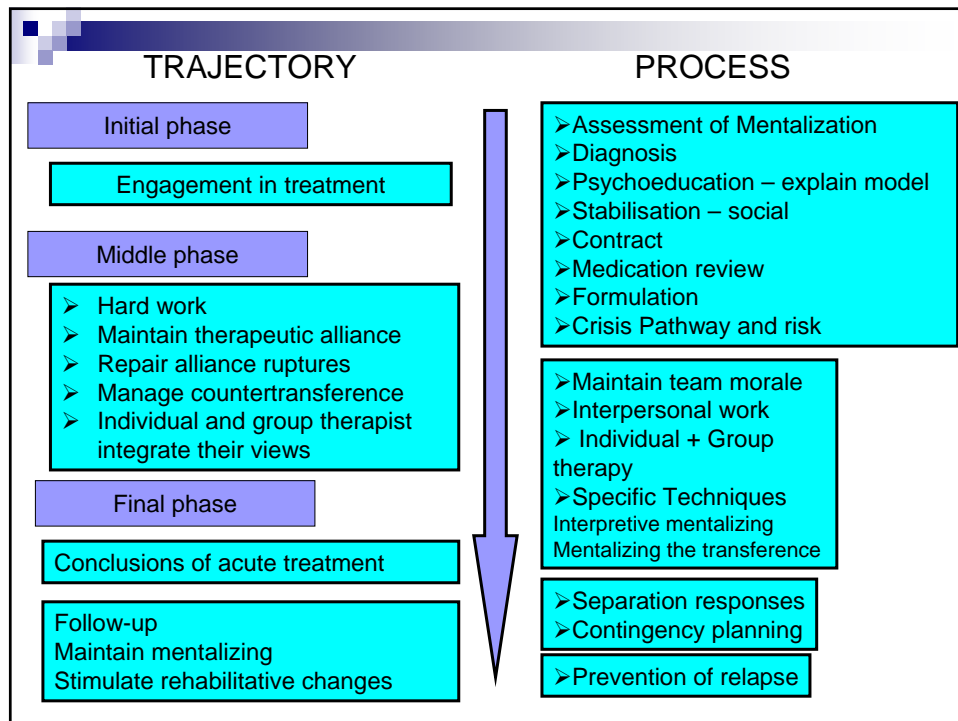


Structure of Mentalization Based Treatment



Formulation: Content

- Aims
 - Organise thinking for therapist and patient – each sees different minds
 - Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exemplified)
 - Modelling humility about nature of truth
- Management of risk
 - Analysis of components of risk in intentional terms
 - Avoid over-stimulation through formulation
- Beliefs about the self
 - Relationship of these to specific (varying) internal states
 - Historical aspects placed into context
- Central current concerns in relational terms
 - Challenges that are entailed
- Positive aspects
 - When mentalisation worked and had effect of improving situation
- Anticipation for the unfolding of treatment
 - Impact of individual and group therapy

Large group exercise

- A patient in emotional crisis telephones you to say that she feels useless and nothing can be done. Even her boyfriend doesn't answer the phone and she feels something awful is going to happen.
 - Talk to her on the phone for a few minutes
 - Observers to note mentalizing and non-mentalizing statements of therapist



