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Mentalization-based psychotherapy practices in patients with borderline personality disorder

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ABSTRACT

Introduction: Mentalization-based psychotherapy (MBT) develops with the importance of establishing attachment relations with patients. MBT focuses on internal mental processes that occur in the therapeutic process that actively improve patient-therapist relationships.

Methods: A woman with preoccupied/anxious attachment is given mentalization-based psychotherapy. The goal of psychotherapy based on mentalization is to develop secure attachment relationships in therapy, use empathy and validation in reciprocal relationships, strengthen the patient's capacity to reduce emotional dysregulation and impulsive behavior, increase self-awareness, control of attention and flexible thinking in the context of emotions and relationships.

Results: The patient has begun to form a secure base attachment. Patients' mentalization has improved along with the formation of secure base attachments, patients are better able to do self-soothing and regulate emotions properly.

Conclusion: In the early years of life, patients have a pattern of interaction with caregivers who lack the need for mirroring. Furthermore, the patient develops into an insecure self and has an inherent preoccupied/anxious attachment. It has an effective representation and attention regulation system that is not functioning so that patients use existing stimuli as the basis of an insecure sense of self. Fonagy termed this condition with incoherent, disruptive "alien self" through controlling and manipulative behavior. The patient externalizes the alien self against the attachment figure. This externalization appears as a countertransference experience in a therapy session, if it can be appropriately managed it will emerge a feeling of coherence in the patient's internal world.

Keywords: attachment, mentalization, psychodynamic, psychotherapy, reflective function.
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INTRODUCTION

Attachment is a deep and ongoing emotional bond that connects one person with another special person over time and distance. The capacity to form secure attachments depends on the primary dyadic relation that was created. Failure to form secure attachments has a significant effect on relationships as adults.[1]

A borderline personality disorder is often associated with disorganized, preoccupied and fearful types of attachments. White in his study mentioned 93% of women with borderline personality disorder have a preoccupied attachment type.[2]

Fonagy said that borderline personality disorder has the characteristics of a disorganized and preoccupied attachment pattern and interference with reflective function (mentalization). People with borderline personality disorder have mentalization that is not stable.[3]

Mentalization, especially mentalized affectivity bridges attachment theory, developmental psychopathology, affect regulation and psychoanalysis. Mentalisation is currently interpreted and measured in various ways. There are three approaches to mentalization[4]:

1. Fonagy and Target (1997, 2002) understand mentalization as a representation of psychological states in the human mind. Measurements can be made to assess the capacity of the reflective function (Reflective Function/RF).
2. The perspective of ego psychology and object relations focused on patients' therapist and mental status in psychotherapy situations. The difference in the quality of mentalization depends on the difference in the ego's attitude towards psychological experience (degree, maturity, continuity of the soul's defense mechanism and ego capacity).
3. Mentalization involves transforming effective experiences by increasing the quantity and complexity of representative networks, including improving the quality of elaboration and harboring something and regulation.

CASE ILLUSTRATION

B, a 21-year-old woman came for psychotherapy because her mother felt B was still often angry when certain events occurred. B was given mentalization-based psychotherapy once a week for more than six months.

B, two siblings, have a younger sister who she thinks is more beautiful. People around often praise the beauty of B's sister and make B envious. B wants more people's

attention for B so they always try their best and are ambitious in terms of school achievement. B has a good voice and can play music and good school performance compared to her younger sister who did not play music and school grades. B felt that this was not enough. B used various methods to achieve her wish so that her friends did not like her. There were often friends who say whether there are men who want to date B like that. This makes B feels sad, especially when B's sister quickly gets a boyfriend while B never dated.

B sometimes gets the chance to appear in a cafe to get acquainted with other musicians. B started getting to know boyfriend over 30, high school graduates and had a history of changing girlfriends. B's parents opposed this, but B still dated the man, because his boyfriend was easy to get along with. B felt that after dating, she learned a lot from her boyfriend about making good friends. B felt like she could start making friends with her college friends.

B's boyfriend decided to start his own business selling food with joint capital with B. B parents felt B was being used by his boyfriend and limit B's allowance. They also forbid B from dating him. B was angry with her parents, feeling that the parents did not understand her boyfriend's role who was so prominent in turning B into someone who could be friends. B also did not understand why parents did not want to finance her boyfriend who, according to B, has a very large role in B happiness. B was also afraid of the status of "single" and was afraid of not having a boyfriend, as her friend used to make fun of her.

