

MBT FOR BPD

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FIRST PRINCIPLES

Treating BPD has been confusing.

If we are to successfully treat BPD we need to first understand what the ***intrapsychic deficits*** are that underlie this debilitating disorder

Deficits differ from **symptoms** but may produce symptoms

Can treat symptoms however treating the deficit(s) that underlie these symptoms is both logically and empirically sound

Effective therapy is tailored to an understanding of the internal processes that directly bear on the onset and course of the clinical problem

DEFICIT UNDERLIES BPD SYMPTOMS

- The phenomenology of BPD is a consequence of the inhibition of mentalization : the ability to understand mental states both in ourselves and in others

MENTALIZATION

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)

(Fonagy & Bateman)

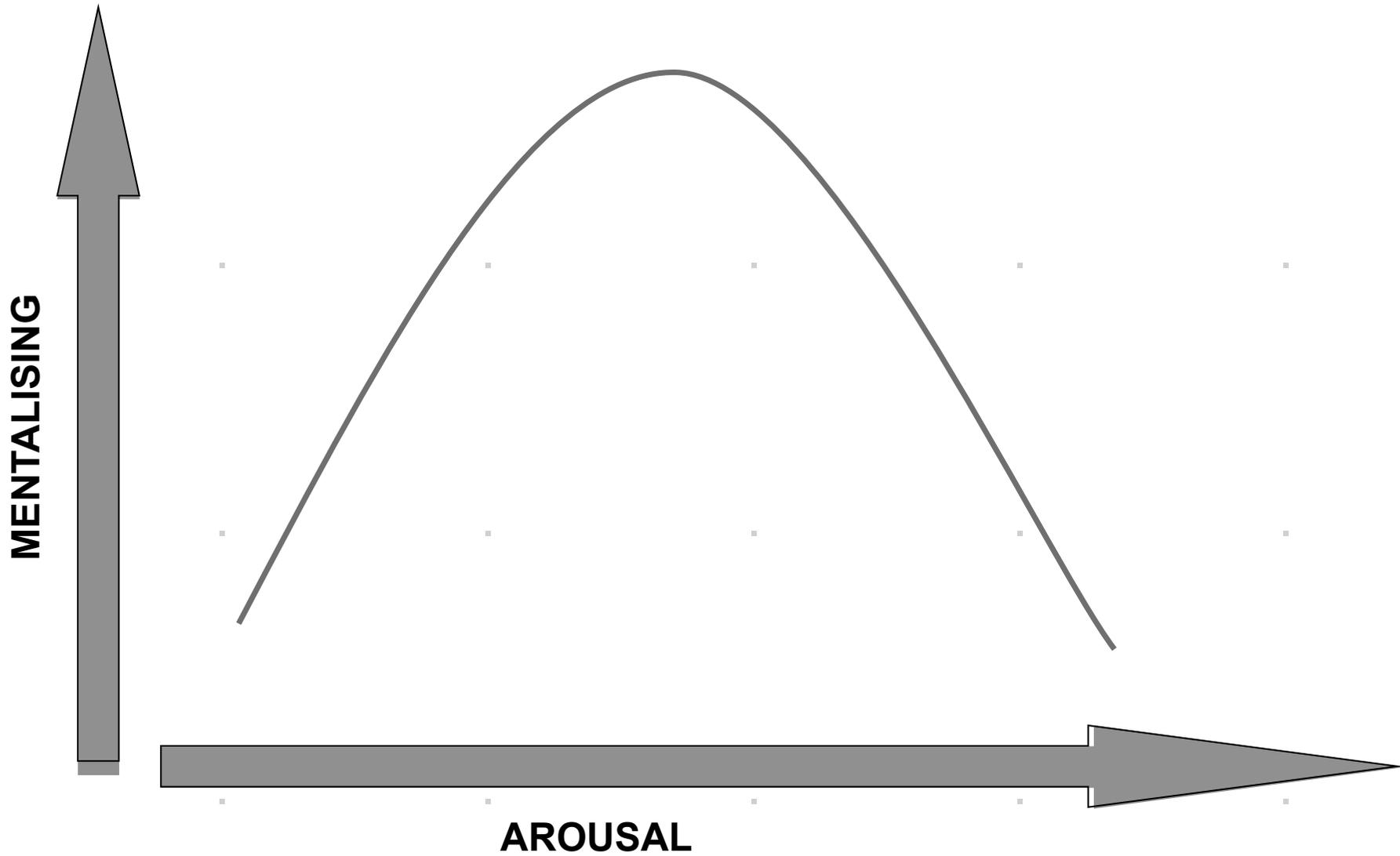
IN ORDER TO ADAPTIVELY PREDICT AND JUSTIFY OUR OWN AND OTHER'S ACTIONS:

- We have to understand that we have **SEPARATE MINDS** that (often) contain **DIFFERENT MENTAL MODELS** of reality that cause our actions;
- We have to be able to infer and represent both the **MENTAL MODELS** of the other's **MIND** and the **MENTAL MODELS** of our own **MIND**

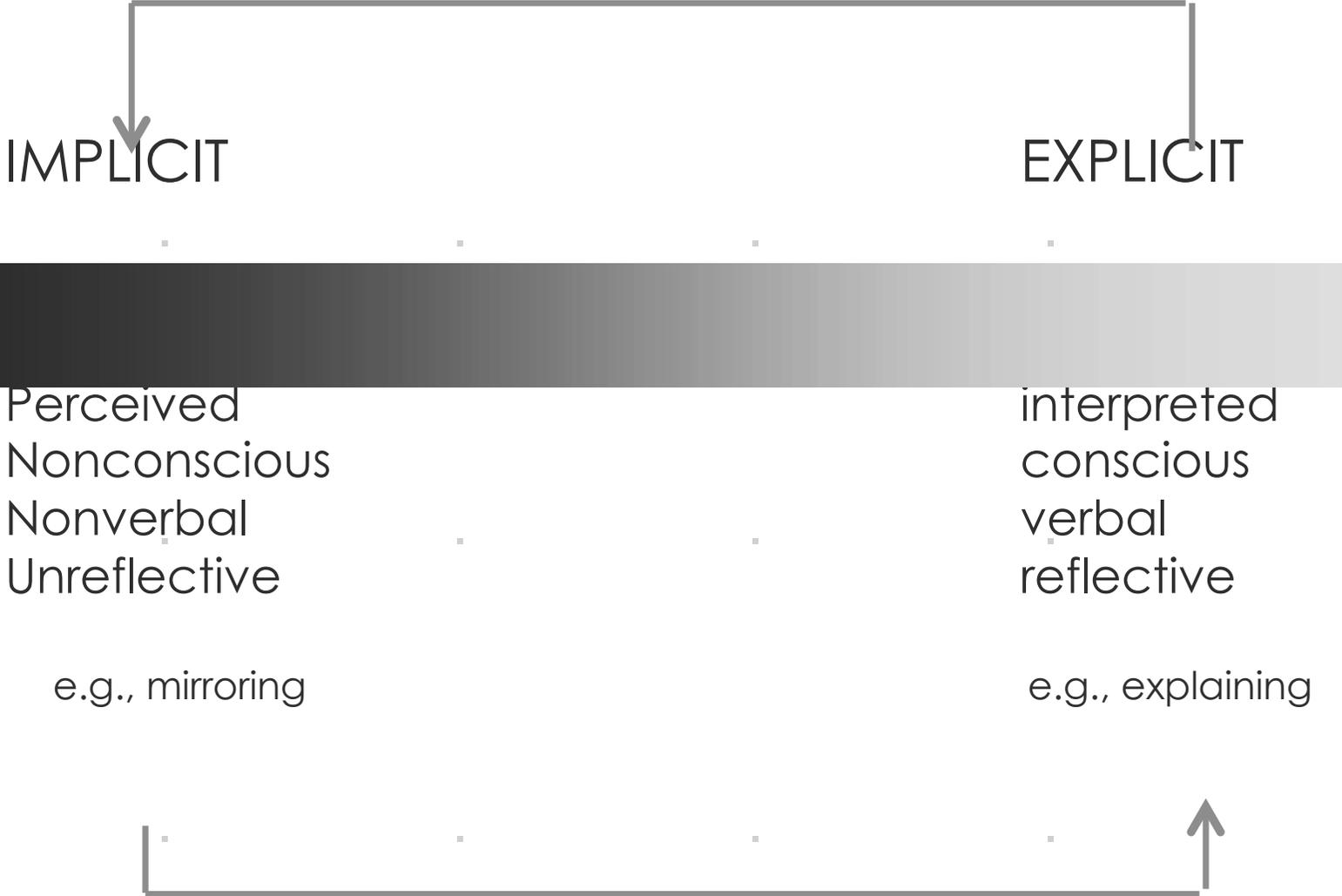
MENTALIZATION : DESCRIPTION

- Is a *process* or a *skill* that can be present to a greater or lesser degree
- Not a fixed property of mind
- Mentalizing capacity varies between individuals and within individuals (across the lifespan as well as across relationships and circumstances)
- Intimately connected to affect regulation. The ability to retain mentalizing in intense interpersonal interactions facilitates affect regulation
- Inverted U shaped phenomenon (automatic, attending, aroused)

MENTALIZATION AND AROUSAL



Mentalizing implicitly and explicitly



What does non-mentalizing look like?

- Excessive detail to the exclusion of thoughts, motivations, feelings
- Focus on external factors eg school, neighbours
- Focus on physical or structural labels (tired, lazy, clever)
- Preoccupation with rules and responsibilities eg “shoulds” and “should nots”
- Denial of involvement in problem
- Expressions of certainty about the thoughts, feelings of others

DEVELOPMENT OF MENTALIZING CAPACITY

- Mentalizing is a developmentally acquired skill, in the context of a secure attachment (via contingent marked mirroring etc), acquired in the first five years of life and gradually elaborated throughout the life-cycle
- Risk factors for the disruption of this development include: emotional abuse, trauma, non-mentalizing relationship systems
- Prior to development of mentalizing are three 'pre-mentalizing' states of mind: 'Teleological', 'Psychic equivalence' and 'Pretend'
- Pre-mentalizing states of mind may persist into adulthood and psychopathology

THE DEVELOPMENT OF THE 'MENTALIZING SELF'

