Mentalization Based Treatment: recent developments

Prof Anthony W Bateman
Three stages of a cumulative process that makes psychotherapy effective

Communication System 1
Content

Ostensive cuing:
Conveys a convincing understanding of the patient as agent that generates self-recognition

Communication System 2
Epistemic trust in psychotherapy

Communication System 3
Generalisation of epistemic trust

Therapist

Increased interest in the therapist’s mind and their use of thoughts and feelings

Patient

Opening to social learning

Benign social environment

Gradual re-emergence of robust mentalizing
Overview of the MBT model: Key Domains
**Domains of MBT – individual and group**

**General Domains**
- Can be evaluated by viewing a whole session
- Two general core domains
  1. Sessional Structure
  2. Not-Knowing Stance

**Major Component Domains**
- Can be evaluated on the basis of the therapist’s interventions
- Four major component domains
  3. Mentalizing Process
  4. Non-Mentalizing Modes
  5. Mentalizing Affective Narrative
  6. Relational Mentalizing

- A typical MBT session involves interventions within these 4 domains
- MBT therapist will train on skills to deliver each type of intervention
Domain - Structure

Individual
- Engagement and warmth
- Identifying priorities
- Identifying focus
- Agreeing collaboratively
- Closure

Group
- Engagement and warmth
- Identifying priorities of members
- Identifying focus through synthesis
- Closure
Domain - Not Knowing Stance

Individual
- Curiosity
- Engagement
- Authenticity of expression
- Genuineness of interest
- Respect
- Tentativeness
- Tolerance for not knowing what the other intends
- Modelling

Group
- Curiosity
- Engagement
- Authenticity of expression
- Genuineness of interest
- Respect
- Tentativeness
- Tolerance for not knowing what the other intends
- Modelling
- Facilitating stance between members
Domain – Mentalizing Process

**Individual**
- Empathic validation
- Acknowledge positive mentalizing
- Managing form of session
  - Stop/slow
  - Rewind and reflect
- Contrary moves

**Group**
- Empathic validation
- Acknowledge positive mentalizing of individual and between members
- Managing form of session
  - Stop/slow
  - Rewind and reflect
- Contrary moves
- Parking for attentional control
Domain – Non-Mentalizing modes

**Individual**
- Psychic Equivalence
- Teleological Mode
- Pretend Mode

**Group**
- Psychic Equivalence
- Teleological Mode
- Pretend Mode
Mentalizing Affects

**Individual**
- Clarification of affective narrative
- Affect identification
- Affect Focus
- Affect and Interpersonal/significant events
- Clarification of interpersonal perspectives self and other

**Group**
- Clarification of affective narrative
- Affect identification
- Affect Focus
- Affect and Interpersonal/significant events
- Clarification of interpersonal perspectives between group members
- Interpersonal affect recognition of self and other
Domain – Relational Mentalizing

**Individual**
- Mentalizing the external relationships
- Mentalizing relationship between clinician/patient
- Mentalizing counter-relationship in intimate relationship
- Mentalizing counter-relationship between clinician/patient

**Group**
- Mentalizing external relationships
- Mentalizing relationship between clinician/patient
- Mentalizing relationship between group members
- Mentalizing counter-relationship between clinician/patients
- Mentalizing counter-relationship between group members
Implementation of MBT Domains

- Structure: 75
- Not knowing stance: 85
- Process: 60
- Non-mentaling modes: 70
- Affect Sig Events: 90
- Relational Mz: 10
Clinical implementation using group relationships

Communication system 1: general process
The mentalizing stance in therapy
(Bateman & Fonagy, 2006)

The **mentalizing stance entails epistemic trust**

- nonjudgmental **inquisitiveness**, curiosity, open-mindedness, uncertainty, **not-knowing**, and interest in understanding better (Allen et al., 2008, p. 183).
- **Benevolence**, acceptance, respect, and **compassion** are implicit in the mentalizing stance (Allen, 2013a; Allen et al., 2008).

