Foreword

It is indeed a heartwarming and substantial privilege to be asked to read and introduce this book, which is one of the most exciting examples of the continuing expansion of the mentalizing family. I will divide the space allocated equally to a brief overview of MBT's achievements and then highlight what Brandon Unruh and Bob Drozek and Anthony Bateman's book has contributed.

Whilst a relative newcomer, the treatment model and theory of MBT has acquired a certain standing within the community of psychological treatment approaches and transdiagnostic models of mental disorder. The origin of this work goes back (an unimaginable) 35 years when we demonstrated for the first time that the security of the parent-child attachment bond at one year of age could be predicted from an interview with a parent regarding their own attachment history prior to the birth of the child. This work, with Miriam and Howard Steele, now both enjoying well-deserved senior positions at the New School in NYC, showed that a parent's capacity to make sense of their early experiences and relationships in terms of their mental states (thoughts, feelings, beliefs, emotions, intentions, et cetera), a capacity we referred to as "reflective function", was a critical factor that shaped the quality of care parents provided to their infants and the security of the evolving attachment relationships (Fonagy et al., 1991). This paper, which, according to Google scholar, has been cited in 2,800 publications, implied that insecure relationships may be perpetuated from one generation to the next. Further follow-ups by Miriam and Howard found parental mentalizing to have long-term predictive power (Steele et al., 2016). In collaborative work with Pasco Fearon we were able to show, using behaviour genetic methods, that the transgenerational process was indeed mediated by social, not genetic, transmission, and could be clearly linked to the quality of care which the child received (Fearon et al., 2006).

The idea that patterns of relating are laid down in early life, may be relatively stable over time, and may be passed from one generation to the next is neither original nor new. The specificity with which mentalizing explains this process is however important when thinking about how mental disorder is generated and how, with thoughtful intervention, it may be prevented, thus breaking intergenerational cycles of disadvantage. This book, as does the MBT tradition in general, stands on the three decades old work linking early experiences, mentalizing and unhelpful patterns of organizing attachment

representations that generate clinical outcomes. Much of the translational work that followed the original studies based at the Anna Freud Centre (celebrating its 70th birthday this year) adopted the developmental framework in which the capacity to mentalize was seen as a developmental achievement partially ensured by the capacity of the child's carers to provide a reflective environment able to build robust mentalizing capacity in the child. The model was described in a hurriedly written book (brilliantly edited by Dr Elizabeth Allison) published twenty years ago which became highly influential, with over 8500 citations, laying out the central hypothesis that attachment-related trauma impairs the development of mentalizing, which subsequently leads to the pattern of emotional dysregulation and self disturbance that is characteristic of borderline personality disorder and related difficulties (Fonagy et al., 2002).

The relationship between attachment and mentalizing would not have had true clinical impact but for the work of an extraordinary clinician, Professor Anthony Bateman. The novel framework for psychological therapy, which I had the privilege of working with Anthony on, had a transformational impact on practice and underpinned the development, evaluation and professional application in the UK and internationally of effective mental health therapies for several different psychological issues that threaten the health and well-being of adults, adolescents, children and families (Bateman & Fonagy, 2010). The research, which evaluated the suitability and effectiveness of the mentalizing approach in personality disorder and other client populations where attachment and mentalizing difficulties are considered important (adolescent self-harm, children in foster care, depression), has all been based on the principles of treatment which Anthony Bateman's work with individuals with BPD established (Bateman & Fonagy, 2006).

