Mentalizing:
Where did we start?
Where are we?
What have we changed our minds about?

Anthony W Bateman
5th International MBT Congress
Haarlem 2019
Historical Trajectory of Ideas and clinical focus

- Dynamic therapy
- Centrality of attachment
- Mentalizing and attachment
- Integrative of dynamic and cognitive process
- Mentalizing as a mediator of change
- Mentalizing as a route to stable epistemic vigilance
- Importance of mentalizing as a social process
- Changing clinical model
Influential characters in Mentalizing

- **UCL/AFC/Elsewhere**
  - Prof George Gergely
  - Professor Pasco Fearon
  - Professor Mary Target
  - Prof Anthony Bateman
  - Martin Debbane
  - Dr Patrick Luyten
  - Dr Liz Allison
  - Professor Alessandra Lemma
  - Professor Eia Asen
  - Dr Trudie Rossouw
  - Dr Dickon Bevington
  - Dr Nick Midgely
Influential characters in Mentalizing

USA

- Dr Jon Allen
- Dr Lane Strathearn
- Dr Karin Ensink
- Dr Read Montague
- Prof Linda Mayes
- Dr Carla Sharp
- Dr Efrain Bleiberg
- Professor Lois Choi-Kain
- Dr Elisabeth Newlin
Influential characters in Mentalizing

- Dawn Bales
- Dr Liesbet Nijssens
- Dr Tobi Nolte
- Dr Svenja Taubner
- Dr Sebastian Euler
- Dr Sebastian Simonsen
- Dr Bjorn Philips
- Professor Finn Skårderud
- Professor Sigmund Karterud
- Dr Morten Kjolbye
- Dr Elfrida Kvarstein
- Dr Mickey Kongerslev
- Dr Sune Bo
Influential characters in Mentalizing

- **Australia**
  - Dr Matt Ruggiero
  - Dr Lynn Priddis
  - Dr Margie Stuchbury
  - Dr Clara Bookless
  - Dr Michael Daubney
  - Dr Joost Hutsebaut
  - Dr Nicole Muller
  - Dr Brandon Unruih
  - Dr Roboin Kissell
  - Dr Dan Kupperi
Psychoanalytic Treatment

- Psychodynamic/analytic therapy not working for severe personality disorder – initially stated by Stern (1938)
- People with BPD considered ‘chronic’, ‘difficult to treat’, ‘have only one in a group’, ‘poor prognosis’
- Behavioural treatments being described for self-harming patients
- Few studies of dynamic interventions in personality disorder
Mentalizing

- Thinking capacities in people with BPD – repudiation of concern with mental states (George Moran)
- Mentalizing first used in 1989 but as operationalized by developmental research in theory of mind rather than as used by Ecole Psychosomatique de Paris
- Failures of MZ apparent to Bion, Rosenfeld, Green, Kernberg and others

BUT

- MZ linked specifically to borderline personality disorder suggesting predictable vulnerability to loss under stress and overlap with narcissistic and antisocial PD
<table>
<thead>
<tr>
<th>Year Range</th>
<th>Articles Published</th>
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<td>1976-1985</td>
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<td>1986-1995</td>
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<td>1996-2005</td>
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<td>2006-2018</td>
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Attachment
Attachment and the deactivation of the social judgment network: What is suppressed?

- Attachment ➔ Suppression of neural machinery associated with social and moral judgements

- Activating the attachment system:
  - Inhibits neural systems that underpin the generation of negative affect
  - Removes system responsible for maintaining cognitive-emotional barrier to person we are with
  - Reduces the need to assess the social validity of that person (‘love is blind’)
  - Reduces influence of memory on affect and affect on cognition (new relationships between the two can emerge)
  - Dominant (pre-conceived) interpersonal judgments are abandoned as less relevant (may indeed interfere with our relationships with those to whom we are strongly attached)
How Attachment Links to Affect Regulation

The forming of an attachment bond
DISTRESS/FEAR

Adverse emotional experience rooted in traumatic relationships

Inhibition of mentalisation

Intensification of attachment needs

Inaccurate judgements of affect, Delayed development of mentalization understanding Failure to understand how emotions relate to situations and behavior

Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse
Self-Reported Attachment Styles and BPD

Choi-Kain et al. (2009)
Implications of the reciprocal activation of mentalisation and attachment (1)

