

## MENTALIZATION-BASED TREATMENT OF BPD

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Psychoanalytically oriented partial hospital treatment for BPD has been shown to be more effective than treatment as usual in a randomized controlled trial and over 18 months of follow-up. Focus of treatment, in the context of group and individual psychotherapy, was on increasing the patient's capacity for *mentalization*, the capacity to think about mental states of oneself and others as separate from, yet potentially causing actions. We summarize the research and outline the essential theoretical and practical components of mentalization-based treatment. Core aspects of treatment include enhancing mentalization, bearing in mind patient deficits, using transference, retaining mental closeness, and working with current mental states. Finally, it is proposed that mentalization is a common theme in psychotherapy of BPD and may explain why different treatments "work."

A number of approaches to therapy with BPD (BPD) have so far been manualized and subject to evaluation (Clarkin, Kernberg, & Yeomans, 1999; Clarkin et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Marziali & Monroe-Blum, 1995; Monroe-Blum & Marziali, 1995; Ryle, 1997; Ryle & Golyukina, 2000). The research so far does not suggest a treatment of choice for borderline patients and different approaches seem to "work" to some extent. In all approaches the effective components of treatment remain uncertain.

We have developed a psychoanalytically oriented treatment in the context of a partial hospital program (PH) that has recently been fully manualized (Bateman & Fonagy, 2004). Treatment focuses on increasing mentalization in borderline patients. Mentalization entails making sense of the actions of oneself and others on the basis of intentional mental states, such as desires, feelings, and beliefs. It involves the recognition that what is in the mind is in the mind and reflects knowledge of one's own and others' mental states as mental states. In effect, mentalizing refers to making sense of each other and ourselves, implicitly and explicitly in terms of subjective states and mental processes. It is a capacity that is acquired gradually over the first few years of life in the context of safe and secure child-caregiver relationships. The

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purpose of this article is to summarize the research so far into mentalization-based treatment (MBT), to outline the theoretical and practical principles, and to argue that mentalization is a common theme of treatments for personality disorder and may explain why apparently differing treatments “work.”

### **OUTCOME RESEARCH OF MENTALIZATION-BASED TREATMENT**

Our initial study (Bateman & Fonagy, 1999) compared the effectiveness of a psychoanalytically oriented PH program using mentalization techniques with routine general psychiatric care for patients with BPD. Treatment took place within a routine clinical service and was implemented by mental health professionals without full psychotherapy training who were offered expert supervision. Results showed that patients in the PH program showed a statistically significant decrease on all measures, in contrast to the control group which showed limited change or deterioration over the same period. Improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduced in-patient days and better social and interpersonal function began after 6 months and continued to the end of treatment at 18 months.

The 44 patients who participated in the original study were assessed at 3-month intervals after completion of the trial using the same battery of outcome measures (Bateman & Fonagy, 2001). Results demonstrated that patients who had received PH treatment not only maintained their substantial gains but also showed a statistically significant continued improvement on most measures, in contrast to the control group of patients which showed only limited change during the same period which, because of continued improvement in social and interpersonal function, suggests that longer term rehabilitative changes were stimulated.

Finally, an attempt was made to assess health care costs associated with PH treatment, compared with treatment within general psychiatric services (Bateman & Fonagy, 2003). Health care utilization of all patients who participated in the trial was assessed using information from case notes and service providers. Costs were compared among 6 months before treatment, 18 months during treatment, and 18 months at follow up. There were no cost differences between the groups during pretreatment or treatment. During the treatment period the costs of PH treatment were offset by less psychiatric in-patient care and reduced emergency room treatment. The trend for costs to decrease in the experimental group during follow up was not apparent in the control group, which suggests that specialist PH treatment for BPD is no more expensive than general psychiatric care and leads to considerable cost savings after the completion of 18 months of treatment.

