33.18
Mentalization-Based Treatment

Anthony W. Bateman, F.R.C.Psych.
Peter Fonagy, Ph.D.

Introduction and Definition

Mentalization-based treatment (MBT) is an evidence-based treatment for BPD. Randomized controlled trials (RCTs) have demonstrated its effectiveness in reducing the core symptoms of BPD and it is currently being studied for other conditions, including antisocial personality disorder (ASPD) and avoidant personality disorder, substance abuse, depression, and eating disorders.

This chapter will outline the theoretical basis of MBT and the core treatment model in relation to BPD.

What Is Mentalizing?

Mentalizing is the social cognitive ability to understand actions by other people and oneself in terms of mental states, including thoughts, feelings, wishes, and desires; it is a very human capability that underpins everyday interactions. In nontechnical language, it is attentiveness to thinking and feeling in oneself and others. It is beyond question that mental states influence behavior. Beliefs, wishes, feelings, and thoughts, whether within or outside people's awareness, always influence what people do. Mentalizing involves a whole spectrum of capacities: critically, this includes the ability to experience one's *own* behavior as coherently organized by mental states, and to differentiate oneself psychologically from others. These capacities are reduced in individuals with a personality disorder, who lose cognitive and emotional coherence, particularly at moments of interpersonal (relational) stress, which challenge one's mentalizing capacities. In the authors' view, many symptoms characteristic of BPD emerge in

association with a distortion or reduction in mentalizing. Based on this understanding of BPD, MBT is a psychotherapy that focuses specifically on the mentalizing vulnerabilities of the patient in the context of an understanding of attachment process, which is the developmental context in which mentalizing is originally acquired.

History

The word “mentalizing” has been in existence for two centuries and in the *Oxford English Dictionary* for the past century. French psychoanalysts introduced the concept into the professional psychotherapy literature in the second half of the 20th century, and mentalizing came into the English professional literature on the cusp of the final decade, conceived of initially as a deficit in autism and as a transiently impaired process associated with profound insecurity in attachment relationships in the developmental psychopathology of BPD. This proposal was the origin for the development of MBT. The approach is rooted in attachment theory and psychoanalytic ideas, but in the interest of parsimony sheds many of the core assumptions of both theoretical approaches while negating neither body of work. Its historical origin is born from the authors' wish to extend what they saw as the clear benefits of using a psychotherapeutic approach to professionals (nurses, rehabilitation or addiction counsellors, activity therapists) who normally did not have opportunities to undertake extensive training in particular psychotherapeutic modalities. The authors wished to extract core elements of a

therapeutic approach that could be linked to experimentally observed distortions of mental function in personality disorders.

Theoretical Issues

The Role of Mentalizing in Therapy

MBT is based on the assumption that failure of mentalizing, while common to everyone, becomes a dominant feature in individuals with personality disorders, leading to both serious interpersonal problems and profound psychological distress. A number of therapies that have been shown to be successful in addressing the difficulties experienced by individuals with BPD appear to strengthen the patient's capacity to mentalize; for example, conversational therapy, cognitive analytic therapy, and certain aspects of dialectical behavior therapy. MBT is unique in attempting to understand the problematic and distressing aspects of severe personality disorder in terms of a failure of mentalizing (see later) and to focus a structured therapeutic approach on addressing problems of mentalizing as they occur in a therapy session. The overarching principle of MBT is to enhance mentalizing in the context of the therapeutic relationship (in both individual and group sessions) by systematically addressing instances of nonmentalizing and using these moments of discourse as opportunities to work with the patient to achieve a fuller psychological understanding of behavior. The significance of this process rests in the hope of generalization from the therapeutic situation to the wider social context. It is in this wider context that, from the perspective of the MBT clinician, the key difficulties blocking the possibility of change lie for the patient with BPD.

The Multidimensional Nature of Mentalizing

Mentalizing is not an entirely stable, consistent, or unidimensional capacity. Neuroscience has identified four distinct components to mentalizing, which the authors have organized into dimensions that they see as helpful for therapists to identify in the clinical practice of MBT:

1. Automatic versus controlled mentalizing
2. Mentalizing the self versus others
3. Mentalizing with regard to internal versus external features
4. Cognitive versus affective mentalizing.

To mentalize effectively requires the individual not only to be able to maintain a balance across these dimensions of social cognition but also to apply them appropriately according to context. Consistent favoring of one or other side (or *pole*) of these dimensions leads to distorted understanding of mental states, associated with profound social and emotional difficulties.

In an adult with personality disorder, consistent distortions of social cognition consequent on imbalanced mentalizing on at least one of these four dimensions would be evident. Commonly, one or more of the dimensions underperforms at one end, and consequently the opposite pole comes to dominate social cognition. For example, excessively emotional thinking emerges in the absence of cognitive mentalizing, or the influence of others dominates if subjective experience of self-states is reduced. From this perspective, different types of psychopathology can be distinguished on the basis of different combinations of impairments along the four dimensions. In other words, personality disorders (and, to some extent, other psychiatric disorders) can be understood according to different characteristic *mentalizing profiles*.

Automatic versus Controlled Mentalizing

The most fundamental dimension to mentalizing is the spectrum between *automatic* (or

implicit) and *controlled* (or *explicit*) mentalizing.

Controlled mentalizing reflects a serial and relatively slow process, which is typically verbal and demands reflection, attention, awareness, intention, and effort. For example, a person might misunderstand someone, so they stop them and ask them to explain more clearly what is underlying their statements, or they focus their own mind to work out what their opinion may be. People tell stories to others about their mental states; they think back into their past and report how they felt long ago; they enjoy autobiographical coherence in their personal lives and tell others about it.

The opposite pole of this dimension, *automatic mentalizing*, involves much faster processing, tends to be reflexive, and requires little or no attention, awareness, intention, or effort. In day-to-day life and ordinary social interaction, most mentalizing tends to be automatic because most straightforward exchanges do not require more attention. People in conversation naturally take turns, adapt their tone and posture to others' emotional states, and reflexively take into account their knowledge.

Self versus Others

This mentalizing dimension involves the capacity to mentalize one's own state—the *self* (including one's own physical experiences)—or the state of *others.* The two are closely connected, and an imbalance signals vulnerability in mentalizing of both others and/or the self. Individuals with mentalizing difficulties are likely to preferentially focus on one end of the spectrum, although they may be impaired at both. Awareness of the mental states of others is in part mediated by neural structures that organize one's own actions (the *mirror neuron system*), moderated by explicit reflective processes that reinforce the self–other distinction. If explicit mentalizing is weakened, the influence of the current mental state of the other will increase.

Internal versus External Mentalizing

Mentalizing can involve making inferences on the basis of the *external* indicators of a person's mental states (e.g., facial expressions, tone of voice, body posture) or figuring out someone's *internal* experience from what P.2896 one knows about them and the situation they are in. This dimension does not simply refer to a process of focusing on the externally visible manifestations versus the internal mental state of others, it also applies to the self—it includes thinking about oneself and one's own mind state versus considering one's current (external) situation and physical (interoceptive) state. Someone who has poor access to and great uncertainty about their subjective experience, for example, as is often seen in individuals with BPD, may come to a conclusion about what they are feeling from the reactions of others as well as from observing their own behavior: for example, their legs are restless, therefore they must be feeling anxious.

Cognitive versus Affective Mentalizing

Cognitive mentalizing involves the ability to name, recognize, and reason about mental states (in both oneself and others), whereas *affective* mentalizing involves the ability to experience and understand associated *feelings* (again, in both oneself and others). Both are required for any genuine experience of empathy or true sense of self-coherence. Some individuals give undue weight to either cognitive or affective mentalizing. People with obsessional characteristics may be masters at explicating in detail the internal states of themselves and others, but this may be devoid of emotional content and meaning. Conversely, people with BPD are flooded with emotion and so prone to automatic process, reactivity, emotional contagion, and poor self–other

differentiation. Intense emotion can disrupt the process of cognitive appraisal that normally helps to regulate it.

Dimensional Mentalizing Profile and BPD

Particularly when arousal increases, as is typical in the context of intense attachment relationships, individuals with BPD easily find themselves switching to automatic mentalizing. Stress and arousal, especially in an attachment context, bring automatic mentalizing to the fore and disengage the neural systems that are associated with controlled mentalizing. Under these conditions, interactions become nonquestioning precisely when they need to be more controlled and contextualized. Thinking becomes impulsive: the individual makes quick assumptions about others' thoughts and feelings, which are not reflected upon or tested. Logic is intuitive,
unreasoned, and nonverbal; it is marked by an unwarranted certainty, which betrays its unreflective origin. As a consequence, patients show severe impairments in interpersonal and intimate relationships; for example, they may be overly distrustful (paranoid) or, indeed, overly trustful (naive).

Table 33.18–1. Modes of Nonmentalizing: Psychic Equivalence

Clinical appearance	Certainty/suspension of doubt
	Absolute
	Reality is defined by self-experience
	Finality—“It just is”
	Internal is seen as equivalent to external
Clinician's experience	Puzzled
	Wish to refute
	Statement appears logical but obviously overgeneralized
	Not sure what to say
	Angry or fed up and hopeless
Intervention	Empathic validation with subjective experience
	Curious—“How did you reach that conclusion?”
	Presentation of clinician's puzzlement (marked)
	Linked topic (diversion) to trigger mentalizing then return to psychic equivalent area
Iatrogenic	Argue with patient
	Excessive focus on content
	Cognitive challenge

Patients with BPD may show excessive concern about their own internal state, that is, they *hypermentalize* in relation to the self. At the same time, these views of the self develop without reference to social reality, namely an awareness of how others perceive one. Failure to balance self-perception with sincere curiosity about how one is perceived by others can lead to exaggerations of the self-image, in both positive and negative directions. A balanced, adaptive

form of self-mentalizing conditioned by the social context is lost.

Patients with BPD pay more attention to external indicators of mental states, and their initial ideas arising from automatic mentalizing are left unchecked by controlled/reflective mentalizing. For example, if the clinician frowns, perhaps pensively, the patient may interpret this as looking angry or disgusted with them; seeing the clinician look at the clock during a session can stimulate an internal state of overwhelming unease and an experience that the clinician wants to be rid of them when, in reality, the internal state of the clinician is concern about the time left to work on the issue being discussed. A focus on external features, in the absence of reflective mentalizing, makes an individual highly vulnerable in social contexts, as it generates interpersonal hypersensitivity.