- Confirms the link between the two systems at a behavioural level
- Capacity to mentalise in the context of an attachment relationship on the part of the parent
  - creates the potential for secure attachment developing in the infant the parent’s capacity to mentalise the infant
  - serves to reduce the child’s experienced need to monitor the parent for trustworthiness
- Theory of mind emerges precociously in children securely attached in infancy over time in individuals whose attachment is secure, there are likely to have fewer calls for the activation of the attachment system ➔ the precocious development of mentalisation.
Attachment, mentalisation and attachment types

Dismissing:

- particularly effective in deactivating social importance → pretend mode
- leads to a reduced availability of long term memories imbued with either positive or negative emotion →
- in interviews that have specifically aimed at activating the attachment system → typical narrative pattern of
  - an inability to recall attachment experiences and
  - recover emotionally laden memories
Mentalizing

Borderline Personality Disorder
Assumed cause of mentalisation deficit in BPD

Past assumption:

- A defensive reaction in vulnerable individuals when confronted with hostile states of mind in the context of interpersonal trauma

Consistent with:

- the association of early neglect with BPD,
- the undermining of the development of symbolisation in the families of maltreated youngsters,
- the high prevalence of attachment trauma,
- the high prevalence of individuals who show no BPD symptoms following trauma
Assumed cause of mentalisation deficit in BPD

Current model:

- Mentalisation deficit can be secondary to the abnormal functioning of the attachment system
  - developmentally early dysfunctions of the attachment system
  - in combination with later traumatic experiences in an attachment context
- The hyper-responsiveness of the attachment system has negative impact upon mentalising.
- Even greater in individuals with insecure attachment histories who are already limited in their capacity to maintain mentalisation in the context of attachment relationships
The inhibition of reciprocally active systems by attachment system explains aspects of BPD

- Rapidly escalating tempo moving from acquaintance to great intimacy
- Removes the system responsible for maintaining a normal emotional barrier between self and others and generates an impression of entangled and preoccupied relationships
- Somewhat unwisely, may remove the need to assess the social validity of the social partner
- Excessively positive character of the initial phase relationships that individuals with BPD form (often labelled ‘idealization’) may reflect the suppression of negative relationship specific affects
The inhibition of reciprocally active systems by attachment system explains aspects of BPD

- Rebound phenomena related to the hypersensitive or hyperactive attachment system
  - affective instability, particularly the characteristic intense brief episodes of dysphoria
  - outbursts of violent anger
  - interpersonal suspiciousness (paranoia) which might reflect overactivity in the second (mentalising) system

- The reduction of the influence of affectively laden episodic memory may relate to the chronic feelings of emptiness often encountered by individuals with this diagnosis.
Testable hypotheses that follow from this model

- (1) mentalisation dysfunctions should be observable only when the attachment system is active (partially True)
- (2) mentalisation dysfunction should be associated with negative affect (Partially True)
- (3) problems of accurate social and moral judgements should correlate with mentalisation capacity (True)
- (4) the degree of disorganisation of attachment relationships should correlate with the likelihood of mentalisation problems (True)
- (5) there are likely to be deficits associated with the retrieval of emotion laden memories when the attachment system is active (True)
- (6) ambiguous stimuli (e.g. polysemous words with attachment and non-attachment meanings) will be more likely to trigger the attachment system of BPD individuals (True)
Failure of Mentalization

Current ‘insurmountable’ life challenges

Excessive demand for excellence

Becoming adult

Rejection

CSA

History of physical maltreatment

Adverse parenting

Genetic & early environmental influence

Activation of attachment system

Disruption of mentalization

Stress reaction (fight/flight)

Genetic & early environmental influence

The Disorganised Self

BOOM BRAIN thinking
(Psychic Equivalence)
or excessive certainty

Malarkey Mode
(Pretend Mode or excessive uncertainty)

QUICK FIX thinking
(Teleological Mode)
Mentalization Based Treatment: change over time?
MBT as a Common Core for Intervention

- Personality Disorder
  - Antisocial Personality Disorder
  - Anxious/Avoidant
  - Narcissistic

- Eating Disorders

- Drug Addiction

- Children/Adolescents/Old age

- Formats
  - Individual
  - Group
  - Families
  - Teams
"The study of mentalizing has been an extraordinarily important addition to the mental health field. Bateman and Fonagy, who are largely responsible for the development of this concept, have done a magnificent job in this revision of their classic textbook. They have added new clinical and research data that will be relevant to all mental health practitioners. This book is a ‘must-read’ contribution, and I highly recommend it."