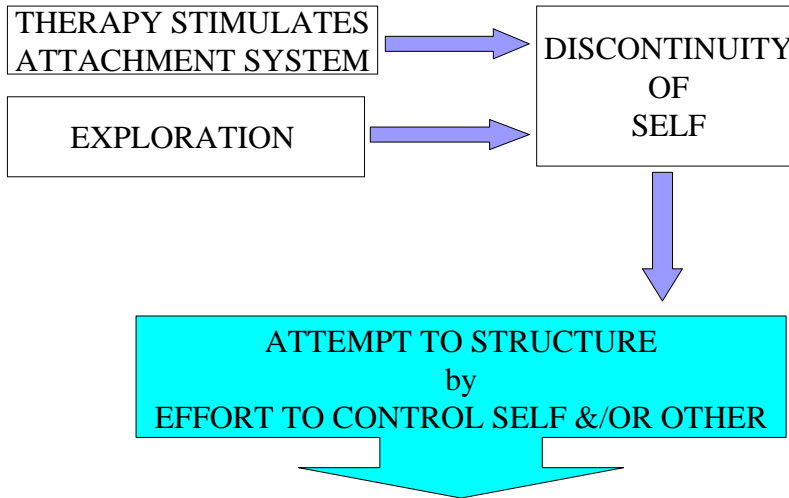
Large Group Exercise

- A patient calls you to say that he has had enough. He feels that no one cares about him. He doesn't know what to do.
 - Talk to him on the phone
 - Observers to note mentalizing and non-mentalizing statements of therapist



Therapist stance

Therapist/Patient Problem



Therapist/Patient Problem



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 your own mistakes

- Model honesty and courage via acknowledgement of your own mistakes
 - Current
 - Future
- Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings

Therapist stance

- Empathic is about how they are thinking and feeling, getting them to describe important
- Cannot explore before empathy
- Use not knowing what to say as clue that something does not make sense and there is something to be curious about
- Curiosity about experience, probing about patients experience serves to validate the experience
- Normalizing is component of moving to transference work – stating feelings in first person: “I would feel X, so surprised you appear not to...”

Essential to the Stance

- Keep it current – what the patient feels right now
- Start by empathising – finding a way of stating that you genuinely understand distress
- Explore in the relational realm not just the intrapsychic
- Lower arousal by bringing it to the person of the therapist
 - What have I done?
- Stick to mentalizing aim in somewhat dogged manner
- Quickly step back if patient seems to lose control

Therapist Stance

- **Reflective enactment**
 - Therapist's occasional enactment is acceptable concomitant of therapeutic alliance
 - Own up to enactment to rewind and explore
 - Check-out understanding
 - Joint responsibility to understand over-determined enactments

Therapist Stance Implicit Mentalization

- The therapist is continually constructing and reconstructing an image of the patient, to help the patient to apprehend what he feels
- Mentalizing in psychotherapy is a process of joint attention in which the patient's mental states are the object of attention
- Neither therapist nor patient experiences these interactions other than impressionistically

Therapist Stance Explicit Mentalization

- Not directly concerned with content but with helping the patient
 - to generate multiple perspectives on the fly →
 - to free himself up from being stuck in the “reality” of one view (primary representations and psychic equivalence) →
 - to experience an array of mental states (secondary representations) and →
 - to recognize them as such (meta-representation).
- Explication draws attention back to implicit representations—feelings for example
 - use language to bolster engagement on the implicit level of mentalization
 - highlight the experience of “feeling felt” (mentalized affectivity)

Therapist Stance Mentalization

- Therapist continually questions his and patient's internal mental state:
 - What is happening now?
 - Why is the patient saying this now?
 - Why is the patient behaving like this?
 - Why am I feeling as I do now?
 - What has happened recently in the therapy that may justify the current state?

Therapist Stance Mentalization

- Using questioning comments to promote exploration
 - What do you make of what has happened?
 - Why do you think that he said that?
 - I wonder if that was related to the group yesterday?
 - Perhaps you felt that I was judging you?
 - What do you make of her suicidal feeling (in the group)?
 - Why do you think that he behaved towards you as he did?

