

Mentalizing: some theory and some practice

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Development of mentalising and BPD

Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

- a pattern of unstable intense relationships,
unstable relationships
- inappropriately intense, anger
- frantic efforts to avoid abandonment
- affective instability,
affective dysregulation
- impulsive actions
impulsivity
- recurrent self-harm & suicidality,
- chronic feelings of emptiness or boredom (dysphoria),
aggression
- transient, stress-related paranoid thoughts
- identity disturbance severe dissociative symptoms



Mentalizing:

A new word for an ancient concept

Implicitly and explicitly interpreting
the actions of oneself and other as
meaningful on the basis of
intentional mental states

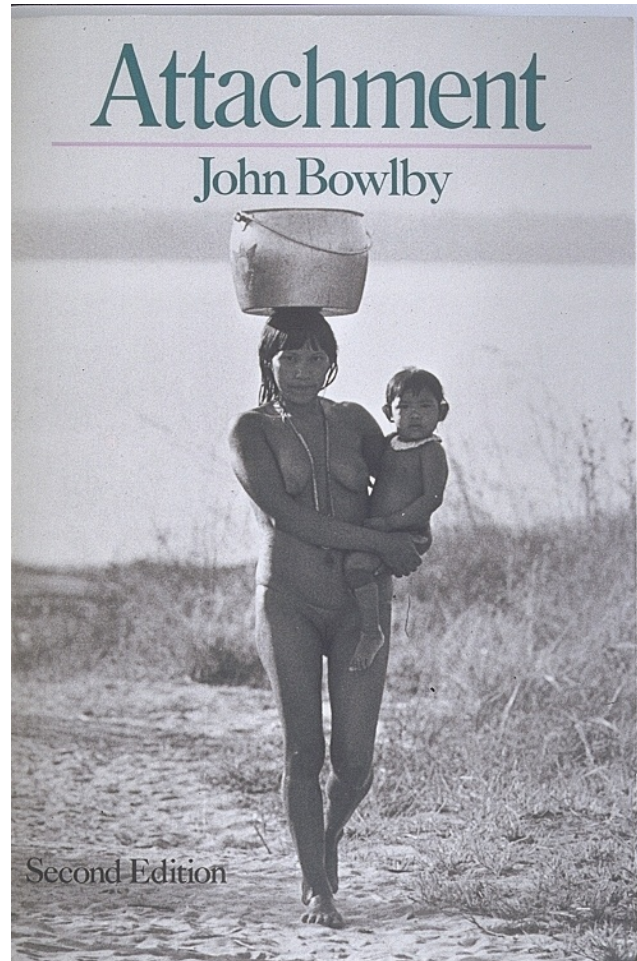
(e.g., desires, needs, feelings,
beliefs, & reasons)

Characteristics of mentalising

- Central concept is that internal states (emotions, thoughts, etc) are opaque
- We make inferences about them
- But inferences are prone to error
- Overarching principal is to take the “inquisitive stance”

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Interpersonal behaviour characterised by an expectation that one's mind may be influenced, surprised, changed and enlightened by learning about another's mind



