Mentalization

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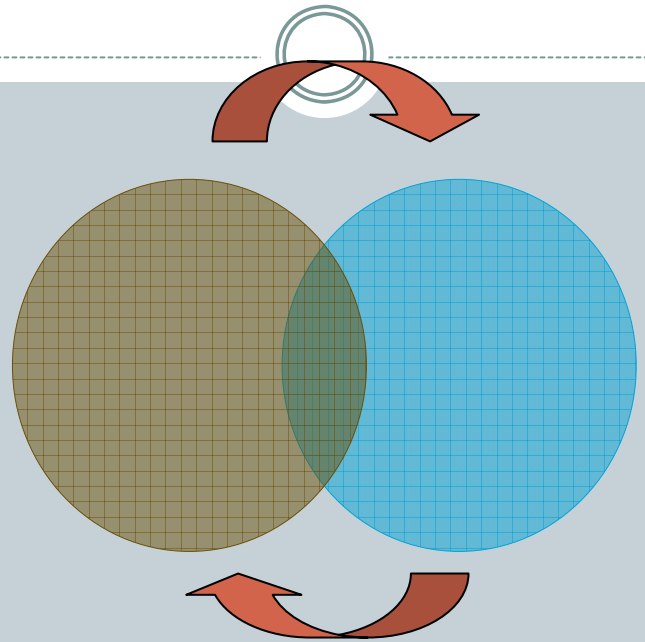
- Anthony Bateman M.D. and Peter Fonagy Ph.D.
- Shauna Dowden Ph.D.

Mentalization: Definitions

" The mental process by which an individual implicitly and explicitly interprets the the actions of herself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons."

Bateman A, Fonagy P (2004), Psychotherapy for Borderline Personality Disorder - Mentalization-Based Treatment. Oxford, U.K.: Oxford University Press.

Mentalization: Two People



SELF

Feelings
Thoughts
Motives
Intentions
Beliefs
Desires
Needs

OTHER

Feelings
Thoughts
Motives
Intentions
Beliefs
Desires
Needs

Imagination
Interaction

Mentalizing interactively and emotionally

- Mentalizing interactively
  - Each person has the other person's mind in mind (as well as their own)
  - Self-awareness + other awareness
- Mentalizing emotionally
  - Mentalizing in midst of emotional states
  - Feeling and thinking about feeling (mentalized affectivity)
  - Feeling felt

