

Cambridge Guide to Mentalization-Based Treatment (MBT)

A complete and practical guide that offers a concise overview of mentalization-based treatment (MBT) and its application in different situations and with different groups of patients to help improve the treatment of mental health disorders. Featuring an introduction to mentalizing and the evidence base to support it, followed by an explanation of the principles of MBT and the basic clinical model in individual and group psychotherapy. Individual chapters offer extensive clinical illustrations of the treatment of patients with depression, psychosis, trauma, eating disorders, and borderline, antisocial, narcissistic, and avoidant personality disorders. The final section of the book outlines the application of mentalizing and MBT in different populations (children, adolescents, families, and couples) and in different settings (the professional community, schools, parental and foster care, and emergency care settings).

Part of the Cambridge Guides to the Psychological Therapies series, offering all the latest scientifically rigorous and practical information on the full range of key, evidence-based psychological interventions for clinicians.

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“This book brilliantly brings together, in accessible language, the research and clinical wisdom that have accumulated over the past 20 years in mentalization-based theory and practice. It definitively establishes mentalization-based treatment as the transdiagnostic treatment it is. Requiring no prior exposure to mentalization-based therapy, this must-read guide provides clinicians with essential tools that can be immediately implemented. Read it! It will be worth it!”

Carla Sharp, John and Rebecca Moores Professor, Associate Dean for Faculty and Research, CLASS Department of Psychology, University of Houston

“Cambridge Guide to Mentalization-Based Treatment (MBT) is destined to become a seminal guide. The authors have invested decades in examining how mental processing influences our well-being and share their brilliant clarity of thought regarding mentalizing theory and relevant research. They further provide rich, detailed, and practical accounts of the guiding principles of MBT and describe potent interventions that can harness mentalizing capacities and improve treatment across a range of clinical problems. This book illustrates important ideas that will be relevant to psychotherapists at all levels who are working to improve their clinical practice.”

Shelley McMaim, Senior Scientist, Centre for Addiction and Mental Health (CAMH) Director, Psychotherapy Division, Department of Psychiatry, University of Toronto

“Must-read book for anyone practicing MBT. The guide is a mind meld of brilliant clinical, scientific, and conceptual brains, clearly showing that MBT is not a “guru therapy” but democratic, full of life and kicking! Having collected the experiences of 30 years of training MBT, this guide is highly didactic with numerous detailed individual and group case descriptions giving insights into the magic potion of how to strengthen mentalizing in very diverse mental problems and clinical settings. MBT follows recommendations of modern psychotherapy research by including all common factors and still provides a convincing narrative for the clinician in terms of disorder conceptualization, goals, tasks, and change theory. With this guide MBT proves that it has become a stand-alone transdiagnostic treatment, with a strong theoretical and empirical underpinnings and—most important for clinicians—very clear and concrete directions for users.”

Svenja Taubner, Professor for Psychosocial Prevention, Medical Faculty Director, Institute for Psychosocial Prevention, University of Heidelberg

“The charm of MBT is the balance between clear hypotheses and one’s own critical ability to constantly question them. Thus, MBT is a psychotherapy factory in the best sense: creative, inspiring, and interface-compatible; for clinical practitioners oriented toward scientific evidence and for researchers oriented toward clinical implementation. This book is a catalyst that will greatly advance both the practice and theory of psychotherapy.”

Martin Bohus, Prof. em. Psychosomatic Medicine and Psychotherapy, Heidelberg University; Central Institute of Mental Health, Mannheim, Germany

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Preface

Justifying another clinical guide to the practice of mentalization-based treatment (MBT) caused considerable discussion and reflection between us: “*Surely this has all been covered well enough over the past two decades?*”; “*Is there anything new to say?*”; “*Are there enough theoretical, research, and clinical changes to warrant a new book?*” Manifestly, our decision to write this book testifies to our conclusion that enough has changed over the past few years both in the theoretical framework underpinning MBT and in its delivery in clinical practice to justify another book. This is a multi-author book rather than a collection of independent chapters by experts. Our aim has been to write a coherent manuscript from beginning to end that summarizes all the varied strands and applications of mentalizing theory without becoming repetitive. In summarizing the new material, we attempt to describe the theory of mentalizing and the clinical interventions applied in a range of mental health problems and contexts in a way that is accessible to the interested reader who has little prior knowledge of the theory and its practical applications. Clinicians need a framework that they can carry with them to inform their interventions along with clinical examples of how to transform that framework into effective clinical practice. This is the aim of this book—to be an MBT starter pack!