Moreover, fostering epistemic trust entails **transparency** on the part of the **therapist**.

- “The patient has to find himself in the mind of the therapist and, equally, the therapist has to understand himself in the mind of the patient if the two together are to develop a mentalizing process. Both have to experience a mind being changed by a mind” (Bateman & Fonagy, 2006, p. 93).
The very experience of having our subjectivity understood—of being mentalized—is a necessary trigger for us to be able to receive and learn form the social knowledge that has the potential to change our perception of ourselves and our social world.

The gift of a mentalizing process in psychotherapy is to open up or restoring the patient’s openness to broader social influence, which is a precondition for social learning and healthy development at any age (Allen & Fonagy, 2014; Fonagy & Allison, 2014).

The greatest benefit from a therapeutic relationship comes from generalizing epistemic trust beyond therapy such that the patient can continue to learn and grow from other relationships.
Structured Sessions – Communication system 1

- Session 1 What is mentalizing and a mentalizing attitude
- Session 2 What does it mean to have problems with mentalizing
- Session 3 Why do we have emotions and what are the basic types
- Session 4 How do we register and regulate emotions? Mentalizing emotions
- Session 5 The significance of attachment relationships
- Session 6 Attachment and mentalization
Formulation – communication system 1

- Aims
  - Organise thinking for therapist and patient – each sees different minds
  - Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exampled)
  - Modelling humility about nature of truth

- Management of risk
  - Analysis of components of risk in intentional terms
  - Avoid over-stimulation through formulation

- Beliefs about the self and others
  - Relationship of these to specific (varying) internal states
  - Historical aspects placed into context

- Central current concerns in relational terms
  - Identification of attachment patterns – what is activated
  - Challenges that are entailed

- Positive aspects
  - When mentalisation worked and had effect of improving situation

- Anticipation for the unfolding of treatment
  - Impact of individual and group therapy
Developing a relational passport

- Psychoeducation
- Explore relational vulnerability from past relationships
- Identify core self and other representations
  - Avatar development between patient and therapist – past and present
- Map attachment strategies in relationships
  - Anticipate unfolding in treatment
- Rehearse prior to group explaining content of relational passport
Mentalizing Group: Generic techniques
The MBT Loop

Notice And Name Interpersonal interaction

Checking

Generalise (and Consider Change)

Checking

Mentalize The Moment Between patients
Mentalizing Group: Specific techniques
Relational mentalizing

- Focus on personal relational passport in group – clinician sides with patient
- Validation of experience of patient to patient interaction
- Exploration of roles in relational process including component of therapist
- Identification of personal sensitivities
- Increase recognition of complexity of interactional process – alternative perspective
- Identify external situation to new perspective to increase social relevance for patient
Identifying problems in relationships

Video

In MBT training/Video Intro to mock group
Siding

- Clinician notes that a patient is vulnerable to other patients actions/comments/focus
- Actively take the side of the vulnerable patient
- Other clinician (if present) takes position of antagonist
- Support the vulnerable patient until mentalizing is rekindled in the group
- Switch sides if necessary when the vulnerable patient is more stable
Mentalizing and Antisocial Personality Disorder

Prof Anthony W Bateman
Mentalization Based Treatment 4th International Conference
Why consider ASPD?

**ASPD**
Highly prevalent amongst UK offending population and is associated with increase likelihood of committing violent behaviours, future reconvictions and recidivism severity.

**Societal and Personal costs**
Physical and emotional damage to victims, criminal justice system involvement, increase of health care, lost employment opportunities, relationship breakdown; family disruption and substance misuse.