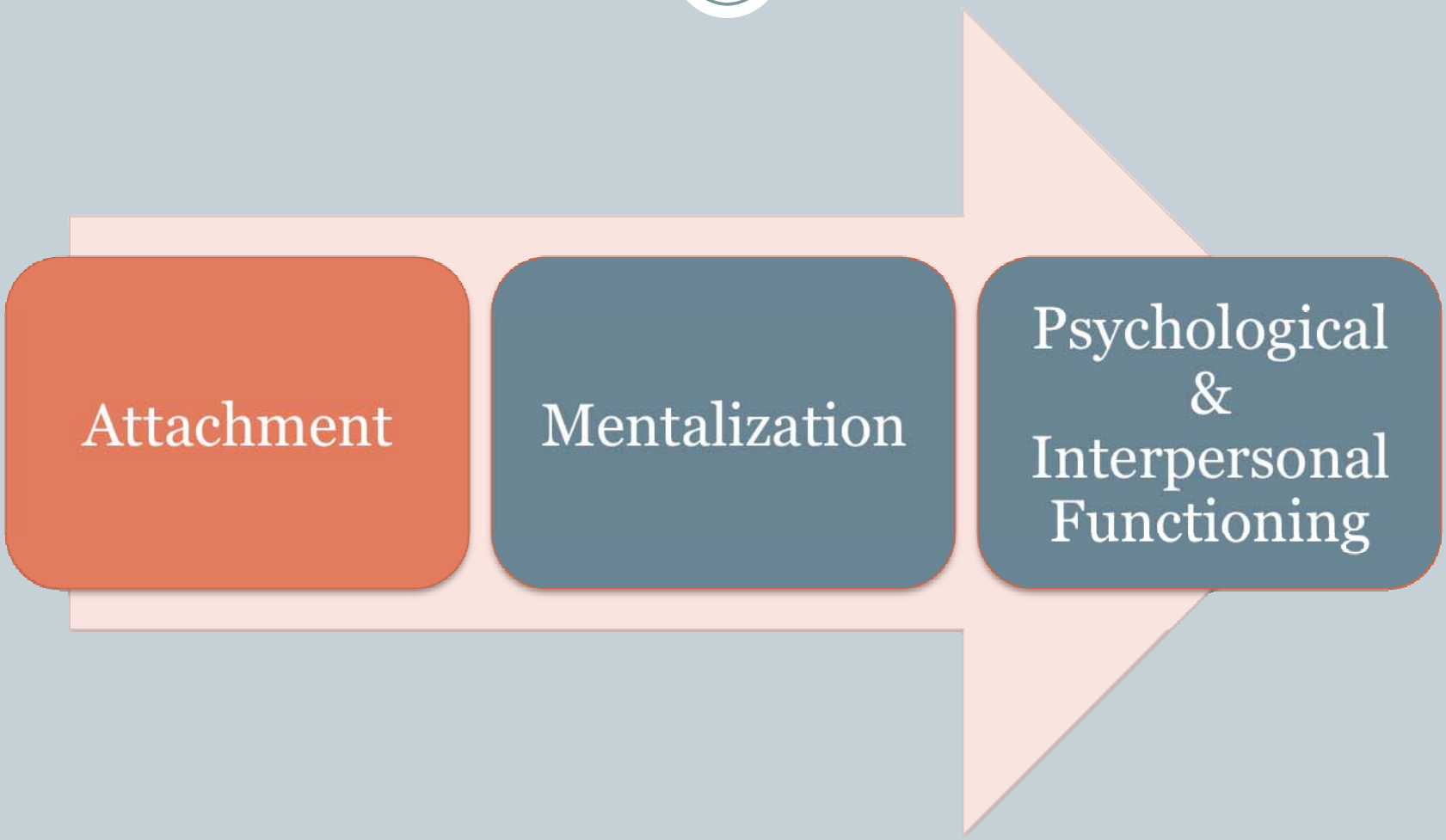
In Other Words: Dejargonified

- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Introspection for subjective self-construction – know yourself as others know you but also know your subjective self (your experience)

Benefits of Mentalizing

- Connection through shared understanding.
- A “meeting of minds”.
- Leads to better interpersonal functioning, and therefore, better chance at getting objectives met in life & relationships.
- Being misunderstood is aversive, it can lead to painful emotions.
- Many BPD difficulties can result from the temporary loss of mentalizing.

Attachment, Mentalization, and BPD



Basic Attachment Theory

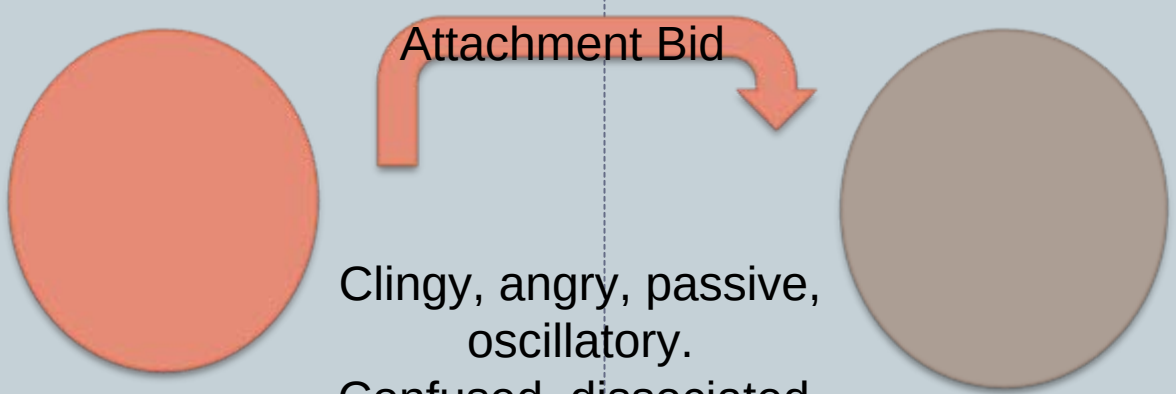
- Two basic tenets of attachment theory (Bowlby):
  - Humans are born with a predisposition to become attached to caregivers
    - Instinctual enactment of behaviors to facilitate attachment
      - Crying, smiling, clinging, cooing
  - Instability of attachment results in
    - Insecurity=> inability to regulate, contain, modulate affect
    - Disturbances in ability to explore and self-enhance
    - Disturbances in future ability to sustain meaningful relationships

Attachment and Borderline Personality Disorder

- BPD is associated with disorganized, preoccupied, and fearful attachment styles (Reviews see Agrawal et al., 2004 and Levy, 2005)
- Borderline Personality Disorder is characterized by disorganized, preoccupied attachment and low Reflective Function (mentalization) (Fonagy et al., 1996)

Attachment Functioning in BPD

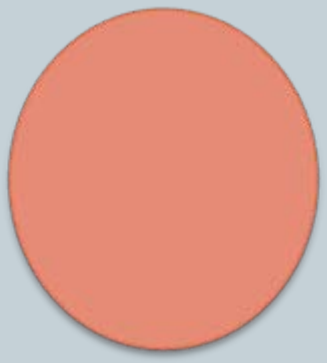
Self **Other**



Clingy, angry, passive, oscillatory.
Confused, dissociated, conflicted, controlling.