Glen O. Gabbard, M.D., Author, Psychodynamic Psychiatry In Clinical Practice

"This timely second edition of the Handbook of Mentalizing in Mental Health Practice illustrates the vast growth in both research and clinical treatment on mentalization. As a transdiagnostic concept, the process of mentalizing is applicable to a wide variety of mental health conditions. This essential, groundbreaking volume belongs in the libraries of all clinicians, regardless of their theoretical persuasion. The editors, Anthony Bateman and Peter Fonagy, deserve high praise for producing this major interdisciplinary work."

Dante Cicchetti, Ph.D., McKnight Presidential Chair, William Harris Professor, Institute of Child Development and Department of Psychiatry, University of Minnesota; Editor, Development and Psychopathology

Anthony W. Bateman, M.A., FRCPsych, is Visiting Professor at University College London, Affiliate Professor in Psychotherapy at Copenhagen University, and Consultant to Anna Freud National Centre for Children and Families in London.

Peter Fonagy, Ph.D., FBA, FMedSci, FACSS, is Professor of Contemporary Psychoanalysis and Developmental Science at University College London.

Edited by
Anthony Bateman, M.A., FRCPsych
Peter Fonagy, Ph.D., FBA, FMedSci, FACSS
Psychotherapy for Borderline Personality Disorder

MENTALIZATION BASED TREATMENT FOR BPD

A PRACTICAL GUIDE

ANTHONY BATEMAN
PETER FONAGY

ANTHONY BATEMAN
PETER FONAGY
Mentalization Based Treatment: Increasingly specific clinical intervention process?
## Domains of MBT – individual and group

<table>
<thead>
<tr>
<th>General Domains</th>
<th>Major Component Domains</th>
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<tbody>
<tr>
<td>• Can be evaluated by viewing a whole session</td>
<td>• Can be evaluated on the basis of the therapist’s interventions</td>
</tr>
<tr>
<td>• Two general core domains</td>
<td>• Four major component domains</td>
</tr>
<tr>
<td><strong>1- Sessional Structure</strong></td>
<td><strong>3- Mentalizing Process</strong></td>
</tr>
<tr>
<td><strong>2- Not-Knowing Stance</strong></td>
<td><strong>4- Non-Mentalizing Modes</strong></td>
</tr>
<tr>
<td>• Both general domains provide the basis for delivering MBT</td>
<td><strong>5- Mentalizing Affective Narrative</strong></td>
</tr>
<tr>
<td>• Impossible to focus work on mentalizing without the two core elements</td>
<td><strong>6- Relational Mentalizing</strong></td>
</tr>
<tr>
<td>• A typical MBT session involves interventions within these 4 domains</td>
<td>• MBT therapist will train on skills to deliver each type of intervention</td>
</tr>
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Addressing Non-Mentalizing Modes

Mentalizing the Affective Narrative

Relational Mentalizing

Safe in Low Anxiety

Safe in High Anxiety

Topology: relationships between domains in therapist interventions
New manual/New adherence scale: 6 Domains

<table>
<thead>
<tr>
<th>Structure</th>
<th>Mentalizing process</th>
<th>Non-mentalizing modes</th>
<th>Mentalizing Affect</th>
<th>Relational mentalizing</th>
<th>Not-knowing stance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Engagemen t interest and warmth</td>
<td>• Empathic validation</td>
<td>• Psychic equivalence</td>
<td>• Affect Identification</td>
<td>• Mentalizing the relationship</td>
<td>• Authentic</td>
</tr>
<tr>
<td>• Identification of priorities for mentalizing (hierarchy of content)</td>
<td>• Managing form of session</td>
<td>• Pretend Mode</td>
<td>• Affect focus</td>
<td>• Mentalizing the counter-relationship</td>
<td>• Curious</td>
</tr>
<tr>
<td>• Identification of focus for mentalizing (content)</td>
<td>• Contrary moves</td>
<td>• Teleological Function</td>
<td>• Affect and interpersonal and/or significant events</td>
<td></td>
<td>• Exploratory</td>
</tr>
<tr>
<td>• Closure</td>
<td>• Clarification and exploration of narrative as mentalizing process</td>
<td></td>
<td></td>
<td></td>
<td>• Respectful</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgement of positive mentalizing</td>
<td></td>
<td></td>
<td></td>
<td>• Reflective</td>
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Available at [https://www.annafreud.org/training/mentalization-based-treatment-training/mbt-adherence-scale/](https://www.annafreud.org/training/mentalization-based-treatment-training/mbt-adherence-scale/)
Formulation Items