Therapist Stance

Highlighting alternative perspectives

- I saw it as a way to control yourself rather than to attack me (patient explanation), can you think about that for a moment
- You seem to think that I don't like you and yet I am not sure what makes you think that.
- Just as you distrusted everyone around you because you couldn't predict how they would respond, you now are suspicious of me
- You have to see me as critical so that you can feel vindicated in your dismissal of what I say

Contrary Moves

Patient/Therapist	Therapist/Patient
Knowing	Unknowing
Self- reflection	Other reflection
Emotional distance	Emotional closeness
Certainty	Doubt

Clinical summary of intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- Explore current emotional context in session by identifying the momentary affective state between patient and therapist
- Identify your contribution to the break in mentalizing
- Seek to mentalize the transference

Workshop Exercise

- Patient to talk about incidents in his/her life
- Therapist
 - Inquisitive stance
 - Therapist to focus patient attention on current situation
 - Stimulate alternative perspectives
 - Demonstrate humility - not knowing
 - Make an error
 - Accepting your own misunderstanding
 - Focus on the incident
 - Intervene to move non-mentalizing to mentalizing
 - Explore the incident

Workshop Exercise

- Patient reports that he has got into an argument at work and suspended pending an inquiry.
- Therapist
 - Inquisitive stance
 - Therapist to focus patient attention on current situation
 - Explore the incident
 - Elaborate mental states of protagonists
 - Stimulate alternative perspectives
 - Demonstrate humility - not knowing
 - Monitor for non-mentalizing and try to Intervene to move patient to mentalizing

Video

Therapist Stance (0-5 & 6.40-7.30)



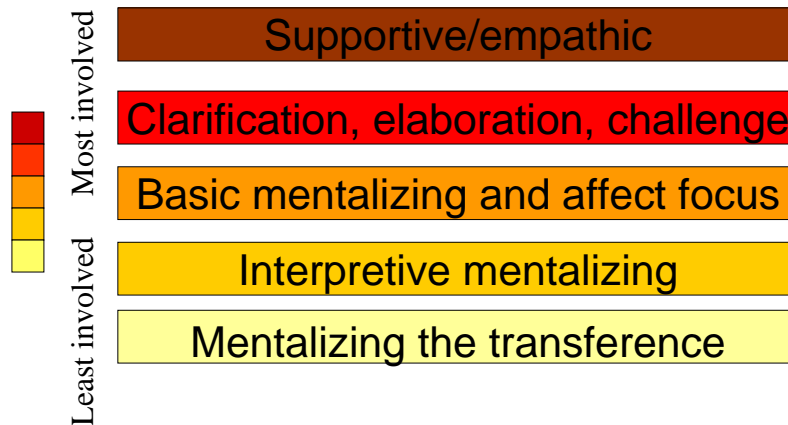
The mentalizing focus



Interventions: principles

- Simple
- Affect focused but remember most reactions are about survival
- Focus on patients mind (not on behaviour)
- Relate to current event or activity – mental reality (evidence based or in working memory)
- De-emphasise unconscious concerns in favour of near-conscious or conscious content

Interventions: Spectrum



Interventions: Supportive & empathic

- Respectful of their narrative and expression
- Positive/hopeful but questioning
- Unknowing stance – you cannot know their position
- Demonstrate a desire to know and to understand
- Constantly check-back your understanding – ‘as I have understood what you have been saying is...
- Spell out emotional impact of narrative based on common sense psychology and personal experience
- For the patient but not acting for them – retains patient responsibility

Interventions: Supportive & empathic

- **Identifying and exploring positive mentalizing**
 - judicious praise – ‘you have really managed to understand what went on between you’
 - Examine how it feels to others when such mentalizing occurs – ‘how do you think they felt about it when you explained it to them’
 - Explore how it feels to self when an emotional situation is mentalized – ‘how did working that out make you feel’
- **Identifying non-mentalizing fillers**
 - Fillers: typical non-mentalizing thinking or speaking, trite explanations
 - Highlight these and explore lack of practical success associated with them

Interventions: Supportive & empathic

- **Provoke curiosity about motivations**
 - Highlight own interest in ‘why’
 - Qualify own understanding and inferences – ‘I can’t be sure but’; ‘may be you’; ‘I guess that you’
 - Guide others’ focus towards experience and away from “fillers”
 - Demonstrate how such information could help to make sense of things



Clarification and Affect Focus



Intervention: Clarification & Affect elaboration

■ Labelling feelings

- During non-mentalizing interaction therapist firmly tries to elicit feelings states
- Therapist recognises mixed emotions– probe for other feelings than first, particularly if first emotion is unlikely to provoke sympathy in others or lead to rejection (e.g. frustration, or anger)
- Reflect on what it must be like to feel like that in that situation
- Try to learn from individual what would need to happen to allow them to feel differently
- How would you need others to *think about you*, to feel differently?

