Mentalization based treatment and addictions

Prof Anthony W Bateman
Bergen May 2016
Summary - theory

- Mentalization based treatment - initially developed for severe personality disorder (BPD and ASPD)
- Drug addiction is a behaviour with personality disorder as a common comorbid diagnosis
- Personality disorder is an attachment/relational/communication disorder
- Drug addiction may share/compete with attachment system reward circuits
Summary - practice

- Relational based treatment essential
- Detachment of attachment system relegates relationships:
  - Motivation
  - Therapeutic alliance
  - Opening epistemic trust through robust mentalizing
  - Emotional regulation
  - Putting mutuality and relationships back into interactions
Attachment and Addiction
Drug addiction

- Addiction is a form of compulsive behavior with an increasing narrowing of the behavioral repertoire towards drug intake.
- The essence of addiction is a subjective sense of a loss of control.
- Addiction involves a poorly understood switch process in which an initially positive, rewarding response to a drug is replaced by preoccupation, compulsive intoxication, and withdrawal symptoms.
- How does this switch occur? Several lines of evidence implicate mesocorticolimbic dopamine in the addiction process.
MacLean (1990) speculated that substance abuse and drug addiction were attempts to replace opiates or endogenous factors normally provided by social attachments.

Panksepp (1998) a common neurobiology to
- mother–infant,
- infant–mother, and
- male–female attachment.

Insel (2003) “Social attachment is an addictive disorder?”
Summary so far from rodents and humans

- **Mesocorticolimbic dopamine reward circuits**
  - an important candidate in addiction,
  - also critical for maternal behavior in rats
  - and pair bonding in voles

- A circuit linking the anterior hypothalamus (MPOA) to the VTA and the nucleus accumbens shell may be especially important for mediating the rewarding properties of social interaction

- The neuropeptides OT and AVP are released by socio-sexual experience in rodents and humans →
  - Can activate this reward circuit → change attachment behaviour (at least in voles)
  - fMRI studies indicate activation of same pathways in relation stimuli relating to own infant and partner

- De-activation of mesial pre-frontal cortex – mentalizing areas

- *We have identified a major neural system underpinning attachment*
The mesocorticolimbic dopaminergic reward circuit in addiction process

Diagram showing the connectivity of brain regions such as Prefrontal/Cingulate Cortex, Thalamus, NAcc Core/Shell, Ventral Pallidum, VTA, Amygdala/bed nucleus of ST.
Personality Disorder and Addiction
Severity of personality disorder and association of factors with drug addiction

<table>
<thead>
<tr>
<th>Life events history</th>
<th>None n(%)</th>
<th>Difficulty n(%)</th>
<th>Disorder n(%)</th>
<th>Complex n(%)</th>
<th>Severe n(%)</th>
<th>$\chi^2$ for linearity</th>
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<td>School, expelled</td>
<td>20 (1.0)</td>
<td>47 (1.2)</td>
<td>34 (1.9)</td>
<td>16 (3.2)</td>
<td>31 (28.2)</td>
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<td>Run-away</td>
<td>35 (1.8)</td>
<td>157 (3.9)</td>
<td>128 (7.1)</td>
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<td>120 (3.0)</td>
<td>80 (4.5)</td>
<td>45 (9.0)</td>
<td>43 (31.9)</td>
<td>209.8***</td>
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<td>Sexually abused</td>
<td>29 (1.5)</td>
<td>113 (2.8)</td>
<td>86 (4.8)</td>
<td>49 (9.8)</td>
<td>16 (14.5)</td>
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<td>132 (14.0)</td>
<td>408 (43.3)</td>
<td>270 (15.1)</td>
<td>95 (19.0)</td>
<td>37 (33.9)</td>
<td>143.2***</td>
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<td>35 (1.8)</td>
<td>72 (1.8)</td>
<td>44 (2.5)</td>
<td>18 (3.6)</td>
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<td>Problem with police</td>
<td>126 (6.5)</td>
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<td>72 (14.4)</td>
<td>49 (45.0)</td>
<td>128.7***</td>
</tr>
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</table>
Trajectories of alcohol abuse and dependency symptoms by adolescent PD diagnosis