The Reemergence of Nonmentalizing Modes and BPD

While the dimensions of mentalizing can reflect anomalies in terms of mechanisms, that is not what the clinician sees. What the patient and the mentalizing clinician experience is a product of a malfunctioning mentalizing system, driven by imbalances in the dimensions of mentalizing. The outcomes of these malfunctions can be grouped into three typical modes of subjectivity for the purpose of illuminating clinical experience. The modes are termed *psychic equivalence mode*, *teleological mode*, and *pretend mode.* These modes are summarized in Tables 33.18–1 through 33.18–3, which also outline MBT interventions to address each nonmentalizing mode.

Table 33.18–2. Modes of Nonmentalizing: Pretend Mode

Clinical appearance	Inconsequential talk/groundless inferences about mental states Lack of affect. Absence of pleasure
	Circularity without conclusion—“spinning in sand” (hypermentalizing)
	No change
	Dissociation—self-harm to avoid meaninglessness
	Body and mind decoupled
Clinician's experience	Boredom
	Detachment
	Patient agrees with clinician's concepts and ideas
	Identification with clinician's model
	Feels progress is made in therapy
Intervention	Probe extent
	Counterintuitive
	Challenge
Iatrogenic	Nonrecognition
	Joining in with acceptance as real
	Insight-orientated/skill acquisition intervention

The nonmentalizing modes are important for the clinician to recognize and understand, as they tend to emerge in the consulting room

and reflect core aspects of the patient's experience. It is important to address them because they cause considerable interpersonal difficulties and result in destructive behaviors.

Table 33.18–3. Modes of Nonmentalizing: Teleological Mode

Clinical appearance	Expectation of things being “done” Outcomes in physical world determine understanding of inner state—“I took an overdose; I must have been suicidal” Motives of others are based on what actually happens Only actions can change mental process “What you do and not what you say”
Clinician's experience	Uncertainty and anxiety Wish to do something—medication review, letter, telephone call, extend session
Intervention	Empathic validation of need
	Do (or do not do) according to exploration of need Affect focus of dilemma of doing
Iatrogenic	Excessive “doing” “Prove” clinician cares in the belief it will induce positive change Elasticity (extending what clinician does, e.g., providing extra sessions, only to rebound with extra constraints) rather than flexibility

Psychic Equivalence Mode

In the *psychic equivalence mode*, thoughts and feelings become “too real” to a point where it is extremely difficult for the patient 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. Patients with BPD who are in this mode describe an overriding sense of certainty about their beliefs, for example, “the therapist does not like me” or “I am a wicked person.” Such a state of mind can be extremely frightening, adding a powerful sense of drama and risk to life experiences. The sometimes extreme reactions of patients are justified by the seriousness and realness with which they can experience their own and others' thoughts and feelings. The vividness and bizarreness of subjective experience can appear as quasipsychotic symptoms and are also manifested in the physically compelling memories associated with trauma. More important to appreciate is that negative affect in this mode will be overwhelming and cause very deep distress to the sufferer. Psychic equivalence permits no alternative perspectives to be taken. The patient can feel locked into an extraordinarily profound sense of pain without the slightest possibility that matters could be any different from how they currently are. This state of hopelessness makes suicidality comprehensible.

Teleological Mode

In the *teleological mode*, states of mind are recognized and believed only if their outcomes are physically observable. Hence, the individual can recognize 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. The teleological mode shows itself in patients who are imbalanced toward the external pole of the internal–external mentalizing dimension—they are heavily biased toward understanding how people (and they themselves) behave and what their intentions may be in terms of what they physically do. Impulsivity involves function in teleological mode and a heavy emphasis on the automatic pole of the automatic–controlled dimension. There is insufficient reflection concerning the impact of one's actions on others, or on oneself. In teleological mode, the individual cannot accept anything other than a physical action as a true expression of the other person's intentions. Friends of a patient might constantly assure the patient of their love and support, and yet none of that feels real: it does not address the “hole” that the patient falls into at certain, especially lonely, times when they feel terrible emptiness. Feeling that interpersonal affection can only be real if it is accompanied by physical behavior explains some risky sexual behavior, but also the need to create physical distractions that help with the feeling that all verbal expressions of interpersonal affection are without real meaning (see case example, later). The teleological mode makes the need for action and generation of “real” change overwhelming. The so-called “manipulativeness” of patients with personality disorder is little more than the experience of a pressing need to feel genuine reactions from others in terms of actions rather than words.

Pretend Mode

In the *pretend mode*, thoughts and feelings become severed from reality. Taken to an extreme, this may lead to
feelings of derealization and dissociation. Patients in pretend mode can discuss experiences without contextualizing these in any kind of physical or material reality, as if they were creating a pretend world. The patient may *hypermentalize* or *pseudomentalize*, a state in which they may say much about states of mind 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 and will achieve no change. The limited capacity to experience a sense of an internal world gives rise to a deep and extremely distressing sense of emptiness. Dramatic action—for example, sometimes violent action against the self—may be experienced as the best way of addressing such feelings.

In summary, imbalances within the dimensions of mentalizing predictably generate the nonmentalizing modes. Psychic equivalence is inevitable if emotion (affect) dominates cognition. Teleological mode follows from an exclusive focus on external features to the neglect of the internal. Pretend mode thinking and hypermentalizing are unavoidable if reflective, explicit, controlled mentalizing is not well established.

Attachment

It is a central tenet of the mentalization-based approach that a sense of self and the capacity to mentalize both develop in the context of attachment relationships. The child observes, mirrors, and then internalizes their attachment figures' ability to represent and reflect mental states. So the reflections need to be *contingent*—that is, related to the child's internal experience—accurate, and *marked*—that is, indicating, for example, using “motherese” (a

special tone of voice), that what is being expressed is a representation of the mind of the child and not that of the caregiver. Hence, the self and others—and the capacity to reflect on the self and others—are inevitably closely intertwined. Disorders that are characterized by severe impairments in feelings of self-identity, a central tenet of the pathology of BPD—, are also characterized by severe deficits in the ability to reflect about others' mental states. However, this should not be taken to mean that an individual whose capacity to mentalize themselves is impaired will always show similar impairments in their ability to mentalize others. For example, individuals with ASPD can often be surprisingly skilled in “reading the mind” of others, but typically lack any real understanding of their own inner world.

In BPD there is commonly a history of early (in particular emotional) neglect, and a disrupted early social environment in general,

and this may contribute to undermining the ability of some individuals to develop full mentalizing capacities. Subsequent adversity or trauma may further disrupt mentalizing, in part as an adaptive maneuver on the part of the individual to limit exposure to a brutalizing psychosocial environment, and in part because the high level of arousal generated by attachment hyperactivation and disorganized attachment strategies serve to disrupt less well-practiced and less robustly established higher cognitive capacities. In addition, genetic influences may be expressed through the mediation of mentalizing.

In sum, the mentalizing model is not strictly an etiological model, although it clearly prioritizes a social psychiatry perspective; it points to a final common developmental pathway that a range of biological, family, and broader social contextual influences may take to generate the range of difficulties that are normally considered under the term “personality disorder.”

Techniques

MBT is a group and individual treatment. It is anticipated that, at times, the patient will experience strong affect while focusing on identified problems in treatment sessions and their mentalizing will be limited or failing, and/or the patient's understanding of the way mental states link to behavior is inadequate.

The clinician addresses this by a structured process (the sessional intervention trajectory) of:

1. Empathy and validation about problem areas
2. Clarification, exploration, and, where necessary, challenge
3. Following a structured process to gently expand mentalizing and encourage the patient to identify the mental states previously outside their awareness.

The process is primarily in the here and now of the session but increasingly, as the patient's mentalizing improves, it comes to concern core attachment relationships, including how these are activated with the clinician and key figures in the patient's life and how they influence mentalizing itself. Gradually, improvements in mentalizing serve to enable the patient to address their distorted representations of personal and social relationships.

Therapeutic Alliance and Engagement in the Model

The assessment and introductory process in MBT facilitates the alliance between patient and clinician (see Table 33.18–4) and introduces the patient to the treatment frame. An MBT-Introductory group of 10 to 12 sessions assists in the development of the formulation and facilitates the alliance. This psychoeducational intervention covers all areas of mentalizing, attachment processes, personality disorder, emotion management, and treatment itself. This

preparatory work aims to ensure patients know what they are facing in trying to address their problems and are fully aware of the method and focus of treatment.

Table 33.18–4. Alliance Building in MBT
Identification of patient's mentalizing vulnerabilities in an understandable form Formulation of problems—agreed between patient and clinician Identification of patient's risk profile and crisis management strategies Agreement of short-term and long-term goals

MBT is collaborative. Nothing can occur without joint discussion, taking into account the mental experiences and ideas of both patient and clinician. The process of mentalizing requires an authentic desire to understand the mental processes of oneself and others. This applies as much to the clinician as to the patient. So the MBT clinician focuses on the patient's mind and attempts to understand their experience. Similarly, the patient is asked to aim to do the same in relation to the clinician—for example, the patient's perspective “Why does my clinician want me to focus on this at the moment?” may be paired with the clinician's, “Why does my patient *not* want to focus on this at the moment?” The therapeutic process has to become a shared endeavor aimed at extending the influence of explicit, reflective, cognitive, internally focused mentalizing. Initial goals, on the road to improved mentalizing, are jointly developed and focused on. The goals cannot solely be those of the patient, although the patient's aims take priority unless they are antithetical to the whole process of treatment. The sharing of responsibility for the therapeutic process is at the core of the effectiveness of the treatment approach in the pursuit of improved mental state understanding.

Assessment involves delineation of the patient's mentalizing vulnerabilities and mentalizing profile, identification of nonmentalizing cycles (see case example, later) and a shared formulation, which includes specific detail of attachment patterns and areas of vulnerability to emotional dysregulation. This has to be understood by the patient and is for both patient and clinician. The formulation identifies common relational fears, for example, abandonment, which stimulate the patient's attachment system and result in the use of maladaptive attachment strategies in interpersonal interactions. In brief, the pattern of the patient's relationships informs an understanding of the relationship in treatment, and the relationship in treatment is used to reappraise the relationships in life outside treatment. Finally, it is important that the patient and clinician consider establishing a goal of improving social function. This will include work, social activity, voluntary work, education and other constructive life-affirming activity.