A number of important questions have arisen from this research. First, although we operationalized treatment for research purposes, a more detailed manual was required if we were to demonstrate that treatment was generalizable across settings and practitioners and could be applied with fidelity by generically trained mental health staff. Second, in common with other treatments of BPD, it remains unclear what exactly are the effective ingredients of treatment. The PH program is a complex, multifaceted interven-

tion including analytic and expressive therapies. There is inevitably a "milieu" effect, and we were unable to show that the target of our interventions, mentalization, had been enhanced in patients treated within the PH program, compared with control patients because of the complexity of measuring reflective function. For research purposes Fonagy (Fonagy, Target, Steele, & Steele, 1998) has now operationalized the ability to apply a mentalizing interpretational strategy as reflective function. Individuals are not expected to articulate this theoretically, but to demonstrate it in the way they interpret events within attachment relationships. Individuals differ in the extent to which they are able to go beyond observable phenomena to give an account of their own or others' actions in terms of beliefs, desires, plans, etc. and in borderline patients this capacity is reduced.

We have operationalized MBT as an outpatient adaptation to answer some of these questions. Outpatient treatment removes the milieu aspect of therapy and focuses solely on mentalization within individual and group analytic therapy. Treatment consists of an individual and group psychoanalytic session once a week for a total of 2 1/2 hours psychotherapy, and is part of a randomized controlled trial that is underway at present. Again, treatment is implemented by generic mental health practitioners trained in mentalization-based treatment and who are offered expert supervision.

### **MENTALIZATION-BASED TREATMENT (MBT) - THEORY**

There are several linked concepts that inform MBT but three stand out. The first is psychic equivalence, the second pretend mode, and the third mentalization itself. The first two concepts refer to ways children, before the acquisition of the capacity to mentalize (and we believe under certain circumstances individuals with BPD), experience the world of mental states. We believe that when mentalization fails, modes of representing psychological experience that antedates full appreciation of the nature of mental states comes to dominate the patient's mental world (Fonagy & Target, 2000). Patients operating in psychic equivalence equate the internal with the external and experience no differences in perspective about the external world because it is experienced as isomorphic with the internal—"I know all that is out there, and all that is out there is known to me." In pretend mode, the mental state is decoupled from external or physical reality, rather than being continuous with it, but is separated from the rest of the patient's mental world. The result of these two modes of function is that in psychic equivalence, experience is too real and therefore overwhelming, whereas pretend is too unreal and therefore detached and isolating. The individual either becomes engulfed by affect, experiencing too much, or underwhelmed, experiencing too little. In the former state, the patient's sense of self fragments, whereas in the latter it becomes rigid and fixed with an illusory stability but without meaning, connection, narrative, and flexibility. It is the integration of psychic equivalent and pretend modes of functioning that give rise to mentalization in which thoughts and feelings can be experienced as representations and inner and outer reality are seen as linked, but separate, and are no longer either equated or dissociated from each other.

Integration of psychic equivalence and pretend mode into a mentalizing stance happens optimally in the context of a playful parent-child relationship. In such a relationship feelings and thoughts, wishes, and beliefs can be experienced by the child as significant and respected on the one hand, but on the other as not being of the same order as physical reality. Both the pretend mode and the psychic equivalent modes of functioning are modified by the interaction with the parent in what Winnicott (Winnicott, 1971) incomparably termed a *transitional space*. From a psychodynamic perspective, we argue that the capacity for mentalization is an intersubjective developmental achievement greatly facilitated by secure attachment (Fonagy, 1997; Fonagy, Target, Gergely, & Jurist, 2002).

Both mentalizing capacity and its attachment context are at the root of self-organization. The ability to conceive of oneself and others as mental agents is essential for the coherence of subjective experience of self in meaningful intersubjective interaction with others (Gergely, 2001). Developmentally, the organization and recognition of internal states as internal states and their representation symbolically (secondary representation) can arise robustly only if the infant was given the opportunity to “observe” these states in the mirroring reactions of his or her caregiver (Gergely & Watson, 1999). So what happens when the attachment context is not secure? The internalization of the caregiver’s image of the child as an intentional being is central. The child’s emerging self-representation will only map fully to what could be called a primary or “constitutional self” (the child’s experience of an actual state of being, the self as it is) if the caregiver is attentive, sensitive, and accessible to him or her in this way. The representation will not be true to the child’s primary experience in the case of early neglect, physical maltreatment, and the associated disorganization of attachment. The caregiver’s hostile intent precludes such an organic self-image. If internal experience is not met by external understanding, it remains unlabelled, confusing, and the uncontained affect generates further dysregulation.