- Core goals collaboratively agreed
- Understanding using developmental/historical vulnerability
- Risk and crisis planning
- Mentalizing vulnerabilities
- Attachment/interpersonal patterns
- Social cue recognition
- Value system
- Anticipation of treatment problems
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
Self-Other and Other-Self

Therapist image of own self representation
Therapist image of the client self representation
Client image of the clinician image of the client self representation
Client imagined self representation

Clinician
Client
Higher Order Representation – We-ness
What brought me to AMYOS

What I think/feel about myself

I find it hard to think/mentialise when....

I can think/mentialise clearly when...

Things from my past

Joint Goals

Relationship Patterns

How others see me/think about me

Possible hurdles in working together

Dr Jasmine Dubost Clinical Psychologist CHQ AMYOS Brisbane Australia 2018
The MBT Loop

Patient and therapist
Notice and Name
Psychic Equivalence

Re-visit if mentalizing returns

Checking
Do not argue

Sensitively move exploration

Clinician

Diversion
To
Linked Exploration
The MBT Loop

Patient and therapist
Notice and Name
Teleological Understanding

Clinician empathises with intensity of experience

Re-visit if mentalizing returns

Checking
Do not argue

Sensitively move exploration

Diversion
to clinician concern about client having to ‘act’ to demonstrate painful mental states.
Or action restricting understanding of others mental states
Mentalizing

- Self-Other
  - Cog-Affective
  - Implicit-Explicit
  - External-Internal

- Psychic Equivalence
- Teleological Mode
- Pretend Mode

- Not Knowing Stance
- Authenticity of interest in mental states
- Uncertainty
- Focusing
- Meaning
- Expanding
- Rewarding
- Regulating

- Contrary Moves
- Rebalancing
- Exercises/Games

- Probe
- Explore
- Diversion/Expansion
- Challenge
MBT in a Nutshell (2)

Attachment Strategies → Identification Anxious Preoccupied Disorganised → Assessment Formulation MBT Psychoeducation → Affect Focus Self-other representation Relational Mentalizing Self-disclosure

Affective Processing → MBT Psychoeducation Emotional Management → Empathic Validation Mentalizing Process → Supportive/Re-phrasing Normalise Identification of basic/social emotion complexity Marking of intensity Contextualise Representation of affective self then and now Effect in current moment Recognition of affects self and other
Mentalization Based Treatment: Where are we going?
Where are we now in terms of attachment?
Criticisms of attachment theory

From psychoanalysis: “mechanistic”
“reductionistic”
“no real metapsychology”
“broad classifications that lose the subtlety and detail of the original material”

From anthropology: “culturally blind”
“socially oblivious”
“misses different family configurations, e.g., alloparenting”
“empirically based on WEIRD people”

WEIRD: Western, Educated, Industrialised, Rich & Democratic
'The universal socialization task for cultures regarding attachment concerns the learning of trust, not ensuring the “secure” attachment of an individual child to a single caregiver in a dyadic relationship. The question that is important for many, if not most, parents and communities is not, “Is [this individual] child ‘securely attached?’”, but rather, “How can I ensure that my child knows whom to trust and how to share appropriate social connections to others? How can I be sure my child is with others and situations where he or she will be safe.”

Thomas S. Weisner, 2014
Borderline Personality Disorder

Emotion Dysregulation/Impulsivity

Self-Concept

Social/Interpersonal Interaction
Borderline Personality, Mentalizing, and the Social World
Rejection-sensitivity in different patient populations

Figure 1. RSQ and QTF scores in different samples

*except social phobia

Stäbler et al., 2011
Rejection Sensitivity in acute and remitted BPD patients

Bungert et al. BPDED, 2015
UCLA Loneliness Scale (n=40 female BPD; 40 HC)
Social judgement scores for each of six dimensions.

http://journals.plos.org/plosone/article?id=info:doi/10.1371/journal.pone.0073440
Judgment bias for approachability and trustworthiness of faces.