Table 33.18–5. Clinical Principles in MBT

The clinician must:

Remain alert to imbalances of the mentalizing dimensions and emergence of nonmentalizing modes Monitor the patient's arousal levels to maintain optimal mentalizing

Seek moments of mentalizing vulnerability related to events in the patient's life or in the session itself Maintain their own mentalizing

Not meet nonmentalizing in the patient with high-level mentalizing

Match interventions to the patient's mentalizing capacity

Clinical Principles in MBT

Clinicians follow a number of principles when treating patients with MBT (see Table 33.18–5). MBT recommends an authentic “not-knowing” stance that forms the bedrock for exploration of the patient's perspective. The not knowing stance refers to respecting the opacity of mental states. Minds can never be “known” and it is important that the clinician recognizes that mental processes generate experiences imbued with uncertainty. The clinician's task is to take an inquisitive stance—a wish to inquire and a willingness to be surprised by the patient's response—with the aim of facilitating the patient's increased awareness of their internal states through a social process. This may be particularly important around the point at which

experiences of ideas and feelings begin to collapse into nonmentalizing modes, leading to destructive behaviors or intolerable feeling states. It is not for the clinician to compensate for the patient's mentalizing failure with their own high-level mentalizing, “explaining” to the patient what they may have experienced. Nonmentalizing in the patient cannot be met by mentalizing in the clinician; it can be met only by “switching on” mentalizing in the patient via the range of techniques that MBT uses in the clinical situation.

Primarily, the clinician is alert to nonmentalizing in terms of the different manifest modes of nonmentalizing, but also in terms of the indications that the patient's functioning is fixed at one pole of any of the dimensions of mentalizing. In general, as described earlier, mentalizing is optimal when the dimensions—for example, emotion and cognition, or representation of self and other—are in balance and nonmentalizing modes are inactive. The key for the clinician is to be constantly aware of imbalance and lack of flexibility in terms of the dimensions and if any dimension is operating in a nonmentalizing mode. Nonmentalizing in a dimension or mode is an indication that intervention is necessary. An exclusive focus on feelings and ideas in relation to the self should suggest to the clinician that exploring the mental states of the other is called for. Similarly, exclusive concern with emotions suggests the need to bring cognitions into the foreground through judicious inquiry.

Second, the clinician monitors arousal levels carefully, ensuring that anxiety is neither too low nor too high, as both interfere with mentalizing. Similarly, if attachment feelings (e.g., in relation to the therapist) become too
strong, a shift to less charged relationships may help restore mentalizing.

Third, the focus of a session is maintained through the clinician always seeking moments of mentalizing vulnerability either in relation to events in the patient's life or in the session itself. Mentalizing failure is best indicated by the clinician's experience of being challenged to understand the patient and consequently feeling a degree of confusion about how to respond.

At these times, rewinding to moments when shared understanding characterized the discourse is the best solution.

Fourth, the clinician makes sure that their own mentalizing is maintained. It is not possible to deliver effective treatment if the clinician's mentalizing is compromised. So the MBT clinician always monitors their own capacities and may even have to explicitly own this experience, for example, by saying that their mind has become muddled and they cannot think. This type of self-disclosure of the mind state of the clinician should not be confused with sharing personal information. Sharing the effect that a patient's actions and state of mind is having on the clinician acts in the service of asking the patient to consider another mind as well as their own and has the implicit aim of enhancing mentalizing.

Sessions are focused. They do not consist of free associative dialogue that seeks to illuminate unconscious process. The target area is working memory or preconsciously held experience. It is expected that a focus for a given session will have been achieved after 10 to 15 minutes of the session, and this focus will then become the pivotal point around which the clinician and patient orient themselves, returning to it whenever nonmentalizing comes to dominate the interaction.

Finally, interventions are carefully matched to the mentalizing capacities of the patient. It is no good offering complex interventions that require considerable thought and appraisal to an individual functioning in psychic equivalence mode. At best, this serves to take over their mentalizing for them, rather than facilitating its rekindling. As stated earlier, nonmentalizing in the patient cannot be recovered by mentalizing in the clinician, but only by reactivating mentalizing in the patient. This is achieved through a series of steps, which underpin the trajectory of every MBT session and may recur several times within each session.

Trajectory of MBT Session and Interventions

Empathic Validation

The initial step in a session is listening to the patient's narrative. Listening to the patient's story allows the clinician to begin by empathic validation. Empathic validation and establishing a shared affective platform held between patient and clinician increases the patient's experience that they are not alone and indicates that another mind can be useful to clarify mental states and increase a sense of agency. Increasing focus on affect and interpersonal interaction during a session and over time provides the context in which to explore ever more complex states of mind within an attachment context that would normally trigger loss of mentalizing.

Empathic validation requires the clinician to find something in the story that they can empathize with. This is not the same as behaving in a sympathetic manner or saying things that repeat the patient's story. Empathic validation seeks to engender in the patient a sense that the clinician really understands the patient, their internal state, and the issue they are talking about. This is the clinical equivalent of attachment-based contingent responsiveness. Validation is an affectively based intervention with important cognitive components; the key component is the creation of a sense of alignment with the patient's internal emotional state by demonstrating an appreciation of the experience and the consequent secondary emotions triggered by a powerful emotional reaction (e.g., the patient's fury with a partner engenders deep distress and anxiety). A lack of appreciation of the patient's emotional experience and its impact on the patient's current state (noncontingent responsiveness on the part of the clinician) is likely to trigger nonmentalizing (e.g., pseudomentalizing) or generate avoidant or other insecure and disorganized attachment strategies. Once contingent responding has increased collaboration and

reduced the patient's arousal, maintaining emotions at a manageable level, the clinician can consider sensitive but less contingent responses to try to stimulate mentalizing about the story the patient brings.

Clarification and Exploration

The second step is clarification and exploration (see case example, later). The “story” the patient brings is clarified. This is not clarification of facts about the narrative or events, although this must also take place. The clinician establishes the facts as quickly as possible. For example, if the patient speaks about an act of self-harm or a suicide attempt, a drunken brawl or an emotional outburst, the clinician quickly elicits when it occurred, who was there, what were the circumstances, and so on. This will indicate the level of risk and provide other important information. More than this, though, the MBT clinician wishes to contextualize events with mentalizing. Clarification establishes the reflection the patient has on the events—what was their “premorbid” state of mind, what were their hopes, what was their experience when they were waiting for their boyfriend to return home, what thoughts intruded into their mind, what feelings did they identify, and can they reflect on it differently now? This process of clarification, in the service of engaging mentalizing, links inextricably with affect identification and exploration, which is the third step.

Affects and Affect Identification

Affects and interpersonal relationships reciprocally interact and are core to the personality problems characteristic of BPD. Unmanageable emotions impinge on relationships, and relationships stimulate powerful feelings. Patients may not be able to identify their feelings accurately but experience

them primarily as inchoate bodily experiences. Working with the patient to identify a range of feelings is part of the clarification and exploration component of MBT (see case example, later). Sometimes, emotions in specific contexts have to be normalized. Too often, patients feel that their experience is wrong; in effect, they invalidate
their own internal perceptions and feel ashamed. It may be that their feeling is appropriate but excessive, or at other times inexplicably absent. All this becomes clear if the clinician systematically focuses on affects. Initially, the affects associated with the events are established, then any reflection on those feelings are clarified, followed by eliciting current concerns about the events.

Clarification of current affect in the session is included as the third step if the patient and clinician retain their capacity to jointly mentalize around the focus. This is more than asking the patient how they feel at the moment or how they “feel about” an experience they reported, although this may be an initial component. The process requires the identification of *current* affect *related to talking about events to the clinician in the session*.

This expansion from identifying affects in relation to events to affect experienced while talking to the clinician about the events is named the *affect focus* of the session. The patient may initially bring intense rage into the session in relation to an experience of rejection, which is gradually clarified as having been caused by characteristic inappropriate behaviors on the part of the patient. The affect focus turns out to be a sense of humiliation the patient experiences in once again failing to manage their own actions in a more effective manner. The aim throughout this process is to build a robust platform of mentalized experience jointly recognized and shared by the patient and clinician, which incorporates the complexity of mental states and moves the

patient beyond a nonmentalizing, narrow oversimplification of their uncontextualized feelings.

The affect focus, that is, identification of the interpersonal interaction in the session and the associated affect, if accurate, heightens the focus on the clinician–patient interaction in the moment of the session. This often indicates that a patient's attachment strategies and relational patterns, or possibly those of the clinician, are being activated. So it allows a move toward *mentalizing the relationship*, the final step of the intervention trajectory.

Presenting Alternative Perspectives

Before extending to incorporate the relationship with the clinician into the patient's narrative, the clinician endeavors to enhance the patient's mentalizing by broadening the patient's perspectives on an event. This follows naturally from clarification and the affect focus, and entails elaborating the mental states of the participants in an event. However, it gradually moves the focus from emotion to cognition. The clinician explores alternative ways of looking an event, at first playfully but sometimes in a mildly challenging manner. If the affect focus helped reestablish more balanced mentalizing, then considering additional possibilities of what may have happened, at the level of thoughts and feelings, helps further reengage the patient's mentalizing processes.

Alternative perspectives may entail reconsiderations of entire scenarios from the point of view of the patient's hypotheses about the thoughts and feelings of others, or a reevaluation of the putative sequence of the patient's reactions—reframing their version of events in the light of alternative thoughts and feelings which they may have also been experiencing. The aim of alternative perspectives is the gentle expansion of the patient's mentalizing, to move from the certainty of affect toward the doubt of cognition. In general, the move is also from situational (external determinants) to exploring putative internal states. If the patient's focus was exclusively on their own state of mind the alternative perspective may bring in the other, while if the focus was on all protagonists other than the patient, the alternative perspective can focus on the self. Overall, the clinician engenders a recognition that a pause for reflection and explicit mentalizing may be of value in addition to intuition and the certainty automatic mentalizing can bring.

Mentalizing the Relationship

The groundwork for mentalizing the relationship will have been done through the development of the formulation, which identifies the predominant attachment strategies of the patient.

