

**CHAPTER 33.18**

**MENTALIZATION-BASED TREATMENT**

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## <H1>INTRODUCTION AND DEFINITION

Mentalization-based treatment (MBT) is an evidence-based treatment for borderline personality disorder (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.

## <H2>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 non-technical 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 our 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.

## <H1>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 bodies 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.

## <H1>THEORETICAL ISSUES

### <H2>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 these 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 non-mentalizing 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.

## <H2>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*.

### <H3>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 our 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.

### <H3>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*), which is 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.

### <H3>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 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.

### <H3>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 or 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.

## <H2>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 non-questioning 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).

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.

## <H2>The re-emergence of non-mentalizing 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, 33.18-2, and 33.18-3, which also outline MBT interventions to address each non-mentalizing mode.

The non-mentalizing 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.

### <H3>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 quasi-psychotic symptoms and are also manifest 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.

### <H3>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 reaction from others in terms of actions rather than words.

### <H3>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 non-mentalizing 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.

## <H2>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”.

## **<H1>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.

## **<H2>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 10–12 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.

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 non-mentalizing 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 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.

## <H2>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 non-mentalizing 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. 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 via the range of techniques that MBT uses in the clinical situation.

Primarily, the clinician is alert to non-mentalizing in terms of the different manifest modes of non-mentalizing, 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 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. 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 10–15 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 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, non-mentalizing 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.

## **<H2>Trajectory of MBT session and interventions**

### **<H3>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 (non-contingent responsiveness on the part of the clinician) is likely to trigger non-mentalizing (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.

### **<H3>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 though 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. This is the third step.

### <H3>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 non-mentalizing, 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.

### <H3>Presenting alternative perspectives

Before extending to incorporate the relationship with the clinician into the patient’s narrative, the clinician endeavours 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 re-establish more balanced mentalizing, then considering additional possibilities of what may have happened, at the level of thoughts and feelings, helps further re-engage 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 re-evaluation 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.

### **<H3>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 re-emergence of the past distorting the present. Such an invalidating attitude will lead to therapeutic rupture because invalidation (a non-contingent 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 non-mentalizing, 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 non-mentalizing process. For the exploration of the therapeutic relationships 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 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:

<EXT>“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].”<ENDEXT>

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 non-mentalizing experience
3. Work with the patient to re-instate 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.

## <H1>CLINICAL ISSUES

### <H2>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.

### <H2>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 under-function 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.

## **<H2>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% of people offered treatment, although in Scandinavia drop-out is as low as 2%. 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 mentalizing of the patient and so is avoided in MBT.

## **<H2>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 non-attachment 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.

## **<H2>Case example**

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 13–15 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.

### **<H3>Formulation and non-mentalizing 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 non-mentalizing interactional cycle of need, demand, rejection, coercion, and the associated non-mentalizing 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 non-mentalizing interactional process was an initial goal of treatment because the interactions occurred frequently and were an important area of vulnerability leading to suicide attempts.

### **<H3>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 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

girlfriend 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 non-mentalizing 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 non-mentalizing 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?

### **<H3>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 non-mentalizing 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.

## **<H2>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.

## <H1>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 non-mentalizing 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.

## <H1>RESEARCH AND EVALUATION

### <H2>MBT for borderline personality disorder

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% in the MBT group vs. 74% in the TAU group), diagnostic status (13% vs. 87%), 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 post hoc analysis of moderators found that the number of personality disorder diagnoses in addition to BPD as 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%, compared with 17% 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 ( $d = 0.5$ – $2.1$ ). 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%). 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 ( $d = 0.7-1.7$ ). 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  $d$ s 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 (aged 14-18 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 sizes were between  $d = 0.58$  and 1.46, representing medium to large effects. Further, 91% ( $n = 10$ ) of the adolescents

showed reliable change on the Brief Symptom Inventory and 18% ( $n = 2$ ) 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.

## <H2>MBT for antisocial personality disorder

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 (National Institute for Health and Clinical Excellence 2010), which confirmed that interventions for ASPD are poorly researched and that evidence on its treatment is scarce. The authors of the NICE guideline concluded that the evidence for treatments for ASPD was extremely limited, and did not support the development of any guideline on treatment recommendations (National Institute for Health and Clinical Excellence 2009). 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, we 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.