Trajectories of marijuana abuse and dependency symptoms by adolescent PD diagnosis

Early alcohol problems and paranoid PD and subsequent trajectory of alcohol symptoms

Trajectories of illicit drug abuse and dependency symptoms by adolescent PD diagnosis

Early marijuana problem and schizotypal PD and subsequent trajectory of marijuana symptoms

Conclusions from Cohen community study

- Specific PDs and conduct disorder independently predict changes in symptom trajectories of SUD across from early adolescence to early adulthood.
- PDs predict persistence of some SUD problems over as much as the following two decades.
- PD may also represent an elevated risk for onset of SUD problems among adolescents who have not yet begun use.
- Parental substance abuse is a risk factor for borderline PD and substance abuse in adolescents.
  - Possibly mediated through problem parenting/abuse/genetics.
Relationships between personality disorder symptoms and substance use problems that were mediated or partially mediated by a personality trait

James, Jeanette Taylor (2007) Impulsivity and negative emotionality associated with substance use problems and Cluster B personality in college students Addictive Behaviors, Volume 32, Issue 4, 714–727
Who specifically benefits from MBT-BPD?
Moderating effect of Narcissistic PD

- Coefficient of difference between slopes = \(-0.14\) (-0.21, -0.08), \(p < 0.000\)

Group x Time interaction: \(\beta = 0.20\), 95%CI: 0.08 - 0.50, \(z = -3.43\), \(p < 0.001\)

3-way interaction: \(\beta = 4.9\), 95%CI: 0.93 - 37.2, \(z = 1.7\), \(p < 0.07\)
Antisocial problems and clinical outcome

Coefficient of difference between slopes = -0.14 (-0.21, -0.08), p < 0.000

Group x Time interaction: Beta = 0.16, 95% CI: 0.06 - 0.48, z = -3.31, p < 0.001
3-way interaction: Beta = 3.7, 95% CI: 0.93 - 17.59, z = 1.74, p < 0.07
Nineteen patients were not free of self-harm, suicide or hospitalization after 18-months of MBT. Who were they?

Coefficient of difference between slopes = -0.14 (-0.21, -0.08), p < .000
Odds of a clinical episode in MBT by therapist

Therapist x Time interaction: n.s.
The Nature of Attachment: Biology, Behaviour, Psychology, Relational
The social brain

1. Medial prefrontal cortex
   - Mentalising proper
     - Implicit ability to infer mental states such as beliefs, feelings and desires

Fletcher et al., 1995; Gallagher et al., 2000; Gilbert et al., 2006 (meta-analysis)
The social brain

2. pSTS/TPJ

- Prediction
  - Biological motion, eye gaze

- Perspective-taking
  - Different physical points of view

Pelphrey et al., 2004a,b; Kawawaki et al., 2006 (review); Mitchell 2007
The social brain

3. Amygdala

- Attaching reward values to stimuli
  - ‘Approach’ vs. ‘avoid’
- Facial expressions

The social brain

4. Temporal poles
   - Social scripts, complex event knowledge

Funnell, 2001; Damasio et al., 2004; Moll et al., 2001, 2002, 2005 (review)
Functions of attachment

- Physical survival
  - Protection of life, then of brain development

- Emotional survival
  - Feeling loveable, interesting → turn to world
  - Stress regulation, being able to tolerate self and others

- Cognitive survival
  - Capacities – attention/focus, social skills and trust, curiosity: exploration and engagement with learning
What does research show us about the importance of this early relationship?