The Nature of Attachment

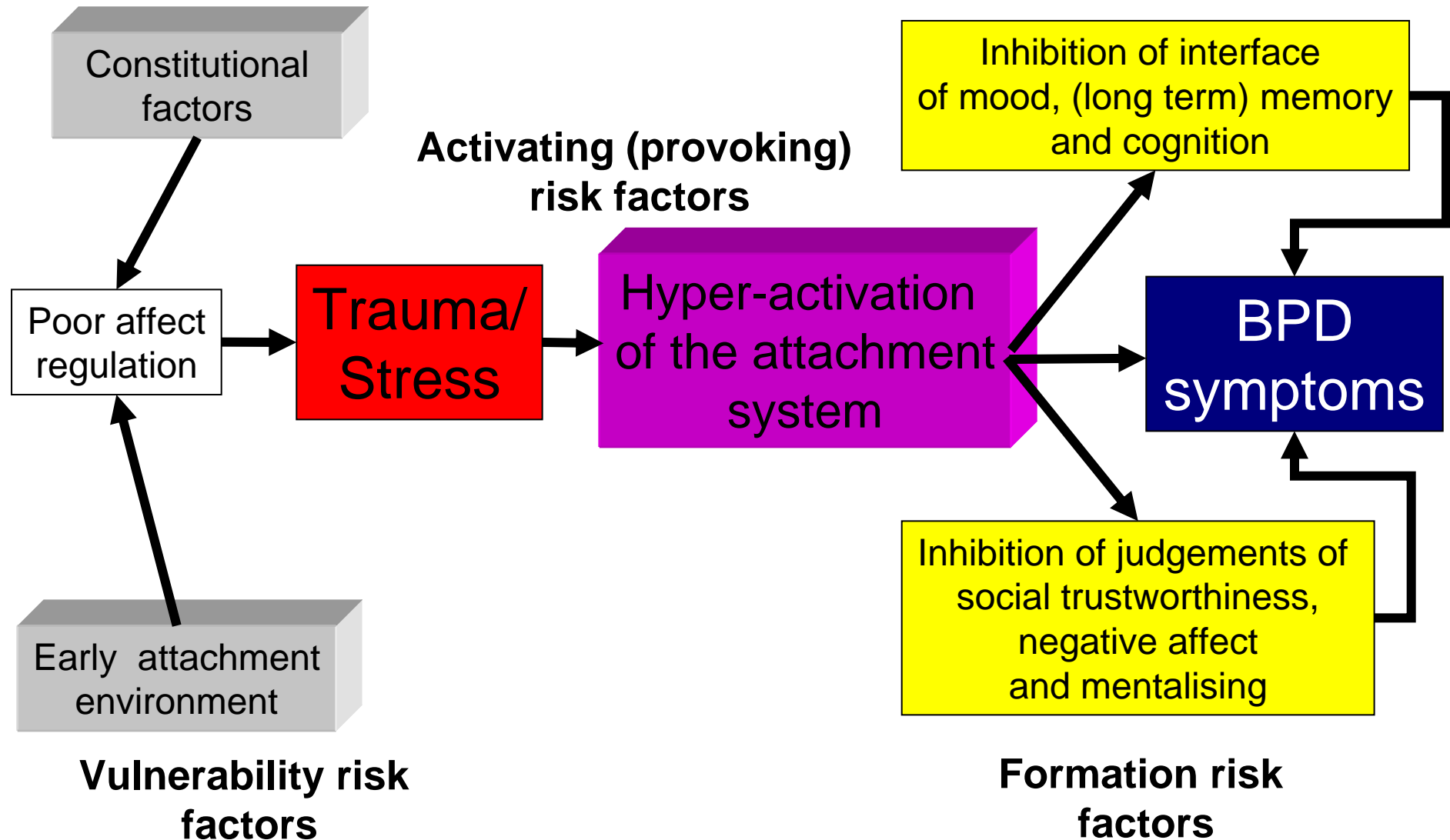
John Bowlby's Discovery: The Nature of the Attachment System

- Universal human need to form close affectional bonds
- Extended period of immaturity → attachment as a behavioral system triggered by fear to ensure the safety of offsprings
- Reciprocity: attachment behaviours of infants are reciprocated by adult caregiving behaviours → creates attachment to particular adult

The Development of Affect Regulation

- Closeness of the infant to another human being who via **contingent marked mirroring** actions facilitates the emergence of a symbolic representational system of affective states and assists in developing affect regulation (and selective attention) → secure attachment
- For normal development the child needs to experience a mind that has his mind in mind
 - Able to reflect on his intentions accurately
 - Does not overwhelm him
 - Not accessible to neglected children

Schematic Model of BPD



The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Psychic equivalence:

- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Experience of mind can be terrifying (flashbacks)
- Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise ”)
- Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Pretend mode:

- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- Linked with emptiness, meaninglessness and dissociation in the wake of trauma
- Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
- In therapy endless inconsequential talk of thoughts and feelings
 - The constitutional self is absent → feelings do not accompany thoughts

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Teleological stance:

- Expectations concerning the agency of the other are present but these are formulated in terms restricted to the physical world
- A focus on understanding actions in terms of their physical as opposed to mental outcomes
- Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Only action that has physical impact is felt to be able to alter mental state in both self and other
 - Manipulative physical acts (self-harm)
 - Demand for acts of demonstration (of affection) by others



