206: Mentalization Based Therapy (MBT), with Dr. Anthony W. Bateman, MA, FRCPSYCH and Dr. Peter Fonagy, Ph.D., FBA

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No conflicts of interest to report on this episode.

What is Mentalization?

Mentalization refers to the capacity to reflect upon and understand one's own state of mind and the states of mind of others. This involves recognizing and making sense of one's own and others' emotions, beliefs, needs and desires. People use this tool consciously and unconsciously to make sense of others and themselves. Often done automatically, a person may form beliefs about the people they interact with, making assumptions about their mental states. These beliefs tend to have a strong influence on the mental state of the person, whether or not they are correct.

We have varying degrees of ability to mentalize both ourselves and others accurately. We can have periods of time where we only see our internal thoughts as the truth and times where we treat our internal thoughts as a perspective. Some mental disorders, such as borderline personality disorder (BPD), cause a person to more frequently lose their ability to mentalize accurately, especially when interpersonal stress occurs.

Mentalization-based therapy (MBT) was developed as a response to the belief that a loss of mentalization is the primary pathology that gives rise to the characteristics of borderline personality disorder. MBT was first implemented in both group and individual therapeutic settings for clients with BPD, and has since been applied to a number of mental pathologies.

What Makes a Person Good at Mentalizing?

Mentalization evolves within attachment-based interactions, with proficient or robust mentalization closely linked to the presence of a secure attachment. This secure foundation is crucial for the development of sophisticated mentalizing abilities as life progresses.

People with a capacity for robust mentalization are often quite resilient in stressful conditions, verbalize accurate empathy, and possess a sense of internal freedom to explore inner thoughts, feelings, desires and experiences. These traits may show through striking creativity, ability to shift perspectives easily, a confidence to explore and verbalize difficult memories, and the capacity to seek and accept help.

As such, these individuals may gain an integrated cohesive narrative of their lives despite facing adversity, and are adept at relationship-recruiting (building relationships with helpful and caring others) and effective coregulation of negative emotions.

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Understanding Borderline Personality Disorder

People with borderline personality disorder show key characteristics including emotional dysregulation, high levels of impulsivity that lead to self-harm and suicidality, and disturbed interpersonal functioning that is manifested in elevated levels of preoccupied and disorganized attachment patterns. These are often shown through:

- Fearful attachment (attachment with anxiety and relational avoidance)
- Extreme discomfort with aloneness
- Hypersensitivity to social environments
- Expectation of malevolence from others
- Reduced positive memories of one-on-one interactions

Studies have revealed that the disturbed nature of social relationships for a person with BPD are likely influenced by the following facets:

- Comorbidity with dissociative disorders, as a response to increased stress associated with emotional neglect and linked to increased suicidal ideation.
- A disturbed sense of identity, stemming from a lack of self-directedness or dysfunctional sense of agency.
- Experiencing unexpectedly intense internal pain with shame in response to negative social events, associated with disturbed relationships and/or childhood abuse and neglect.

To navigate their challenging perceptions of reality, individuals with borderline personality disorder (BPD) frequently adopt maladaptive coping mechanisms. Disorganized attachment patterns in individuals with BPD contribute to marked variations in mentalization; they might experience significant deficits in understanding mental states or engage in hypermentalization—overconfidently inferring the thoughts, motivations, or feelings of others. Many patients primarily display hyperactivation or deactivation strategies, but some oscillate between the two as one or the other strategy fails.

Hyperactivation strategies may be used by an anxious person with BPD, who may make strong attachments to others quickly and easily. These often result in inappropriately intense relationships and inhibits proper judgment of the trustworthiness of others. Not surprisingly, these relationships often end in disappointment. When met with disappointment or unmet needs, a person with BPD may quickly become dismissive, hostile, or critical, further damaging relationships. Through these responses, individuals with BPD show a prominent loss of ability to mentalize, failing to understand their own mental state and those of others.

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Patients may employ deactivation strategies, such as emotional distancing, to manage stressful relationships. However, with increased stress, these patients often lead to insecurity, an increase in negative self-representations, heightened internal distress, and physiological indications of stress. They may maintain a calm veneer, but then display an increase in autonomic manifestations of stress. These individuals might not recognize the link between their physiological stress responses and the ongoing social or conversational context, often attributing discomfort to external factors unrelated to the actual stressor. In the aftermath of utilizing deactivation strategies, these individuals may persist in efforts to mentalize—trying to comprehend their own and others' mental states—yet often do so ineffectively, leading to a cycle of hypermentalization characterized by repeated but unsuccessful attempts to grasp underlying mental states.

Mentalization-Based Therapy as a Tool to Manage Borderline Personality Disorder (BPD)

Recognizing the need and developing the ability to mentalize despite stressful situations can help BPD patients overcome many of their pathological responses and deficits in affect. The core features of BPD appear to be connected on multiple levels, and MBT was developed to provide a sound and empirically supported approach to helping these individuals.

