

Mentalization-based therapy (MBT): an overview

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Abstract

Objective: This paper provides an overview of mentalization-based therapy (MBT). Multiple strands of research evidence converge to suggest that affect dysregulation, impulsivity and unstable interpersonal relationships are core features of borderline personality disorder (BPD). The MBT approach to BPD attempts to provide a theoretically consistent way of conceptualising the inter-relationship of these features.

Methods: MBT makes mentalizing a core focus of therapy and was initially developed for the treatment of BPD in routine clinical services, delivered in group and individual modalities. This article provides a brief overview of mentalizing and its relevance to BPD, provides an overview of MBT and notes a number of current trends in MBT.

Results: MBT provides clinicians with an empirically supported approach to BPD and its treatment.

Conclusions: Whilst mentalizing is viewed as an integrative framework for therapy, more knowledge is needed as to which of the therapies are of most benefit for individual patients.

Keywords: behaviour, borderline personality disorder, mentalization, mentalization-based therapy, psychotherapy

Mentalizing is the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes. It renders subjective states and relationships intelligible and is a dynamic, multifaceted ability with particular salience in attachment relationships. Without mentalizing there can be no robust sense of self, no constructive social interaction, no mutuality in relationships and no sense of personal security.¹ There is a decreased capacity to think about mental states or to provide a coherent narrative account of past relationships.

Borderline personality disorder

The ability to mentalize develops in the context of an attachment relationship and is linked to the caregiver's ability to give meaning to the infant's internal states, which in turn is communicated back to the infant through contingent marked mirroring.² A lack of contingency between the infants' emotional experience and the caregivers' mirroring leads to a decreased ability in the infant to represent affect and decreased effortful attention control. In this interaction, the attachment

system meets further stress when it approaches the attachment figure, leading to hyperactivation of the attachment system in interpersonal contexts.³ There is an inverse relationship between mentalization and activation of the attachment system.

When mentalizing is compromised, subjective internal experiences and the interpersonal world stop making sense. Mentalization-based therapy (MBT) for borderline personality disorder (BPD) is founded on the theory that vulnerability to frequent loss of mentalizing and slower recovery of mentalization in the context of interpersonal relationships is the fundamental pathology. This leaves patients vulnerable to rapidly-changing emotional states and impulsivity. Hyperactivation of the attachment system leads to inappropriately intense attachments with others and also an inhibition of neural systems associated with judging the trustworthiness of

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others. It also leads to prementalistic modes of functioning, where experiences are either too real or meaningless, or the understanding of motives is purely in the physical realm. All of these distortions of subjectivity are associated with intense psychic pain.

In psychic equivalence mode, the patient assumes that what is in their mind accurately reflects reality and is unable to consider alternative explanations for behaviour. For example, if they feel abandoned, they assume the person involved must be purposefully rejecting them. In this state, they are at risk of being over-aroused. The second non-mentalizing mode is pretend mode. In pretend mode, the mental world is decoupled from external reality, so there isn't continual development of internal reflection with any shift and change related to external information. Internal reality is dissociated from the external reality, so there is no bridge between the two. Finally, the non-mentalizing modes include a teleological understanding of the world, in which meaning is determined by physical outcomes. The patient judges things on what actually happens in the physical world. This determines how the intent of the other person is understood.

Methods

MBT

The evidence base and treatment method is most clearly organised as a therapy for BPD. Traditional MBT is organised around an 18-month period with weekly individual and group sessions, crisis planning and integrated psychiatric care. Individual sessions allow patients to focus on the details of the mentalizing process, within a close attachment relationship; group sessions, when carefully managed for arousal levels, facilitate the practice of mentalizing in a more complex interactional process. Integrating group and individual processes enables perspective taking from individual to group sessions, and vice versa: 'what made me like that when I was in the group?' Currently, no dismantling studies have been done, so the necessity of having both individual and group therapy for good outcomes remains uncertain.