Intervention:

Clarification & Affect elaboration

- Clarification is the 'tidying up' of behaviour which has resulted from a failure of mentalization
- Establish important 'facts' from patient perspective
- Re-construct the events
- Make behaviour explicit– extensive detail of actions
- Avoid mentalizing the behaviours at this point
- Trace action to feeling
- Seek indicators of lack of reading of minds

Current affective interpersonal experience

- Define the current affective state shared between patient and therapist
- Do this tentatively from your own perspective
- Do not suggest it is the patient's experience
- Link the current affective state to therapeutic work within the session itself

Therapist Affect

- Focus the patient's attention on therapist experience when it offers an opportunity to clarify misunderstandings and to develop prototypical representations
 - Highlight patient's experience of therapist
 - Use transference to emphasise different experience and perspective
 - Negotiate negative reactions and ruptures in therapeutic alliance by identifying patient and therapist roles in the problem

Challenge

Intervention: Challenge

- Aim is to 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 if they seem to respond
- Intervention should be outside the expected frame
- Use humour when possible

Intervention: Challenge

- **Stop and Stand**
 - Persist and decline to be deflected from exploration - 'Bear with me, I think we need to continue trying to understand what is going on'
 - Steady resolve - 'I can understand that you want me to support what you are doing but I don't think that would be right because...'
 - Convert deceit into frank truth - 'although you feel he has so much that he wouldn't miss it, the fact is that having stolen it you are a thief'
 - Identify affect attached to action – 'I can see that although you tried not to 'con' them, the pleasure and delight of doing it seems to have been stronger'
 - Ensure 'here and now' aspects are included in the challenge

Intervention: Challenge

■ Stop and Stand

- Clarify your boundary (should be a repetition of boundary agreed when therapy began) whilst giving your understanding of patients position in relation to it – ‘I think that you continue to attend simply so that you can force me to watch you deteriorate but I can’t continue to do that. We need to tackle this.
- When all avenues explored state impasse – ‘As far as I can tell we are going round in circles. When I say something you simply dismiss it as rubbish and whilst I am willing to accept that it sometime is, I cannot accept that it always is.
- Recruit group members to recognise impasses and shift from ‘dialogue of the deaf’ to a mentalizing discussion
- State own position – ‘If we can’t get around this I may have to say that treatment has failed and should finish
- Monitor countertransference to ensure no acting out by therapist

Workshop Exercise – Stop and Stand

- Patient – describe something in your life and in doing so make some gross assumptions either about the therapist or about someone in your story
- Therapist
 - Use techniques learned so far
 - Stop and stand

Basic Mentalizing

Interventions: Basic Mentalizing

- **'Stop, Listen, Look'**
 - During a typical non-mentalizing interaction in a group
 - stop and investigate
 - Let the interaction slowly unfold – control it
 - highlight who feels what
 - Identify how each aspect is understood from multiple perspectives
 - Challenge reactive “fillers”
 - Identify how messages feel and are understood, what reactions occur
 - What do you think it feels like for X?
 - Can you explain why he did that?
 - Can you think of other ways you might be able to help her really understand what you feel like?
 - How do you explain her distress/overdose
 - If someone else was in that position what would you tell them to do
- **Recruiting**
 - Gemma is obviously angry. Can anyone help her with this because I wonder if beneath it she is beginning to feel ignored

Interventions: Basic Mentalizing

■ **Stop, Re-wind, Explore**

- Lets go back and see what happened just then. At first you seemed to understand what was going on but then...
- Lets try to trace exactly how that came about
- Hang-on, before we move off lets just re-wind and see if we can understand something in all this.