**Major public health implications**
Associations with psychiatric co-morbidity, substance abuse, suicide, family violence and early death.
ASPD characteristics

- Failure to conform to social norms with respect to lawful behaviours
- Deceitfulness
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness
- Reckless disregard for safety of self or other
- Consistent irresponsibility
- Lack of remorse

None of these features is endearing to others. The self-serving attitude of people with ASPD and unpredictability makes people wary of them.
Preliminary evidence
IOP: ASPD treatment study

Observed and Predicted Means for SCL-91: GSI Scale

N=40  difference between groups at 18-months
-0.45 (-0.80, -0.11), p<.011

Adjusted for Random Slope
N=40

difference between groups at 18-months
-0.61 (95% CI: -1.05, -0.17), p<.007
N=40
difference between groups at 18-months
-0.64 (95% CI: -1.09, -0.18), p<.006
N=40

difference between groups at 18-months

-0.48 (95% CI: -0.78, -0.18), p<.002
difference between groups at 18-months
-0.58 (95% CI: -0.89, -0.28), p<.000

N=40

IOP: ASPD treatment study
Observed and Predicted Means for Social Adjustment Scale
IOP: ASPD treatment study

Observed and Predicted Means for Frequency of Acts of Self-harm

Difference between groups at 18-months

\(-0.48\) (95% CI: \(-0.69\), \(-0.18\)), \(p<.000\)

Adjusted for random intercept and initial values
IOP: ASPD treatment study

Observed and predicted mean frequency of suicide attempts

difference between groups at 18-months

-0.28 (95% CI: -0.68, -0.08), \( p < .02 \)

Poisson random effects regressions adjusted for random intercept
difference between groups at 18-months
-0.58 (95% CI: -0.89, -0.28), p<.003
MOAM
Mentalization for Offending Adult Males
ISRCTN32309003 DOI 10.1186/ISRCTN32309003
Antisocial personality disorder: a disorder of mentalizing
Imbalance of mentalization generates problems

Implicit-Automatic-Non-conscious-Immediate.

Mental interior cue focused
- Impulsive, quick assumptions about others' thoughts and feelings not reflected on or tested, cruelty
- Lack of conviction about own ideas
- Unnatural certainty about ideas
- Unlikely to be convinced of own ideas
- Overwhelmed by emptiness, seeking intense experiences
- Hyper-vigilant, judging by appearance
- Overwhelming dysregulated emotions
- Rigidity in assertion of self, controlling others' thoughts and feelings

Explicit-Controlled-Conscious-Reflective

Mental exterior cue focused
- Does not genuinely appreciate others' perspective
- Pseudo-mentalizing, interpersonal conflict 'cos hard to consider/reflect on impact of self on others
- Hyper-vigilant, judging by appearance
- Evidence for attitudes and other internal states have to come from outside
- Overwhelming dysregulated emotions, not balanced by cognition come to dominate behavior
- Evidence for attitudes and other internal states has to come from outside

Cognitive agent: attitude propositions
- Unnatural certainty about ideas
- Anything that is thought is REAL
- Intolerance of alternative ways of seeing things
- Overwhelmed by emptiness, seeking intense experiences
- Overwhelming dysregulated emotions
- Not balanced by cognition come to dominate behavior
- Lack of contextualizing of feelings leads to catastrophizing

Affective self:affect state propositions

Other system
- Hypersensitive to others' moods, what others say
- Fears 'disappearing'
- Rigid assertion of self, controlling others' thoughts and feelings
Self - Other
Mentalizing
Self and Other problems in ASPD

Self
- Fixed perspective e.g. misunderstood, ill-treated ‘v’ self-important, grandiose self
- Schematic representations of self in world
  - Hierarchical relationships – passive, submissive, subservient ‘v’ dominant, controlling, bullying
- Narcissistic self – deactivated attachment, self-serving

Other
- Reduced interest
- Diminished
- Rigid representation of others
- Support self representation, especially of officials/establishment/systems
- Controlling, coercive of mental states and behaviour
- Self/Alien self stabilises through other
Cognitive – Affective Mentalizing
Empathy in psychopathic and ASPD offenders
Empathy

- Offenders show empathy deficits in both the cognitive and the emotional domain when compared with the non-offender controls.
- Confounded by education levels to some extent with higher educational level associated with better cognitive empathy.
- Delinquency and violent offending may be more associated with reduced empathy than psychopathy itself.