The format, that is, group and individual sessions, and the structure of MBT are similar to another evidence-based treatment, dialectical behaviour therapy (DBT). The two treatments are not incompatible. DBT group therapy is organised around the delivery of skills to manage emotional dysregulation, self-destructive behaviour and interpersonal problems; MBT attempts to help individuals maintain mentalizing within interpersonal contexts *before* it is lost, so that emotional dysregulation, self-destructive behaviour and interpersonal problems are controlled and do not cascade towards the non-mentalizing processes, which result in the prototypical behaviours of BPD. MBT and DBT set goals compatible with a coherent theoretical base, to improve mentalizing and attachment functioning, and to have a life worth living, respectively; both focus on self-destructive

actions and the therapy interfering process, using careful mentalizing analysis or chain analysis of the events; both recognise the active contributions of the clinician to the therapy process, e.g. self-disclosure, accepting therapist errors, reciprocal communication in DBT and presentation of an alternative perspective in MBT; both use team supervision or therapist support as part of the treatment; and finally, both use empathic validation as a core technique, thus seeing the perspective of the patient. The primary area of difference is the level of focus on the relationship processes in therapy. DBT uses the relationship with the patient as a vehicle for skills coaching, and perhaps, as part of a dialectic; MBT uses it as a dialectic to rebalance mentalizing, but primarily as a focus to study mentalizing in the interpersonal/relational domain, which is the core area of problems for people with personality disorder.

A number of core MBT techniques have been defined and Interventions are organized around a series of therapeutic steps, forming the 'Intervention Spectrum':

- Supportive/empathic;
- Clarification, elaboration and challenge;
- Basic mentalizing, identifying affect and affect focus; and
- Mentalizing the relationship.

The aim and actual outcome of an intervention are more important in MBT than the type of intervention itself. The primary aim of any intervention is to re-instate mentalizing when it is lost or help maintain it, in circumstances where it may be lost.

The focus of treatment needs to be on stabilizing the sense of self, sustaining mentalizing in the interpersonal context of therapy and maintaining an optimal level of arousal during interactions with others. Overall, interventions are simple and easy to understand, and affect focused. The therapist actively engages the patient and focuses on the patient's mind, rather than their behaviour. The focus is on current events or activities: whatever is the patient's currently-felt mental reality (working memory). Use is made of the therapist's mind as a model.

Mentalizing in psychotherapy is a process of joint attention, in which the patient's mental states are the object of attention. The therapist is continually constructing and reconstructing an image of the patient, to help the patient to apprehend what he feels. The therapist presents a sense of the patient to himself and continually questions his and the patient's internal mental state, using questioning comments to promote exploration and to highlight alternative perspectives.

There are four important dimensions of mentalizing: self-other, cognitive-affective, the external-internal focus and the explicit-implicit balance in the mentalizing process. People can become fixed in one of these poles and the MBT clinician tries to re-balance them.

The series of steps and the therapeutic stance aim to stimulate mentalizing in the patient. The loss of capacity to mentalize in one person rarely exists in a vacuum; it often migrates into the interpersonal world, creating mentalization failures in those around them.² The therapist is constantly at risk of losing their mentalizing in the face of a non-mentalizing patient. These enactments can be explored with 'stop and rewind' in a collaborative way.

The initial task is assessment, formulation and safety planning. It is a very collaborative process. As a joint process, the therapist aims to identify the patient's reason for seeking treatment, placing them in a historical and current context. Throughout, the therapist is juxtaposing their own understanding of the patient's experience. The presenting problem is discussed in terms of difficulties in mentalizing, and there is a focus on understanding the specific types of impairments of mentalization and the specific attachment contexts in which they manifest to help inform treatment.

The initial foci are on developing a therapeutic alliance and on stabilization of emotional expression. Caution should be taken to not offer treatment in an overstimulating environment of attachment or a therapy that intensifies the therapist-patient relationship too early.

A basic component in MBT is the therapist's stance. The stance includes humility, a sense of not knowing, taking time to identify differences in perspectives, legitimising and accepting different perspectives, and actively asking the patient about their experience and comfort in stating when something is not clear. There is active monitoring of one's own misunderstandings. Patients are encouraged to explore their own mental processes and experiences, and are exposed to possible alternative perspectives. It is better to ask questions like 'What is it that you feel about that?' and say, 'If it were me, I would feel...'