Some practice

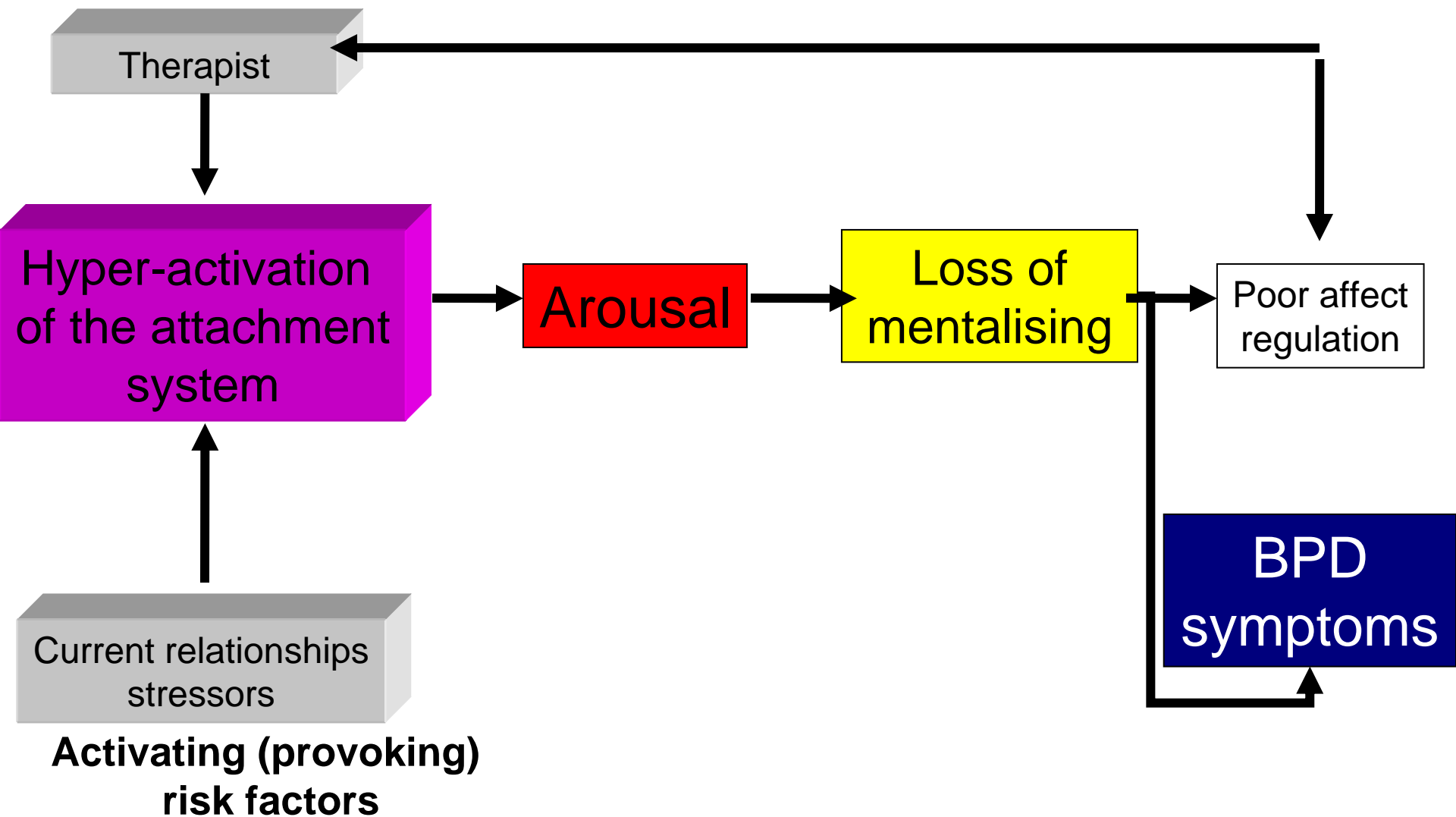
Some consequences for therapy

- Open-minded
 - Focus on mental processes
 - Therapist mental process accessible to patient
 - Beware of stimulating fantasy about therapist
 - Perspectives are impressionistic
- Work within the attachment relationship
 - Seek to stimulate mentalizing within emotional states
 - Maintain mentalizing within relationship
- Interventions contingent and marked
 - Is it you or the patient or both?
 - Contrast perspectives
- Beware the still face and low reactivity and over-stimulation of attachment

Being misunderstood

- Although skill in reading minds is important, recognising the limits of one's skill is essential
- First, acting on false assumptions causes confusion
- Second, being misunderstood is highly aversive
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection

Schematic Model of Interoception





Therapist stance

Therapist Stance

■ Not-Knowing

- Neither therapist nor patient experiences interactions other than impressionistically
- Identify difference – ‘I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you’.
- Acceptance of different perspectives
- Active questioning
- Eschew your need to understand – do not feel under obligation to understand the non-understandable.

■ Monitor you own mistakes

- Model honesty and courage via acknowledgement of your own mistakes
 - Current
 - Future
- Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings

Essential to the Stance

- Keep it current – what the patient feels right now
- Start by empathising – finding a way of stating that you genuinely understand distress
- Explore in the relational realm not just the intrapsychic
- Lower arousal by bringing it to the person of the therapist
 - What have I done?
- Stick to mentalizing aim in somewhat dogged manner
- Quickly step back if patient seems to lose control

Interventions:

Mentalizing the Transference

■ Working in the transference

- Emphasis on current
- Demonstrate alternative perspectives
- Contrast patient's perception of the therapist to self-perception or perception of others in the group
- Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
- Highlight underlying motivation as evidenced in therapy

Components of mentalizing the transference

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist's own distortions)
- Collaboration in arriving at an understanding
- Present an alternative perspective
- Monitor the patient's reaction
- Explore the patient's reaction to the new understanding

Interventions:

Mentalizing the Transference

■ **Dangers of using the transference**

- Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient feel that whatever is happening in therapy is unreal
- Thrown into a pretend mode
- Elaborates a fantasy of understanding with therapist
- Little experiential contact with reality
- No generalization

Components of mentalizing the countertransference

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.