■ **Labeling with qualification** (“I wonder if...” statements)

- Explore manifest feeling but identify consequential experience – ‘Although you are obviously dismissive of them I wonder if that leaves you feeling a bit left out?’
- ‘I wonder if there are some resentments that make it hard for you to allow yourself to listen to rules. Lets think about why the rules are there?’
- ‘I wonder if you are not sure if it’s OK to show your feelings to other people?’

Workshop Exercise

- Patient does not feel that you understand and think that it would be better to have another therapist.

■ Therapist

- Clarification
- Elaboration and affect focus
- Stop and stand if necessary
- Rewind and explore
- Work within the current relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.

Workshop Exercise

- Patient has been shouting at staff. Therapist has to address what has been happening.
- Therapist
 - Clarification
 - Elaboration and affect focus
 - Stop and stand if necessary
 - Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.

Transference and
Countertransference

Interventions: Interpretive Mentalizing

■ **Transference tracers – always current**

- Linking statements and generalization
 - 'That seems to be the same as before and it may be that
 - 'So often when something like this happens you begin to feel desperate and that they don't like you'
- Identifying patterns
 - It seems that whenever you feel hurt you hit out or shout at people and that gets you into trouble. May be we need to consider what happens otherwise.
- Making transference hints
 - I can see that it might happen here if you feel that something I say is hurtful
- Indicating relevance to therapy
 - That might interfere with us working together

Interventions: Mentalizing the Transference

■ **Working in the transference**

- Emphasis on current
- Demonstrate alternative perspectives
- Contrast patient's perception of the therapist to self-perception or perception of others in the group
- Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
- Highlight underlying motivation as evidenced in therapy

Components of mentalizing the transference

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist's own distortions)
- Collaboration in arriving at an understanding
- Present an alternative perspective
- Monitor the patient's reaction
- Explore the patient's reaction to the new understanding

Interventions: Mentalizing the Transference

- **Dangers of using the transference**
 - Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient feel that whatever is happening in therapy is unreal
 - Thrown into a pretend mode
 - Elaborates a fantasy of understanding with therapist
 - Little experiential contact with reality
 - No generalization

Components of mentalizing the countertransference

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.

Typical Countertransferences

- Pretend mode
 - Boredom, temptation to say something trivial
 - Sounding like being on autopilot, tempting to go along
 - Lack of appropriate affect modulation (feeling flat, rigid, no contact,)
- Teleological
 - Anxiety
 - Wish to DO something (lists, coping strategies)
- Psychic equivalence
 - Puzzlement, confused, unclear, excessive nodding
 - Not sure what to say, just going
 - Anger with the patient

Workshop Exercise

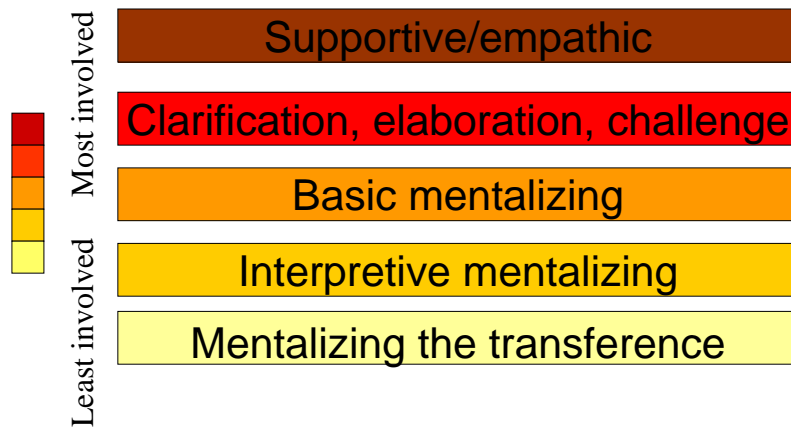
- Patient states that when you are going on holiday next week they will kill themselves. It will be your fault..
- Therapist
 - Affect focused clarification
 - Elaboration in context of current relationship
 - Work within the relationship
 - Mentalize the transference