Attachment Functioning in BPD

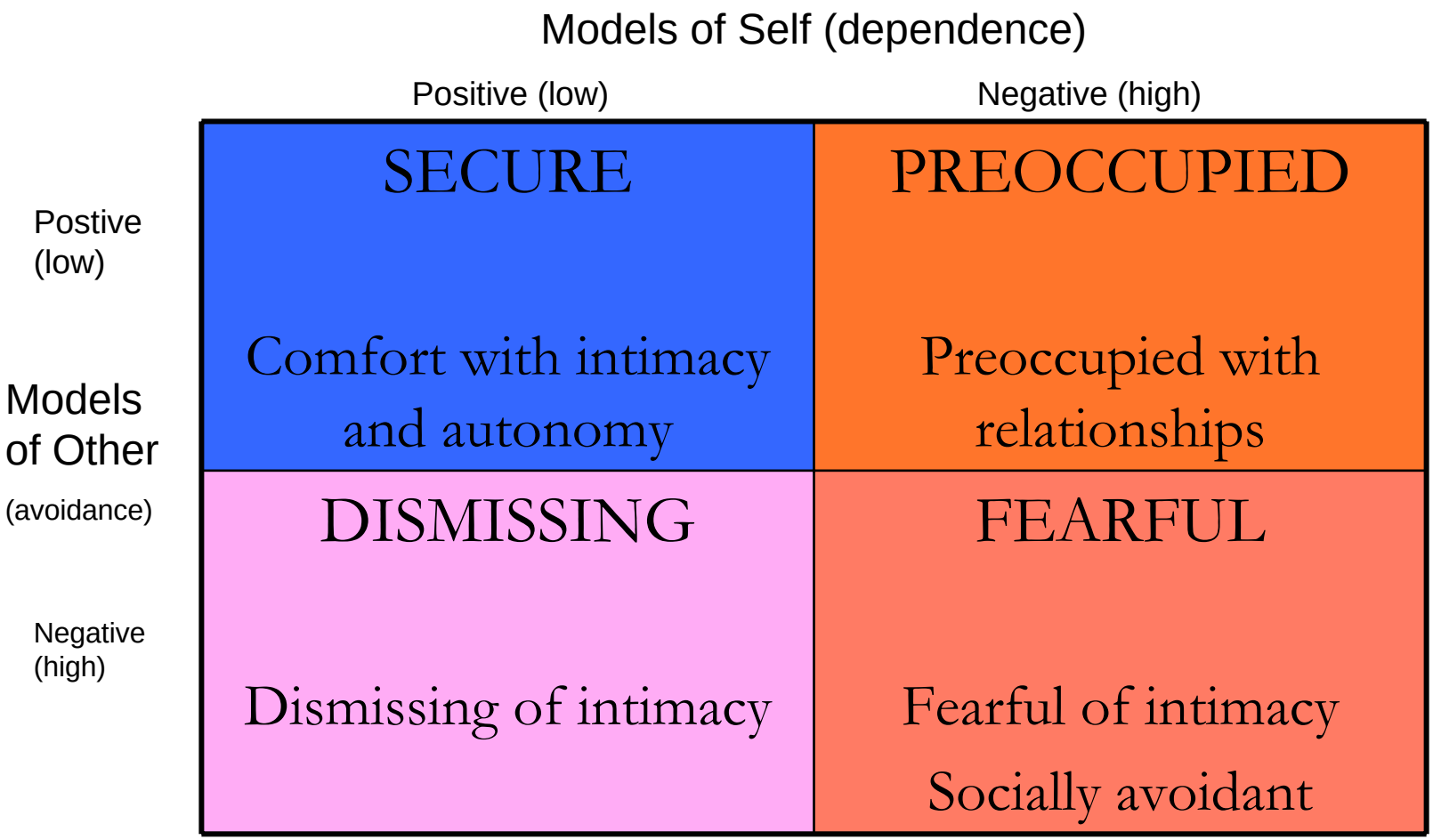
Self **Other**