Mentalizing the relationship in a session is conceptualized as a training ground for managing difficult feelings in interpersonal situations in daily life through maintaining mentalizing while within an emotional interaction. The authors have identified a number of steps for the clinician to consider, which follow closely the three steps of technique described above. First, the clinician has to empathically validate the patient's perception of the clinician. If the patient says that they experience the clinician in a particular way, then the clinician needs to find part of that experience that they can validate. The clinician actively avoids invalidating the patient's experience. Second, the clinician needs to work out their contribution to the patient's experience of the clinician. The clinician does this explicitly by thinking aloud about it and asking the patient to explain how they have come to that conclusion. This questioning must be authentic and genuinely curious, and must not come from a perspective that implies that the patient's experience is inaccurate or a reemergence of the past distorting the present. Such an invalidating attitude will lead to therapeutic rupture because invalidation (a noncontingent response) will lead to increased arousal and a consequent reduction in mentalizing. Mentalizing the relationship can meaningfully take place only in the context of mentalizing. Once the clinician has accepted their role in the relational process, the next step of more detailed exploration can occur. In this step, the aim is to

generate a more complex understanding of the relationship, to see it from a different angle, and to see what its relevance is for the patient's life. It is not to engender insight in the sense of understanding the operation of the past in the present, although this may arise as part of the patient's broader understanding of their emotional experience. Critically, the past is used only sparingly as an explanation of the present, in case considering the past leads to a nonmentalizing, reductionist “short-cut” that obscures rather than elaborates the patient's current experience. In MBT, the clinician is cautioned about offering historical interpretation in the context of nonmentalizing process. For the exploration of the therapeutic relationship to contribute to enhanced mentalizing, the clinician works toward increased complexity and the establishment of multiple mental models of relationships.

Mentalizing the *counter-relationship*, or the feeling in the clinician, is the counterweight to mentalizing the
relationship. The feelings and mind state of the clinician are given considerable weight in MBT—not as representing the patient's projected feeling, but as a meaningful aspect of an interactive relationship, to be used to demonstrate how minds affect minds. MBT clinicians monitor their experience of the patient. Not knowing what to say to the patient may be the best indicator of the patient's inadequate mentalizing. The dominance of the pretend mode in the patient may be indicated by a sense of boredom, while teleological mode may be indicated by a sense of confusion and anxiety. The interaction becomes the subject of useful concern, removing obstacles to mentalizing and enhancing accurate mentalizing of the relationship. For example, if the clinician is frightened of a patient with ASPD, this is an important feeling in the clinician that interferes with treatment and dictates the form of the therapeutic relationship. The clinician finds a way of expressing

their experience of the patient in a way that makes it palatable and recognizable as something worth exploring. The authors recommend that this is done through a number of steps. First, the clinician works out exactly what their feeling is and what it relates to in the patient–clinician interaction. Second, the clinician considers the patient's likely response to an explicit statement of this current feeling state, and states this before talking about the current feeling. Third, in the dialogue, the clinician identifies the experience as their own, marks it, and, finally, monitors the patient's reaction to the statement:

> “It is possible that what I am going to say may make you feel I am telling you off or being critical but I assure you that is not the case [anticipating the response of the patient].
>
> The problem is that when you sit forward like that and raise your voice I start to feel anxious and under threat [identifying the behavioral evidence and focus of external mentalizing, presenting his own affect and the effect it has on him].
>
> I realize that this may be me [marking the feeling] but it makes it difficult for me to concentrate on what you are talking about [additional effect on him, interfering with the relationship].”

From here the patient's reaction can be taken into account and the session can continue. But if the threatening attitude and angry presentation is something that permeates all the patient's relationships, then further exploration is essential.

In conclusion, the key to MBT is to:

1. Develop a focused narrative around the problems of the patient, especially interpersonal issues 2. Infuse the narrative with mentalizing process and prevent a collapse into nonmentalizing experience

3. Work with the patient to reinstate mentalizing when it is lost, to prevent destructive behavior and personal distress. Mentalizing oneself with others is the basis of satisfactory social and personal relationships, which so often is the goal of people with psychiatric problems and yet seems to them so unreachable.

Clinical Issues

Indications

MBT is effective in treatment for severe BPD. Patients in the early studies of the intervention (see Research and Evaluation, later) had made serious suicide attempts, been admitted to psychiatric hospital for risk, and/or had self-harmed. Both men and women were included in trials and patients showed high levels of comorbidity. Analysis of the data suggested that patients who showed comorbidity for a number of personality disorders, including ASPD, did preferentially better in MBT than comparison treatment. At a clinical level, patients with marked interpersonal problems who have a personality disorder rooted in mentalizing vulnerability and attachment problems may benefit from MBT.

Limitations

Patients treated with MBT show a reduction in life-threatening behaviors and distressing psychiatric symptoms at the end of treatment, require less mental health care, and demonstrate improved social and interpersonal functioning. Nevertheless, long-term follow-up shows that patients continue to underfunction in their personal lives. Follow-up over up to 8 years shows that individuals remain with lower levels of social and relational satisfaction than expected, although the benefit of the therapy remains possible to detect.

It should be noted that the evidence for mentalizing mediating therapeutic change in MBT is currently limited, and more evidence is available in relation to mentalizing mediating change in other treatment modalities.

Complications

Psychotherapy can be harmful and MBT is probably no exception. However, MBT pays particular attention to ways in which patients may be harmed by treatment. On the basis that patients with BPD are uniquely sensitive to attachment process, and the stimulation of attachment reduces mentalizing, the MBT clinician focuses on levels of arousal in treatment sessions, constantly trying to balance arousal and mentalizing, ensuring that the therapeutic relationship is not a source of excessive attachment stress. Overstimulation of patients with avoidant attachment patterns is likely to trigger retreat and drop-out. Drop-out rates in MBT in clinical services in the United Kingdom are around 15 percent of people offered treatment, although in Scandinavia drop-out is as low as 2 percent. This suggests that the treatment overall is acceptable to people with BPD.

The aim of treatment is to increase the robustness of the patient's mentalizing capacity, and yet clinicians in many psychotherapeutic modalities may often tell patients “how they feel” or “what they are really saying.” This undermines the mentalizing of the patient and so is avoided in MBT.

Contraindications

MBT is a generic treatment constructed to optimize access both by creating a low-demand treatment protocol and by facilitating access to training by a range of professionals. Individuals who have problems with mentalizing rooted in nonattachment contexts—for example, those with ASPD or psychosis—may not benefit from MBT; if they do, the mechanism of change should be assumed to be different from that in BPD. Individuals with relatively simple problems, such as phobias or uncomplicated depression, may do better with more direct approaches such as cognitive-behavioral therapy. Even within a population of patients with BPD, patients with more complex presentations (multiple personality disorder diagnoses) are more likely to require MBT than those with a single BPD diagnosis, who may do as well in structured clinical management.

A 24-year-old patient, Sharon, was referred following a number of suicide attempts. She self-harmed, engaged in frequent polydrug misuse, and described emotionally volatile and occasionally violent relationships with men. She had a 2-year-old daughter who had recently been removed by child protection services. The clinician was able to take a detailed history, which elicited a number of vulnerability factors. Sharon was taken into care at the age of 5 and had a number of foster placements. She experienced recurrent sexual abuse from a carer around the age of 8. Her behavior was described in social reports as “over-sexualized” around the time of puberty and she attended an adolescent unit from the age of 13 to 15 years. She left school at 16 years having not attended for the previous year. The formulation was developed, which included these vulnerability factors but also identified the interpersonal vulnerabilities that led to mentalizing failures. The clinician explored two relational events with her boyfriend in which she had been violent, and two contexts in which she had tried to kill herself. Unsurprisingly, these events were interlinked

Formulation and Nonmentalizing Interactional Patterns

In the formulation in MBT, mentalizing vulnerability points are identified and placed in the context of attachment strategies. In this patient there was evidence that she had an insecure attachment with marked ambivalence. She would seek something from her boyfriend, but when he did not respond she became desperate and increasingly demanding and clinging, eventually attacking him. She stated that if she could not “have him” she would “prefer to die,” or alternatively she would “trap him” forever by getting pregnant. This nonmentalizing interactional cycle of need, demand, rejection, coercion, and the associated nonmentalizing modes were jointly explored, written down and shared with the patient. It is anticipated that the pattern will occur in relation to the clinician in a less intense way—the patient might seek some reassurance, for example, and the clinician may fail to respond contingently, triggering feelings of rejection. Identification and reduction of the nonmentalizing interactional process was an initial goal of treatment because the interactions occurred frequently and were an important area of vulnerability leading to suicide attempts.

Clarification and Elaboration and Affect Identification

Sharon reported that she had been in a fight with her boyfriend. She had telephoned her boyfriend to find out when he would be back from work because she was looking forward to seeing him and to tell him that she loved him. He said that he was leaving soon and would be back within an hour. A few minutes later, a friend telephoned and, in their conversation, said that she had seen Sharon's boyfriend in a

bar with a blonde woman only 30 minutes ago. When the boyfriend arrived home, Sharon asked why he had said that he was at work when she knew he was in a bar with a blonde woman. He said that he had called in for a drink on the way home. They had an argument during which Sharon attacked him and then, after smashing some crockery, cut herself.

Clarification of mental states about this event suggested that Sharon initially felt that she was looking forward to seeing her boyfriend, which was why she phoned him. His response was “contingent” with her feeling for him—he said he would be home soon. When her friend reported having seen him in a bar, this feeling was replaced with doubt about his love for her and a sense of rejection. Rapidly, she started to have thoughts that he was having an affair with the blonde woman, and in the context of feeling a loss of being loved this was experienced in psychic equivalence—“I am unlovable”—with some elements of hypermentalizing about his motives—“he was having an affair and I am certain of it.” This was the nonmentalizing cycle and associated modes identified in her formulation.

When Sharon's boyfriend arrived home, there was no doubt in her mind about what had happened. He was unable to persuade her it was not true. In nonmentalizing states, actions are the only meaningful way of communicating and she was therefore left with being coercive to “make” him love her. But to do this she tried to lock him in the house so he could not go out and she demanded sex. He resented this, refused, and the violence occurred. At this point her demand was driven by teleological belief that only his actions could prove his love for her.

The task in MBT is now to identify how Sharon manages her initial excitement about seeing her boyfriend, the sudden collapse of these feelings, and her collapse into psychic equivalent thoughts about his infidelity. To do this the clinician engages in detailed delineation of her mental states while asking her to re-present them to herself to instill a sense of uncertainty: can she manage emotional turmoil between excitement and disappointment; can she question her certainty over her boyfriend's activities and motives; can she engage with him to establish a more robust way of managing the distrust in their relationship other than teleological demand?