Workshop Exercise to use Basic Mentalizing and mentalizing transference

- Patient – Discuss an important relationship and allow the story to unfold when prompted
- Therapists: Basic mentalizing
 - Stop, Look, and Listen and explore important content
 - Stop, rewind, and explore
 - Stop and stand if patient uses non-mentalizing
- Therapist: transference tracers and mentalizing the transference

Guidance on which intervention when

Interventions: Spectrum





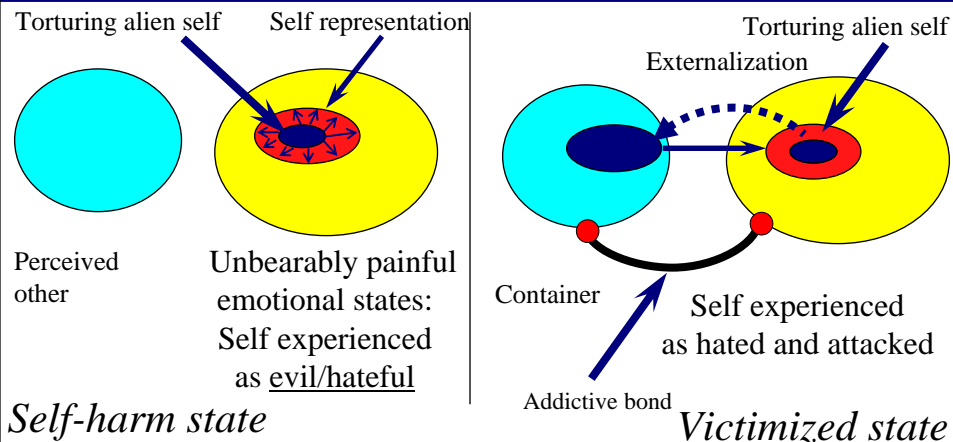
Which Intervention to use when?

- If in doubt start at the surface – support and empathy
- Move to ‘deeper’ levels only after you have performed the earlier steps
- If emotions are in danger of becoming overwhelming take a step towards the surface



Clinical Intervention:
Self Harm and the
Alien Self

Theory: Self-destructiveness and Externalisation Following Trauma



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.

You are a child, quite possibly you are just making this up for some attention, finding an excuse for why you can't stay in college or get a job. Maybe you don't have an excuse, you are just a stubborn little child.

From what everyone tells you perhaps that is true.

You have doubt. You are willing to listen to someone else.

For now that is the only reason why you are not, at this moment trying to do it.

Understanding suicide and self-harm 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 →
suicide attempts, self-cutting*

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 feel anxious that you might do something?' → Mentalizing functional analysis

How do I deal with? Self-harm

■ Affect

- Feeling of badness = I am bad (psychic equivalence) = Self-harm
- Explore rejection, loss, hurt, abandonment, and panic
- Emptiness and experience of a void or 'black hole'
- Link to context

Mentalizing Functional Analysis

- Stop and Rewind to point before mentalizing was lost
- Stop and Explore a point when mentalizing was taking place – system restore!
- Micro-slice mental states towards the self destructive act
- Continually move around self and other mental states
- Place responsibility for keeping mind on-line back with the patient
- Ask patient to identify when she could have possibly re-established self-control

Mentalizing Functional Analysis

- Empathy and support
 - You must not have known what to do?
 - Oh dear! That must be disappointing after all this time.
 - Define interpersonal context
 - Detailed account of days or hours leading up to self-harm with emphasis on feeling states
 - Moment to moment exploration of actual episode
 - Explore communication problems
 - Identify misunderstandings or over-sensitivity
 - Identify affect
 - Explore the affective changes since the previous individual session linking them with events within treatment
 - Review any acts thoroughly in a number of contexts including individual and group therapy.