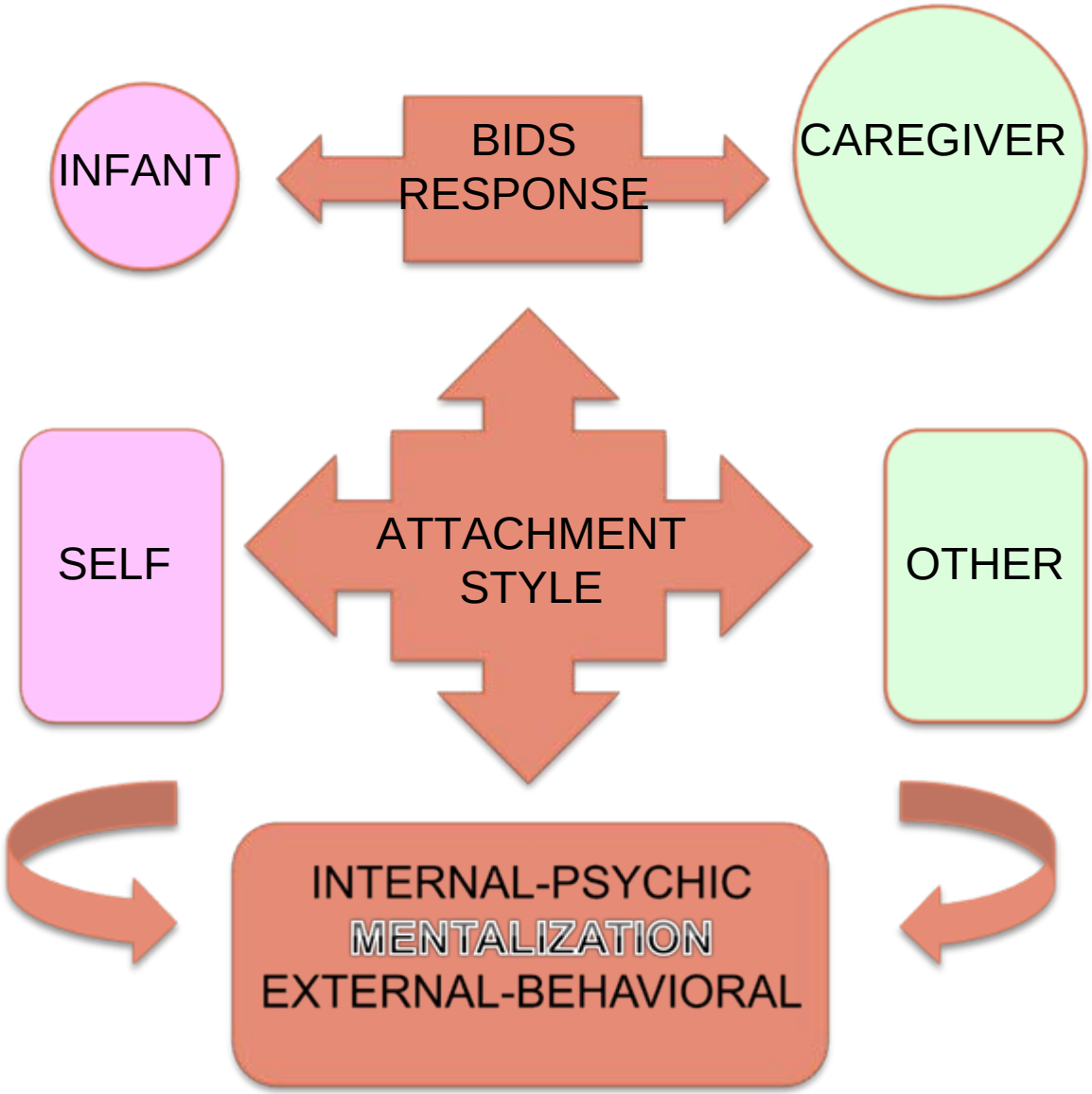
Involving, overprotective, inconsistent.
Hostile, helpless, fearful, frightening.

