SPECIAL ARTICLE

Mentalization-based treatment for patients with borderline personality disorder: an overview

Terapia de mentalização para pacientes com transtorno de personalidade borderline: uma atualização

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Abstract

Objective: *To describe the concept of mentalization, and its application in understanding the development of psychopathology in patients with borderline personality disorder; to give an account of the main features of mentalization-based treatment; to summarise the evidence supporting its effectiveness.* ***Discussion:*** *Mentalization is a predominantly preconscious mental activity that enables the individual to understand him/herself and others in terms of subjective states and mental processes. Psychological trauma in childhood is associated with deficits in mentalization and with the development of borderline personality disorder. Mentalization-based treatment is a psychodynamically-oriented manualized psychotherapy for borderline personality disorder that aims to develop a therapeutic process in which the patient's capacity for mentalization becomes the focus of treatment. Randomized controlled trials have demonstrated the effectiveness of this treatment for patients with borderline personality disorder.* ***Conclusions:*** *The development of a psychodynamically-oriented therapeutic intervention that specifically targets the deficits involved in the psychopathology of borderline personality disorder is a crucial step in increasing the effectiveness of treatment. Mental health professionals should be adequately prepared to deliver effective interventions to their patients, such as mentalization-based treatment.*

Descriptors: *Borderline personality disorder; Mental health; Psychotherapy; Psychopathology; Clinical trials*

Resumo

Objetivo: *Descrever o conceito de mentalização e sua aplicação no entendimento do desenvolvimento da psicopatologia em pacientes com transtorno de personalidade borderline; descrever as principais características da terapia de mentalização; sumarizar as evidências que demonstram sua efetividade.* ***Discussão:*** *Mentalização é uma atividade mental predominantemente pré-consciente que capacita o indivíduo a compreender a si mesmo e aos outros em termos de estados subjetivos e processos mentais. Trauma psicológico na infância está associado com déficits na capacidade de mentalização e com o desenvolvimento de transtorno de personalidade borderline. A terapia de mentalização é uma psicoterapia psicodinâmica manualizada para o tratamento de pacientes com transtorno de personalidade borderline. Seu objetivo é desenvolver um processo terapêutico no qual a capacidade de mentalização do paciente seja o foco do tratamento. Ensaios clínicos randomizados têm demonstrado sua eficácia no tratamento deste grupo de pacientes.* ***Conclusões:*** *O desenvolvimento de uma psicoterapia de orientação psicodinâmica que foque especificamente nos déficits envolvidos na psicopatologia do transtorno de personalidade borderline é um passo crucial para o aumento da efetividade do tratamento. Profissionais da área da saúde mental devem estar adequadamente preparados para oferecer intervenções efetivas aos seus pacientes, como a terapia de mentalização.*

Descritores: *Transtorno da personalidade borderline; Saúde mental; Psicoterapia; Psicopatologia; Ensaios clínicos*

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Introduction

Borderline personality disorder (BPD) is a chronic and disabling condition, affecting 1-2% of the general population and 10-20% of psychiatric patients[1-3]. It is associated with significant impairment of patients' lives and relationships[4].

Mentalization-based treatment (MBT) is a psychodynamically-oriented manualized psychotherapy for BPD, which has been shown to be effective in randomized controlled trials (RCTs)[5-7]. In this overview, we briefly describe: 1) the concept of mentalization, which is useful in understanding the development of psychopathology in patients with BPD; 2) the structure of MBT; 3) all empirical studies conducted to date that evaluated its effectiveness.

The concept of mentalization

Mentalization is the capacity to make sense implicitly and explicitly of oneself and of others in terms of subjective states and mental processes, such as desires, feelings and beliefs[8]. It is a predominantly preconscious and imaginative mental activity, and constitutes a largely intuitive emotional reaction[8,9].

The awareness that our behaviour is driven by mental states gives us a sense of continuity and control which is central to the subjective experience of oneself as an agent. This simultaneous experience and interpretation of emotion, which is crucial to its regulation, can be described as mentalized affectivity[9,10]. Allen indicates that mentalizing implicitly entails a pre-reflective sense of connectedness to the agentive self: *"one has a sense of oneself as an emotional, engaged agent"*[11].

The capacity to understand the behaviour of others in terms of their likely thoughts and feelings is a major developmental achievement and is facilitated by secure attachment relationships. Our understanding of others depends on whether as infants and children our own mental states were adequately understood by our caregivers[12]. Consequently, the developmental process is somewhat vulnerable to disruption through social adversity, in particular early neglect[13]. Individuals who have suffered such experiences, probably in combination with a genetic predisposition, are more likely to lose this capacity when emotionally challenged.

