Mentalisation Based Therapy

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Common Factors

- Theoretically coherent treatment approach
- Attachment relationship: therapist and pt
- Focus on mental states and relationships
- Application for long enough
- Maintain therapeutic relationship in spite of attacks
- Full recognition of the extent of the pts functional deficits

Treatment Package

- highly structured,
- relatively simple to deliver
- robust
- consistent,
- but not inflexible

All these approaches

- Present a view of the pts internal world which is stable, coherent, can be clearly perceived and may be adopted as the reflective part of the self (self-image)
- Can be seen as stimulating attachment to the therapist while asking the pt to evaluate the accuracy of what he thinks about others and himself.

Effective components?

- Remain unclear
  - Emotional?
  - Cognitive?
  - Creation of a coherent narrative?
  - Reduction of cognitive distortions?
  - Emotional experience of secure base?
- But common feauture of all components is a focus on mentalisation

Structure of MBT

- Mind of the patient is the focus of treatment
- Objective:
  - for the patient to find out more about what he thinks and feels about himself and others
  - how these thoughts influence his response to others
  - how errors in understanding himself and others lead to actions in an attempt to maintain stability and make sense of incomprehensible feelings

BPD: mentalisation failure

- Overly focused on labels
- Black and white
- Convined they know what motivates others
- Behaviour is taken to have only one meaning
- Judgemental, fault finding, denies own involvement
- Preoccupation with rules and regulations
- Overly detailed, neglects motivations, feelings

Pseudo- mentalisation

- Intrusive Pseudo-mentalisation:
- Separateness or opaqueness of minds not respected: Thinks they know what others think or feel
  - too sure, detailed conclusions based on assumptions
  - convinced that they know what others are about
  - self-serving
  - not in service of empathic understanding

Pseudo-mentalisation

- Overactive:
  - Excessive energy invested in thinking about how people think and feel

Pseudo-Mentalisation

- Destructively Innacurate:
  - Inaccuracy that denies subjective experience of other:
  - Cast in terms of accusations: You were asking me to hit you. You provoked me.
  - Can be bizarre: You are trying to drive me crazy
  - Denying someone's real feelings and replacing them with a false construction

Misuse of Mentalisation

- Uses mentalisation to control the mind of the other
- Lack of empathic resonance, used in manner that is detrimental to those mentalised, sadistic, inducing guilt, anxiety, shame
- Deliberately undermines capacity of others to mentalise by generating arousal (physical threats, shouting, abusive language, humiliating)

Trauma

- Shutting off of mentalisation: Dissociation
- Induces vacuous or panicked state of mind in others
- Stopping thinking: substance abuse , self-injury

Aggression

- Seen as failure to mentalise the impact on the other
- In Fonagy's model, this is the result
  - failures in attachment relationship
  - failure in being

Program

- assessment
- formulation
- 18 months day hospital or outpatient
- individual therapy
- group therapy

Assessment

- Detailed assessment of relationship patterns
- Capacity to think about other's ractions and have a sense of their own part
- Is mentalisation failure pervasive?
- Specific to trauma?
- How severe is mentalisation failures?

AAI questions that reveal RF

- Do you have any ideas why your parents behaved the way they did?
- What impact did what happened to you as a child have on your personality?
- Can you think fo childhood experiences that created problems for you?
- In relation to abuse, trauma, losses, how did it affect you then, and now?

Formulation

- Given to patient and discussed with them
- Presenting difficulties
- Family relationships
- Engagement in therapy: anticipating pattern
- Nature of relationship difficulties
- Other problem areas such as inability to show anger
- Self destructive behaviour

Formulation: Mentalisation

- Identifies different types of mentalisation difficulties (such as concrete mentalising and anti-reflective mentalising)
- Identifies mentalisation strengths

Mentalising Stance

- Patient's mental states are the object of joint attention
- Active questioning
- Highlight alternative perspectives
- Questions suggesting reflection

Tecniques

- Non-prescriptive
- Maintain motivation
- Demonstrate support, reassurance and empathy
- Model reflectivity
- Positive hopeful attitude, but questioning
- Point out discrepancy between self and ideal

Tecniques

- Clarification
- Affect elaboration
- Stop and stand: dealing with impasse
- Stop, listen and look
- Stop, rewind and explore
- I wonder if…
- Transference

Crisis Pathway

- Develop a strategy with the patient for when suicidal ideation becomes overwhelming
- Help patient to identify a pathway to access help to prevent seious self-destructive acts
- Identify, anticipate and (mentalise) situations where patient may feel overwhelmed
- Work on ways in patient can develop a mental representation of therapist in his absence

Transference?

- Attachment contexts can rapidly evoke intense affect and spectacular failures in mentalisation
- What happens in relationship is focused on
- But in a much slower way
  - It seems that I might have done something that made you feel I am not interested in you – can we look at it?
  - Aims to make pt consider there might be many reasons for behaviours, and they cannot assume to know

Group Work

- Very challenging for pts with BPD
- Learn not to get lost in the minds of others
- Maintain a sense of themselves

- Initially structured and psychoeducational
- Develop an awareness of mentalisation, some tools and practice in explicit mentalisation

content

- Introduction to mentalisation
  - Explicit and implicit mentalising
  - What it is
  - Difference to intellectualisation, rationalisation
  - Influence of emotional states on mentalisation
  - Personal examples of when mentalisation failed
  - Examples of everyday intimate relationships

Other themes

- Understanding personal characteristics
- Understanding attitudes
- Understanding motivations
- What makes « me » me
- Understanding self through the other

Phase 2: implicit mentalisation

- Much more treacherous territory
- Much of it happens automatically
- Cant do it mechanically
- Dominated
  - by our defences
  - Explicit rationalisations
- Maintain a sense of ourselves and emotions
- Understand inner experience, its meaning

MBT and TFP: commonalities

- Psychodynamic treatments: Here and Now
- Internal world and representation
- Attachment important in etiology
- Self and other representation seen as important
- Mentalisation seen as central for quality of relationship and coherence of self
- Actively uses relationship with therapist

Distinction: Focus and Aims

- MBT
  - Develop a Reflective Self
  - Affect regulation
- TFP
  - Change in personality
  - Integration of affects: aggression
  - Reduction of primitive defences like splitting and integration of split polarised representaions
  - Consolidation of Identité
  - Implict assumption that it is possible to work, have a plan to manage suicidality

Differences: Conceptualisation

- MBT: Attachment, Trauma, Mentalisation

- TFP: Temperament, Attachment, Trauma,
- Excess of negative affects
- Splitting to protect good representation
- Extreme, rapidly oscillating representations block personality integration, realistic image of self and other, leads to affect dysregulation

MBT and TFP: Interventions

- Both use clarification
- Facilitate mentalisation
- TFP interventions focus on mentalising and stopping splitting, developing integrated representations
  - Requires therapists with good psychotherapy skills
- MBT uses techniques that are more accessible
  - Can be used by all therapists

Conclusion

- Transparent, respectful treatment
- MBT can be used in hospital contexts
- Can be used alongside DBT…. And TFP
- Is relatively accessible to therapists and pts
- Group: Excellent psycho-education program
- Attachment focus: pros and cons (biological can seem to be neglected)