Caregiver Response

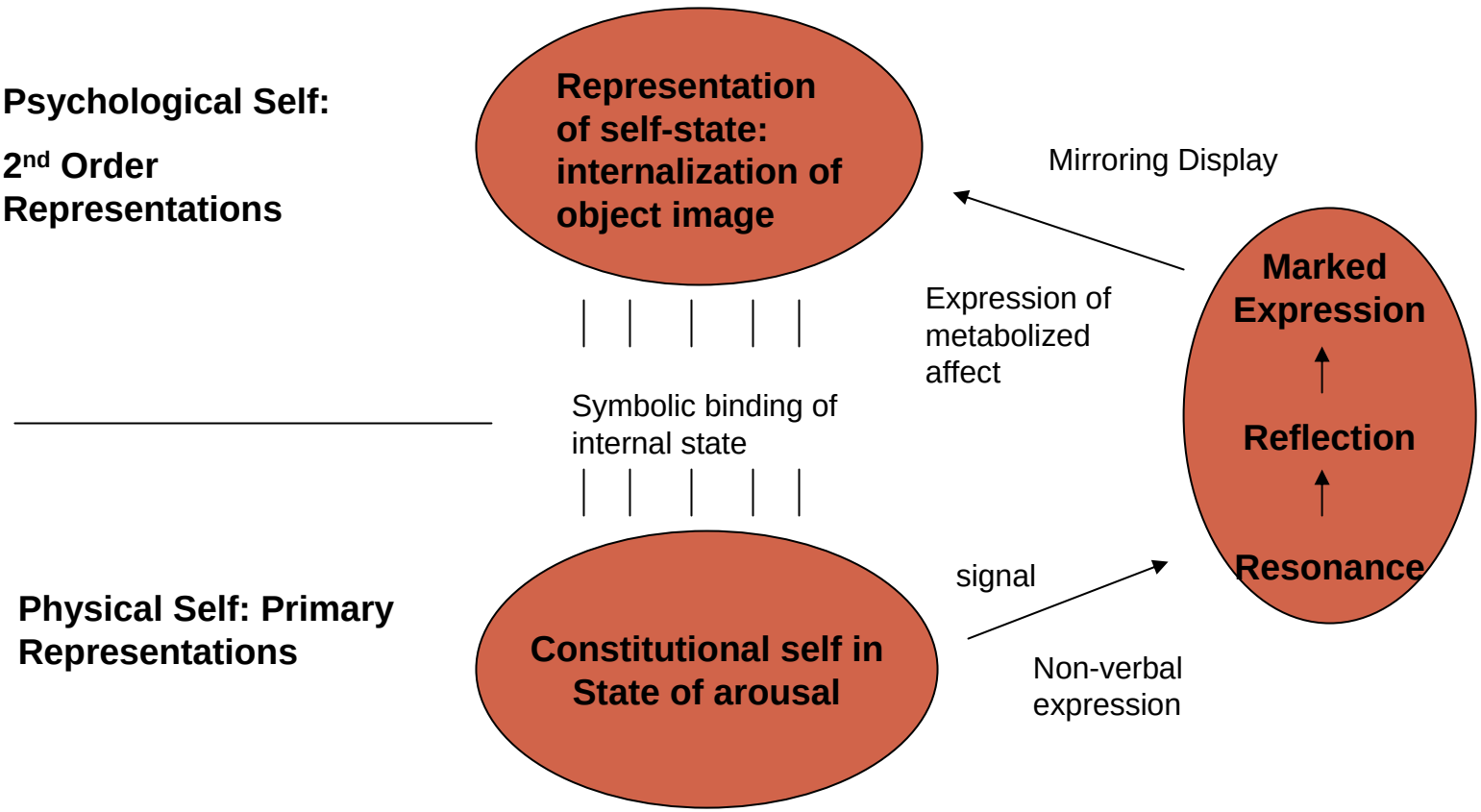
Models of Self and Other in Attachment (Bartholomew & Horowitz, 1991)