A failure of mentalization initiates a re-emergence of non-mentalizing ways of thinking that developmentally antedate this capacity: the psychic equivalence, the pretend and the teleological mode. Psychic equivalence, characteristic of children aged two to three years, entails a lack of differentiation between external reality and its subjective representation and by intolerance of alternative perspectives. In pretend mode, typical in two-year-olds, the individual assumes no connection between internal and external reality, the mental world being decoupled from external reality. In the teleological mode, an individual only acknowledges the existence of mental states when they are evidenced in concrete and physically explicit forms. These earlier mental structures manifest as concreteness of thought, impulsivity, affect dysregulation and a propensity for acting out[8,9,14]. An unstable or reduced mentalizing capacity is a core feature of BPD.

The roots of a failure of mentalization in patients with BPD

In a normal infant caregiver interaction, infants will find a modulated version of their internal states mirrored by their caregivers, in a manner that indicates that their state of mind are those being reflected, not the caregivers'. These congruent responses are necessary to help infants to evolve a representation of their internal states which they use to regulate affects in themselves and understand them in others. When mirrorring is incongruent, it is hypothesized that children internalize representations of the caregivers' state of mind rather than a representation of their own experience. This creates an "alien" sense of self, i.e., the child internalizes the image of the caregiver as part of his/her self-representation[10,15].

A poorly mentalized response to the infant on the part of the parents can undermine the healthy development of some of the infant's social cognitive capacities, especially the regulation of affect and the functioning of focused attention[16]. Several factors can disrupt the normal development of mentalizing. Foremost amongst these is psychological trauma in childhood, especially if perpetrated by attachment figures. Trauma generates fear which arouses the attachment system, i.e., the child seeks protection, but the proximity to an adult in turn generates more anxiety, which further intensifies the need for comforting[9]. The prolonged activation of the attachment system may be an additional obstacle to the development of normal social functioning, since it might inhibit or decouple the capacity to mentalize[17].

There are at least three routes by which mentalization may be disrupted, contributing to the development of pathology in patients with BPD. First, psychological defenses may be habitually activated to protect the individual from thinking about the mental states of caregivers who have malevolent thoughts towards him/her, inhibiting the development of mentalization. Second, shifts in brain activity may occur as a consequence of trauma that switch off mentalizing more readily in traumatized individuals. Third, attachment trauma can result in a hypersensitivity of the attachment system and a rapidly accelerating pace of intimacy may result[9,18].

Many facets of borderline personality functioning can be understood as the consequence of a failure of mentalization and the associated capacities for affect representation, affect regulation and attentional control, together with the re-emergence of primitive forms of subjectivity, and, finally, the profound disorganization of the self-structure. To summarize, the phenomenology of BPD can be conceptualized as the consequence of: 1) the attachment-related inhibition of mentalization, 2) the re-emergence of modes of experiencing internal reality that antedate the developmental emergence of mentalization, and 3) the constant pressure for projective identification through the re-externalization of the self-destructive alien self[8,14].

Mentalization-based treatment for patients with BPD

The recovery of mentalizing in the context of attachment relationships can be considered as a common mechanism of many psychosocial treatments for BPD. The overall aim of MBT is to develop a therapeutic process in which the patient's perception of one's own mind and the minds of others becomes the focus of treatment. The objective is that the patient should discover how one thinks and feels about oneself and others, how that dictates one's responses, and how errors in understanding oneself and others lead to actions that are attempts to retain stability and make sense of incomprehensible feelings[9,14,19].

Two variants of MBT have been empirically tested. The first variant is a day hospital programme to which patients attend on a 5-day per week basis, with a maximum duration of 18-24 months. The second is an 18-month intensive outpatient treatment which consists of one individual session of 50 minutes and one group session of 90 minutes per week. In both variants the individual therapist is different from the group therapist. Risk and instability of social circumstances are the primary considerations in determining which programme an specific patient will be offered[9].

The treatment has three main phases. The initial phase begins with an assessment of mentalization capacity, while the history is being taken. It is assessed in the context of important relationships that require most mentalization in response to high levels of affect. The assessment provides a map of important interpersonal relationships and their connections to key problem behaviours. It ends with a diagnosis, an explanation of the possible causes of BPD, the goals of treatment and an explanation of how it works. A limited contract is established, a review of medication is performed and a crisis pathway is developed[9].

The intermediate phase is characterized by fostering the therapeutic alliance while maintaining a mentalizing stance. Therapists' constant focus is on the current state of mind of the patient, whilst giving their own perspective on the patient's state of mind[9,20]. Therapists take an inquisitive or not-knowing stance, emphasizing that mental states are opaque and that they cannot have the same ideas as the patient about what is in the patient's mind. When therapists take a different perspective to the patient, this is verbalized and explored, highlighting alternative perspectives and avoiding assumptions about whose viewpoint has greater validity. The task is to identify the thought processes that have led to alternative viewpoints and to consider each perspective in relation to the other[14].