The principles of MT technique, brilliantly illustrated in the present book, are not all that Anthony has brought to the MBT tradition. Accessibility is perhaps the most important of these. Some of it goes back to the practical constraints that drove the original development of the intervention. Anthony Bateman, in almost his first clinical leadership role, inherited a psychodynamic partial hospital (The Halliwick Day Hospital) where clinical capacity for specialist intervention was far exceeded by clinical need (a situation still not uncommon in public mental health settings in the UK). His task was deceptively simple: to create a theory-grounded intervention for individuals with severe (almost exclusively borderline) personality disorders that would have therapeutic value and could be administered with minimal training by individuals who had not been psychotherapeutically trained but had experience in treating severe mental health problems through their training in nursing, social work, occupational therapy, psychology and even psychiatry. MBT, as established by Anthony Bateman, remains

remarkable for taking a non-stigmatising approach towards a client group who suffer more from stigma linked to their mental health condition than perhaps any other, giving hope to patients by promoting kindness and understanding – the concepts that lie at the heart of mentalizing. Perhaps it is this considerateness that makes MBT relatively easy to implement with clinical groups who have often become suspicious as a result of the many disappointments they have experienced with support previously received.

The approach Anthony, with some support from me, has developed turned out to be massively successful both clinically and in terms of popularity (Bateman & Fonagy, 2004b). It combined our psychoanalytic understanding of personality and its disorders with understanding gleaned from the rapidly developing neuroscience of social cognition (Frith & Frith, 2003). Inspired by developmental psychology and neuroscience, a set of interventions were created that helped clinicians understand the atypical thinking of those with a diagnosis of personality disorder and provided simple rule-based interventions to address these in a way believed to be beneficial to the individual concerned (Bateman & Fonagy, 2006).

Half a dozen randomized controlled trials showed robust benefits of MBT relative to treatment as usual for BPD and associated problems (Bateman & Fonagy, 1999, 2001, 2004a, 2009, 2013, 2019b; Bateman et al., 2016; Robinson et al., 2014; Robinson et al., 2016). It is easy to forget that Bateman's work established MBT as the first therapy to offer clear evidence of lasting patient benefit, including at five and eight year follow-up (Bateman et al., 2020; Bateman & Fonagy, 2008). The evidence confirmed that those receiving treatment enjoyed a more fulfilling and gratifying quality-of-life in terms of reduced use of services and greater likelihood of being involved in full-time education or employment.

Mentalizing as a psychotherapeutic approach continued to grow under Anthony Bateman's stewardship (Bateman & Fonagy, 2012, 2019a), as did the developmental neuroscience from which it drew some of its inspiration. But the two fields continued to develop separately to enrich our understanding of development, cognition and psychopathology. Only relatively recently has neuroscience reached out to the clinical mentalizing researchers to establish common understanding (Gilead & Ochsner, 2021). In the meantime MBT grew as a treatment approach. In collaboration with the Anna Freud Centre, Anthony Bateman oversaw the provision of professional training to practitioners around the globe to incorporate this research-based intervention into the widest range of practices. Over 15,000 practitioners from 36 different countries have received training in one of the MBT family of interventions, with demand for training places continuing to outstrip supply. MBT training centres have been established in

seven European countries and three North American locations and training sessions have been held in all the nations of the UK as well as the United States, Austria, Finland, Japan, Italy, the Netherlands, Germany, Chile, Spain, Hong Kong, Sweden and Canada. While both Drs Unruh and Drozek have contributed significantly to this training effort, it is Anthony Bateman's remarkable energy that has ensured that the dissemination of MBT has been so extensive. In a recent follow-up survey of practitioners who had received training in MBT interventions, 87% of the almost 300 who responded reported that MBT had been very useful or extremely useful to their practice and 89% reported that MBT had been very beneficial or extremely beneficial to their patients.