Affect Sessional Focus and Mentalizing the Relationship

The clinician asked Sharon how she felt about her boyfriend now and she said that she still felt that he did not care for her. She was miserable. But, in addition, she felt that she had created problems, which was “typical of me.” This is identification of current affect in relation to the focus. But, as she was talking to the clinician, she said that she felt that the clinician was judging her and would give up on treating her as it had happened again. She was a failure. This is the identification of current affect in the session and was quickly explored. At this point Sharon became coercive to some degree, suggesting that the clinician could not stop seeing her and to prevent it she would take an overdose. It becomes possible at this point to mentalize the relationship. Sharon thinks that the clinician will not meet her need and so automatically engages in a nonmentalizing interactional process. This needs to be discussed in the context of the clinician stating that it is not in his mind to stop seeing her in treatment (statement of clinician counter-relationship), so it is important to understand what is fuelling her belief and to question it. It is not for the clinician to interpret the repetition in the session of the interaction with the boyfriend but to define the emotional need that Sharon reacts to that makes her become coercive.

Goals of Treatment

The primary aims of MBT are to rekindle mentalizing when it is lost, to maintain it when it is present, and to increase the resilience of the individual's capacity to keep it going when it would otherwise be lost. But mentalizing is about something. So, the development and maintenance of mentalizing is initially focused on the core symptoms of BPD (or another condition), such as suicide attempts, self-harm, and other self-destructive behaviors and emotional instability. This is followed by emphasis on interpersonal problems because the key area of vulnerability to losing mentalizing in BPD is the interpersonal domain, especially when attachment processes are activated. So the clinician–patient relationship is a significant area of scrutiny. Patient and clinician increase attentiveness to mental states and interpersonal contexts in which they become disordered.

Ethical Issues

A key feature of MBT is the collaborative stance, which engages patients in a mutually agreed protocol, each phase of which focuses on achieving shared understanding between the patient and the clinician. In other words, it may be argued that MBT clinicians are less likely to encounter ethical issues than proponents of other therapeutic approaches in which collaboration is perhaps seen as a necessary condition but not the aim of the treatment.

However, MBT clinicians should be well aware that the nature of the clinical problems they are dealing with invariably and unavoidably creates ethical issues daily. Working with a person whose capacity to represent themselves in an agentive way is lacking, whose attachment system is disorganized, and who is extremely vulnerable to creating a dependent relationship, will present a consistent problem for the clinician to avoid exerting undue influence. MBT clinicians—like therapists working in other orientations—can prolong relationships beyond their useful timespan, citing the patient's need for their input as justification. In particular, when patients pay for their treatment either themselves or through a third party, financial exploitation is a real and present risk. Beyond this, undue influence may manifest through the uncritical acceptance of the clinician's frame of reference: a nonmentalizing individual has no alternative and gratefully grabs hold of a powerful, coherent model when it is presented to them. The teleological predisposition of patients sometimes leads clinicians to find themselves caught up in action-oriented attempts to address the patient's distress, offering more than they should, yet delivering less than they could.

Research and Evaluation

MBT for BPD

There have been several recent reviews of psychosocial interventions for BPD. These recognize the evidence base for MBT for BPD

as generally inferior only to that for dialectical behavior therapy, although not from a health economic perspective. Encouragingly, a large qualitative study of patients' treatment goals established that the goals of MBT were closely allied with what patients hoped to gain from their therapies.

A small number of RCTs and a number of naturalistic studies have tested the effectiveness of the MBT approach for BPD patients.

In an RCT of MBT for BPD in a partial hospital setting, an 18-month program achieved significant and enduring changes in mood states and interpersonal functioning. Outcome measures included frequency of suicide attempts and acts of self-harm, number and duration of inpatient admissions, service utilization, and self-report measures of depression, anxiety, general

symptom distress, interpersonal function, and social adjustment. The benefits, relative to treatment as usual (TAU), were large, with a number needed to treat of approximately two; in addition, the benefits were observed to increase during the follow-up period of 18 months. Analysis of participants' healthcare use suggested that day hospital treatment for BPD was no more expensive than general psychiatric care and showed considerable cost savings after treatment. A follow-up study of BPD patients 5 years after all treatment was completed and 8 years after initial entry into treatment, comparing patients treated with MBT and those receiving TAU, found that those who received MBT remained better than the TAU group. Superior levels of improvement were shown on levels of suicidality (23 percent in the MBT group vs. 74 percent in the TAU group), diagnostic status (13 percent vs. 87 percent), service use (2 years vs. 3.5 years), and other measurements such as use of medication, global functioning, and vocational status.

Two well-controlled single-blind trials of outpatient MBT have been conducted, one with adults with BPD and the second with adolescents presenting to clinical services with self-harm, the vast majority of whom met BPD criteria. In both trials, MBT was found to be superior to TAU in reducing self-harm, including suicidality, and depression. Importantly, in the adult trial, the control group received a manualized, highly efficacious treatment, structured clinical management; MBT was superior to this intervention, particularly in the long term. A posthoc analysis of moderators found that the number of personality disorder diagnoses in addition to BPD was the key indicator of severity that predicted the need for the MBT approach, as structured clinical management appeared to have little benefit on most outcome measures among these patients. Furthermore, in the trial with an adolescent sample, improvements generated by MBT appear to have been mediated by improved levels of mentalizing, reduced attachment avoidance, and amelioration of participants' emergent BPD features; participants treated with MBT showed a recovery rate of 44 percent, compared with 17 percent of those who received TAU. Ongoing follow-ups of both these trials indicate that improvements in the MBT groups have been at least maintained, and in most cases improvements continued after treatment termination, and differences relative to the comparison group remain significant.

Three recent studies provide further support for the efficacy of MBT in BPD. An RCT from Denmark investigated the efficacy of MBT versus a less intensive, manualized supportive group therapy in patients diagnosed with BPD. Patients were randomly allocated to MBT (n = 58) or the manualized supportive therapy (n = 27). Each intervention was delivered in combination with psychoeducation and medication. Both the combined MBT treatment and the less intensive supportive therapy brought about significant improvements on a range of psychological and interpersonal measures (e.g., general functioning, depression, and social functioning) and decreased the number of diagnostic criteria met for BPD; effect sizes were large (d = 0.5 to 2.1). The combined MBT was superior to the less intensive supportive group therapy on clinician-rated Global Assessment of Functioning. An 18-month naturalistic follow-up found that treatment effects at termination were sustained at 18 months. Half of the patients in the MBT group met criteria for functional remission at follow-up, compared with less than one-fifth in the supportive therapy group, but three-quarters of both groups achieved diagnostic remission, and almost half of the patients had attained symptomatic remission. A limitation of this study is that the same clinicians delivered both interventions (and thus there was a high risk of spillover effects between the two treatments); incomplete data was a further significant limitation. In a second study from Denmark, a cohort of patients treated with partial hospitalization followed by group MBT showed significant improvements after treatment (average length 2 years) on a range of measures including Global Assessment of Functioning, hospitalizations, and vocational status, with further

improvement at 2-year follow-up.

A quality improvement study examined the outcomes for BPD patients treated in an MBT program in a Norwegian specialist treatment unit compared with a former psychodynamic treatment program. This longitudinal comparison had a sample of 345 BPD patients, including 282 patients treated on the psychodynamic program and 64 who received MBT, who had comparable baseline severity and impairments of functioning on all measures. Outcome measures included Symptom Checklist-90 symptom distress, interpersonal problems, and global functioning assessed routinely throughout treatment, and suicidal/self-harming acts, hospital admissions, medication, and occupational status assessed at baseline and discharge. The change in program from traditional psychodynamic therapy to MBT led to a reduction in unplanned discharges (MBT had a low drop-out rate of 2 percent). Measured benefits from the change of program included greater improvements in symptom distress and interpersonal, global, and occupational functioning. Although the change was associated with the introduction of MBT, specific causal attributions are hard to establish in such a design.

A naturalistic study in the Netherlands investigated the effectiveness of an 18-month manualized program of MBT in 45 patients diagnosed with severe BPD. There was a high prevalence of comorbidity of DSM-IV Axis I and Axis II disorders. Results showed significant positive change in symptom distress, social and interpersonal functioning, and personality pathology and functioning; effect sizes were moderate to large (d = 0.7 to 1.7). The study also showed that the use of additional treatments and psychiatric inpatient admissions decreased significantly during and after treatment. The lack of a control group in this study limits the ability to draw conclusions about the efficacy of MBT. Another study applied propensity score matching to determine the best matches for 29 MBT patients from within a larger (n = 175) group who received other specialized psychotherapeutic treatments. These other specialized treatments yielded improvement across domains, which was generally only moderate; in contrast, pre–post-effect sizes were consistently large for MBT, with Cohen's d for reduction in psychiatric symptoms of −1.06 and −1.42 at 18 and 36 months, respectively, and ds ranging from 0.81 to 2.08 for improvement in domains of personality functioning. Given the nonrandomized study design and the variation in treatment dose received by participants, the between-condition difference in effects should be interpreted cautiously. A multisite randomized trial by the same group comparing intensive outpatient and partial hospitalization-based MBT for patients with BPD is currently underway.

A recent naturalistic pilot trial studied the feasibility and effectiveness of an inpatient adaptation of MBT in 11 female adolescents (14 to 18 years) with borderline symptoms. One year after the start of treatment, significant decreases in symptoms and improvements in personality functioning and quality of life were observed; effect P.2904
sizes were between d = 0.58 and 1.46, representing medium to large effects. Further, 91 percent (n = 10) of the adolescents showed reliable change on the Brief Symptom Inventory and 18 percent (n = 2) moved to the functional range on this measure. A report of the application of MBT principles to a therapeutic community also yielded positive results. Patients who completed 18 months of treatment showed significant self- and clinician rated symptomatic improvement and significant change on clinician-administered measures of social and occupational functioning.

MBT for ASPD

Research into treatment for ASPD up to 2009 is summarized in the United Kingdom's National Institute for Health and Clinical Excellence clinical guideline for ASPD, which confirmed that interventions for ASPD are poorly researched and that evidence on its treatment is scarce. The authors of the guideline concluded that the evidence for treatments for ASPD was extremely

limited, and did not support the development of any guidance on treatment recommendations. Two Cochrane reviews concluded that there was no consistent evidence for any intervention for ASPD, and recommended that research to test interventions for the disorder is urgently needed.