Clinical Note
- How to increase emotional empathy without increasing, for example, recognition of other vulnerability and opportunity to increase exploitation?
- How to increase perspective taking and not mimicry and dissimulation?
- How to increase other empathy and the two-way components of empathy?
Forest plots for facial cues for the six emotions. Dawel et al 2012
Forest plots mean effect sizes vocal cues for the six emotions. Dawel et al. 2012.
Shame
Centrality of ‘moral’ emotions

- Shame and guilt are “negative” or uncomfortable emotions
  - Shame involves a negative evaluation of the entire self vis-à-vis social and moral standards.
  - Guilt focuses on specific behaviors (not the self) that are inconsistent with such standards.
- Shame and guilt lead to different “action tendencies” (Lindsay-Hartz, 1984)
  - Guilt is apt to motivate reparations.
  - Shame is apt to motivate efforts to hide or disappear or attack.
Shame

- Different types of shame described
  - malignant aggressive (blame, attack, avoid)
  - benign life shame (motivating, behaving morally/socially/interpersonally)

- Shame
  - Low concern for others and High concern for self
  - Threat of social exclusion
  - Triggers physical pain which suggests immediate action if not moderated
Shame and aggression

- Positive correlations:
  - shame-proneness and physical aggression
  - shame-proneness and verbal aggression for adults, college students, adolescents, and children
  - shame proneness and anger, hostility, and externalization of blame

- Male college students’ anger fully mediated the relationship between shame and psychological abuse of a partner
ASPD and Attachment
Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse.

- Exposure to maltreatment
- Intensification of attachment
- Inhibition of mentalisation

Inaccurate judgements of facial affects,
Delayed theory-of-mind understanding
Failure to understand the situational determinants of emotions
ASPD and Attachment

**Dismissing/Avoidant**
- Devaluing
- Limited coherent recall
- Inadequate evidence
- Positive view of self
- Negative view of others
- Fragile independence

**Disorganised**
- Opposing states of mind
- Lapse in monitoring of discourse/reasoning
- Poor self-scrutiny and limited access to stable states of mind
MBT and core domains of interventions
Summary – MBT-ASPD
The interpersonal cycle

Affect stress activates attachment

Hypo-activate or De-activate attachment
De-stabilisation of self due to unstable mentalizing
Lower emotional empathy
+ Harbinger of shame
= Failure of self other mentalizing

Coercive interpersonal relationships

Regulation of emotions and interpersonal interaction in ASPD

Control Threat

Externalisation to maintain mentalizing and integrity of self
Domains of MBT

Not-Knowing Stance
- Mentalizing
- Process
- Affective
- Narrative

Sessional Structure
- Non-Mentalizing
- Modes
- Relational
- Mentalizing
Topology: relationships between domains in therapist interventions

- Mentalizing Process
- Addressing Non-Mentalizing Modes
- Mentalizing the Affective Narrative
- Relational Mentalizing
Therapeutic challenges:
Engagement and defining goals
Externalising and drop-out from treatment
Henriette Löffler-Stastka; Victor Blueml; Christa Boes; Psychotherapy Research 2010, 20, 295-308.
Engaging the clients

- Initial assessment interviews – positive, hopeful, relevant to their problems
- Education about PD and effects
- Instilling beliefs about possibility of change
- Alliance and rapport
- Motivational interviewing
- Understanding emotions – identification in self and other, discussion, managing
- Accepting hierarchy and pretend mode (initially)
Values check – define with client

- Independence and self-determination
  - Making important decisions regarding your own life and having the freedom to determine your own actions
  - High degree of independence from those in leadership positions, planning your own working processes independently.

- Achievement and Success
  - Ambitiously and determinedly striving to achieve goals and being successful through your own achievement.

- Power and influence
  - Achieving a position in which you can determine or regulate things, and having influence on other peoples’ actions.
Values check – define with client

- Social status
  - Preserving your reputation in public.
  - Behaving in a manner to ensure respect
  - Being aware of the attention
  - Making sure others see you in the way you want
- Safety and health
  - Protecting yourself from danger
  - Protecting your own and your family’s health.