- That the agentive, mentalizing, psychological sense of self is rooted in the **attribution of mental states**: The experience of a mind that has the infant's mind in mind
- The '**social biofeedback model**': That the capacity to mentalize emerges through interaction with the caregiver via a process of **contingent marked mirroring**
- Assists in developing affect regulation
- Develops child's sense of having a mind

Pre- mentalizing states

Teleological Mode (Fonagy & Target, 1997)

- Sees others' behaviour not in terms desires, plans and projects but more as associative- 'if this then that'
 - A focus on understanding actions in terms of their physical as opposed to mental outcomes
 - Clients 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
 - Pre-mentalizing children 'know' a lot about their world without being able to read people's minds
- e.g. client 'knows' that her partner loves her because he bought her flowers

Pre- mentalizing states

Psychic Equivalence (Fonagy & Target, 1997)

- When clients takes the product of their depressive/paranoid/manic thinking as the real thing
- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Experiences of mind can be terrifying because they are felt as real

e.g.. Client who believes I am bored with her and would rather be reading my book (which I have inadvertently left on my table)

Pre- mentalizing states

Pretend Mode (Fonagy & Target, 1997)

- The external world is shut out, inhabiting an exclusive imaginary space
- No bridge between inner and outer reality
- Client may withdraw into realm of fantasy –not being ‘real’ in therapy
- Linked with emptiness, meaninglessness and dissociation in the wake of trauma

e.g. client may engage in endless, unbelievable storytelling which places client in a ‘good’ or ‘innocent’ light. Any attempt to challenge these ‘facts’ will be resisted and client will insist upon the veracity of their stories. To the client they **are** true.