A feasibility study of MBT for ASPD reports findings from a small sample (*n* = 9) receiving group and individual MBT. Preliminary results on the Overt Aggression Scale suggested that the participants rated the severity of their aggression toward others and themselves as decreasing over the first 6.5 months of treatment; in contrast, their rating of irritability did not change. Psychiatric symptom severity on the Brief Symptom Inventory showed a reduction in the distress participants experienced in relation to their symptoms at a 6-month follow-up, with participants reporting greatest decreases in distress resulting from symptoms of depression, anxiety, and hostility.

Finally, the authors note that a significant subsample of the participants in the outpatient treatment trial of MBT for BPD described earlier also met criteria for ASPD. A separate analysis of these individuals with comorbid ASPD revealed that they benefited significantly from MBT.

References

Allen JG. *Mentalizing in the Development and Treatment of Attachment Trauma.* London, UK: Karnac Books; 2013.

*Allen JG, Fonagy P, Bateman AW. *Mentalizing in Clinical Practice.* Washington, DC: American Psychiatric Publishing; 2008.

Asen E, Fonagy P. Mentalization-based therapeutic interventions for families. *J Fam Ther.* 2012;34:347–370.

Bateman AW. Treating borderline personality disorder in clinical practice. *Am J Psychiatry.* 2012;169:560– 563.

Bateman A, Bolton R, Fonagy P. Antisocial personality disorder: a mentalizing framework. *FOCUS.* 2013;11:178–186.

Bateman A, Fonagy P. 8-year follow-up of patients treated for borderline personality disorder: mentalization based treatment versus treatment as usual. *Am J Psychiatry.* 2008;165:631–638.

*Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *Am J Psychiatry.* 2009;166:1355–1364.

Bateman AW, Fonagy P, eds. *Handbook of Mentalizing in Mental Health Practice.* Washington, DC: American Psychiatric Publishing; 2012.

*Bateman A, Fonagy P. *Mentalization-Based Treatment for Personality Disorders: a Practical Guide.* Oxford, UK: Oxford University Press; 2016.

Bateman AW, Gunderson J, Mulder R. Treatment of personality disorder. *Lancet.*

2015;385:735–743.

Bateman A, Krawitz R. *Borderline Personality Disorder: an Evidence-Based Guide for Generalist Mental Health Professionals*. Oxford, UK: Oxford University Press; 2013

Bateman A, O'Connell J, Lorenzini N, Gardner T, Fonagy P. A randomised controlled trial of mentalization based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. *BMC Psychiatry*. 2016;16:304.

Bevington D, Fuggle P, Fonagy P. Applying attachment theory to effective practice with hard-to-reach youth: the AMBIT approach. *Attach Hum Dev.* 2015;17:157–174.

*Fonagy P, Luyten P. A multilevel perspective on the development of borderline personality disorder. In: Cicchetti D, ed. *Developmental Psychopathology*, 3rd ed. New York: John Wiley & Sons; 2016.

*Fonagy P, Luyten P, Allison E. Epistemic petrification and the restoration of epistemic trust: a new conceptualization of borderline personality disorder and its psychosocial treatment. *J Pers Disord.* 2015;29:575–609.

Gergely G. Ostensive communication and cultural learning: The natural pedagogy hypothesis. In: Metcalfe J, Terrace HS, eds. *Agency and Joint Attention.* Oxford, UK: Oxford University Press; 2013.

Ha C, Sharp C, Ensink K, Fonagy P, Cirino P. The measurement of reflective function in adolescents with and without borderline traits. *J Adolesc.* 2013;36:1215–1223.

National Institute for Health and Clinical Excellence. *Antisocial personality disorder: treatment, management and prevention*. London: The British Psychological Society and the Royal College of Psychiatrists; 2010.

Robinson P, Hellier J, Barrett B, et al. The NOURISHED randomised controlled trial comparing mentalisation based treatment for eating disorders (MBT-ED) with specialist supportive clinical management (SSCM-ED) for patients with eating disorders and symptoms of borderline personality disorder. *Trials*. 2016;17:549.

Rossouw TI, Fonagy P. Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *J Am Acad Child Adolesc Psychiatry.* 2012;51:1304–1313.

Sharp C, Ha C, Carbone C, et al. Hypermentalizing in adolescent inpatients: Treatment effects and association with borderline traits. *J Pers Disord.* 2013;27:3–18.

Sharp C, Fonagy P. Practitioner Review: Borderline personality disorder in adolescence – recent conceptualization, intervention, and implications for clinical

practice. *J Child Psychol Psychiatry*. 2015;56:1266–1288.

Sharp C, Venta A. Mentalizing problems in children and adolescents. In: Midgley N, Vrouva I, eds. *Minding the child: Mentalization-based interventions with children, young people and their families.* London, UK:
Routledge; 2012.

Preface

The aim of our first 'practical guide' to mentalization based treatment (MBT) was to provide an understandable, accessible, and comprehensive account of MBT as used in daily clinical practice. We hoped that the book, in conjunction with only limited additional training, would make clinicians feel confident that what they were about to deliver in clinical practice was MBT, or at least resembled MBT. But over the past few years it has become apparent that we were not specific enough about some of the core components of the model, perhaps because we ourselves were unclear about some of the essential and less essential aspects of MBT; hence, the need for a completely new book. In addition the theoretical underpinnings of MBT, the structure of treatment, and some of the interventions recommended to promote mentalizing needed clarifying. We hope that this new practical guide elucidates some of the more confusing aspects of MBT.

More importantly, there was an urgent need for a new practical guide because MBT has changed over the past decade; the model and its clinical application are continually being informed by new understanding generated from research. Indeed, MBT 'looks' distinctly different now compared to a decade ago, and no doubt it will be different again in another decade. But we hope that the core components we describe here will remain as the foundation stones for further developments. In our attempt to summarize the model more accurately the book has become longer, but we hope this will not put off interested readers.

MBT has been more successful than we ever anticipated, perhaps more so than it deserves. It was initially developed for borderline personality disorder but is now used to treat patients with a range of disorders. We do not cover the adaptations for different disorders in this book, with one exception, MBT for antisocial personality disorder. This book contains an outline of the manual currently being used as the basis for a research trial of MBT for antisocial personality disorder. Other adaptations, for example, MBT for people with eating disorders, substance abuse, depression, and adolescents who self-harm are outlined in an earlier publication (Bateman & Fonagy, 2012).

The popularity of MBT requires some explanation. First, clinicians easily understand the ideas underpinning the model and recognize that promoting mentalizing is something they are already doing in their clinical work. So it has given a clearer framework to their clinical interventions. Second, it has broad application, being rooted in developmental psychology and social cognition. Consequently, mentalizing interventions have become part of a wide range of treatments used across the lifespan, from mother–baby, to adolescence, to adulthood, through to old age. Third, MBT was developed as a psychological treatment to be delivered by skilled general mental health professionals, making it feasible for people without specialist therapeutic training to learn relatively easily. Fourth, MBT overlaps considerably with other treatments for personality disorder, and sits comfortably within the range of radical behaviour therapists and psychoanalysts, all of whom have embraced it to a greater or lesser extent. Finally, MBT started out, and has continued, as a treatment that is firmly rooted in research. This has provided much-needed evidence for effectiveness, increased interest from researchers and enabled interested practitioners to argue for its

use in hard-pressed clinical services.

Introduction and summary of mentalization-based treatment

This next section of the preface introduces the reader to mentalization-based treatment (MBT). We recommend reading this before embarking on study of the subsequent chapters. The aim is to orientate the reader to the overall treatment method and, we hope, to allow a more critical reading of the more detailed information in the chapters that follow.

MBT is a structured treatment. It has carefully managed trajectories in terms of both the time in treatment over 12–18 months, and in sessions. It is delivered in individual and group formats. The aim of treatment is to increase the resilience of individuals' mentalizing capacities.

Many techniques increase the mentalizing capacities of patients, and a wide range of psychotherapy processes facilitate mentalizing. Consequently, MBT overlaps with a number of 'named' therapies, ranging from the manifestly cognitive therapies to explicitly psychoanalytic treatments. The key difference is the extent of the emphasis on mentalizing as the target of treatment.

The core of MBT is to rekindle mentalizing when it is lost, to maintain it when it is present, and to increase the resilience of the individual's capacity to keep it going when it would otherwise be lost. In the case of people with borderline personality disorder, the key area of vulnerability to losing mentalizing is the interpersonal domain, and so the clinician–patient relationship is a significant area of scrutiny.

In brief, at times the patient experiences strong affect while focusing on identified problems in individual or group sessions and his/her mentalizing appears to be limited or failing, and/or the patient's understanding of the way mental states link to behaviour is inadequate. The clinician addresses this by a structured process (the sessional intervention trajectory) of (a) empathy and validation, (b) clarification, exploration and, where necessary, challenge, (c) following a structured process to gently expand mentalizing and encourage the patient to identify the mental states previously outside their awareness. The process is primarily in the here and now of the session but increasingly, as the patient's mentalizing improves, comes to concern core attachment relationships, including how they are activated with the clinician and key figures in the patient's life and how they influence mentalizing itself. Gradually, improvements in mentalizing serve to enable the patient to address their distorted representations of personal relationships.

First and foremost, MBT is collaborative. Nothing can occur without joint discussion, taking into account the mental experiences and ideas of both patient and clinician. The process of mentalizing necessitates an authentic desire to understand the mental processes of oneself and others. This applies as much to the clinician as to the patient. So the MBT clinician focuses on the patient's mind and attempts to understand his/her experience. Similarly, the patient is asked to do the same in relation to the clinician – for example, '*Why does my clinician want me to focus on this at the moment?*' may be paired with '*Why does my patient* not *want to focus on this at the moment?*' The therapeutic process has to become a shared endeavour. Initial goals, on the road to improved mentalizing, are jointly developed and focused on. The goals cannot solely be those of the patient, although his/her aims take priority unless they are antithetical to the whole process of treatment.

The assessment process and pathway to treatment prepare the patient for treatment itself. The assessment involves delineation of the patient's mentalizing vulnerabilities and a shared formulation, which includes specific detail of attachment patterns and areas of vulnerability to emotional dysregulation. This has to be understood by the patient and is for *both* patient and clinician. It is no good if it is understood only by the clinician, who may have considerable ability to make sense of the patient's problems; this would mean that the patient's non-mentalizing is being met with the clinician's mentalizing, which goes against a clear principle of MBT. Non mentalizing in the patient cannot be met by mentalizing in the clinician; it can be met only by 'switching on' mentalizing in the patient. The formulation is a work in progress and can be changed at any time. An MBT-Introductory group of 10–12 sessions assists in the development of the formulation. It covers all areas of mentalizing, attachment processes, personality disorder, emotion management and treatment itself. This preparatory work means the patient knows what he/she is facing in trying to address his/her problems and is fully aware of the method and focus of treatment.