Extensive experience with borderline personality disorder led to the following conclusions that piloted and framed the development of MBT:

- Mentalization, the understanding of the internal states of others, is a developmental achievement and not guaranteed with age.
- This development depends on the quality of attachment relationships throughout life, and particularly in one’s early years.
- An ability to skillfully mirror others’ affects has an impact on developing personal affect regulation and self-control, alongside the ability to mentalize.
- Disrupted early attachments or trauma can lead to diminished ability to mentalize and incoherent self-structure.
  - The capacity to mentalize varies in response to emotional arousal and interpersonal context. For example, a person may be able to mentalize well in a professional setting, but is unable to mentalize when considering parental, or other familial relationships that have strong attachment qualities.
  - A person’s ability to manage their own affect and attention have an influence on their ability to develop mentalization skills.
  - The inability to effectively mentalize, coupled with a disorganized sense of self, is crucial in forming the core characteristics of BPD. This manifests particularly in intense relationships where individuals with BPD might revert to earlier, less sophisticated ways of understanding mental states. They face a compelling urge

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to project internal experiences, often perceived as unbearable or painful, onto external circumstances. This process not only hinders their ability to relate to others in a stable manner, but also exacerbates the disorder's fundamental features.
  - Therapy focused on developing mentalization in the context of attachment relationships can help behavioral and affective aspects of BPD.

Since its conception, several studies have tested these hypotheses and demonstrated the efficacy of MBT for patients with borderline personality disorder. Dr. Anthony Bateman and Dr. Peter Fonagy demonstrated its efficacy in 2008 through a study comparing MBT with treatment as usual for patients with BPD over a time period of 8 years. Another study published in 2019 accomplished a systematic review of the efficacy of MBT in addressing the symptoms of BPD.

Dr. Bateman's and Dr. Fonagy's 8 Year Follow-Up

This study was conducted with the purpose of analyzing both the immediate efficacy and long-term maintenance of treatment gains from treatment with MBT versus psychotherapy treatment as usual for patients with BPD.

One group of patients underwent either 18 months of intensive partial hospitalization mentalization-based treatment, at approximately 9 hours of therapy per week for a total of 648 treatment hours, while the other group underwent treatment as usual for BPD. The MBT group then continued with less intensive MBT groups twice a week, for an additional 18 months (144 more treatment hours). The standard treatment group did not have any interventions after the initial 18 months. Then, both groups were followed for an additional 5 years without any further interventions.

Significant differences were found at the 18-month check in, 36-month check-in, and the final 8 year check in. And, differences in the MBT vs standard treatment groups were increased over the 5 years periods for each outcome.

BPD patients who underwent MBT treatment had lower rates of attempted suicide, decreased need for psychiatric services, fewer hospitalizations, almost negligible percentages of patients taking multiple medications, significantly lower percentages of emergency room visits, and a greater percentage of patients who were employed or in school. These outcomes were nearly opposite for the standardized patient group, with increased or unchanged negative outcomes as more time passed after treatment.

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Vogt and Norman Systematic Review on MBT and BPD

This paper compared 14 studies on MBT and BPD after identifying, screening, and assessing for eligibility the 1,399 articles available. As a whole, the findings were consistent across the 14 studies, showing significant improvement of psychiatric symptoms with mentalization-based therapy in BPD patients with effect sizes (*d*) ranging from 0.59 to 1.79.

Similar to the study by Bateman and Fonagy, these studies compared MBT with standardized treatment modalities including supportive group therapy, standard psychiatric care, and traditional psychodynamic approach. Only one study revealed a similar effect size (*d* =1.21) for both the MBT and standard treatment groups. The remaining studies reported better outcomes with MBT and larger effect sizes.

Other outcomes measured included :

- Reduction in BPD-specific symptoms (assessed by the Borderline Symptom List)
- Reduction in self-harm behaviors
- Reductions in suicide attempts
- Reductions in personality disorder-related symptoms (using SIPP-118 questionnaire)
- Efficacy in treating comorbid depression or anxiety
- Improvement in quality of life
- Reduction in medication needs
- Improvement of social adjustment and life satisfaction (using the Social Adjustment Scale)

As a whole, the studies in the review indicated that MBT has significant potential to reduce the symptoms, distresses, and severity of comorbidities, while increasing the quality of life and relationships in patients with BPD.

What is a Mentalizing Stance?

A mentalizing stance is an aspect of the therapist's general attitude that predisposes him to assume that the patient knows more than he does. This “not-knowing” stance allows him to maintain curiosity and humility toward the patient’s perspective. When Dr. Bateman first began working with BPD patients, he unknowingly assumed this stance through his genuine curiosity and lack of understanding why a person would want to commit suicide. Rather than assuming he knew why they thought or felt a certain way, he was disposed to ask, which helped him and his patients immensely.