The Hyperactivation of the attachment system in BPD

- We assume that **the attachment system in BPD is “hypersensitive”** (triggered too readily)

Indications of attachment hyperactivity in **core symptoms** of BPD

- Frantic efforts to avoid abandonment
- Pattern of unstable and intense interpersonal relationships
- Rapidly **escalating tempo** moving from acquaintance to great intimacy

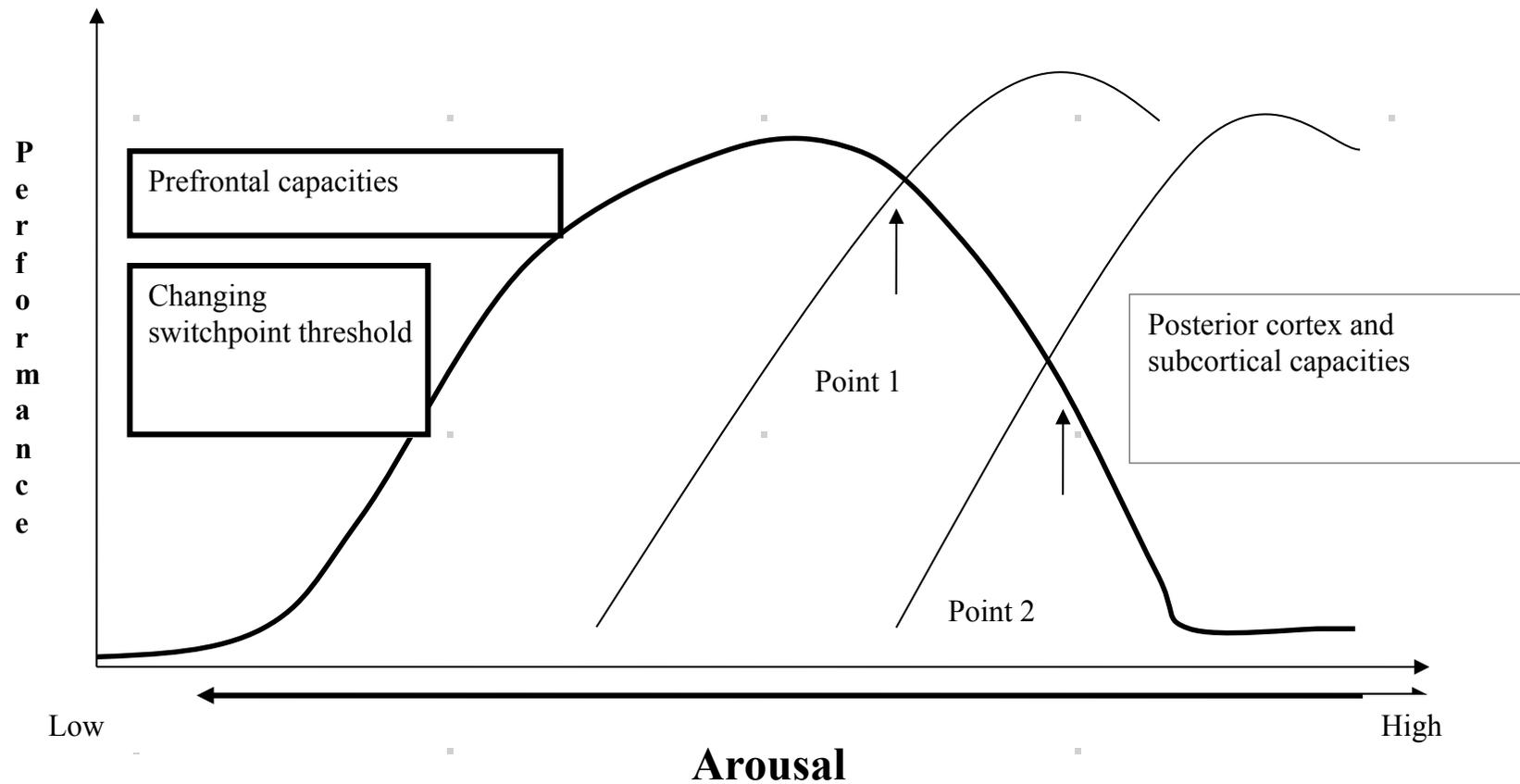
CLINICAL FEATURES (SYMPTOMS) OF BORDERLINE PERSONALITY DISORDER (DSM-IV: 5 OF 9)

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

MENTALIZATION AND PSYCHOPATHOLOGY (OR: WHEN MENTALIZING FAILS)