- Regulation of the brain system – emotion regulation
- Sense of security – distress will be met by comforting
- Faster development of cognitive capacities
- Sense of identity – a firmer sense of knowing oneself
Ainsworth’s Attachment Classification

- **Secure**
  - explores readily
  - anxious with stranger
  - seeks contact on reunion
  - readily comforted

- **Insecure avoidant or resistant**
  - less anxious about separation
  - no proximity-seeking on reunion
  - impoverished exploration
  - or distressed but not comforted by reunion
Extended Attachment Classification

- **Disorganized-disoriented** infants
  - freezing, hand clapping, wish to escape

- Arousal of attachment system
  - attachment figure is haven of safety and source of stress

- Associated with
  - severe neglect
  - physical abuse
  - sexual abuse
Attachment Disorganisation in Maltreatment

Adverse Emotional Experience

The ‘hyperactivation’ of the attachment system
Disorganized Attachment and Institutionalization

Attachment and cognitive functioning: the development of competence in logical reasoning

Source: Jacobson et al
Secure Relationships Calm Children’s Stress Hormone Response

Sensitive Care Calms Children’s Stress Hormone Response in Parent’s Absence

Delayed Intervention Harms Development
Bucharest Early Intervention Program

IQ/DQ (Mean)

Age of placement in foster care (months)

Tested at 3 1/2 Years Old

Tested at 4 1/2 Years Old

“normal” range

Source: Nelson et al. (2007)
Science, 318, 1937
Instability Disrupts the Stress Response System — But Relationships Reverse the Effect

Psychoneuroendocrinology, 32, 892
How Attachment Links to Affect Regulation

Down Regulation of Emotions

BONDING

EPISTEMIC

TRUST

The forming of an attachment bond
The mental outcomes of attachment problems
What is mentalizing?

Mentalizing is a form of *imaginative* mental activity about *others* or *oneself*, namely, perceiving and interpreting *human* behaviour in terms of *intentional* mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
Impulse of mentalization generates problems

**Implicit-Automatic-Non-conscious-Immediate.**
- Impulsive, quick assumptions about others' thoughts and feelings not reflected on or tested, cruelty
- Does not genuinely appreciate others' perspective. Pseudo-mentalizing, Interpersonal conflict 'cos hard to consider/reflect on impact of self on others

**Explicit-Controlled-Conscious-Reflective**
- Mental interior cue focused
- Lack of conviction about own ideas
- Seeking external reassurance
- Overwhelming emptiness, Seeking intense experiences
- Hyper-vigilant, judging by appearance. Evidence for attitudes and other internal states have to come from outside

**Cognitive agent:attitude propositions**
- Unnatural certainty about ideas
- Anything that is thought is REAL
- Intolerance of alternative ways of seeing things.
- Overwhelming dysregulated emotions, Not balanced by cognition come To dominate behavior. Lack of contextualizing of feelings leads to catastrophizing

**Imitative frontoparietal mirror neurone system**
- Hypersensitive to others' Moods, what others say. Fears 'disappearing'
- Rigid assertion of self, controlling others' thoughts and feelings.

**BPD**
- Imitative frontoparietal mirror neurone system
- Hypersensitive to others' Moods, what others say. Fears 'disappearing'
- Rigid assertion of self, controlling others' thoughts and feelings.

**Belief-desire MPFC/ACC inhibitory system**
- Imitative frontoparietal mirror neurone system
- Hypersensitive to others' Moods, what others say. Fears 'disappearing'
- Rigid assertion of self, controlling others' thoughts and feelings.
Attachment, mentalisation and attachment types

- Dismissing:
  - particularly effective in deactivating social importance ➔ pretend mode
  - leads to a reduced availability of long term memories imbued with either positive or negative emotion ➔
  - in interviews that have specifically aimed at activating the attachment system ➔ typical narrative pattern of
    - an inability to recall attachment experiences and
    - recover emotionally laden memories

Performance

Prefrontal capacities

Changing switchpoint threshold

Posterior cortex and subcortical capacities

Arousal

Low

High

Point 1a

Point 1
Prementalizing Modes of Subjectivity

- **Psychic equivalence:**
  - Mind-world *isomorphism*; *mental* reality = outer *reality*; internal has power of external
  - *Intolerance* of alternative perspectives ➔ concrete understanding
  - Reflects domination of *self:*affect state thinking with *limited internal focus*

- **Pretend mode:**
  - Ideas form no bridge between inner and outer reality; *mental* world *decoupled* from external reality
  - “dissociation” of thought, *hyper-mentalizing* or *pseudo-mentalizing*
  - Reflects explicit mentalizing being dominated by *implicit*, *inadequate internal focus*, *poor belief-desire reasoning* and vulnerability to *fusion with others*