There is overwhelming pressure on the child to develop a representation for internal states. The child seeks out aspects of the environment contingently related to his self-expressions. Winnicott warned us that failing to find his or her current state mirrored, the child is likely to internalize the mother’s actual state as part of his or her own self structure (Winnicott, 1967). When confronted with a frightened or frightening caregiver, the infant takes in as part of himself the mother’s feeling of rage, hatred, or fear, and her image of him as frightening or unmanageable (Fonagy & Target, 1995). This painful image must then be externalized for the child to achieve a bearable and coherent self-representation simply because it is foreign. We have called the resulting incoherence within the self-structure an “alien self” (Fonagy & Target, 2000). Once internalized and lodged within the self-representation, this hostile “alien” representation will have to be expelled not only because it does not match the constitutional self, but also because it is persecutory. The consequences for interpersonal relationships and for affect regulation are then disastrous (Carlsson & Sroufe, 1995) and we conceive of the flawed self-organization that follows disorganized attachment as a vulnerability. In particular, the poorly constructed self-structure of such children sensitizes them to later trauma.

Expulsion of the alien self results, at the simplest level, in a terrifying external world because the persecutory parts are experienced as outside. At a more complex level, it is felt essential that the alien experiences are owned by another mind, so that another mind is in control of these parts of the self. This might be part of the explanation why, strikingly, people with BPD frequently find themselves in interpersonal situations where they are maltreated or abused by their partner.

Although accepting that the relationship between childhood maltreatment and BPD is complex, the statistics on the sequelae of childhood sexual abuse seem quite relevant to this point. It is known that victims of childhood abuse who are revictimized are most likely to suffer from severe mental health problems, including (as we have seen frequently) BPD. According to one study, 49% of abused women, compared with 18% of women without the experience of sexual abuse had been battered by their partners (Briere & Runtz, 1987). In a large study with a sample representative of San Francisco, between 38% and 48% of women abused (depending on the severity of abuse) had physically abusive husbands, compared with 17% of nonabused women (Russell, 1986). This should in no sense be taken to mean that the men involved in the battering are any less culpable. Individuals with experiences of maltreatment appear to be drawn to individuals who are likely to maltreat them, we would argue, to increase the opportunity of externalizing intolerable mental states concerning themselves. As might be expected on the basis of this, many sexual assaults experienced by college-aged survivors of sexual abuse occur at the hands of a known individual (Gidycz, Hanson, & Layman, 1995). Indeed, one survey demonstrated that 81% of the adult sexual assaults experienced by revictimized women were perpetrated by male acquaintance of the survivor (Cloitre, Scarvalone, & Difede, 1997).

### **MENTALIZATION-BASED TREATMENT - PRACTICE**

The consequences for psychodynamic therapeutic technique of this reframing of BPD as a failure to develop a robust self-structure are considerable. In particular, many practitioners may currently practice in a way that assumes cognitive and emotional capacities in patients that they simply don't have. In BPD, mentalization is enfeebled and almost absent in moments of arousal and at these times actions represent the maladaptive restoration of a rudimentary mentalizing function chiefly aimed at creating the illusion of self-coherence. Actions become a desperate attempt to protect the fragile self against the onslaught of overwhelming threat of disintegration or persecution from within, often quite innocently triggered by an other (thus the reaction may often seem disproportionate to the provocation). The experience of humiliation or threat, which the individual tries to contain within the alien part of the self, comes to represent an existential threat and is therefore abruptly externalized. If it is not, then suicide may become the only solution in an attempt to save the self. But if the alien self is placed outside and perceived as part of the other, it is disowned and, if it cannot be controlled via a coercive interaction, it may be seen as possible to destroy once and for all through verbal attacks or violence. The other is essential not just

to create the illusion of coherence but also to be there to be destroyed. This re-equilibrates the individual. In this sense, attacks on the other are a gesture of hope, a wish for a new beginning, a desperate attempt to restore a relationship, even if in reality they may have a tragic end. This is why borderline patients require rather than enjoy relationships. Relationships are necessary to stabilize the self-structure but are also the source of greatest vulnerability because in the absence of the other, when the relationships break down, or if the other shows independence, the alien self returns to wreak havoc (persecute from within) and to destabilize the self-structure. Vulnerability is greatest in the context of attachment relationships because the activation of attachment relationships representations (Internal Working Models, Bowlby, 1973) are most likely to have been traumatic and thus to be least imbued with mental state representations.