The MBT family is growing. The thinking around clinical practice now belongs to a large and growing community of clinicians and researchers advancing our understanding of both mentalizing as a developmental process and its challenges in clinical groups. The MBT community's thinking is remarkably coherent, linking attachment and mentalizing to social functioning, and coupling these with the core elements of MBT practice. MBT's thinking has impacted the development of a range of psychological treatments. Mentalizing has become a word used by clinicians practising many modalities and it is perhaps unsurprising that giant clinician treatment developers claim MBT to be a subspecialty within their own preferred way of working. Both Aaron Beck and Salvador Minuchin have suggested that MBT, on closer inspection, was a development of cognitive behavior therapy and systemic thinking respectively. The developers of MBT have never aimed to develop a new "school" of psychotherapy. We consider MBT to be a set of techniques perhaps more comfortable within the common factors approach than as a member of a family of psychotherapies or as a specialist orientation of its own. MBT clinicians and researchers, encountering clinical problems and using the basic ideas of the original model, have developed adaptations that are manualized, where possible evaluated in randomized controlled trials, and disseminated to the broadest number of potential practitioners and supervised by experienced trained clinicians in the subspecialty.

And this brings us to the most recent addition to the family, MBT-N or MBT for pathological narcissism. MBT-N is an ingenious, creative and brilliant adaptation of the theoretical and practical principles of MBT, which genuinely advances the value and relevance of the MBT approach. To restate in summary form, the two conceptual advances that drive MBT–N are: (1) the concept of the alien self and (2) the novel concept of the me-mode.

The approach advanced in Drozak, Unruh and Bateman's book extends substantially and helpfully the clinical model of the alien self. Those familiar with the work will recall that the internalization of a non-congruent contingently related mirroring figure can create a vulnerability for instability within the self representation of the child. The self is constituted from interpersonal interaction experiences with others, as suggested by dialectic philosophical tradition as well as interactional social psychological and psychoanalytic models. If early mirroring is absent or inaccurate the child, looking for a representation for its subjective experiences in the outside world, internalizes an absence or worse still a hostile representation into the experiencing self. The self then includes within itself a representation of the other which is nevertheless felt to be a part of itself - albeit an incongruent part. As mentalizing is helpful in creating coherence, the alien self remains a vulnerability rather than a pathology. The propensity for disorder becomes evident at times when the illusory coherence of the self is lost, as is likely to occur when there is a breakdown in mentalizing. At these moments the incongruence of the self becomes painful and the fragmentation is experienced as an existential threat.

We have argued that incongruence of this kind is acutely distressing and is commonly managed by identifying a vehicle, a person, in the social environment who can be nudged or manipulated into adopting representations that belong to another (alien) self – historically, the caregiver inaccurately mirroring the self. With trauma history, as is common in borderline personality disorder, internalization of an abusive and destructive figure into the self structure creates an experience of sometimes indescribable self-hatred that can only be managed through identifying a vehicle incorporating hostility for it in the social world - someone who adopts the attitudes of hatred and creates a relationship of persecution with the now serially victimized object of maltreatment. Distressing and uncomfortable as these solutions often turn out to be, they are preferred to the alternative of internal persecution and instability in self experience.

Of course this model would not explain the typically grandiose and superior attitude of the individual with pathological narcissism (PN). Drawing on developmental literature, Drozak, Unruh and Bateman identify the high prevalence of inaccurate but positive interactions between parents and those who come to be at risk of developing PN. This creates an analogous but different challenge for self organization in these individuals. There is incongruity in the self structure but this feels alien because it is inappropriately, unrealistically and excessively positive. The discomfort of incongruity, its existential threat, is the same but the alien part is not hateful but excessively loving. So extrusion (projection) still has to happen to save the self but it comes with a loss of positive experience as the extruded part of the self is loving rather than critical (as in BPD).

Although finding external individuals to idealize (the vehicle for this excessively positive stance) is a recognizable feature of PN, it is the exaggerated value placed on the self which defines the disorder.

The brilliant insight guiding the model of treatment described in this book is a recognition that the kind of extrusion or projection described in BPD can easily be observed in NPD except that the incongruent parts of the self are placed into the self-image rather than external object. It is the self image that becomes the vehicle for the alien self, bringing with it relief in terms of increased coherence and also validation in terms of self-admiration and (inauthentic) pride.