- **Teleological stance:**
  - A focus on understanding actions in terms of their *physical* as opposed to mental *constraints*
  - Cannot accept anything other than a modification in the realm of the *physical* as a true index of the intentions of the other.
  - Extreme *exterior focus*, momentary *loss of controlled* mentalizing
  - *Misuse* of mentalization for teleological ends (harming others) becomes possible because of lack of *implicit as well as explicit* mentalizing
Theory: Birth of the Agentive Self

Attachment figure “discovers” infant’s mind (subjectivity)

Infant internalizes caregiver’s representation to form psychological self

Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality ➔ mentalization
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

Attachment

Figure

Absence of a representation of the infant’s mental state

Mirroring fails

Child

The nascent self representational structure

The Alien Self

Internalisation of a non-contingent mental state as part of the self

The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics
**Theory:** Self-destructiveness and Externalisation Following Trauma

- **Perceived other**
- **Torturing alien self**
- **Self representation**

Unbearably painful emotional states:
- Self experienced as evil/hateful

**Self-harm state**

*Attack from within is turned against body and/or mind.*
**Theory:** Self-destructiveness and Externalisation Following Trauma

**Self-harm state**

*Perceived other*  

- *Unbearably painful emotional states:* Self experienced as evil/hateful

*Addictive bond*

*Victimized state*

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops.
If someone was causing you pain or simply tormenting you, perhaps not everyday for the whole day, parts of a day, or for days and weeks on end,

You could if you were brave or desperate enough, defend yourself, by perhaps attacking (and eliminating) your persecutor.

But what if this thing you hate, was inhabiting your head?

You can’t exactly say please leave my body, you can’t do anything to get it to just pack up and leave because technically, physically that isn’t possible.

You can say fuck you. I hate you. You can self-harm with the hugest force your body can withstand, with all you can muster.
You can do that. You can be very very angry and show them who’s boss, you won’t stand for it, you won’t take it lying down. You want to be heard, you want to say right, you think you can hurt me? I’ll show you, I’ll show you how much I can hurt you!

But you and this thing, you are inhabiting one body. You attack this thing you attack yourself. You don’t have a choice though. That’s a sacrifice you make over and over.

Eventually, you realise the only way to get rid of this thing, once and for all is getting rid of yourself. What choice do you really have?
No doctor can specify the problem. No medication can fix the problem that can’t be specified.

You fail to understand yourself. You can’t explain to your family and docs, they can’t help you because you do not talk.

You doubt yourself “do I even have a problem?”

People in real life often treat you like you don’t have a real problem. They talk to you stupidly, you complain that they don’t understand, you look a fool. Perhaps that is why you don’t talk to them anymore.

Maybe you don’t have a problem anyway.
Pretend Mode: a central role in drug addiction
HOC deficit manifests as dysfunction of social cognition

Facial emotion recognition
- Hypersensitivity to subtle facial cues of negative emotions
- Increased arousal that impairs recognition of overt emotions
- Faster eye movements to the eyes of negative faces
  - Enhanced amygdala activation
  - Reduced by administration of oxytocin

Trust appraisal and rejection sensitivity
- Neutral faces are less trustworthy
  - NOT reduced by administration of oxytocin

Cognitive empathy
- Impaired ToM – impaired perspective taking
- Enhanced performance in RME
  - It does not require explicit meta-representation of the other’s mind
  - Lower activation of theory of mind brain circuit
    - Even during enhanced performance at RME

Affective empathy
- Automatic (unconscious) imitation of negative expressions
  - Enhanced right-mid insular activity (self-origin of emotions)
  - Reduced anterior insula (other-origin of emotions)
Adolescents hypermentalize more than adults and under-mentalize less (Fossati et al)