Early and Late Attachment Cycles



Developmental Model

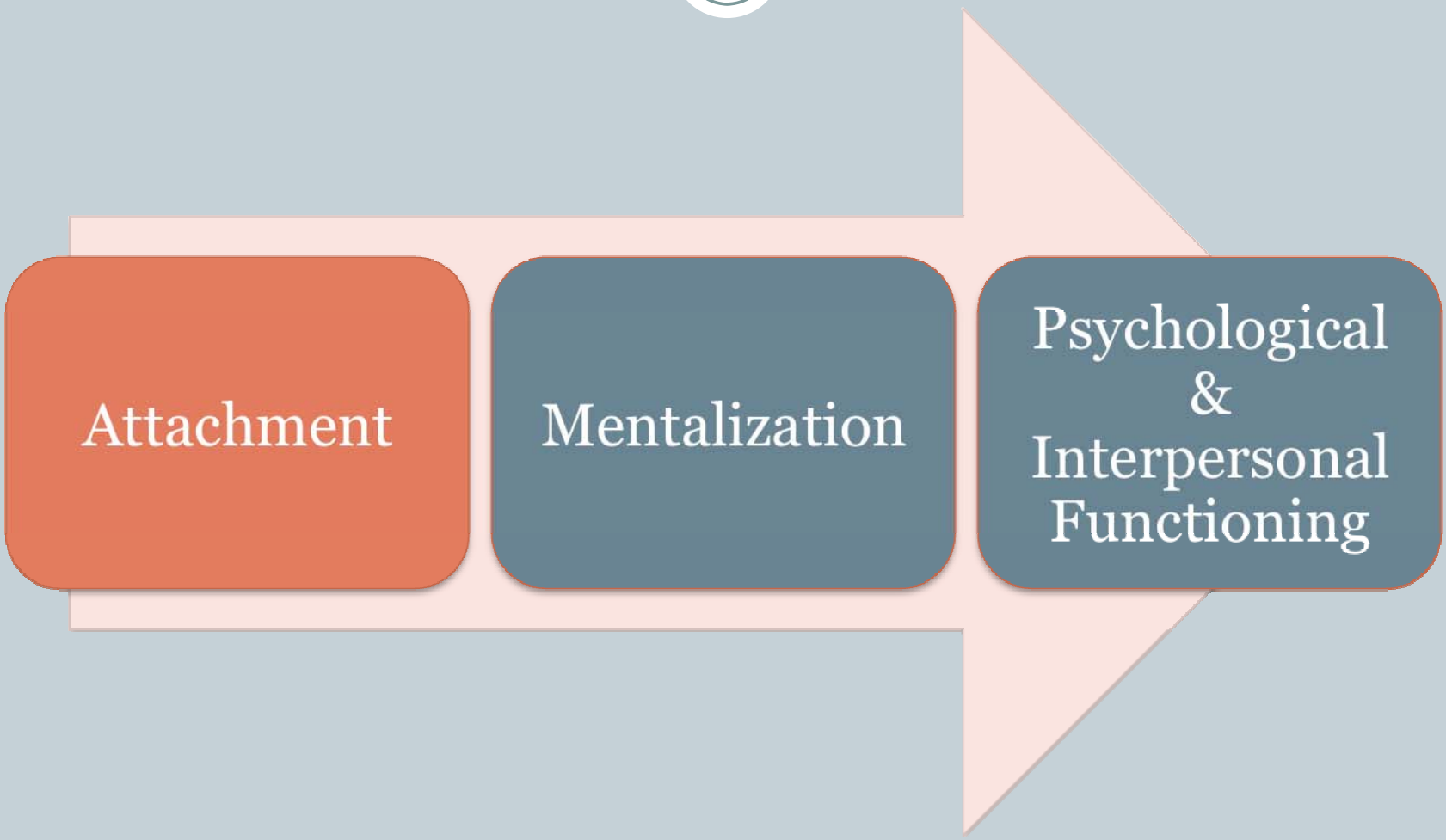


Fonagy et al., 2002

Problems of Attachment and MTZ in BPD

- Intense, dependent, confused, controlling bids for attachment that does not re-regulate (and might intensify distress)
- Vacillatory (involved=>exhausted) and hostile, helpless, fearful caregiver responses
- Mentalizing capacities go offline leading to being either overwhelmed or disconnected in perspectives on interpersonal interactions
- Prementalistic states lead to symptomatic activity (interpersonal instability, self-harm, impulsivity, dissociation, paranoia

Attachment, Mentalization, and BPD



Mentalizing Instabilities in BPD

- BPD is defined as a problem of instability of mentalizing
  - Individuals with BPD are often better at mentalizing than others at times, and under specific conditions, mentalizing fails
    - Hyperactivated attachment (high distress, activating but ineffective attachment bids)
    - High affective intensity
  - When individuals with BPD are symptomatic, this is associated with mentalizing going “off-line”
  - Prementalistic states arise