### CORE TECHNIQUES

The focus in MBT is on stabilizing the sense of self and we have defined some core underpinning techniques to be used in the context of group and individual therapy. To implement these effectively, greater activity on the part of the therapist is required with more collaboration and openness than is implied in the classical analytic stance. The “blank analytic screen” has no role in the treatment of these patients. In psychodynamic treatment of borderline patients, the therapist has to become what the patient needs him to be, the vehicle for the alien self, the carrier of alternative but not destabilizing perspectives. And yet to become the alien self is to be lost to the patient as a provider of different perspectives and therefore of no help to him. The therapist must aim to achieve a state of equipoise between the two—allowing himself to do as required yet trying to retain in his mind as clear and coherent an image of his own state of mind along side that of the patients as is possible to achieve. This is what we have called the mentalizing stance of the therapist (Bateman & Fonagy, 2003) .

### ENHANCING MENTALIZATION

A therapist needs to maintain a mentalizing stance to help a patient develop a capacity to mentalize. Self-directed mentaliztic questions are a useful way of ensuring that a focus on mentalizing is maintained. Why is the patient saying this now? Why is the patient behaving like this? What might I have done that explains the patient's state? Why am I feeling as I do now? What has happened recently in the therapy or in our relationship that may justify the current state? These are typical questions that the therapist will be asking himself or herself within the mentalizing therapeutic stance and is perfectly at liberty to ask them out loud in a spirit of enquiry. This approach pervades the entire treatment setting. In group therapy, techniques focus on encouraging patients to consider the mental states and motives of other members as well as their own—"Why do you think that she or he is feeling as she does?"

Crucially, the therapist is not looking for complex unconscious reasons, but rather for the answers that common sense or folk psychology would sug-



gest to most reasonable people. Folk psychology is the natural and intuitive understanding of human action on the basis of mental states that we use ubiquitously in our interactions with each other and in our efforts to understand ourselves. Folk psychology includes the various mental concepts we naturally use, such as desires, feelings, goals, and beliefs. Folk psychology is much more than that; it encompasses the narrative structures in which these everyday psychological concepts are embedded, namely, the sequential stories that compose an autobiographical sense of self. In this broad sense, as Bruner aptly put it, folk psychology “is a culture’s account of what makes human beings tick” (Bruner, 1990, p. 13). We believe that even as professional clinicians, we rely far more on folk psychology than scientific psychology in our interactions with patients (Allen & Fonagy, 2002).

Focusing the therapist’s understanding of his or her interactions with the patient on the patient’s mental state will allow the therapist to link external events, however small, to powerful internal states that are otherwise experienced by the patient as inexplicable, uncontrollable, and meaningless. A focus on psychological process and the here and now, rather than on mental content in the present and past is implicit in this approach. An important indicator of underlying process and the here and now is the manifest affect that is specifically targeted, identified, and explored within an interpersonal context in MBT. The challenge for the professional working with the patient is to maintain a mentalizing therapeutic stance in the context of countertransference responses that may provoke the therapist to react, rather than to think. Understanding within an interpersonal context why the situation arose in the first place, why such an externalization became necessary, is the likely immediate solution to this challenge.

#### INTERPRETATION AND BEARING IN MIND THE DEFICITS

Bearing in mind the limited processing capacities of borderline patients in relation to attachment issues, patients cannot be assumed to have a capacity to work with conflict, to express feelings through verbalization, to use metaphor, to resist actions, and to reflect on content, all of which form part of standard psychoanalytic process. These attributes depend on a stable self-structure and ability to form secondary (symbolic) and perhaps tertiary representations (e.g., your feelings about my thoughts about your wishes) which buffer feelings, explain ideas, and give context and meaning to interpersonal and intrapsychic process. Borderline patients’ enfeebled mentalizing capacity and emergence of psychic equivalence means that feelings, fantasies, thoughts, and desires are experienced with considerable force because they cannot be symbolized, held in a state of uncertainty, and given secondary representation with meaning. Under these circumstances the use of metaphor and the interpretation of conflict is more likely to induce bewilderment and incomprehension than to heighten the underlying meaning of the discourse. The use of these techniques is minimised in MBT.