MASC Performance

Fossati, Borroni, Dziobek, Fonagy & Somma

$p < .005, d = 0.23$

$p < .001, d = -0.30$
Diagnostic Interview Schedule for children and hyperMZ

- **CDISC mood disorders** vs. those without mood disorders: hypermentalizing at admission ($t = -.16$, $df = 164$; $p = .86$) or discharge ($t = .40$, $df = 163$; $p = .68$).
- **CDISC anxiety disorders** vs. those without anxiety disorders: hypermentalizing at admission ($t = -.40$, $df = 163$; $p = .68$) and discharge ($t = -1.09$, $df = 163$; $p = .27$).
- **CDISC externalizing disorders** vs. those without ext disorders for hypermentalizing at admission ($t = -1.46$, $df = 163$; $p = .14$) and discharge ($t = .38$, $df = 163$; $p = .70$).
- These findings suggest that the tendency to hypermentalize was **specific to BPD pathology** rather than pathology of mood, anxiety or conduct.
Hypermentalizing leads to emotion dysregulation which leads to borderline personality features (Sharp et al., 2011, J.Am. Acad. Child. Adol. Psychiat., 60, 563-573.)

* \( p < .05 \), ** \( p < .01 \), *** \( p < .001 \)

<table>
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<th>( \beta )</th>
<th>( R^2 )</th>
<th>P</th>
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<td>.383**</td>
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<td>.375</td>
<td>.036</td>
<td>.686**</td>
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Correlations between mentalizing and emotion regulation and borderline features (Sharp et al., 2011)

Multi-mediational model

Attachment Security -> Hypermentalizing
-0.315*

Hypermentalizing -> Borderline Features
0.617**

Emotion Dysregulation -> Borderline Features
-1.742

Emotion Dysregulation -> Attachment Security
-0.156

Borderline Features -> Emotion Dysregulation
0.352***
Therapeutic Challenge
Problems for psychological intervention

- Problem is personality disorder as a general factor for treatment
- Decoupling of attachment system
- De-activation of mentalizing
- Detachment ➔ Pretend mode
- Requirement to stabilise through alien self ➔ externalization to others and/or drug
- Management of affect (shame) with drugs
Externalising and drop-out from treatment

Henriette Löffler-Stastka; Victor Blueml; Christa Boes; *Psychotherapy Research* 2010, 20, 295-308.

![Diagram showing factor scores for externalizing and searching factors in different samples](chart.png)
Paradox of treatment

- Less is More – overactivation increases coercive behaviours, drug seeking behaviour and aggression
- Focus on imbalances in mentalizing
  - Identify absent mentalizing rather than symptoms resulting from non-mentalizing e.g. drug seeking behaviour/aggression
  - Bolster good interpersonal mentalizing and reduce focus on poor mentalizing
  - Rebalance dimensions by increasing absent pole rather than decreasing overactive pole
Engagement in treatment

- Explanation of model
- Involvement of experts by experience
  - Completer sits in group and holds advice ‘surgery’
- Identification of joint goals beyond drug use
- Broader focus than addiction process/aggression/violent events – these are an end-product and not the problem
Summary and orientation to MBT
The Therapeutic Challenge

The stabilisation of mental processes on ASPD+BPD depends on **rigid** externalization of the *alien self (onto drug/person)*

Threats to this externalisation cause arousal of the attachment system and experience of problematic emotions (shame)

Inability to control internal states leads to increase externalization

**Mentalization failure**  
*Shame, Anger, Fear, Bad*

Violent control of the perceived source of threat, detach attachment, drug use to re-stabilise
Some General Principles - MBT

- Primary aim is to increase capacity to mentalize self and others
- Maintain or Regain mentalizing of clinician
- Monitor patient mentalizing capacity
- Manage arousal levels
- Focus on patient’s mind
- Seek out moment of mentalizing vulnerability
- Address current events and immediate states of mind
- Step-wise intervention process starting with empathic validation
Core Summary for new clinicians (1)

1. Collaborative process
2. Formulation of patient problems early in treatment and a focus in each session
   - Trajectory of overall treatment and in each session
3. Identification of non-mentalizing process
4. General Attitude
   - Not-knowing stance

Principles for clinician
- Aim to re-store or maintain mentalizing
- Interventions consistent with the patient’s mentalizing capacity
- Identification of mentalizing poles
Core Summary for new clinicians (2)