Recognition of the importance of effective mentalizing as a higher-order mental processing system that underpins social processes and individual resilience has stimulated ever more research about its developmental origins and its centrality—or otherwise—in mental health problems. This in turn has led MBT, a general model of intervention organized to enhance an individual’s mentalizing, to become more refined in terms of how to help people rebuild their ability to mentalize in challenging interpersonal and social environments. We never considered our initial iterations of the clinical model to be the final say on how to facilitate robust mentalizing, and we continue to develop our transdiagnostic approach to helping individuals to build resilience in their relationships and social interactions. Indeed, outcome research suggests that although MBT is effective across a range of symptomatic domains, many patients continue to show problems with social adaptation and personal life satisfaction. Too many of them fail to reach their full potential in satisfying relationships and life achievements, both at the end of treatment and in the long term. We feel that we have made progress in broadening the ambitions of our treatment approach, but clearly there is much further to go in developing the effectiveness of MBT. To some extent this book summarizes where we have got to.

We have attempted to make the focus of the book the clinician struggling with a patient of greater acuity and complexity than they might have encountered before. The mentalizing model of mental disorder conceptualizes mental health problems as developmental, certainly emerging from different routes (genetic, individual historical, cultural, societal, environmental, both internal and external, and so on), but ultimately narrowing through a single funnel of the uniquely human capacity to think socially—that is, to mentalize. Problems of mentalizing can occur for different reasons, and the manifestation of these problems will obviously reflect individual attributes and histories, as well as the social context within which the individual lives. There is great clinical merit to the developmental psychopathology concept of equifinality.

The causes may be complex and multifarious, yet the intervention that addresses an important common mediator creates a pragmatic therapeutic opportunity. We are not, in this book or elsewhere, attempting to reduce the multiple forms of mental disorder to a single cause. Yet the high rate of so-called comorbidity of mental disorders calls for us to try to identify common factors that may be involved in many disorders, which can offer a transdiagnostic approach to remediation. This book views mentalizing as one such common factor. Mentalizing allows the clinician to create a therapeutic framework that supports them, when confronted with a confusing range of presentations in a single patient, to offer both generic and problem-specific interventions. We are not sure whether in MBT we have got the balance right between generic and specific—both are needed for sure. Our overarching conceptualization that enduring mental health problems reflect a lack of capacity to adapt to the social world and the unproductive resistance to change despite the information available to the individual rests on the concept of epistemic trust—that is, the ability of the human mind to be open or closed to social influence. Epistemic vigilance may be a natural state, but hypervigilance points to a state of “hearing but not listening,” and therefore failing to internalize social knowledge offered by others. Mentalizing may be a key to generating epistemic trust and dissolving the epistemic dysfunction that characterizes the persistence of mental disorder. If this is so, it might explain why enhancing mentalizing helps in such a transdiagnostic way and has been studied as an intervention for a wide range of mental health problems. Improved social understanding not only corrects unforced errors of social cognition in relation to self and others, but it also opens the person to new understandings, garnered from the therapy room in the first instance, but then, beyond that, from the attachment partnerships—family relationships, work, and community relations—to which all of us are exposed. These constantly and consistently influence our understanding of ourselves and others, keeping us on the interpersonal straight and narrow. This understanding is relatively new, but it has increased our confidence in advocating a generalist approach to psychological therapy that is relatively easy to adopt and enhances—or rather draws on—many existing models of psychological intervention. We are fond of saying that there is little that is new in MBT, and that it draws on psychological principles that are simply part of our evolutionary heritage. Yet it is the fundamental truth of this statement that has encouraged us to produce yet another book representing a further attempt to find the correct balance between the general and the specific for clinicians and for those who benefit from this most remarkable of mechanisms of human processes of interpersonal healing—psychotherapy.

In Part I of this book (Chapters 1 and 2) we cover the history of mentalizing and MBT, outline some of the basic developmental processes that contribute to robust mentalizing, summarize the outcome research, and consider what makes things go wrong during childhood and adolescence. In Part II (Chapters 3–5) the key clinical principles that are followed in MBT are set out. We hope that throughout this book we have used enough everyday language to cut through the jargon for clinicians coming fresh to the mentalizing world to lay the foundations of clinical practice. We chart the progress of Sarah, who has borderline personality disorder (BPD)—the mental health problem on which our therapeutic approach initially focused—by describing the implementation of MBT for BPD in a stepwise fashion. The principles underpinning MBT (Chapter 3) and all the different stages of the core model are illustrated as they are used in clinical practice in her individual (Chapter 4) and group (Chapter 5) sessions. Sarah is a “prototype”—that is, she is a fictionalized composite of someone with a diagnosis of BPD, rather than a real patient.