Yet the deficit in the capacity for mentalization can be masked by an apparent intellectual ability that lures therapists, especially during assessment, into believing that borderline patients understand the complexity of alternative perspectives, accept uncertainty, and can consider difference.

Sadly, these assessments are made before the therapist has become an attachment figure for the patient and deficits seen in BPD are to a large measure specific to attachment relationships. Once the attachment system is activated by the reliability and safety of the therapeutic setting, the patient's mentalization is likely to deteriorate and his or her deficits become more evident. Most obvious is the apparent lack of constancy, what may be described as the paradoxically ephemeral nature of apparently deeply held beliefs. In fact, at one moment a borderline patient may hold a particular view and yet at another time maintain the opposite is true and continuity of feeling, belief, wish, and desire may be lost between therapeutic sessions. Although in some patients this would lead to conflict because two ideas, even if opposing, can be held in mind at the same time, contemplating genuine alternatives is often experienced as toxic to the self-structure of the borderline patient and so it is avoided. Here lies the root of what is described as "black and white thinking" in the cognitive behavioral therapy (CBT) literature and is referred to as "splitting" by psychoanalysts. Constancy of belief and consistent experience of others elude the borderline patient, resulting in idealization at one moment and denigration the next. The task of the therapist is to establish continuity between sessions, to link different aspects of a multicomponent therapy, to help the patient recognize the discontinuity, and to scaffold the sessions without holding the patient to account for sudden switches in belief, feeling, and desire. The borderline patient does not lie but is unable to hold in mind different representations and their accompanying affects at any one time. All are equally true, and the therapist must accept the balance between opposing perspectives and work with both even though they appear contradictory.

#### USE OF TRANSFERENCE

In many respects, our approach to transference owes much to that of Otto Kernberg, John Clarkin, Frank Yeomans and their group (Kernberg, Clarkin, & Yeomans, 2002; Clarkin, Yeomans, & Kernberg, 1998; Clarkin, Foelsch, & Kernberg, 1996; Clarkin et al., 1999; Kernberg, 1992). We clearly share a dynamic approach to the understanding of mind and a therapeutic approach that stresses understanding, interpretation, and a focus on affect. However, there are also important differences and nowhere are these differences more clear than in our approach to the transference. In transference focused psychotherapy (TFP) patients are seen as re-establishing dyadic relations with their therapists that reflect rudimentary representations of self-other relationships of the past (so called part-object relationships). TFP considers the externalization of these self-object-affect triads to be at the heart of therapeutic interventions. For the MBT model, the role relationships established by the patient through the transference relationship are considered preliminary to the externalization of the parts of the self the patient wishes to disown. To achieve a state of affairs where the alien part of the self is experienced as outside rather than within, the patient needs to create a relationship with the therapist through which this externalization may be achieved. Once it is achieved, and unwanted parts of the self are felt to be reassuringly outside rather than within, the patient has no interest in the rela-



tionship with the therapist and may wish to repudiate it totally. Focusing the patient's attention on the relationship can be felt by them as undermining their attempts at separating from the disowned part of themselves and consequently be counterproductive.

It is therefore important that exploration within the transference is built up over time and there is a de-emphasis on reconstruction. Transference distortion is used as a demonstration of alternative perspectives—a contrast between the patient's perception of the therapist or of others in the group and that of others. At first, reference to different perspectives and internal influences that may be driving them should be simple and to the point. Both patient and therapist have to start from a position of “not knowing” but trying to understand. Direct statements about the relationship between the patient and therapist may stimulate anxiety and be experienced as abusive. Only toward the middle or end of therapy when stable internal representations have been established is it likely to be safe to use the “heat” of the relationship between patient and therapist in a more direct way to explore different perspectives.

