information
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