Prementalistic States

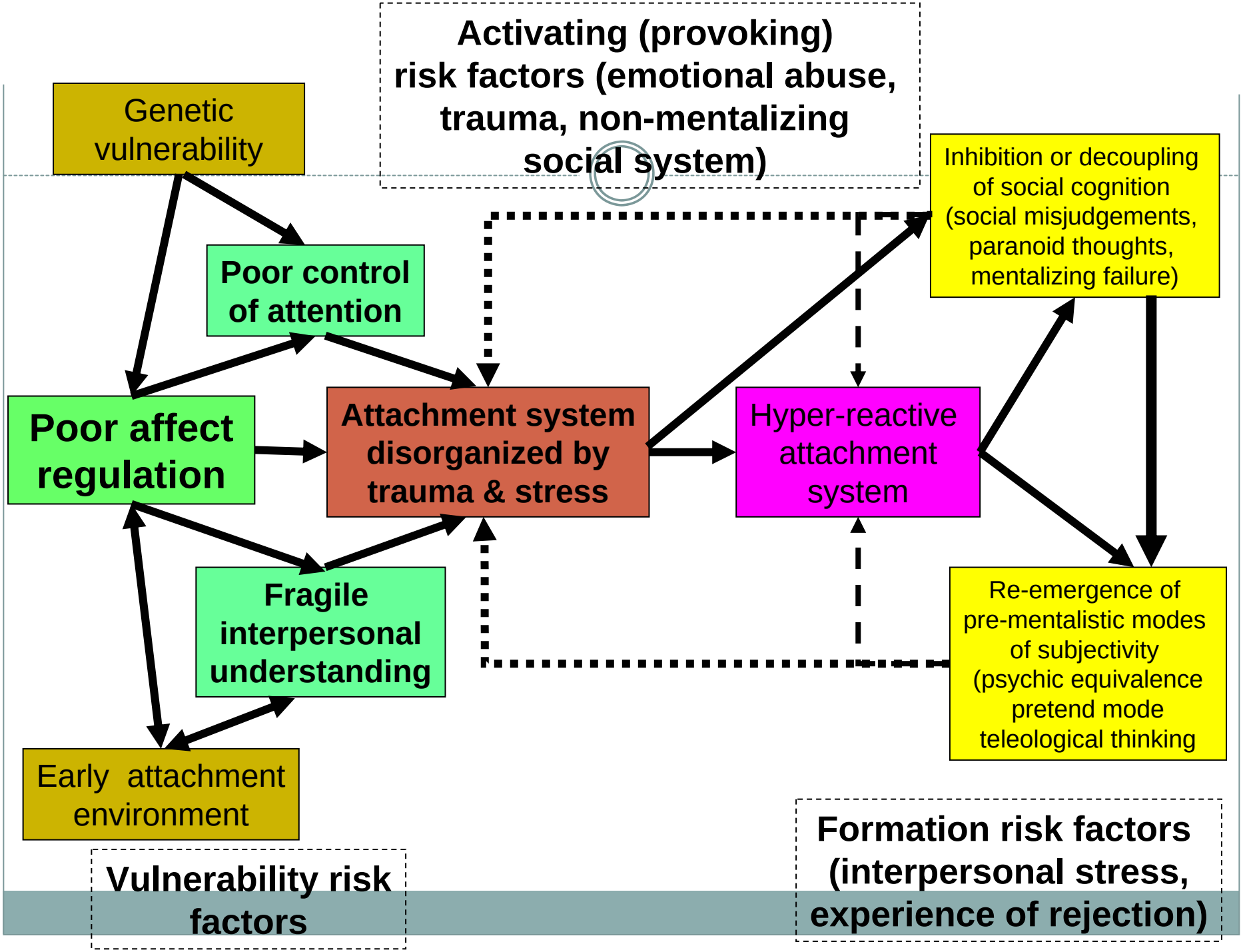
- Psychic equivalence:
  - Mental reality = outer reality
  - Experience of mind can be terrifying (flashbacks)
  - Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise ”)
  - Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)

Prementalistic States

- 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

Prementalistic States

- Teleological stance:
  - Expectations of others are are formulated in concrete, purely observable terms
  - A focus on understanding actions in terms of their physical as opposed to mental outcomes
  - Only action that has physical impact is felt to be able to alter mental state in both self and other
    - Physical acts (self-harm) communicate internal states
    - Demand for acts of demonstration (of affection) by others


Activating (provoking) risk factors (emotional abuse, trauma, non-mentalizing social system)
Genetic vulnerability
Poor control of attention
Poor affect regulation
Attachment system disorganized by trauma & stress
Inhibition or decoupling of social cognition (social misjudgements, paranoid thoughts, mentalizing failure)
Hyper-reactive attachment system
Fragile interpersonal understanding
Re-emergence of pre-mentalistic modes of subjectivity (psychic equivalence pretend mode teleological thinking
Early attachment environment
Vulnerability risk factors
Formation risk factors (interpersonal stress, experience of rejection)