- Willingness to adapt
  - Observing social norms and rules in groups.
  - Not attracting attention through antisocial behavior.
Values check – define with client

- Care and nurturing
  - Caring about the needs and the wellbeing of others.
- Reliability and loyalty
  - Being reliable and trustworthy with other people.
- Tolerance
  - Accepting and respecting new-comers, as well as opinions and beliefs that are diverse.
ASPD and Group MBT
Group challenges

- Engagement and attendance
- Hierarchy and power
- Sensitivity and lack of trust
- Risk
- Confidentiality and disclosure
- Boundary violations/Drugs and Alcohol
- Specific counter-relationship responsiveness – fun and humour, minimise events
Assessment
Code of conduct
Outline of treatment

Code of conduct
Agree group principles
MBT-I

MBT
Clinician:
Some general considerations
Clinician – general stance

- Modelling mentalizing of self
  - Counter-relationship expression
- Adherence to not knowing stance in face of rigid, forceful statements
  - Authenticity – person in the room
- Identification of joint principles – respect, mentalizing
  - Gender/race/money/power and hierarchy
- Avoidance of joining with psychic equivalence
Clinician - shame

- Clinician needs to be sensitive to unmasking/exposing client sensitivities in group
- Negative feelings of shame may lead to externalization of blame which may lead to higher levels of verbal and physical aggression
- Aggressive and antisocial individuals often use cognitive distortions related to others to justify their activities and in doing so induce humiliation in others
Clinician - mentalizing the counter-relationship

- Anticipation of response/reaction of client
- Mark your statement
- Do not attribute what you experience to the client
- Keep in mind your aim
  - Re-instate your own mentalizing
  - Identify important emotional interaction that affects therapy relationship
  - Emphasise that minds influence minds
Focus on
Self and Other
Affect recognition
Empathic Validation – Affect and Effect

- Interest in and Reflection on **Affect**
- Identification of feelings
- Normalising when possible in context of present and past
- Seeing it through their eyes
- What **effect** does this experience have on them
Increase affective understanding between participants

- Accurate understanding of emotion in other
  - observe embodied mentalizing
  - external focus on affect ‘v’ internal affect state

- Increase in empathy for others
  - increase eye focus
  - constrained by others emotion

Later

- Recognition and acceptance of emotion in self – shame and other emotions
Focus on
attachment strategies
Developing a relational passport: preparation for group

- Psychoeducation
- Explore relational vulnerability from past relationships
- Identify core self and other representations
  - Avatar development between patient and therapist – past and present
- Map attachment strategies in relationships
  - Anticipate unfolding in treatment
- Rehearse prior to group explaining content of relational passport
Identifying attachment strategies and exploring relationships

Video

(in presentations 2018)
Relational interaction – attachment hyperactivation leading to hypoactivation

- **Increase**
  - Recognition of attachment strategies
  - Identification of triggers of activation
  - Understanding of affects and need of others

- **Decrease**
  - Concern for self in affect arousal and rapid switch to control other
  - Externalising core aspects of self
  - Self-serving uses of others e.g. for narcissistic needs
Key mentalizing components in MBT-ASPD Group

- Identification of non-mentalizing interactions
- Focus on emotions
  - Understanding emotional cues - external mentalizing and its link to internal states
  - Recognition of emotions in others – other/affective mentalizing – cognitive and emotional empathising (look angry but feel hurt and desperate)
  - Identification and naming of current feelings in self
Mentalizing and Narcissitic Personality Disorder – clinical perspectives
What is mentalizing?