To make this simple idea work the authors needed to bring a second ingenious extension to the basic MBT theory. They distinguish between the *I-mode* and the *me-mode*, two developmentally sequenced categories of experience related to the self. The I-mode, defined by philosophy of mind as the source of identity, remains unchanged, the sum total of agentive self experience. This is the sense of experiencing that James recognised as the golden thread of Sameness that continues from infant behavior through childhood and remains a core aspect of the human mind across the lifespan: a sense of coherence and stability gifted to us (we maintain) by mentalization. As James wrote “The mind can always intend, and know when it intends, to think of the Same. This sense of sameness is the very keel and backbone of our thinking.”(James, 1890, p.235). This sense sameness is located within the I-mode. The I-mode, which contains agency, of course requires coherence: this is why incongruent components that would compromise coherence of action need to be projected. However, externalizing positive and favorable components of the self into the external world opposes the pleasure principle or the principle of reinforcement learning. In common parlance we might say, it does seem rather a shame, particularly for individuals who for biological or social reasons are struggling with enduring problems of self-esteem.

The solution which the authors suggest is both elegant and compelling. Where better for a person with fragile self-evaluation to place such an inconvenient but pleasing aspect of self than into the me-mode, the representational structure which William James memorably named “self as object”. In the current model the me-mode is a self representational structure based on the experience of the self in the social context. It is an object that is described or narrated rather than an entity that is validated by its coherence and action, and consequently i-mode is unable to tolerate incongruity. The me-mode belongs to a developmentally later stage when the capacity to construct an identity based on self narrative emerges (McAdams, 2008; McAdams et al., 2004). By creating a story and a set of meanings around personal attributes we create meaning

around events in our lives and interconnect past, present and expected experiences that collectively generate a unit of experience around William James' (1890) "self as object" or "me". PN is not different in having a me-mode. It is what the me-mode contains that differentiates PN.

The me-mode is the separate individual a person refers to when talking about their personal experiences that feels sustainable over time. It of course changes as the narrative alters but, normally we deal with that through the usual flexibility that mentalizing offers us. It is most likely that the me-mode comes to fruition as part of or after puberty when the demand for autonomy and the need to relate to and learn from peers becomes dominant (Debast et al., 2017). It is only after the emergence of metacognitive capacity sufficient to create an integrated, evolving, coherent story of the self in interaction with the social world, that the individual becomes able to represent themselves to others, drawing together their significant life experiences (Adler et al., 2016; McAdams, 2008). The me-mode is a narrative identity that is more ideographic, dynamic, and contextual than the I-mode can be because self agency demands coherence. You cannot do two things at the same time, go at once left and right - or you can but the result can be unattractive. The me-mode, being a narrative is therefore in most of us more malleable to change: to change in psychotherapy or, perhaps even more likely, through other social experience such as changed relationships (McLean, 2017).

Not so for the individual with pathological narcissism. If the me-mode is a vehicle for a projection which safeguards the coherence of the I-mode, such luxury cannot be afforded. In a person whose modification of their representational self structure was enforced by the need to maintain coherence in the I-mode, any change in representation signals the return of the extruded object back into the self - creating incongruence and existential anxiety. For the BPD patient who creates a persecutor externally and repeats again and again their history of maltreatment and exploitation, there is no option of withdrawing the projection without creating the hatred within the self with self-harm and suicidal intent. The same challenge faces the person with NPD. They cannot change. The grandiose self-love has to be part of their personality even if it ill fits the reality of their life. For them the flexibility of the me-mode representational structure is unavailable.