Mentalizing Functional Analysis

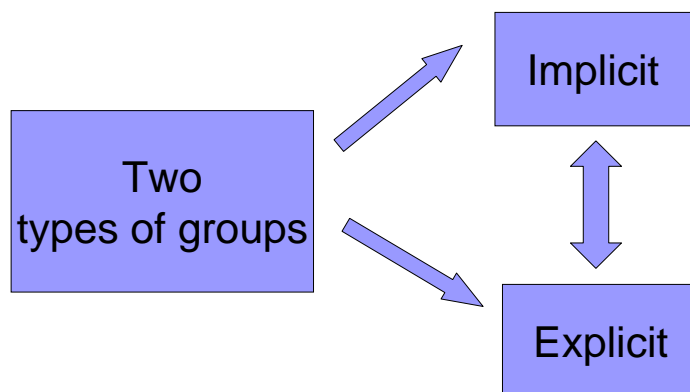
- Explore conscious motive
 - How do you understand what happened?
 - Who was there at the time or who were you thinking about?
 - What did you make of what they said?
 - Challenge the perspective that the patient provides if therapeutic alliance is robust
- DO NOT
 - mentalize the transference in the immediacy of a suicide attempt or self-harm
 - Interpret the patient's actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the 'heat' of the moment. It will alienate the patient.

Workshop exercise

- Patient describes having cut himself and requiring sutures.
- Therapist
 - Identify feelings
 - Develop context
 - Integrate the relationship with you in the discussion
 - Aim to re-instate a continuity of self-structure by kick starting mentalizing
 - If unsuccessful work on what you and patient are to do

Mentalizing and Group Psychotherapy

Mentalizing and Groups





i-MBT

An introduction to mentalising



iMBT Structure

- 2 therapists
- Observer(s)
- 6-12 members
- 12 sessions of 1.5 hours
- Diagnoses definite or probable BPD

Explicit Mentalizing Group

■ Exercises

- are arranged in a sequence progressing from emotionally 'distant' scenarios to some which are more personalized.
- Are related to personal experience only when the group have developed a cohesive atmosphere and some trust has been established between participants.
- are developed to ensure that there is a focus on 'self' or 'other' and on the perceptions and experiences of others about self or self about others.
- Move between explicit and implicit mentalizing


Introductory part of 1st session

- Introductions
- Details of group times, duration, structure etc
- Rules of group (eg confidentiality, alcohol)
- Information sheet provided
- Topics
 - Personality structure
 - Emotions, cognitions, behaviours
 - The interpersonal realm



Structure of each session

- Feedback from previous session and task
- Activity to explore mentalising
- Information provided
- Task for the week



MBT Lite Introductory Week 1

What is mentalising?

- Discussion of what is in our mind
- What does it involve
- Being aware of thoughts and feelings
- Is it the same as empathy
- Includes oneself as well as others
- Mentalising and emotion - Disrupts mentalising

MBT Lite Introductory Week 1

- Clinical examples given
 - Making assumptions – my boss does not say hello to me. This means he does not like me.
 - I later rant at someone unnecessarily
 - Becoming ruminative
 - Certainty
- Exercise to take home – Notice moments of non-mentalising in self and others

MBT Lite Introductory Week 2

What is personality?