Although we use the categories of borderline, antisocial, narcissistic, and avoidant personality disorder, and so on, in this book to delineate different mental health presentations, this is done primarily to link with earlier literature. Throughout, we emphasize that the mentalizing approach follows a dimensional system and transcends the issue of categorization. MBT requires a clinician to assess an individual's personality in terms of the dimensional domains of mentalizing, rather than to establish the presence or absence of specific descriptive characteristics that make up a "category" of diagnosis. The details of the (im)balance of dimensional mentalizing components that may be creating disruption to the patient's social experience are at the center of a personalized evaluation; the patient's formulation avoids categories and is organized around process and function. We hope that this personalized approach is clear throughout the chapters. Sarah has a range of experiences and behaviors that create problems for her and others, and yet—like so many of our patients—she is trying hard to manage her emotions and reactivity to others and is motivated to change. Targeting mentalizing requires the clinician to see things from Sarah's perspective and to respond to them compassionately so that she experiences the clinician as seeing her as she sees herself. This generates epistemic trust (trust in the knowledge that the therapist conveys) within the patient–therapist relationship, which we see as a requirement if the change we observe is to become enduring and Sarah is to take advantage of the opportunities in her life. Sarah is depicted as a typical MBT patient—she is moderately responsive to treatment.

Groups are an essential part of MBT. The aim of the group is to support learning about oneself with and through others, and some specific interventions that differentiate MBT groups from other group treatments are outlined in Chapter 5. Sarah starts in the group and gradually begins to participate and learn about herself through others—a process that gradually leads to increasingly robust and effective mentalizing. Learning about oneself through others in a group is the main format used in MBT for antisocial personality disorder (MBT-ASPD) (described in Chapter 7), which, along with other adaptations of MBT, is covered in Part III (Chapters 6–12). In these chapters, the way in which treatments diverge from the original model for BPD are discussed as they apply to other personality difficulties. In adapting the model for different disorders, clinicians follow the principles at the heart of MBT, define and formulate the mentalizing problems of the person in front of them rather than define their "disorder," and tailor their interventions accordingly. Again, although we use the categories of personality disorder, this is only to link the reader to the area of discussion. The MBT clinician is rarely concerned with "disorders" and "diagnosis," but instead tries to ensure that the person behind the "personality function" is assessed in terms of the dimensional domains of mentalizing. Through the lens of interpersonal understanding that the mentalizing perspective offers, we see people thinking, feeling, wishing, and desiring, rather than simply as mental disorders or personality disorders. The observation and gentle enhancement of mentalizing is at the center of everything that the MBT clinician does. To some extent, the labels of the different types of disorders are translated into different commonly observed patterns in the way that we as individuals think and feel about ourselves and other people, which to a greater or lesser extent characterizes all of our patients (and, dare we say, all of us). So, the clinician implementing MBT for narcissistic aspects of personality functioning (MBT-NPD) (Chapter 6), for antisocial aspects (MBT-ASPD) (Chapter 7), or for avoidant, anxiety-dominated features of social function (MBT-AvPD) (Chapter 8) follows the same core principles (Chapter 3) and the pattern of interventions

outlined in MBT-BPD (Chapter 4), but tweaks the MBT format and process of intervention according to the mentalizing formulation of the individual. We see no binary distinction between the more stable and slower-changing aspects of functioning usually encapsulated by the description “personality disorder” and the more specifically described and arguably episodic mental disorders. Both involve characteristic failures of mentalizing, offering therapeutic opportunities for MBT, which are discussed in the chapters that come next. The approach to the treatment of mental-state disorders such as depression (Chapter 9) and psychosis (Chapter 10) further confirms our transdiagnostic approach. Each chapter outlines a mentalizing framework and formulation of the problem areas, and then describes the interventions that naturally arise from these constructions of the patient’s mental function.