Transference is not seen as the primary vehicle for change in the patient's representational system. We are not suggesting that therapists avoid transference, which is essential for effective treatment. We suggest that its use is incremental and moves from distance to near depending on the patient's level of anxiety. Most patients with severe BPD rapidly become anxious in intimate situations and too sharp a focus on the patient-therapist relationship leads to panic that is manifested as powerful and, sometimes uncontrollable, expressions of feeling. This leads to a dissociative experience and a sense that their own experience is invalid. If such transference interpretations are made, then the patient is immediately thrown into a pretend mode and gradually patient and therapist may elaborate a world, which however detailed and complex, has little experiential contact with reality. Alternatively, the patient either angrily and contemptuously drops out of therapy, feeling that their problems have not been understood, mentally withdraws from treatment, or establishes a false treatment that looks like therapy but is in fact two individuals talking to themselves.

#### RETAINING MENTAL CLOSENESS

Retaining mental closeness is the primary vehicle of MBT. It is done simply by representing accurately the current or immediately past feeling state of the patient and its accompanying internal representations and by strictly and systematically avoiding the temptation to enter conversation about matters not directly linked to the patient's beliefs, wishes, feelings, etc. The initial task in MBT is to stabilize emotional expression because without improved control of affect there can be no serious consideration of internal representations. Although the converse is true to the extent that without stable internal representations there can be no robust control of affects, identification and expression of affect is targeted first simply because it represents an immediate threat to continuity of therapy and potentially to the patient's life. Uncontrolled affect leads to impulsivity and only once this is under control is

it possible to focus on internal representations and to strengthen the patient's sense of self.

The therapist must be able to distinguish between his or her own feelings and those of the patient and be able consistently to demonstrate this distinction to the patient. Specifically, feelings belonging to the therapist must not be attributed to the patient or interpreted as such. This repeats the developmental trauma of the patient who, as we have suggested, takes others' feelings and representations in as part of himself or herself but these fail to map onto his or her own state and lead to destabilization of the self-structure or an illusory stabilization.

A mismatch or discrepancy between the representation of the patient's state by the therapist and the actual state of the patient compels patients and therapists to examine their own internal states further and to find different ways of expressing them if communication is to continue. In addition, the therapist has to be able to examine his or her own internal states and be able to show that they can change according to further understanding of the patient's state. Similar descriptions have been advanced by those who place therapeutic emphasis on breaches, negotiations, and repairs of the therapeutic alliance (Safran & Muran, 2000).

#### WORKING WITH CURRENT MENTAL STATES

There can be little therapeutic gain from continually focusing in the past. Recovering memories is now recognized as a somewhat risky aim with BPD patients (Brenneis, 1997). We would wish to add to these risks the possibility of encouraging borderline patients to enter a pretend - psychic equivalent mode of relating. In this mode, patients (unbeknownst to the therapist) no longer use the same circumspect subjective criteria of historical accuracy, which most of us do but rather assume that because they experience something in relation to a childhood (usually adult) figure, it is bound to be true. To avoid these risks, the focus of MBT needs to be on the present state and how it remains influenced by events of the past, rather than on the past itself. If the patient persistently returns to the past, the therapist needs to link back to the present, move the therapy into the "here and now," and consider the present experience.

Intense feelings about remembered experiences are felt in the present and should be dealt with as a current experience. They are not explored as a justified or unjustified reaction to a past event. Rather, the therapist assumes that regardless of the past significance of the experience, something (internal or external) in the current life of the patient triggered the memory and the trigger, rather than the memory, must be the focus of the exploration.

#### BRIDGING THE GAPS

The absence of adequate second-order (symbolic) representations of self-states creates a gap between the primary affective experience of the borderline patient and its meaning and a continuous and intense desire for understanding what is experienced as internal chaos. This gap has to be

bridged in therapy with a view to strengthening the secondary representational system.