Following this preparatory work, the patient is offered individual and/or group MBT. Initially, this was organized around an 18-month programme of weekly group and individual sessions. However, evidence that this is the optimal arrangement or the most appropriate length is not available. As a consequence, MBT is now offered for shorter lengths of time and also as individual therapy or group therapy alone. These are modifications to the research model that should be considered experimental.

At the outset of treatment, clear goals are established with the patient. The initial goal is engagement in and commitment to treatment, and this is accompanied by agreement to try to reduce harmful activities and self-destructive behaviour and stabilize social circumstances where possible. Improvement of personal and social relationships, although a long-term aim, is detailed in the assessment formulation and worked on throughout treatment. In order to develop the formulation, the clinician identifies common relational fears, for example abandonment, which stimulate the patient's attachment system and result in the use of maladaptive attachment strategies in interpersonal interactions. Identification and recognition of these strategies and patterns is done early in treatment so that they become the relational focus in treatment when appropriate. Both patient and clinician need to become sensitive to these attachment strategies when they become apparent in the treatment setting so that they can be scrutinized carefully. In short, the pattern of the patient's relationships informs an understanding of the relationship in treatment and the relationship in treatment is used to re-appraise the relationships in life outside treatment. Finally, it is important that the patient and clinician consider establishing a goal of improving social function. This will include work, social activity, voluntary work, education and other constructive life-affirming activity. This should be thought about at the beginning of treatment, not as an 'add-on' towards the end of treatment.

Clinicians follow a number of principles when treating patients with MBT. Primarily, the clinician is alert to non-mentalizing not only in terms of the different non mentalizing modes, namely *psychic equivalence*, *pretend mode*, and *teleological function*, but also in terms of the patient being fixed at one pole of any of the dimensions of mentalizing (the dimensions of mentalizing and non-mentalizing modes are discussed in Chapter 1). In general, mentalizing is optimal when the dimensions – for example emotion and cognition, or representation of self and other – are in balance and non-mentalizing modes are inactive. The key for the clinician is to be constantly aware of imbalance and lack of flexibility in terms of the dimensions and if any dimension is operating in a non-mentalizing mode. Non-mentalizing in a dimension or mode is an indication that intervention is necessary. Secondly, the clinician monitors arousal levels carefully, ensuring that anxiety is neither too low nor too high, as both

interfere with mentalizing. Thirdly, the focus of a session is maintained through the clinician always noticing moments of mentalizing vulnerability either in relation to events in the patient's life or in the session itself. Fourthly, the clinician makes sure that his own mentalizing is maintained. It is not possible to deliver effective treatment if the clinician's mentalizing is compromised. So the MBT clinician always monitors his own capacities and may even have to say, for example, that his/her mind has become muddled and he cannot think. This type of self-disclosure of the mind state of the clinician should not be confused with sharing personal information. Sharing the effect that a patient's actions and state of mind has on the clinician is in the service of asking the patient to consider another mind as well as his/her own. In all relationships we have to be sensitive to others states as well as our own. Without this, there can be no constructive dialogue and intimate understanding. So it is important that the effect the patient has on the clinician and what is in the clinician's mind is accessible to the patient. Finally, interventions are carefully matched to the mentalizing capacities of the patient. It is no good offering complex interventions that require considerable thought and appraisal to an individual functioning in psychic equivalence mode! This takes over their mentalizing, rather than facilitating it. As mentioned earlier, non-mentalizing in the patient cannot be met by mentalizing in the clinician, but only by reactivating mentalizing in the patient. The patient's mentalizing must be brought 'on-line'. This is done through a series of steps, which underpin the trajectory of every session.

The initial step in a session is listening to the patient's narrative. Sometimes, the clinician may start the narrative if there is an overriding reason to do so, for example, when the clinician is concerned about risk or the treatment breaking down, or the patient is in danger of impulsive acts, or the clinician experiences intolerable emotion, such as being frightened of the patient. Listening to the story the patient brings allows the clinician to begin working on empathic validation. Empathic validation requires the clinician to find something in the story that he/she can empathize with. This is not the same as behaving in a sympathetic manner or saying things that repeat the patient's story. Empathic validation seeks to engender in the patient a sense that the clinician has understood his/her internal state, that the clinician really 'gets' the patient and the issue he/she is talking about. Often, the clinician seeks the patient's basic emotion and it is this experience that is validated rather than subsequent social or secondary emotions. Validation is an affectively based intervention; the key component is contingency with the patient's internal emotional state. Non-contingent responsiveness on the part of the clinician at this point is likely to trigger non mentalizing or generate avoidant attachment strategies in the patient. Once a contingent responsiveness has increased collaboration and even reduced arousal, maintaining emotions at a manageable level, the clinician can consider sensitive but non-contingent responses to try to stimulate mentalizing about the 'story' the patient brings. Sessions are focused. They do not consist of free associative dialogue that seeks to illuminate unconscious process. The target area is working memory or pre consciously held experience. It is expected that a focus for a given session will have been achieved after 10–15 minutes of the session, and this focus will then become the pivotal point around which the clinician and patient orient themselves, returning to it whenever non-mentalizing becomes to dominate the interaction.

The 'story' the patient brings is then clarified. This is not clarification of events, which must also take place. It is assumed that the clinician will clarify the events and the facts as quickly as possible. For example, if the patient speaks about an act of self harm or a suicide attempt, a drunken brawl or an emotional outburst, the clinician quickly clarifies when it occurred, who was there, what were the circumstances, and so on. This will indicate the level of risk and provide other important information. More than this, though, the MBT clinician wishes to surround the events with mentalizing. Clarification establishes the reflection the patient has on the events –

what was their ‘pre-morbid’ state of mind, what were their hopes, what was their experience when they were waiting for their boyfriend to return home, what thoughts intruded into their mind, what feelings did they identify, and can they reflect on it differently now? This process of clarification, in the service of mentalizing, links inextricably with affect identification and exploration.

Affects and interpersonal relationships reciprocally interact and are core to the personality problems characteristic of borderline personality disorder. Unmanageable emotions impinge on relationships, and relationships stimulate powerful feelings. Patients may not be able to identify their feelings accurately but experience them primarily as inchoate bodily experiences. Working with the patient to identify a range of feelings is part of the clarification and exploration component of MBT. Sometimes, emotions in specific contexts have to be normalized. Too often, patients feel that their experience is ‘wrong’; in effect, they invalidate their own internal perceptions and feel ashamed. It may be that their feeling is appropriate but excessive, or at other times inexplicably absent.

Clarification of current affect in the session is the next step if the patient and clinician retain capacity to mentalize around the focus. This is more than asking the patient how he/she feels at the moment, although this may be an initial component. It is identification of *current* affect *related to the session* rather than a current affect related to the *focus*. So, for example, a patient may feel sad in the session that her boyfriend was less committed to their relationship the night before and that this led her to become angry with him. This is identification of affect in relation to the focus. But, at the same time, she may have a sense of something untoward happening as she talks about it in the session, perhaps concerned that the clinician will judge her or see her as being the person at fault in the situation she describes. This is the identification of affect currently being shared between the patient and clinician in the session. This is named the *affect focus* of the session. It is an interpersonal component of affect. Commonly, this is implicit. In MBT, the clinician tries to make the implicit process more explicit; this rebalances the implicit–explicit dimension of mentalizing. All too often, relationships become stuck in the implicit pole. People reach an impasse and do not talk about something even though it influences their interactions beneath the surface. It is the task of the MBT clinician to bring important components of the interaction to the surface. For example, a patient may not feel like talking about something. As the interaction progresses, it is apparent that the clinician thinks that the patient needs to talk about the subject, but as the clinician asks questions to get the patient to expand on the subject, he retreats. Very soon, a reciprocal interaction is set up, characterized affectively by both patient and clinician becoming a little frustrated – but the gentle probes of the clinician and subtle retreats of the patient camouflage this. Making the affects of both patient and clinician explicit in relation to this interactional process is the affect focus. So the clinician might say, *‘I see that we have set up an interaction in which I keep pushing you to talk and you keep pushing me away or running off. Hazarding a guess, are you a bit frustrated that I won’t leave it alone? From my part I realise that I too am a bit frustrated. I can see that we have not really agreed it is an area that we need to talk about. What do you think?’*

The affect focus, that is, the identification of the interpersonal interaction in the session and the associated affect, if accurate, heightens the focus on the clinician–patient interaction in the moment of the session. Inevitably this often indicates that a patient’s attachment strategies and relational patterns, or possibly those of the clinician, are being activated. So it allows a move towards *mentalizing the relationship*. The groundwork for mentalizing the relationship will have been done through the use of *transference tracers* over time. Transference tracers are straightforward links between patterns of relationships over time, or bridging statements that establish similarities between the patient’s attitudes and behaviours to

people in his/her life and the way he/she relates to the clinician – *'Understandably you feel distrustful of others, and so why would you trust me? It would be a bit odd if you did.'* Transference tracers are not necessarily followed up with detailed exploration but are more conversational pointers to the links. The focus of the session is not disrupted by their use. In contrast, when mentalizing the relationship, the very focus is on developing an alternative perspective on an important aspect of the patient–clinician relationship. Has it arisen because of the patient's sensitivity to particular interactions? Does it indicate an area of vulnerability for the patient in relationships which undermines his/her self-esteem and their ability to enjoy relationships?

Mentalizing the relationship in a session is the training ground for managing difficult feelings in interpersonal situations in daily life through maintaining mentalizing while within an emotional interaction. We identify a number of steps for the clinician to consider. First, the clinician has to empathically validate the patient's perception of him. If the patient says that she experiences the clinician in a particular way, then the clinician needs to find part of that experience that he can validate. He actively avoids invalidating the patient's experience. Second, he needs to work out his contribution to the patient's experience of him. He does this explicitly by thinking aloud about it and asking the patient to explain how she has come to that conclusion. This questioning must be authentic and genuinely curious, and must not come from a perspective that implies that the patient's experience is distorted or inaccurate. Such an invalidating attitude will lead to disaster because invalidation, a non-contingent response, leads to excessive arousal and a consequent reduction in mentalizing. Mentalizing the relationship can meaningfully take place only in the context of mentalizing. Once the clinician has accepted his role in the relational process, the next step of more detailed exploration can occur. Here the aim is to generate a more complex understanding of the relationship, to see it from a different angle, and to see what its relevance is for the patient's life. It is not to engender insight in the sense of understanding the operation of the past in the present.