- Each group starts with open feedback for 15 mins
- Developmental perspective
- How do we experience personality
- What is likely to disturb sense of identity
- What happens when identity disturbed or threatened
- What if we protect ourself via destructive acts to self or others

Examples of activities

- Talk to your neighbour: what are your expectations of the group?
- Look at photos provided. What is the person feeling?
- Someone is ½ hour late for you (or vice versa). What are you feeling, thinking?
- Select an object that reflects something about you.
- Think of a time you withdrew from someone you know quite well

Examples of information provided

- Mentalising
- Borderline PD
- Assumptions
- Attachment
- Cognitions
- Anxiety curve and the pause button



Examples of Tasks

- Be aware of changes in your mood and what might be causing them
- Monitor own attachment behaviour
- Monitor own reading of others' behaviour
- Monitor others' reactions to us



MBT Group

Interactive and intersubjective
mentalising

Basic Group Techniques

- Open questions
- Circular questioning, curiosity, empathic challenge, exploring narrative, normalisation, alliance, boundaries,
- Multiplicity of perspectives
- Intersubjective space in here and now
- Interpersonal
- BAN group interpretations OR group explanation/comment

Concurrent MBT Group

- Combined 'v' Conjoint
 - Combined = same therapist individual and group
 - Conjoint = separate therapists
- Advantages/disadvantages for each

Ivaldi et al (2007)

- Combined individual and group cognitive-evolutionary therapy (mostly borderline PD) (n=85) 'v' individual cognitive-evolutionary therapy as a single modality (n=24).
- Results seemed to favour the combined treatment on a range of outcome measures (drop out rates, GAF, symptom reduction, quality of life and self harm).

Group Analysis

- The central idea of group analysis is that the individual develops through the very acts of becoming a responsible group member through negotiations with the other group members
 - rules and regulations
 - confidentiality
 - norms of behavior
 - needs for sharing and tolerance
 - participating in creating the group mentality that encourages exploration of shameful affects and thoughts.
- The group analytic slogan for such group themes is "leave it to the group".

MBT group

- *Primary task of the group is to provide a training ground for mentalization*
- Closer to (American) psychodynamic group psychotherapy than group analysis.
- More individually oriented.
- Therapists do not wait to see how “the group deals with it”
- Intervene when there is an opportunity for, or need for, mentalizing work.
- Actively promote group interaction

MBT Group

- Therapist openly and repeatedly explains the primary task of the group
- Praise the group by acclaiming mentalizing when it happens
- Structure the group work by
 - Not allowing aggressive outbursts to escalate
 - Stopping the group process when it is unproductive or is missing important opportunities for mentalizing exploration in the here and now
 - Initiating careful step for step explorations of crucial intersubjective transactions
 - Demonstrating and explaining the primacy of the here and now.

Why this change in emphasis?

- Poor research evidence behind the Foulkesian claim that groups with severe personality disorders can develop productive group culture by the help of a minimally engaged group analyst.
- Literature is full of anecdotes of chaotic situations with borderline and narcissistic patients
- Dropout rates are high
 - most often explained by the patients as painful negative affect states being activated, but not being resolved, by the group (Hummelen et al., 2006).
- Tendency to underestimate the mentalizing deficits of borderline patients and to expose them to group situations far beyond their capacity.

Implicit mentalizing group

The aims of the implicit mentalizing group are

- To promote mentalizing about oneself
- To promote mentalizing about others
- To promote mentalizing of relationships

Implicit mentalizing group

- The therapist will at times need to take control of the group while still remaining a participant, not an observer
- Anxiety levels of both group and individuals must be monitored to ensure they become neither too high nor too low
- Interventions aiming to increase mentalizing within the group in the immediacy of the moment are key to the group's constructive development

Implicit mentalizing group: ways to explore understanding of each other

- Focus on what a patient is saying asking him to clarify and expand
- Ask other patients for their understanding of what is being said during moments of uncertainty
- Generalize the problem – 'Has anyone else experienced this?'
- Return to a topic sensitively or if necessary Stop and Stand if the group dismisses something of manifest importance

■ **Implicit mentalizing group: ways to explore understanding of each other**

- Generate a group culture of enquiry about motivations
- Insist that patients consider others' perspectives and work to understand someone else's point of view
- Challenge inappropriate certainty and rigid representation
- Therapist should directly express own feelings about something that he believes is interfering with group progress

■ **For further Information**

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- All slides available at:
<http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>