6. Principles for clinician (cont’d)
   - Focus on maintaining clinician mentalizing
   - Authentic and open-minded clinician
   - Alert to breaks in mentalizing
   - Monitoring of the state of affective arousal
   - Focus on contingency and marking of interventions

7. Trajectory of sessions: interventions structured from empathic validation to exploration, clarification, and challenge through affect identification and affect focus to mentalizing the relationship itself

8. Explicit identification of clinician feelings related to the patient’s mental processing
### Theory to Practice: Contrary Moves

<table>
<thead>
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<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
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<td>External focus</td>
<td>Internal focus</td>
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<td>Self- reflection</td>
<td>Other reflection</td>
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<td>Emotional distance</td>
<td>Emotional closeness</td>
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<tr>
<td>Cognitive</td>
<td>Affective</td>
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<tr>
<td>Explicit</td>
<td>Implicit</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
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Therapist Stance

- **Not-Knowing**
  - 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’.
  - Acceptance of different perspectives
  - Active questioning
  - Eschew your need to understand – do not feel under obligation to understand the non-understandable.

- **Monitor you own misunderstandings**
  - Model honesty and courage to accept mentalizing errors via acknowledgement of your own misunderstanding
    - Current
    - Future
  - Suggest that misunderstandings offer opportunities to re-visit to learn more about contexts, experiences, and feelings
Core areas for mentalizing treatment for personality disorder with drug addiction

- **Increase**
  - Emotional management
    - Shame
  - Relational elements
    - Joint goals
    - Therapeutic alliance/non-judgemental stance/empathic validation
    - Ostensive cues
    - Interpersonal focus

- **Decrease**
  - Pretend Mode
  - Concern for self in affect arousal and rapid switch to control other
  - Externalising core aspects of self
  - Self-serving uses of others
Maintaining Motivation

- Demonstrate support, reassurance and empathy as you explore the patient's mind.
- Model reflectivity.
- Identify the discrepancy between the experience of the self and the ideal self – ‘how you are compared with how you would like to be’.
- ‘Go with the flow’ or ‘roll with the resistance’.
- Re-appraise gains and identify areas of continuing problem.
- Highlight competencies in mentalizing and listen for mentalizing strengths.
Elephant in the room

“I’m right there in the room, and no one even acknowledges me.”
Pretend Mode in clinical practice
# Modes of non-mentalizing

## PRETEND MODE

| Clinical form | Inconsequential talk/groundless inferences on mental states  
Lack of affect. Absence of pleasure  
Circularity without conclusion – spinning in sand  
(hypermentalizing)  
No change  
Dissociation – self harm to avoid meaninglessness  
Body-Mind decoupled |
|----------------|------------------------------------------------------------------------------------------------------------------|
| Therapist experience | Boredom  
Detachment  
Patient agrees with your concepts and ideas  
Identification with your model  
Feels progress is made in therapy |
| Intervention | Probe extent.  
Counter-intuitive  
Challenge |
| Iatrogenic | Non-recognition  
Joining it with acceptance as real  
Insight orientated/skill acquisition intervention |
Challenge
Challenge - aims

- Bring non-mentalizing to an abrupt halt even if only momentarily
- Surprise the patient’s mind; trip their mind back to a more reflective process
- Grasp the moment – stop and stand - if they seem to respond
- Steady Resolve
Challenge - indicators

- Persistent non-mentalizing especially in high risk contexts
- Pretend Mode
- Fixed position in one or more dimensions of mentalizing
- Inadequate progress in treatment
Challenge - characteristics

- Infused with compassion
- Non-judgemental
- Unheralded, left-field, surprise
- Outside the normal therapy dialogue but within the frame of professional treatment
- Targets affect using empathic validation more often than cognition
- Use humour when possible
Challenge - strategies

- Counter-intuitive statements
- Mischievous or Whacky comments – would you like a cup of tea – English Breakfast or Earl Grey?
- Therapist emotional expression to re-balance patient emotional expression
- Frank but Fair
Drug use, not-knowing stance, and exploration
The Mentalizing Stance

