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Comparison Between Mentalization Based Therapy and Transference Focused Psychotherapy

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Mentalization-Based Treatment and Borderline Personality Disorder

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Mentalization

- Mentalization is when we attribute intentions to each other, when we understand each other and ourselves as driven by underlying motives and recognize that these take the form of thoughts, wishes and various emotions.

- A precondition for good interpersonal relations

- Is a process or a skill that varies between and within individuals

Mentalization

- Seeing ourselves from the outside and others from the inside
- Having mind in mind
- Introspecting for subjective self-construction--knowing yourself as others know you but also knowing your subjective (internal) self
- Past-, present-, and future-oriented

What is Mentalization Based Therapy?

- MBT created in the 1990s to meet the need for more effective intervention to Rx BPD.
- Origins in psychodynamic psychotherapy – pragmatic cherry-picking of techniques from other models that enhance robust mentalizing ranging from the manifestly cognitive therapies to explicitly psychoanalytic treatments.
- Studiously avoids interventions that have potential to *undermine* mentalizing

Evidence

- Volkert, Jana, Sophie Hauschild, and Svenja Taubner. "Mentalization-based treatment for personality disorders: efficacy, effectiveness, and new developments." *Current Psychiatry Reports* 21 (2019): 1-12.

First and foremost, MBT is collaborative.

- Nothing can occur without joint discussion,

taking into account the mental experiences and ideas of both patient and clinician. The process of mentalizing necessitates an authentic desire to understand the mental processes of oneself and others.

The assessment process and pathway to treatment prepare the patient for treatment itself.

The assessment involves delineation of the patient's mentalizing vulnerabilities and a shared formulation, which includes specific detail of attachment patterns and areas of vulnerability to emotional dysregulation. This has to be understood by the patient and is for *both* patient and clinician.

Clear goals are established with the patient.

- The initial goal is engagement in and commitment to treatment, and this is accompanied by agreement to try to reduce harmful activities and self-destructive behavior and stabilize social circumstances where possible.

- In the formulation, the clinician identifies common relational fears. Identification and recognition of these strategies and patterns is done early in treatment so that they become the relational focus in treatment when appropriate.

The pattern of the patient's relationships informs an understanding of the relationship in treatment and the relationship in treatment is used to re-appraise the relationships in life outside treatment.

It is important that the patient and clinician establishing a goal of improving social function. This will include work, social activity, voluntary work, education and other constructive life-affirming activity. This should be thought about at the beginning of treatment, not as an 'add-on' towards the end of treatment.

The MBT written formulation

- is developed collaboratively and considered as work in progress rather than a final document
- makes explicit links to aspects of treatment that will help the patient reach the goals
- addresses beliefs about the self and their relation to internal states
- construes the patient's current concerns in relational terms
- makes reference to historical factors that place current concerns in a developmental context
- anticipates problems that might arise in individual and group treatment.

How is mentalizing facilitated?

- The core of MBT is to rekindle mentalizing when it is lost, to maintain it when it is present, and to increase the resilience of the individual's capacity to keep it going when it would otherwise be lost. In the case of people with borderline personality disorder, the key area of vulnerability to losing mentalizing is the interpersonal domain, and so the clinician–patient relationship is a significant area of scrutiny.

- At times the patient experiences strong affect while focusing on identified problems in sessions and his/her mentalizing appears to be limited or failing, and/or the patient's understanding of the way mental states link to behavior is inadequate.

- The clinician addresses this by a structured process (the sessional intervention trajectory) of (a) empathy and validation, (b) clarification, exploration and, where necessary, challenge, (c) following a structured process to gently expand mentalizing and encourage the patient to identify the mental states previously outside their awareness.

The initial step in a session is listening to the patient's narrative.

- Sometimes, the clinician may start the narrative if there is an overriding reason to do so, for example, when the clinician is concerned about risk or the treatment breaking down, or the patient is in danger of impulsive acts, or the clinician experiences intolerable emotion, such as being frightened of the patient.

Listening to the patient's story allows the clinician to begin working on empathic validation

Empathic validation requires the clinician to find something in the story that he/she can empathize with. This is not the same as behaving in a sympathetic manner or saying things that repeat the patient's story.

Empathic validation seeks to engender in the patient a sense that the clinician has understood his/her internal state, that the clinician really 'gets' the patient and the issue he/she is talking about. Often, the clinician seeks the patient's basic emotion and it is this experience that is validated rather than subsequent social or secondary emotions.

Empathic Validation

- Here we see the way in which MBT aims to provide accurate contingent responsiveness to patients' emotional experience which is new often for them and required for transformative therapeutic effects.
- Validation is an affectively based intervention; the key component is contingency with the patient's internal emotional state.
- Non-contingent responsiveness on the part of the clinician at this point is likely to trigger nonmentalizing or generate avoidant attachment strategies in the patient. The high risk for interpretation to be experienced as a non-contingent response makes it outside the MBT approach to treatment.

Once a contingent responsiveness has increased collaboration and reduced arousal, the clinician can consider sensitive but non-contingent responses to try to stimulate mentalizing about the ‘story’ the patient brings. Sessions are focused. They do not consist of free associative dialogue that seeks to illuminate unconscious process. The target area is working memory or preconsciously held experience.

It is expected that a focus for a given session will have been achieved after 10–15 minutes of the session, and this focus will then become the pivotal point around which the clinician and patient orient themselves, returning to it whenever non-mentalizing becomes to dominate the interaction.

Principles when treating patients with MBT

Primarily, the clinician is alert to non-mentalizing not only in terms of the different nonmentalizing modes, namely *psychic equivalence*, *pretend mode*, and *teleological function*, but also in terms of the patient being fixed at one pole of any of the dimensions of mentalizing.

Multidimensional Construct, Balanced along Dimensions

- Automatic — Controlled
- Internally Focused — Externally Focused
- Self-Oriented — Other-Oriented
- Cognitive Process — Affective Process

(Bateman & Fonagy, 2012)

Constant awareness of imbalance and lack of flexibility in terms of the dimensions

- Imbalance indicates that intervention is necessary.

- Secondly, the clinician monitors arousal levels, ensuring that emotional intensity is neither too low nor too high, as both interfere with mentalizing.

- Thirdly, the focus of a session is maintained through the clinician always noticing moments of mentalizing vulnerability.

- Fourthly, the clinician makes sure that his own mentalizing is maintained. It is not possible to deliver effective treatment if the clinician's mentalizing is compromised.

Understanding a misunderstanding: Mentalizing at its best