In MBT, the therapist focuses on simple interchanges that show how he or she believes the patient is experiencing him or her, and avoids describing a complex mental state to the patient. Interpreting a more complex psychological process, however accurate or inaccurate it may be, either pushes the patient into pretend mode or creates instability in which the patient becomes more and more uncertain and confused about himself as the contradictions and uncertainties are pointed out. Change is generated in borderline patients by brief, specific interpretation and clear answers to questions. Clever ideas from the therapist too early in therapy stimulate pretend mode and are used by the patient to stabilize himself or herself in a labyrinth of thought with no connection, depth, or personal meaning and the gravest danger for the therapist is filling the gap in this way rather than bridging it. The patient appears to make rapid gains in therapy as he takes on and develops comments and interpretations from the therapist. But this is an illusion and leads to pretend therapy, which is ultimately shallow and barren (although, in our experience at least, not uncommon with this group of patients). There are a number of clues that make it clear that this evident high degree of mentalization is more apparent than real. First, it has an obsessive character. Second, it becomes apparent over time that there can be dramatically different mental models of things which are readily exchangeable. The patient appears unaware of this contradiction and expresses surprise if challenged by the therapist. In general it is best not to confront the patient with inconsistency, at least initially, since, in pretend mode, they have no access to their previous understanding of others. Third, their elaboration is overly rich and frequently assumes complex and improbable unrealistic aspects. Talking to them about their own thoughts and feelings leads to rapid agreement without obvious scrutiny and when reflectiveness occurs it doesn't seem to have any ramifications. Finally, there is no "felt feeling" or mentalized affectivity (Fonagy et al., 2002). The concept pertains to the integration of emotional experience with knowledge of its origin, relevance, and meaning. The patient who talks about affect that is not felt at the same time is severing the internal connection between second-order representations and constitutional self-states. The sessions become empty.

#### MENTALIZATION: THE COMMON THEME IN PSYCHOTHERAPEUTIC APPROACHES TO BPD

It is perhaps inevitable that approaches to treatment of BPD share common structural features (Bateman & Fonagy, 2000) but we would argue that the potential effectiveness of all treatments depends not so much on their frame but on their ability to increase a patient's capacity to mentalize.

In a condition characterized by disturbance in relationships, it is not surprising that the establishment of reasonable relationship processes in the therapeutic context is in the foreground of most approaches. Although it is relatively easy to discuss this topic under the heading of nonspecific factors in psychological therapy that contribute to the effectiveness of all forms of psychotherapy (Wampold, 2001), we believe that it is desirable to be far

more precise about the specific aspects of relationship processes that are therapeutic for individuals with BPD; hence the guiding construct of our therapeutic approach that psychotherapy with borderline patients should focus on the capacity for mentalization. We believe that an important common factor in the psychotherapeutic approaches to BPD is the shared potential to recreate an interactional matrix of attachment in which mentalization develops and sometimes flourishes. The therapist mentalizes the patient in a way that fosters the patient's mentalizing, which is a key facet of the therapeutic relationship. The crux of the value of psychotherapy with BPD is the experience of another human being having the patient's mind in mind. That is, we consider the process of interpretation to be at the heart of the therapy, rather than the content of the interpretations or the nonspecific, supportive aspects of therapy. The explicit content of interpreting is merely the vehicle for the implicit process that has therapeutic value.

We recognize that this is not by any means a novel approach. Concepts such as insight, empathy, the observing ego, and even introspection have been in existence throughout the "psychotherapeutic century" (Fonagy et al., 2002). The concept of mentalization, in our view, crystallizes the biological and relational processes that underpin the phenomena that these venerable clinical concepts denote. It is important to remind ourselves that mentalization is not the same as introspection. Mentalization can be both implicit and explicit. Implicit mentalization is a nonconscious, unreflective, procedural function. As Simon Baron-Cohen stated: "We mind-read all the time, effortlessly, automatically and mostly unconsciously." (Baron-Cohen, 1995). Explicit mentalization is only likely to happen when we hit an interactive snag (Allen, 2003). Explicit mentalization, particularly when it is of a higher order, can be the apparent substance of psychological therapy, for example Person A can reflect on his awareness of what Person B thinks about Person A's feelings or thoughts—a technique used specifically in our group therapy.

So what are the strong arguments in favor of mentalization as a key aspect of effective psychotherapeutic process? First, the foundation of any therapeutic work must by definition be implicit mentalization. Without social engagement there can be no psychological therapy, and without mentalization there can be no social engagement. Secondly, since the work of John Bowlby (Bowlby, 1988) it has generally been agreed that psychotherapy invariably activates the attachment system and as a component generates secure base experience. In our view, this is important because the attachment context of psychotherapy is essential to establishing the virtuous cycle of synergy between the recovery of mentalization and secure base experience. The experience of being understood generates an experience of security, which facilitates "mental exploration," the exploration of the mind of the other to find oneself therein.