The dispositional traits characteristic of pathological narcissism are within the I-mode but the story the person weaves around these occurs in the representational context which demands a certain degree of mentalizing to ensure coherence. Limitations in mentalizing will impact on narrative coherence and are likely to threaten well-being and

may explain clinical referral for the broad range of reasons which Drozak, Unruh and Bateman hypothesize (Lind et al., 2019, 2020). When fully functioning, the me-mode - James' self as object representation - effectively distracts, preoccupies and relieves from the disruption of self experience threatened by incongruity within the I-mode. When mentalizing fails, the threat to self cohesion becomes real and pre-mentalistic modes of thinking come to dominate the me-mode. At this point the individual may no longer be able to distinguish, as the authors suggest, the me-mode from the I-mode. If a person in the concreteness of psychic equivalence no longer experiences the representational self as a construction but as a reality and imagines their representation, their self-image, as having properties of an agent to guide as opposed to narrate action, they will appear to all observing them as grandiose. Escape to pretend mode may be a solution. It is tempting to think that narcissistic pathology is the me-mode in 'pretend I-mode '.

All this of course is new thinking which this book proposes along with a step-by-step comprehensive guide to helping individuals manage these problems and navigate the issue of self-evaluation and self-esteem. The breakdown of mentalizing causes a conflation of the representational and the agentive mode whereby the person feels crushed by their self representation as if it were an aspect of physical reality. But the model brings a very clear and once again brilliantly insightful goal to the treatment. Recovering mentalizing does not need to confront the exaggerated positive self experience which has caused difficulties in self coherence in the first place. The goal is the recovery of mentalizing that enables the representational me-mode to act as container for the exaggerated sense of self-worth which caused problems in the first place. In representational me-mode, the self narrative can be adjusted to contain both high self-worth and the exigencies of life circumstance which might at times challenge this asssessment. The therapy, as in the treatment of borderline personality disorder, is not focused on altering the alien self. The mental economy of self structure is likely to make that a fruitless exercise. It is aligning alien parts of the self with a coherent self representation that is the challenge for therapy, but one which the authors make abundantly clear the patient needs to achieve themselves.

What the book offers is an exquisite, brilliantly written, highly astute set of guidelines on how to manage the recovery of mentalizing with patients whose narcissism is pathological. The inset boxes, the tables and the case histories reflect the authors' vast and almost unique experience in navigating these patients through the crisis that is likely to have caused the collapse of mentalizing and with it created conflicts between the person's lived life and their imagination, their fantastic self narrative, which they cannot by themselves bridge. The trigger, as described in the book, for the collapse of

mentalizing is an inconsistency (which the person cannot reconcile) between their experience of themselves and the world's experience of them. Normally the discrepancy, like cracks in plaster, can be papered over by mentalizing, finding sometimes ingenious solutions for fitting square pegs into round holes. The internal or external conflicts that compromise this process and increase emotional arousal, which itself represents a threat to mentalizing, have to be negotiated in the mind but also outside, in the social world. The cognitive and emotional content of the me-self or me-mode is often the focus of psychotherapeutic approaches, be it from a cognitive behavioral or a psychodynamic tradition. The authors suggest an alternative, a process-oriented approach where the therapist's commitment is to engaging the patient in activities that validate their view of the world without generating unnecessary conflict and endangering their capacity to mentalize. In this process, the separation of the I-mode and me-mode is achieved without necessarily dramatically altering either, although changes will invariably arise through the emergence of more balanced mentalizing that ceases to prioritize rigidly the self over the other (or indeed the other over the self).

I consider MBT-N to be a major innovation. It is so both in terms of clarifying the multilevel nature of self structure and interfacing it with mentalizing, and in terms of offering what may turn out to be vital help for individuals whose chronic struggle with self-esteem leaves them vulnerable to depression, self destructive acts, and sometimes suicidality. The book also opens an opportunity for us to work with and try to understand a group of individuals who have previously perhaps received inappropriate treatment from MBT practitioners. The increased subtlety of the MBT approach described here, the nuances which enable us to respond accurately, contingently, in a gentle and marked mirroring manner is ultimately what we hope from the MBT approach in general – not quite a school of therapy but perhaps more than a set of randomly assembled techniques, somewhere in between. Perhaps a tradition?

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