**Nicol et al., 2013 Plos One**

Direction of bias
Implications for understanding and changing MBT
But is mentalizing the key process leading to varied outcomes across multiple domains?
But is mentalizing the key process leading to varied outcomes across multiple domains?

Early adversity

Insecure/disorganized attachment?
Mentalizing problems?

Psychopathology
Physical Health
Educational
Relationships
Social
Occupational
But is mentalizing the key process leading to varied outcomes across multiple domains?
The learner's imagined self narrative

1. The informer's image of the learner's self narrative
2. The informer's image of the learner's self narrative
3. The learner's image of the informer's image of the learner's self narrative
4. The epistemic match
5. Opening of epistemic channel for knowledge transfer

The informer
The learner
Figure 1 The Natural Pedagogy Model of Personality Disorder

Social Dysfunction
- History of adversity
- Insecure/disorganized attachments
- Emotion dysregulation

Communication Failures
- Loss of balanced mentalizing
- Failure of ostension
- Social disruption

Epistemic Mistrust
- Loss of interest in social communication
- High epistemic vigilance or hypervigilance
- Compromised social network

Imperviousness to Social Influence
- Limits on social learning processes
Implications for understanding and changing MBT:
working with mentalizing and early adversity
Effects of non-mentalized abuse
ADAPTATION = adaptation to a particular social context
Complex PTSD
Complex PTSD

- Traumatic experience
- Intrusions
- Avoidance
- Affective dysregulation
- Negative Self Concept
- Disturbed relationships
Abuse
Physical/Sexual
Neglect
Bullying
Violence between parents

Experience mind alone
Coping strategies
Defence
Organisation
Attachment disorganisation

Short term
Anger
Rage

Long Term
Alone
Something wrong with me
Who am I
Self doubt
Emotions
- Disgust
- Fear
- Threat
- Powerlessness
- Lust
- Desire

Thoughts
- What is happening
- Why is this happening
- I would rather die
- I will not survive

Sensory
- Images
- Olfactory
- Physical
- Sexual arousal
Self Structure

I am Bad

I am evil

I am special

I am disgusting

Escape
(teleological solutions)
Dysfunctional Memory
- Painful Memory Processing
- Fragmented Memories
- Retrieval sensitivity
- Intrusions/Flashbacks/Negative bias

Ineffective Mentalizing
- Poor affective regulation
- Intense/dissociation
- Numbness
- Dysfunctional Self concept
- Misread social cues
- Epistemic hypervigilance
- Mistrust/Overtrust – partner choice

Ineffective Mentalizing
- Pretend Mode
- Psychic Equivalence
- Teleological

ESCAPE – internal/physical
AVOID - external
RIGIDITY – mental
SOCIAL - reactive
Aims of Treatment

- Facilitate general mentalizing
- Increase mentalizing of trauma leading to coherent memories
- Reduction of problematic affective symptoms e.g. dissociation
- Reduce self-destructive behaviours
- Increase social affiliation
  - Stable self-structure
  - Experience inclusiveness through empathic interaction
  - Reduce negative bias of exclusion
Initial phase of Mentalizing Treatment

- Psychoeducation about trauma and PTSD
- Formulation of interference in current life e.g. attachment fears and difficulties trusting
- Recognition of current active trauma symptoms e.g. flashbacks
- Follow MBT-Intro for monitoring of daily life between sessions
- Therapeutic alliance and ability to manage arousal and ruptures
- Identify and label non-mentalizing modes and triggers
Second Phase – address trauma experiences

- Exploring events of trauma
  - Manage non-mentalizing modes
- Affective experience within small elements of trauma memory
  - Manage non-mentalizing modes
- Increasing coherence of narrative
- Focusing on self representational development
Third phase

- Mourning/acceptance
  - loss of wished for coherent self
  - Absence of we-ness when it was needed and being alone in social world
- Re-evaluating trust in social world
- Establishing new self coherence
- Addressing interaction within social context
- Ending of treatment
Thank you for mentalizing!

For further information
anthony.bateman@ucl.ac.uk

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