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Despite the proven efficacy of MBT, it is well-known that the skill, attitude, and other traits of a therapist have a significant effect on the efficacy of any given therapy. For mentalization-based therapy to achieve its maximum potential, the therapist must take a mentalizing stance toward the patient throughout their interactions.

The mentalizing stance can be difficult to achieve and maintain throughout a therapeutic relationship. Particular language by the therapist is encouraged to be avoided, such as “You must be feeling….” Simply by using the word “must,” a therapist implies they knew what the patient was feeling without an explicit expression of that feeling. Even if the therapist is correct, receiving the patient’s representation of that feeling, without clouding the therapist’s representation communicates more clearly what the patient is experiencing. A less prescriptive phrasing might be, “I wonder if you might be feeling…” or “Could it be that you feel…?”

Likewise, traits of the BPD patient can make it difficult to maintain mentalization as well. Often, these patients will quickly agree with any suggestion given by the therapist, and enter into pretend-mode functioning. This inhibits access to their true internal world and does not allow them to access their true feelings or mental processes.

Despite taking on a mentalizing stance full of curiosity, a therapist can creatively ask questions to introduce alternative perspectives and help the patient explore their internal world.

Five components that characterize a mentalizing therapeutic stance include:

1. Humility, coming from a sense of not-knowing.
2. Patience, in order to take the time to identify different perspectives.
3. Validation and acceptance of different perspectives.
4. Active questioning concerning the patient’s experience. Asking “what” questions for details of the experience, rather than “why” questions regarding explanations.
5. Carefully demonstrating the need for additional understanding concerning statements that do not make immediate sense (without assumptions). The therapist with curiosity states “I don’t understand…” or “This or that is unclear….”

Reflective Functioning

The Reflective Functioning Scale is assessed through detailed analysis of transcripts from the Adult Attachment Interview (AAI). It specifically evaluates the extent to which an individual can thoughtfully and coherently reflect upon and understand their own and others’ internal mental states, such as thoughts, feelings, and motivations, especially in the context of attachment relationships. This process involves recognizing how these internal states influence behavior in oneself and in interpersonal interactions.

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The skillful use of reflective functioning is found to be heavily linked to the efficacy of a therapist in applying therapeutic interventions. In fact, one study found that 70.5% of the variance in therapist effectiveness was attributed to their ability to utilize reflective functioning (Cologon et al., 2017).

A study by Levy et al. (2006), showed when comparing transference focused therapy, dialectical behavioral therapy and supportive psychotherapy, only transference focused therapy showed an improvement in reflective function (from 2.86 to 4.1).

We will return to reflective function in future episodes, as this is such a vital tool to understand.

Further Application of Mentalization

Since the development of MBT for borderline personality disorder, it has been successfully applied to people with antisocial personality disorder, substance use disorders, eating disorders, at-risk mothers with infants and children, with families and adolescents, in schools, and in managing social groups.

The ability to think upon, and seek to understand with humility, the inner world of another person is an invaluable tool. If people are able to create a sensible framework for motivation behind the actions or behaviors around them, it creates more predictability amidst a lack of control. Other benefits of mentalization, or reflective functioning, include:

- A maintenance of attachment security.
- Developing a more mature ability to distinguish between appearance and reality. For example, a person who experienced trauma from a parent may be able to distinguish, “He was unloving, but I am not unlovable.”
- Enhanced communication.
- Encouragement for meaningful connections between internal and external worlds. This allows a person to achieve deeper connections with others, and thus have more meaningful, understanding relationships.

Healing Takes Time

When considering “how long it takes to heal”, patients often desire a clear answer. But, the truth is, it takes years and years. Far longer than the average number of therapy sessions an insurance company approves for mental health disorders in the United States. However, it is important to recognize that healing does not stop after therapy.

A person healing from BPD, or another mental health disorder, will eventually see improvement in their lives over a long period of time if therapy is effective. Different situations, relationships,

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or events in their lives slowly improve and contribute to their healing along the way. MBT and other therapies strive to increase a person's capacity to relate to others and the world around them.

Developing mentalization skills increases the capacity to relate to others and the opportunity to create a "virtuous" cycle (positive-feedback loop) that expands their ability to understand and build healthy relationships. For example, a small increase in understanding allows a person to act more generously or thoughtfully in a certain relationship. Those changes in behaviors then create positive responses from the other person, which again changes the way the patient behaves toward them in a positive way. Over the course of time, these improvements in relationships can affect other relationships or social aspects of their lives. Thus, one positive change has the potential to lead potentially endless positive change.

This benefit was demonstrated in Dr. Bateman's and Dr. Fonagy's 8-year study, in which patients' quality of life continued to improve for at least 5 years after their MBT therapy had ended. Unfortunately, patients in the group without MBT did not see the same benefits. Ideally, any therapeutic intervention would cause a positive feedback loop over time that can sustain a patient's mental health improvement over the course of their lives.

Resource Library:

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