## <H1>SUGGESTED CROSS-REFERENCES

The neuroscience of social interaction is discussed in Section 1.22. The theoretical aspects of classical psychoanalysis and other psychodynamic schools are discussed in Sections 6.1 and 6.3, respectively, while psychoanalysis and psychoanalytic therapy are discussed in Section 30.1 respectively. Personality assessment of adults and children is covered in Section 7.6. Personality disorders are discussed in Chapter 23. Adult antisocial behavior, criminality, and violence are discussed in Section 26.2. Normal child development and adolescent development are covered in Sections 32.2 and 32.3, respectively. Reactive attachment disorder of infancy and early childhood is considered in Section 47.1, and child maltreatment is discussed in Section 52.2.

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**Table 33.18-1 Modes of non-mentalizing: psychic equivalence**

<b>Clinical appearance</b>	<ul style="list-style-type: none"> <li>• Certainty/suspension of doubt</li> <li>• Absolute</li> <li>• Reality is defined by self-experience</li> <li>• Finality—“It just is”</li> <li>• Internal is seen as equivalent to external</li> </ul>
<b>Clinician’s experience</b>	<ul style="list-style-type: none"> <li>• Puzzled</li> <li>• Wish to refute</li> <li>• Statement appears logical but obviously overgeneralized</li> <li>• Not sure what to say</li> <li>• Angry or fed up and hopeless</li> </ul>
<b>Intervention</b>	<ul style="list-style-type: none"> <li>• Empathic validation with subjective experience</li> <li>• Curious—“How did you reach that conclusion?”</li> <li>• Presentation of clinician’s puzzlement (marked)</li> <li>• Linked topic (diversion) to trigger mentalizing then return to psychic equivalent area</li> </ul>
<b>Iatrogenic</b>	<ul style="list-style-type: none"> <li>• Argue with patient</li> <li>• Excessive focus on content</li> <li>• Cognitive challenge</li> </ul>

**Table 33.18-2 Modes of non-mentalizing: pretend mode**

<b>Clinical appearance</b>	<ul style="list-style-type: none"> <li>• Inconsequential talk/groundless inferences about mental states</li> <li>• Lack of affect. Absence of pleasure</li> <li>• Circularity without conclusion—“spinning in sand” (hypermentalizing)</li> <li>• No change</li> <li>• Dissociation—self-harm to avoid meaninglessness</li> <li>• Body and mind decoupled</li> </ul>
<b>Clinician’s experience</b>	<ul style="list-style-type: none"> <li>• Boredom</li> <li>• Detachment</li> <li>• Patient agrees with clinician’s concepts and ideas</li> <li>• Identification with clinician’s model</li> <li>• Feels progress is made in therapy</li> </ul>
<b>Intervention</b>	<ul style="list-style-type: none"> <li>• Probe extent</li> <li>• Counterintuitive</li> <li>• Challenge</li> </ul>
<b>Iatrogenic</b>	<ul style="list-style-type: none"> <li>• Non-recognition</li> <li>• Joining in with acceptance as real</li> <li>• Insight-orientated/skill acquisition intervention</li> </ul>



**Table 33.18-3 Modes of non-mentalizing: teleological mode**

<b>Clinical appearance</b>	<ul style="list-style-type: none"> <li>• Expectation of things being “done”</li> <li>• Outcomes in physical world determine understanding of inner state—“I took an overdose; I must have been suicidal”</li> <li>• Motives of others are based on what actually happens</li> <li>• Only actions can change mental process</li> <li>• “What you do and not what you say”</li> </ul>
<b>Clinician’s experience</b>	<ul style="list-style-type: none"> <li>• Uncertainty and anxiety</li> <li>• Wish to do something—medication review, letter, telephone call, extend session</li> </ul>
<b>Intervention</b>	<ul style="list-style-type: none"> <li>• Empathic validation of need</li> <li>• Do (or do not do) according to exploration of need</li> <li>• Affect focus of dilemma of doing</li> </ul>
<b>Iatrogenic</b>	<ul style="list-style-type: none"> <li>• Excessive “doing”</li> <li>• “Prove” clinician cares in the belief it will induce positive change</li> <li>• Elasticity (extending what clinician does, e.g., providing extra sessions, only to rebound with extra constraints) rather than flexibility</li> </ul>

**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

**Table 33.18-5 Clinical principles in MBT**

The clinician must:

- Remain alert to imbalances of the mentalizing dimensions and emergence of non-mentalizing 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 non-mentalizing in the patient with high-level mentalizing
- Match interventions to the patient's mentalizing capacity