Typical Countertransferences

■ Pretend mode

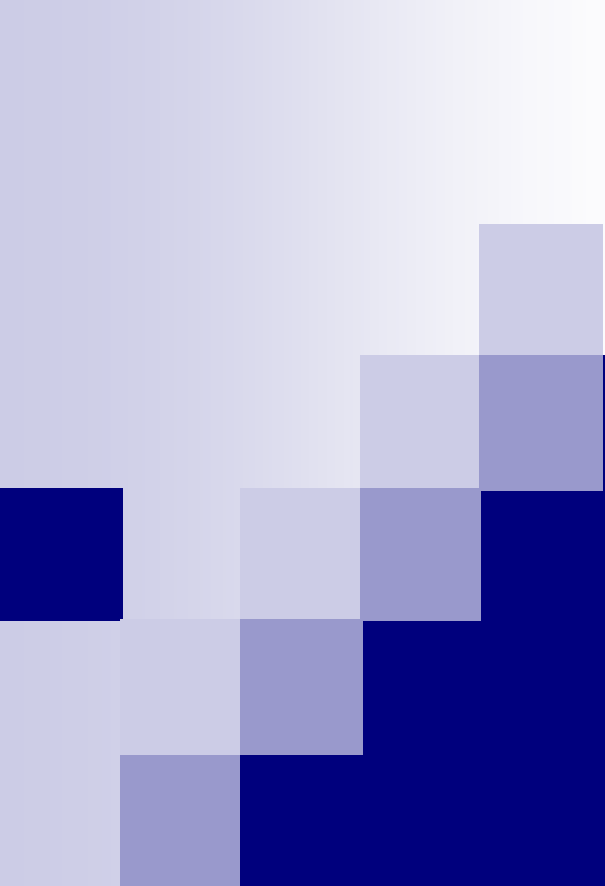
- Boredom, temptation to say something trivial
- Sounding like being on autopilot, tempting to go along
- Lack of appropriate affect modulation (feeling flat, rigid, no contact,)

■ Teleological

- Anxiety
- Wish to DO something (lists, coping strategies)

■ Psychic equivalence

- Puzzlement, confused, unclear, excessive nodding
- Not sure what to say, just going
- Anger with the patient



Mentalising as a common feature of Psychotherapies

Mentalisation: a common theme of all therapies for BPD

- All psychotherapies develop an interactional matrix in which the mind becomes a focus
- Therapists consider the patient by representing them in their mind and communicating that representation to them
- experience of patient is of another human having their mind in mind → **Process more important than content**

Psychotherapeutic Techniques

de Groot, E., Verheul, R., Trijsburg, R. (2008) An integrative perspective of psychotherapeutic treatment for borderline personality disorder. *Journal of Personality Disorders* 22 332-352

Techniques	MBT	DBT	TFP	SFT
Psychoeducation	+	++	+	++
Motivational	+	++	+	+
Behavioural	--	++	--	+
Cognitive	+	++	+	++
Affective	++	++	-	++
Interpersonal	++	++	+	++
Psychodynamic	++	-	++	+
Mindfulness	--	++	--	--
Experiential	++	++	-	++
Nonverbal	+	+	--	--

Mentalisation: a common theme of all therapies for BPD

- Therapy activates an attachment system which is a pre-requisite for mentalisation
- Therapists reconstruct in their own mind the mind of the patient – label feelings, explain cognitions, identify implicit beliefs
- Therapy is a shared attentional process which strengthens interpersonal function and integrative mechanisms
- Content of interventions is mentalistic irrespective of model
- Dyadic nature of therapy fosters capacity to generate multiple perspectives

The nature of BPD therapies

- Many individuals with BPD ‘recover’ to a significant extent without extensive formal therapeutic intervention
- Many therapies are highly effective for BPD
- Many therapies appear to do harm to individuals with BPD or at least appear to be able to impede a natural process of recovery
- The Fonagy & Bateman Principle:
 - *A therapeutic treatment will be effective to the extent that it is able to enhance the patient’s mentalising capacities without generating too many iatrogenic effects.*
 - *Iatrogenic effects are reduced if intensity is carefully titrated to patient capacities and if treatment is coherent and flexible.*



Thank you for mentalizing!

For further information

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<http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>