- **Poor affect regulation-** impulsivity, doing rather than thinking, reactivity in relationships
- **Difficulty in relationships-** lots of misunderstandings, fears, rigidity around expectations
- **Fragile sense of self-** loss of coherent self in relation to other, or to affective triggers

DUAL AROUSAL SYSTEMS MODEL: IMPLICATIONS OF THE HYPERACTIVATION OF ATTACHMENT (ARONSON,)



Treatment Issues

The therapeutic relationship leads to activation of the attachment system which is prone to hyperarousal:

- Rigid schematic representation
- Non-mentalizing
- Concrete mentalizing (Psychic Equivalence)
- Pseudo mentalizing (pretend)

Therapist needs to be aware of when arousal of the attachment system has led to breaks in mentalizing and aim to wind back to when mentalizing was interrupted

Aims of MBT

To promote mentalizing about oneself

To promote mentalizing about others

To promote mentalizing of relationships

Via

Structure

Therapeutic Alliance

Focus on interpersonal and social domain

Exploration of patient-therapist relationship

Aims and Processes of MBT

Stimulate a mentalizing process

The therapist avoids nonmentalizing techniques- those likely to reduce mentalizing in the patient or undermine the mentalizing process. eg. making assumptions

Effective implementation requires the clinician to focus on their own capacity to mentalize.

MBT Processes

- continual reworking of perspectives
- understanding of underlying mental states
- ability of the patient to maintain mentalizing in the context of the attachment relationship with therapist facilitates affect regulation and decreases enactment risk (both outside and inside therapy)
- Empathy is important, hyperarousal needs to be monitored

Focus is on current rather than past and the therapist's task is to maintain mentalizing in both him and the patient while simultaneously ensuring that emotional states are active and meaningful.

MBT

Therapeutic Stance

- Therapist's attitude is curious and "not knowing"
- Therapist uses his/her mind in open and authentic fashion

Structure is important

- Interventions are tailored to the patient's mentalizing capacity
- Stages of therapy and mentalizing development
- Therapist tracks when mentalizing is lost and pre-mentalizing modes are evoked and tries to re-establish mentalizing

Mentalizing the patient therapist relationship

- Later stage of therapy
- Structure to mentalizing the transference

INTERVENTIONS: SPECTRUM

Progression over time

- Supportive/empathic
- Clarification, elaboration, challenge
- Basic mentalizing
- Joint Affect focus
- Mentalizing the relationship

INITIAL MBT STUDY

(BATEMAN A, FONAGY P. AJP 1999, 2001)

44 patients in *partial hospital program* assessed 3 monthly, compared MBT with Standard Clinical Management. MBT group showed:

- Improvement in depressive symptoms,
- Decrease in suicidal and self-mutilatory acts
- Reduced inpatient days
- Improved social and interpersonal function began

Improvements began after 6 months and continued to end of treatment at 18 months.

No cost difference between MBT partial hospital treatment and general psychiatric care and leads to considerable cost savings after the completion of 18-month treatment.

Follow- up at 8 years:

Patients treated in the MBT program

- Remained better than those receiving treatment as usual
- Although maintaining their initial gains at the end of treatment, their general social function remained somewhat impaired.
- Many more were in employment or full time education than the comparison group, and only 14% still met diagnostic criteria for BPD compared to 87% of the patients in the comparison group

MORE MBT STUDIES

(BATEMAN & FONAGY, AMJP, 2009)

A further randomized controlled trial of MBT in an outpatient setting (MBT-OP) has been completed.

134 patients were randomly allocated to MBT-OP or SCM.

- Substantial improvements were observed in both conditions across all outcome variables.
- Patients randomized to MBT-OP showed a steeper decline in both self-reported and clinically significant problems including:
 - suicide attempts and hospitalization
 - severe incidents of self harm
 - Interpersonal distress
 - social adjustment problems
 - symptoms of mood disturbance

External Validity

Netherlands group: 45 Dutch patients with **severe BPD** treated with MBT over 18 months showed significant improvements across domains similar to above study. (Bales et al., *JPD*, 2012)

TRAINING

- Sydney in August, Brisbane in February
- Anna Freud Centre, London (see website)

Supervision

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