Third, the therapist of all patients, but particularly those whose experience of their mental world is diffused and confusing, will continually construct and reconstruct in their own mind an image of the patient's mind. They label feelings, they explain cognitions, they spell out implicit beliefs. Importantly, they engage in this mirroring process, highlighting the marked

character of their verbal or nonverbal mirroring display. Their training and experience further hones their capacity to show that their reaction is related to the patient's state of mind, rather than their own. It is this often rapid nonconscious implicit process that enables the patient with BPD to apprehend what he feels.

Fourth, mentalizing in psychological therapies is prototypically a process of shared, joint attention where it is the mental state of the patient where the interests of patient and therapist intersect. The shared attentional processes entailed by all psychological therapies in our view serve to strengthen the interpersonal integrative function made up of affect regulation, effortful control by attentional mechanisms, and mentalization (Fonagy, 2003). It is not simply what is effortfully focused on by both patient and therapist that we consider therapeutic from this point of view, but the fact that patient and therapist can jointly focus on a shared aspect of subjectivity.

Fifth, the explicit content of the therapist's intervention will be mentaliztic regardless of orientation, whether the therapist is principally concerned with transference reactions, automatic negative thoughts, dialectics, reciprocal roles, or linear thinking. These approaches all entail explicit mentalization in so far that they succeed in enhancing coherent representations of desires and beliefs. This is supported by the common experience that such efforts at explicit mentalization will not be successful unless the therapist succeeds in drawing the patient in as an active collaborator in any explication. One may view psychotherapy for borderline individuals as an integrative process where implicit and explicit mentalization are brought together in an act of "representational redescription," the term Annette Karmiloff-Smith (Karmiloff-Smith, 1992) used to refer to the process by which "implicit information in the mind subsequently becomes explicit knowledge to the mind." (p. 18).

Finally, the dyadic nature of therapy inherently fosters the patient's capacity to generate multiple perspectives. For example, the interpretation of the transference is viewed as presenting an alternative perspective on the patient's subjective experience. We view this as optimally freeing the patient from being restricted to the reality of one view, experiencing the internal world in a mode of psychic equivalence. This process also becomes accessible through engagement in group psychotherapy. In either setting, mental states are represented at the secondary level and are therefore more likely to be recognized as mental representations. It should be remembered that this will only be helpful if implicit and explicit mentalization have not been dissociated and feelings are genuinely felt, rather than just discussed.

## CONCLUSION

It is our belief that the relatively safe (secure base) attachment relationship with the therapist provides a relational context in which it is safe to explore the mind of the other in order to find one's own mind within it. This is a unique experience for individuals with BPD because their pathology serves to distort the subjective experience of the other to a point where they have little hope of finding their constitutional self. The maladaptive interpersonal processes, whether we label these projective identification or pathological

reciprocal roles, in most ordinary social contexts only enable these patients to find in their social partner parts of themselves that they desperately needed to discard in the first place, be that terror, contempt, excitement, or pain.

The engagement in a psychotherapeutic context, either individually or in groups, or we believe, preferably both, does far more than provide nurturance, warmth, or acceptance. A limitation of therapy lies in the therapist's capacity to mentalize, constricted by his or her own attachment history, his or her current interpersonal circumstances, and his or her constitutional capacities. It is the threat to the mentalizing capacities of the therapist that borderline patients represent that Gabbard (2003) has so helpfully drawn our attention to. Our capacity to mentalize freely is readily compromised by the patient's insistent use of psychic equivalence and pretend modes of representing subjectivity. These, and the experience of our minds being taken over by the alien parts of the patient's self, may dramatically curtail our value to these patients when we feel unsafe, threatened, depressed, or just empty of mind in their presence.

Placing mentalization as central to therapy with borderline patients may unify numerous effective approaches to the treatment of this challenging group of patients. Although providing a common understanding of why a range of disparate approaches all "work," the implication of this formulation is not that all approaches are equally effective and the best approach is a judicious combination of existing techniques. Therapists will need to ensure that whatever techniques they use, mentalization is kept firmly in mind.

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