In Chapter 11, MBT for individuals who have experienced trauma is discussed, and an MBT-trauma focused (MBT-TF) intervention approach is described. In its original iteration for BPD, MBT took into account the fact that most patients had a considerable history of attachment trauma. Working on the sequelae of these experiences was incorporated into the model. Data suggest that to some extent this generic clinical approach to the effects of trauma on the patient worked—those who had experienced identifiable trauma had treatment outcomes that were no worse than those who did not report a history of trauma. Nevertheless, it is apparent that some symptoms of complex trauma may need special attention. Again, the first step requires reframing trauma from a mentalizing perspective. Understanding the relationship between mentalizing and trauma is detailed in the first part of Chapter 11. Based on the four mentalizing themes of trauma—being alone, mental isolation and avoidance, shame, and epistemic vigilance—the MBT therapeutic approach (MBT-TF) is then discussed. Unusually for an approach to complex trauma, MBT-TF is delivered in a group format on the basis that the patients may be able to share with and learn more from others whom they see as having had the same experiences as them. Individual sessions may be added to support the patients in the group. Chapter 12, the final chapter of Part III, covers eating disorders, which are seen in MBT as conditions arising in the context of developmentally determined mentalizing problems, genetic predispositions, attachment, and childhood and adolescent adversity. We argue that the range of symptoms associated with eating disorders may share the function of being different attempts at social self-regulation. This is important. The focus of MBT for eating disorders is then not so much on body weight and shape, for example, but on dysfunctional relationships and social anxieties, and the mentalizing problems that maintain the disorders.

The chapters that make up Part IV consider the use of mentalizing as a framework for working with children (Chapter 13), adolescents (Chapter 14), families (Chapter 15), and couples (Chapter 16), and in a range of contexts (Chapter 17). Finally, Chapter 18 discusses the organization of a service using mentalizing to inform the overall assessment and care of those who present in crisis situations in emergency settings.

Anthony Bateman

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Chloe Campbell

Patrick Luyten

Martin Debbané

A Note from the Series Editor

I remember when I first met Sarah Marsh, Editor at Cambridge University Press - it seems like a lifetime ago now. We met at a café in central Edinburgh in June 2017 to discuss an idea that she had to create a series of books focussed on evidenced based Psychological Therapies. The idea was simple – the books would be attractive to a trainee and simultaneously to an expert clinician. We wanted to enable readers to conceptualise a psychological difficulty using different theoretical models of understanding, but not become overwhelmed by the volume of information. We saw the need for a series of books that could be easily read and yet would examine complex concepts in a manageable way.

So, when Sarah asked me if I would become the Series Editor, I couldn't say no. What we could never have predicted back then, when making early plans for the series, was that we would soon face a global pandemic. There were days when we didn't even know whether we could leave our house or if our children could go to school - the world effectively stopped. Yet through all the chaos, uncertainty and fear, I saw the determination and successes of those around me shine through. I was in awe of the resilience of my own son, Patrick, who lived his adolescence in 'lock-down'. I watch him now and the young man he has become – he walks tall with a quiet confidence. I am so proud as he and his friends laugh together and now enjoy what most of had previously taken for granted: their freedom at university. In a similar way, I watched the many authors of these books, most of whom are busy and tired clinicians, continue to dedicate their precious time to this venture – an incredible achievement through a most challenging time. They each welcomed me into their academic, clinical and theoretical worlds, from all over the globe. They have all been an honour to work with. I would personally like to thank every contributor and author of this series for their hard work, determination and humour even in the darkest of days. Despite all of the unknowns and the chaos, they kept going and achieved something wonderful.

I would like to thank Sarah, and Kim Ingram at Cambridge, for giving me the opportunity to be Series Editor. I have loved every minute of it; it has been a longer journey than we anticipated but an amazing one and for that I am incredibly grateful. Sarah and Kim are my friends now – we have literally lived through a global pandemic together. It has been my absolute pleasure to work together and in collaboration with Cambridge University Press.

Patricia Graham, Series Editor

Consultant Clinical Psychologist, NHS Lanarkshire, UK

Acknowledgments

This book would not be complete without thanking all those around us who have put up with us over many years and given us ideas that we can take as our own, when they are in fact theirs and should be attributed as such. To them we apologize and we hope that our integration of their ideas into the mentalizing framework has done them a modicum of justice. We thank the series editor, Patricia Graham, for encouraging us to write this book, and the publishers for waiting patiently for a manuscript that was “nearly finished” for a considerable period of time. Finally, the support provided by colleagues at the Anna Freud Centre and the Research Department of Clinical, Educational and Health Psychology at University College London with clarifying, editing, and finalizing the manuscript was second to none—thank you.