The therapists' task is to stimulate a mentalizing process and make it an essential feature of the therapeutic process. The continual reworking of perspectives on self and others, in the context of an intense attachment relationship, is central to the process of change. The work is on current experiences, and the therapist maintains mentalizing or reinstates it, both in themselves and their patient, whilst ensuring that emotional states are active and meaningful. Too much arousal leads to impaired mentalizing; however, under-emphasis on the relationship with the patient leads to avoidance of emotional states.

Interventions should be used, aimed at decreasing arousal and allowing for the best chance of reinstating mentalization. Safe interventions are to demonstrate empathy with the patient's current subjective experience, exploration, and clarification, and rarely, a challenge.

Once in therapy and the process associated with the not knowing stance is established, the therapist sensitively increases the focus on the relationship between the patient and therapist. The aim is to help the subject to maintain mentalizing in an interpersonal context. When the patient is able to reflect to some extent on current states of mind, the next steps are: identifying affect, establishing an affect focus and mentalizing the relationship.

The affect focus is the clinical exemplification of moving the patient around one of the dimensions of mentalizing. It is an intervention designed to identify implicit mentalizing and to make it more explicit, when the MBT clinician and the patient share some implicit process. It requires the clinician to recognise that both he and the patient are making unquestioned, jointly held, unspoken, assumptions. So the clinician names the shared experience not as something that resides solely with the patient or with himself, but as something that is shared between them. Having made this shared dilemma explicit, the clinician develops the mentalizing process around this interpersonal affectively-charged area.

Example: A patient who was easily anxious in a session managed his arousal by turning away from the clinician, falling silent and then saying, 'Yeah, yeah, I don't know'. Implicit in this interactive process was an assumption on the part of the patient that the clinician wanted him to talk more and there was some truth in this, for the clinician probed further at such times. It was also apparent that the patient struggled with fears of becoming emotionally dysregulated, to the extent of having to leave the session. The clinician was in a similar position, in terms of assuming on his part that the patient wanted to say more and yet probing further could increase anxiety, so he was wary of asking additional questions. Will another question generate too much arousal, leading to iatrogenic dysregulation? At this point, MBT suggests the clinician identify the shared dilemma, making the implicit anxiety more explicit. In this example, the clinician said:

'We are both uncertain at the moment I think with me concerned that if I probe more it will make things worse for you and yet this is an area of problem that we have to explore more. It looks to me like you are kind of saying don't go further as well because it might not be safe to continue. Where are you in this?'

Transference in MBT is used in a different way than in other therapies. First, there is validation of the patient's transference feelings. Next, the triggers generating the feelings are identified with the associated behaviours, feelings and thoughts explicitly discussed. Then the therapist accepts enactment by them, explicitly acknowledging even partial enactments by them, even as inexplicable voluntary actions. The next step is collaboration in aiming to arrive at an alternate explanation: an expansion of the understanding of events and experience. This is done by both therapist and patient looking at each other's

thoughts and feelings, with an inquisitive stance. The therapist then summarizes the alternative experience, with careful monitoring of the patient's reaction to it. The aim is to focus the patient's attention on another mind and to contrast their own perception of themselves with how they are perceived by others. Whilst similarities with patterns in past relationships may be identified, the aim is not insight nor to give the patient an explanation, but to highlight other puzzling phenomena that require thought and contemplation.

More recent trends

Over time, the structure of MBT has remained; but there has been some change in emphasis, in terms of technique:

1. Whilst there is an ongoing emphasis on the development of a joint formulation with the patient, risk assessment and crisis plans are stressed from the beginning of treatment;
2. There is more focus on the trajectory, within the individual sessions. These are: the joint development of a focus; regulation of arousal; identification of non-mentalizing mode; empathic validation of experience; and an intervention aiming to restore mentalizing;
3. MBT tries to integrate current research into practice. There is more emphasis on therapists being contingent and marking interventions, by making it explicit to the patient when the therapist is describing their state of mind and experience. Mentalizing theory is being applied to a number of disorders including PTSD, eating disorders and depression; in different contexts and in different groups of patients.¹

Results and Conclusion

Even though there is an evidence base for MBT in BPD,^{4–10} more research is needed. Whilst mentalizing is viewed as an integrative framework for therapy, more knowledge is needed as to which of the therapies are of most benefit for individual patients.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

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