Mentalizing the *counter-relationship*, or the feeling in the clinician, is the counterweight to mentalizing the relationship. The feelings and mind state of the clinician are given considerable weight in MBT – not as representing the patient's projected feeling, but as a meaningful aspect of an interactive relationship, to be used to demonstrate how minds affect minds. This interaction becomes the subject of concern and scrutiny. For example, if the clinician is frightened of his patient with antisocial personality disorder, this is not taken, from a clinical intervention standpoint, as arising from the patient, but as an important feeling of the clinician that interferes with treatment and which may be important in the way the patient develops relationships. The clinician finds a way of expressing his experience to the patient that makes it palatable and recognizable as something worth exploring. We recommend that this is done through a number of steps. First, the clinician works out exactly what his feeling is and what it relates to in the patient–clinician interaction. Second, he considers the patient's likely response to his explicit statement of his current state, and states this before he talks about his current feeling. Third, in the dialogue, he identifies the experience as his own, marks it, and finally he monitors the patient's reaction to his statement.

'It is possible that what I am going to say may make you feel I am telling you off or being critical but I assure you that is not the case (anticipating the response of the patient).

The problem is that when you sit forward like that, stabbing the air with your finger, and raise your voice I start to feel anxious and under threat (identifying the behavioural evidence and focus of external mentalizing, presenting his own affect and

the effect it has on him).

I realise that this may be me (marking the feeling) but it makes it difficult for me to concentrate on what you are talking about (additional effect on him interfering with the relationship).'

From here the patient's reaction can be taken into account and the session can continue. But if the threatening attitude and angry presentation is something that permeates all the patient's relationships then further exploration is essential.

This concludes our brief summary of essential aspects of the basic treatment model. Adherence to the model is rated using the MBT adherence scale (Karterud et al., 2013). This scale may be used to focus discussion in clinical supervision. It is available on the Anna Freud Centre website at http://annafreud.org/training research/mentalization-based-treatment-training/mbt-adherence-scale/
Remember that the key is to develop a focused narrative infused with mentalizing process. Process refers simultaneously to the internal process in the patient's mind and to the interpersonal process between the minds of the patient and clinician and to the internal process of the clinician's mind as they relate to an agreed focus. Mentalizing with others is the basis of satisfactory social and personal relationships, which must surely be the goal of us all.

This summary would not have been possible without the work of many other people. We are grateful to all those clinicians and researchers around the world who have taken an interest in MBT and added to its evidence base. Without them, this new book would not have come about and MBT would not have travelled so far. It always seems invidious to mention individuals, and no doubt we may offend by missing out some people, so we must thank the whole teams who have made us think more, added to the clinical model, and enthusiastically questioned the whole endeavour. Groups in Australia, Denmark, The Netherlands, Norway, New Zealand, Sweden, the USA and the UK have all been influential. But in particular, we thank Sigmund Karterud and the team at the clinic for personality psychiatry in Oslo for their research and work on adherence and mentalizing and groups; Finn Skårderud, Bente Sommerfeldt and Paul Robinson for their work in eating disorders; Dawn Bales and her colleagues in the Netherlands for their assiduous adherence to the model and their informative research and training programmes delivered from MBT Netherlands; John Gunderson, Lois Choi-Kain and Brandon Unruh at McLean Hospital in Boston, USA, for their integrative approach to MBT and for developing a successful MBT clinic and training programme; Robin Kissell and her team for her trying to bring MBT to the west coast of the USA, and Jon Allen, John Oldham, Efrain Bleiberg and Carla Sharp for making a home for MBT at the Menninger Clinic in Texas; Robert Green, Dave Carlyle and Robin Farmar for their research on MBT in general mental health services and enthusiasm for developing the model in New Zealand; Linda Mayes, Arietta Slade, Norka Malberg and Nancy Suchman at Yale for their work on MBT and parenting; Morten Kjølbye, Henning Jordet, Sebastien Simonsen and Erik Simonsen in Denmark, for their research and clinical developments; and Michael Daubney, Lynn Priddis, Clara Bookless, and Margie Stuchbery in Australia for their adaptations and clinical wisdom. There are many others too numerous to name, but thank you. Last but not least, we should thank our colleagues in London who have worked with us over the past decade to develop MBT as both a theory and a practice: Liz Allison, Eia Asen, Dickon Bevington, Martin Debbané, Pasco Fearon, Peter Fuggle, George Gergely, Alessandra Lemma, Patrick Luyten, Nick Midgley, Trudie Rossouw and Mary Target.

Finally, whenever you think that this book 'reads' well, it is a result of the assiduous work of Chloe Campbell and Clare Farrar, both of whom spent considerable time

trying to make sense of our work, insisting we eliminated inconsistency and frank errors, and clarified our many confusing statements. Any parts that do not read well are those paragraphs that we slipped past them. We also thank our publishers, who waited patiently for the final manuscript.

Above all, we want to thank the patients and their families who have taught us all we know about these cruel conditions.
Anthony Bateman
Peter Fonagy

London, May 2015

Karterud, S., Pedersen, G., Engen, M., Johansen, M. S., Johansson, P. N., Schluter, C., . . . Bateman, A. W. (2013). The MBT Adherence and Competence Scale (MBT-ACS): Development, structure and reliability. *Psychotherapy Research, 23*, 705-717.

Bateman, A. W., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Publishing.

Patient Information for Role Play throughout MBT Training

Jennifer is a 28 years old.. She has Borderline Personality Disorder (BPD) characterised by emotional dysregulation, impulsivity, and relationship problems.

She has a son aged 5 years. She has joint custody with his father and looks after her son 4 days a week and every other weekend. Her son is a 'child in need' but not under child protection and sees a child support worker monthly. She separated from living with his father over a year ago.

Her current complaint is that she cannot bear to be alone when her son is not with her. She goes out all the time and meets other people if she cannot meet her current boyfriend. He is supportive and she thinks the relationship is a good one. He shows a lot of affection to her. But when he is working at the weekends she finds she becomes restless and goes out to bars where she meets men and flirts with them.

Emotions

Rapidly changing mood states and reactive with anger to social and personal slights. Her emotional state can change without obvious warning and she cannot focus at those times due to high anxiety and anger.

Impulsivity

Jennifer engaged in self-harm by cutting for many years during her adolescence. She stopped when her son was born.

She took an 'accidental' overdose 1 year ago and continues to express suicidal thoughts at times. These are in the context of arguments with her son's father about care of their child. She is concerned that she will take another overdose as it comes into her mind regularly.

Drug addiction until 3 years ago - She used cocaine and cannabis for a number of years but reduced the use to a low level after the birth of her son. She has now been clear of all drugs for over 6 months.

Relationships

She separated from her long term partner (the father of her child now aged 5) around 1 year ago. She has joint custody with his father. She feels 'normal' when she is looking after her son but when she is on her own in her flat she becomes anxious and needs to see people. Consequently, she goes out frequently because in her own words 'I am desperate to be with other people'.

Her previous partner was controlling and at times would be violent. She does not believe that she was in danger and so continued the relationship until 1 year ago when she told him to leave. He eventually wanted to return but she refused to allow it. Child protection services were involved and concluded that joint custody with the father was viable and safe.
She now has another relationship with a man who she thinks is devoted to her. She recognises that she causes problems in this relationship by constantly asking for re assurance. She repeatedly asks him if he loves her and frequently asks about his previous girlfriends and how they compare to her. He is irritated by this as he is unable to re-assure her and reduce her anxieties.

Previous therapy

Group therapy - for her drug addiction for 2 years. Her attendance was sporadic. She attended for short periods and then did not attend until there were threats of discharge. She then attended again but attended only around 50% of the time.

Individual therapy - weekly following her 'accidental' overdose 2 years ago. She attended for 8 sessions and then only occasionally for 2 months. A clinical review was organised but she did not attend. She then contacted with high anxiety a week later demanding to be seen. When seen she was offered continuation of weekly therapy which she attended for 3 weeks but then decided that she was better and no longer wanted to continue.

Criminal History – 6 years ago - official police warning for threatening behaviour in the street when she was using drugs.

Medication - none currently.

Family History

Her parental relationships are described as 'a shit storm' most of the time.

Father – Died 8 years ago from alcohol related ill-health. Abandoned the family when Jennifer was aged 8. Reported to have been violent towards her – hitting and used to discipline her using long periods of isolation as punishment. Also violent to Jennifer's mother.

Mother – described as 'dependent and needy' by Jennifer. They are still in contact and meet up so she can see her grandchild.

Sibling – half-sister who is 6 years younger.

Presentation in role play

You present as someone who is able to talk about herself and you are a likeable person who appears to want to please the interviewer. You try to give answers that you think will be helpful to your interviewer. You describe many of the symptoms of BPD identified above, indicating that most of them are dependent on environmental triggers. You feel good when you are with other people and bad when you are alone.

MBT Formulation

SELF

PAST

What has happened in my life?
How have these things affected me?
What has happened gave me strengths and coping abilities?

PRESENT

Triggering Situations
What situations do I struggle with?
What "triggers" me?
In what situations do most of my interpersonal difficulties occur?

How do I see my relationships at these times?
How do I see myself when I'm struggling?

OTHERS

Anticipated Issues in Group
How do I experience other people when I am struggling?

FEELINGS

HOW DO I COPE WITH THIS?
Positive coping?
Self-harm/destructive behaviour?
Isolation/avoidance?

MENTALIZING DIFFICULTIES
What keeps me from being more balanced at these times?
Do I get stuck thinking only about other people or myself?
Do I only focus on actions or word, or not pay enough attention to these? Do I cut-off from feelings, or just feel so overwhelmed I can't think? Do I feel on auto-pilot or sometimes overly controlled and not spontaneous?

IN TREATMENT

How might my difficulties come up in the group and what would be the best way of going forward?
What could happen in group that would worry me?

Goals

What are my goals for therapy?
What strengths and resources do I have that can help me?