Therapists are required to observe their own non-mentalizing errors, which are treated as opportunities to learn more about feelings and experiences. They must articulate what has happened in order to demonstrate that they are continually reflecting on what goes on in their mind and on what they do in relation to the patients. This models reflectiveness and allows patients to discover a way of perceiving themselves and others through the therapeutically generated experience of a mind considering a mind[14].

Regarding the interpretation of transference, MBT aims to focus the patient's attention on the mind of a therapist, and to assist patients in the task of contrasting their experience of interaction with how that may be perceived by another mind. The aim is not to offer insights to the patients as to why their perception of therapists may be distorted in specific ways, but rather to model and engender curiosity as to why, given the ambiguity of interpersonal situations, they might have chosen a specific version. Thus, therapists look at the motivation that people have for manifesting a specific kind of transference, but the exploration is focused on encouraging a thinking stance[9]. The following clinical vignette illustrated this aspect of the treatment: *Patient: You don't care about me, you think I'm boring. Therapist: I'm not sure what I've done, but I must have done something that makes you convinced of that. Do you have any idea what I might have done? Patient: I saw you looking at your watch. Therapist: I do recall that. Perhaps the way you are feeling at the moment it is inconceivable that there could be another explanation for me looking at my watch other than finding you a burden. Patient: It's obvious you were bored. Therapist: Why do you think it is so hard to think of any other possibility? Patient: I'm so boring. I always feel that you don't want to be with me and that you would rather be somewhere else. Therapist: I see. So when you saw me look at my watch you might have thought that I would rather be doing something else than be here with you? Patient: I thought I had lost you. I felt that you had gone*[9].

The final phase of the treatment starts at the 12-month point. The emphasis is on the interpersonal and social aspects of functioning, along with consolidating earlier work and considering the separation responses associated with loss. A follow-up treatment plan is developed collaboratively[9].

Research evidence for the effectiveness of MBT

Bateman and Fonagy compared the effectiveness of MBT by partial hospitalization (PH) with standard psychiatric care for patients with BPD in an RCT[5]. Forty-four patients were randomized, and 19 were evaluated in each group. Treatment for the PH group consisted of once-weekly individual and thrice-weekly group MBT, once-a-week expressive therapy oriented toward psychodrama techniques, and a weekly community meeting. The control group care consisted of regular psychiatric review, inpatient admission as appropriate, and outpatient follow-up as standard aftercare. Treatment with MBT showed significant gains compared to the control on measures of suicidality, self-harm and inpatient stay. These benefits became apparent at 6–12 months of treatment, and a follow-up 18 months after the end of day hospital treatment, when all the 44 randomized patients in the initial trial were evaluated, demonstrated further improvements[6]. Five years after discharge, the group treated with MBT continued to show clinical superiority compared to the control group on measures of suicidality, diagnostic status, service use, use of medication, and vocational status[7].

Subsequently, Fonagy and Bateman conducted the Intensive Out-Patient MBT Randomized Controlled Trial (IOP). The IOP aimed to explore the effectiveness of outpatient intervention, with separate individual and group psychotherapeutic components, implemented by generically trained mental health professionals relative to structured clinical management with a supportive psychotherapy component. MBT treatment was implemented according to the same manual, together with an initial group treatment for 3 months targeting suicidal behaviour. Patients in the comparison group were treated with individual and group supportive psychotherapy, received a similar amount of professional attention, but without the manualised interventions offered to the MBT group.

Initial results showed a more marked decrease in suicide attempts in the MBT group, with a reduction in relative risk of 0.5 in the control group and of 1 in the MBT group. This was also true for the reduction of self-harm (reduction in relative risk of 1.4 in the control group and 1.8 in the MBT group) and hospitalization (reduction from 30% to 18% in the control group, and from 27% to 3% in the MBT group)[21].

Taken as a whole, these studies show that MBT is effective at short- and long-term basis, when delivered in a day-care programme and also in an outpatient programme, which enhances the external validity of the technique.

Conclusions

Deficits in the mentalization capacity, which are characteristic of several disorders[22], are a key feature of BPD. RCTs have demonstrated the long-term effectiveness of MBT for the treatment of patients with BPD, and mental-health professionals should be adequately trained to deliver effective interventions, such as MBT, to their patients. The development of psychodynamic interventions that aim to identify and repair the specific deficits involved in the psychopathology of a disorder is central to the task of increasing the effectiveness of psychoanalytically oriented treatments[23].

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** Modest*
*** Significant*
**** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.*
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