Inquisitive:
Tentative, curious, measured enthusiasm for mental states

Holding the Balance
Narrative flow
Vs.
Interventionist

Terminating
Inaccurate or non-mentalizing interactions

Reinforcing
Positive mentalizing
Drug addiction/Self-harm

**Function**
- To re-establish the self-structure following loss of mentalizing

**Intervention**
- Explore reasons for destabilisation of self-structure
- ‘Tell me when you first began to recognise that you had to get drugs?’ ➔ Mentalizing functional analysis
Understanding violence in terms of the temporary loss of mentalization

- **Loss ➔**
  - Increase attachment needs ➔ triggering of attachment system ➔

- **Failure of mentalization ➔**
  - Psychic equivalence ➔ intensification of unbearable experience ➔
  - Pretend mode ➔ hypermentalization meaninglessness, dissociation ➔
  - Teleological solutions to crisis of agentive self ➔ control of threat ➔ drug related behaviour
Step-wise Intervention

- Contingent response = empathic validation with current state
- Establish joint reflection on precursors of drug behaviour and not on drug behaviour itself
- Affect focus if no joint reflection – presentation of shared dilemma
- Identify moment of ‘loss’, attachment trigger and context
- Work towards recognition/awareness of vulnerability points and context representation
Mentalizing Functional Analysis

- Empathy validation and support ➔ collaborative stance
- Define interpersonal context
  - Detailed account of days or hours leading up to drug behaviour with emphasis on mental/feeling states
  - Moment to moment exploration of events prior to actual episode
  - Explore communication problems
  - Identify misunderstandings or over-sensitivity
- Identify affect
  - Explore the affective changes since the previous individual session linking them with relevant aspects of treatment
  - Review any acts in relation to treatment – how could treatment focus better to prevent this action again? What can we do better?
Affects/Shame
Shame and guilt are “negative” or uncomfortable emotions

- Shame involves a negative evaluation of the entire self vis-à-vis social and moral standards.
- Guilt focuses on specific behaviors (not the self) that are inconsistent with such standards.

Shame and guilt lead to different “action tendencies” (Lindsay-Hartz, 1984)

- Guilt is apt to motivate reparations.
- Shame is apt to motivate efforts to hide or disappear or attack.
Shame

- Different types of shame described
  - malignant aggressive (blame, attack, avoid)
  - benign life shame (motivating, behaving morally/socially/interpersonally)

- Shame
  - Low concern for others and High concern for self
  - Threat of social exclusion
  - Triggers physical pain which suggests immediate action if not moderated
Shame and aggression

- Positive correlations:
  - shame-proneness and physical aggression
  - shame-proneness and verbal aggression for adults, college students, adolescents, and children
  - shame proneness and anger, hostility, and externalization of blame

- Male college students’ anger fully mediated the relationship between shame and psychological abuse of a partner

- Clinical Note
  - Negative feelings of shame may lead to externalization of blame which may lead to higher levels of verbal and physical aggression
  - Clinician needs to be sensitive to unmasking/exposing in group
  - Aggressive and antisocial individuals often use cognitive distortions related to others to justify their activities
Key mentalizing components in affect recognition and management

- Identification of non-mentalizing interactions
- Focus on emotions
  - Understanding emotional cues - external mentalizing and its link to internal states
  - Recognition of emotions in others – other/affective mentalizing – cognitive and emotional empathising (look angry but feel hurt and desperate)
  - Identification and naming of current feelings in self
Summary: Core areas for treatment

- Increase
  - A) affective understanding
    - Recognition and acceptance of emotion in self – shame and other emotions
    - Accurate understanding of emotion in other – observe embodied mentalizing
    - Increase in empathy for others - ?increase eye focus ➔ Constraint by others emotion
  - B) Relational pattern (self/other) identification
    - Processing of positive experience of self with others
    - Recognition of fixed relational patterns outside and in group
Summary: Core areas for treatment

- Decrease
  - Pretend Mode
  - Concern for self in affect arousal and rapid switch to control other
  - Externalising core aspects of self
  - Self-serving uses of others
Thank you for mentalizing!

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