Mentalizing is a form of *imaginative* mental activity about *others* or *oneself*, namely, perceiving and interpreting *human* behaviour in terms of *intentional* mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
Narcissistic Personality

Two types of narcissistic function:
- Grandiose
- Oblivious
- Sensitive
- Thin-skinned
Grandiose-Oblivious subtype

- Exaggerated sense of self-importance
- Sense of entitlement and require constant, excessive admiration
- Believe they are superior and can only associate with equally special people
- Expect to be recognized as superior even without achievements
- Exaggerate achievements and talents
- Preoccupied with fantasies about success, power, brilliance, beauty or the perfect mate
Grandiose-Oblivious subtype

- Monopolize conversations and belittle people they perceive as inferior or threat
- Expect special favors and unquestioning compliance with their expectations/opinions
- Take advantage of others to get what they want
- Lack empathy
- Envious of others and believe others envy them
- Behave in an arrogant or haughty manner, coming across as conceited, boastful and pretentious
Thin-skinned Narcissism:
vulnerable and hypervigilant subtype

- Highly sensitive to what others are saying
- Listens carefully for slights or subtle criticisms
- Inhibited/shy
- Shuns being centre of attention
- Prone to shame and hurt feelings
Mentalization Based Treatment for ASPD/NPD -

- Assessment
  - Mentalizing profile
  - Understanding of attachment strategies

- Group
  - Presentation of relational patterns
  - Explore mentalizing in context of participant interactions
Impulse of mentalization generates problems

Implicit-Automatic-Non-conscious-Immediate.

- Impulsive, quick assumptions about others' thoughts and feelings not reflected on or tested, cruelty
- Does not genuinely appreciate others' perspective. Pseudo-mentalizing, Interpersonal conflict 'cos hard to consider/reflect on impact of self on others

Explicit-Controlled-Conscious
Reflective

- Mental interior cue focused
- Lack of conviction about own ideas
  - Seeking external reassurance
  - Overwhelming emptiness, Seeking intense experiences
  - Hyper-vigilant, judging by appearance.
  - Evidence for attitudes and other internal states have to come from outside

Cognitive agent:Attitude propositions

- Unnatural certainty about ideas
  - Anything that is thought is REAL
  - Intolerance of alternative ways of seeing things.
  - Overwhelming dysregulated emotions, Not balanced by cognition come to dominate behavior. Lack of contextualizing of feelings leads to catastrophizing

Other system

- Hypersensitive to others' Moods, what others say.
  - Fears 'disappearing'
  - Rigid assertion of self, controlling others' thoughts and feelings.

Affective self:affect state propositions

Self system
Narcissism and Attachment

- Grandiose subtypes – secure or dismissive, avoidant attachment
- Vulnerable subtypes – fearful or preoccupied, anxious attachment
- High functioning narcissist may feel as comfortable with others as other securely attached individuals
Narcissism and Attachment
Arietta Slade (2014)

- Attachment strategies activated in response to fear and anxiety

- Fear
  - related to existence
  - emotional survival
  - being ‘known’ within framework of attachment relationship
Narcissism and Attachment

**Dismissing/Avoidant**
- Devaluing
- Idealising
- Limited coherent recall
- Inadequate evidence

**Pre-occupied/Anxious**
- Enmeshed
- Entangled
- Angry/Passive

**Disorganised**
- Opposing states of mind
- Lapse in monitoring of discourse/reasoning
Clinical presentation of dismissive attachment

- Actively derogating of previous attachment experiences
- Contemptuous attitude towards others
- Denigration of attachment figures who are seen as foolish, inferior
- Deny dependency and need for help
- Dismiss other perspective if not congruent with own
- Diminish the clinician who does not accept rigid narratives
- Insist on being admired
Deficits in social cognition

- Neurocognitive deficits in empathic processes, facial recognition, motor imitation
- Capacity for cognitive empathy – motivations, thoughts, beliefs and feelings of others without identifying with them may remain
Attachment, Mentalizing
Narcissistic functioning :

Video
In MBT training/ASPD training
Clinical intervention in Group

- Not knowing attitude essential
- Focus on self-other interaction
- Acceptance of different experiences
- Sustain narcissistic need during exploration to avoid de-compensation
- Expression of client/clinician experience in terms of counter-responsiveness
Thank you for mentalizing!

For further information
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Slides available at:
http://www.ucl.ac.uk/psychoanalysis/people/bateman