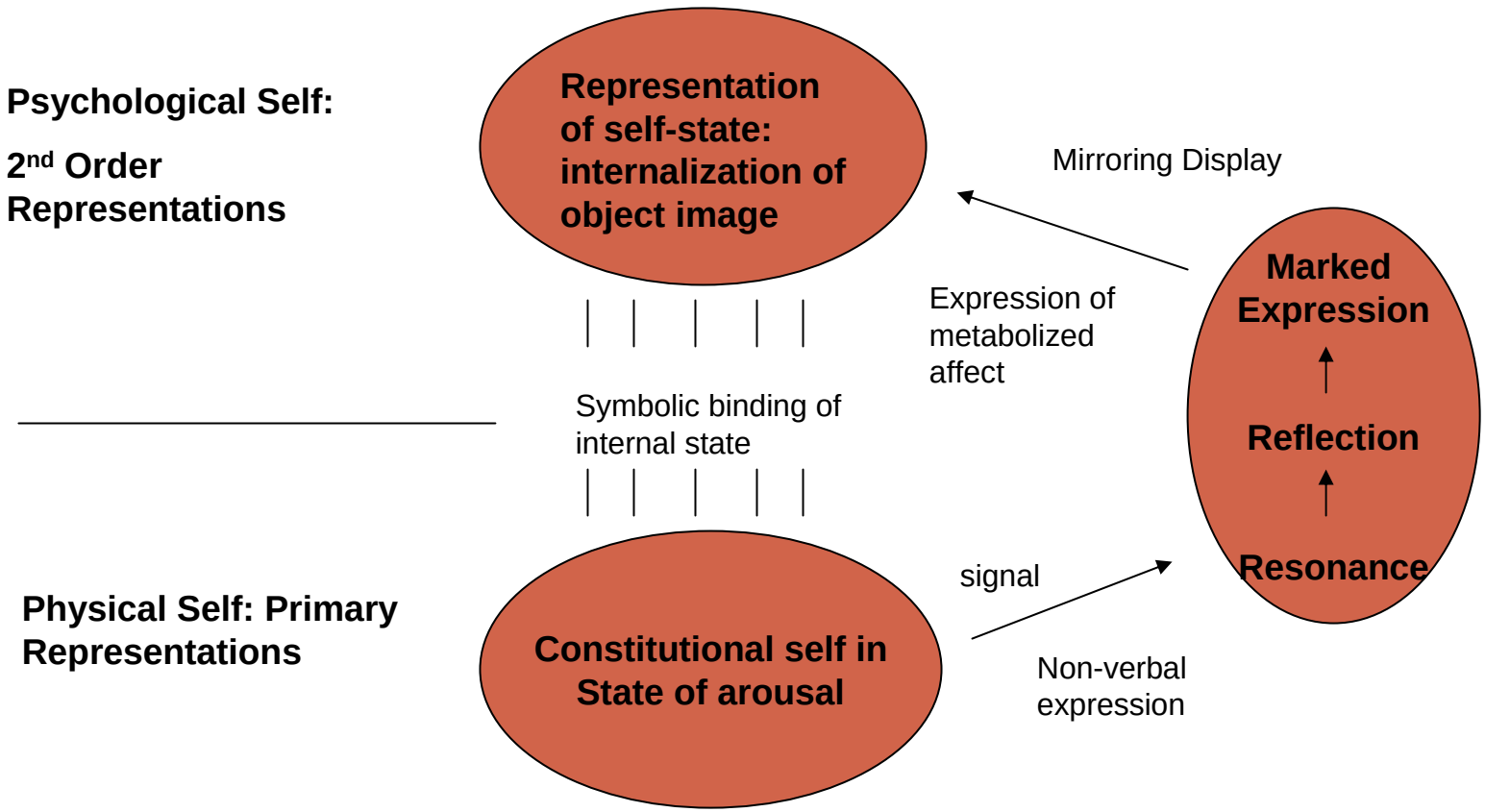
Mentalization Based Treatment

FUNDAMENTALS OF TECHNIQUE

Tasks of Mentalizing Therapists

- Monitoring mentalizing=> Intervene when mentalizing goes offline
- Monitor attachment=> regulate attachment so its activated but not too hyperactivated
- Maintain mentalizing stance
- Promote restoration of mentalizing

Managing the Attachment and MTZ



Fonagy et al., 2002

Mentalizing Therapist Stance

- Not-Knowing, but Curious
- 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 because he hates you'.
- Acceptance of different perspectives
- Active questioning

Mentalizing Therapist Stance

- 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 both in the moment and in the future
- Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings

Mentalizing Therapist Stance

- Empathic about how they are thinking and feeling, getting them to describe is important
- Cannot explore before empathy
- Use not knowing what to say as clue that something does not make sense and there is something to be curious about
- Curiosity about experience, probing about patients experience serves to validate the experience
- Normalizing is component of moving to transference work – stating feelings in first person: “I would feel X, so surprised you appear not to...”

Therapist's Mind

- Therapist continually questions his and patient's internal mental state:
- What is happening now?
- Why is the patient saying this now?
- Why is the patient behaving like this?
- Why am I feeling as I do now?
- What has happened recently in the therapy that may justify the current state?

Turning Your Thoughts Into Technique

- Using questioning comments to promote exploration
- What do you make of what has happened?
- Why do you think that he said that?
- Perhaps you felt that I was judging/misunderstanding you?
- Why do you think that he behaved towards you as he did?

Pearls about Using MTZ

- Understand the nature of BPD symptoms as problems of disorganized insecure attachment and unstable mentalization
- Identify moments of lost mentalizing
- Be curious and mentalize yourself and the individual with BPD
- Use marked and contingent mirroring to stabilize the attachment and facilitate mentalizing
- Reflect on what happens when mentalizing is restored

Resources

- Bateman & Fonagy's Mentalization-based Treatment for Borderline Personality Disorder (2006)
- Bateman & Fonagy's Handbook of Mentalizing in Mental Health Practice (2011)
- Allen, Fonagy, Bateman's Mentalizing in Clinical Practice (2008)

For further Information

- Mentalization Based Treatment Intensive Training January 2012: email Abredice@partners.org