THERAPY PROCESS

B was given mentalization-based psychotherapy once a week for more than six months. In the process of therapy B expresses anxiety when a boyfriend was far from B, making B unable to make good friends. This makes B always wants to be close to her boyfriend. B revealed one way to be friends was to make fun of her in front of friends so that she makes them laugh. That way B feels safe to make friends.

"*I'm the one who is late on thinking, carelessly sometimes I make materials joking with my friends. That way I feel closer to them. I also let them call me by the nickname "Ning" which is more Javanese and makes me more down to earth with them. Usually a friend thinks that I am a high-ranking B, grades must be good and difficult to make friends.* "

One time B discussed her frustration with a friend who suddenly said the patient's ugliness was a joke. B immediately felt the need for her boyfriend's presence to appease her, because she did not know how to behave to friends who made her upset.

B: "*This is all because A is far from me .... if there is him I can be more friends. Now I have started to return to the way B used to be, not knowing what to do when with friends ...* "

Therapist: "*When there is A, B can be more friends ...*"

B: "*Yes Doc, I often pay attention to why my boyfriend A has many friends and how A goes to his friends. For example A made fun of himself and then his friend laughed happily. That's what I did to a friend and it worked. But today a friend suddenly said that I was ugly, they laughed, but I felt hurt in my heart ...* "

Therapist: "*... I see ... with B giving an example of making fun of B, friends think that sometimes making fun of B is okay ...*"

B: "*I see, doc ... but I don't like it ...*"

Therapist: "*If B doesn't like it, then B doesn't need to make fun of you in front of friends ....*"

B: "*Yeah doc ..*."

The therapist slowly invites B to see how she makes friends by making fun of her, making friends think occasionally making fun of B was okay. If B didn't like to be used as a joke, B needs to change what B says to friends when gathering.

"*I started to express good things about friends when I met them, like praising their bright faces that day, the color of the clothes that brightens the atmosphere. It turns out it worked, they said my face had started to cheer up again and was not confused anymore to be able to talk with my friend....* "

B finds new way to talk to her friends which makes her more comfortable.

DISCUSSION

Fonagy and Target stated that secure attachment enables reflective functions, namely the caregiver's ability to reflect verbally on a thought situation that affects feelings, perceptions, intentions, beliefs and behavior. By doing this the caregiver shows the child that they understand the child's emotional and thought situation.[3]

Cozolini states language with emotional attunement allows children to connect words and feelings, integrating neural networks and neural growth. Verbal interactions based on emotions, sensations, behavior and knowledge enable the child's brain to incorporate various aspects of experience incoherent behavior. When parents are unable to show verbal coherence between a child's internal and external experiences, the child loses the capacity to understand and regulate the inner and outer world.[5] Ability of language to integrate with the nervous structure and organizational experience is not formed at the conscious level. When a child is unable to express experiences with a coherent narrative, the child's ability to manage stressors (emotional regulation) is eliminated. Emotional attunement with narrative construction will form a brain network and determine a person's attachment scheme along with the person's ability to regulate thoughts and feelings.[5] Therapist will have successful and meaningful interactions with patient when therapist awareness of subtle cues of sensory-perceptual communications increased.[3] Therapist awareness and increasingly expanded self-integration make the therapist more capable of assisting patients in achieving integration and awareness.

Mentalization-based treatment (MBT)

B has preoccupied / anxious attachment and was given psychotherapy based on mentalization (Mentalization-based Therapy). The goal of psychotherapy based on mentalization is to develop secure attachment relationships in therapy, use empathy and validation in reciprocal relationships, strengthen the patient's capacity to reduce emotional dysregulation and impulsive behavior, increase self-awareness, control of attention and flexible thinking in the context of emotions and

relationships.[6]

Mentalization-based therapy develops with the importance of establishing attachment relations with patients. MBT focuses on the internal mental processes that occur in the therapeutic process that actively improve the patient-therapist relationship. Following is the description of MBT on B according to the MBT protocol according to Fonagy[7]:

1. Collaborative Approach and Formulation of Patient Problems
   Patients have patterns of interaction with caregivers who do not provide fulfillment of mirroring needs, in their early years. When B was born, his father and mother were at school, so they had less time with B and did not provide reassurance and validation (mirroring self-object). Mentalizing in infants' needs affects the mirroring process, when infants do not have a marked effect, reflecting approach mentalizing typically develops in psychopathological implications.[8] This situation makes the patient create a pattern of attachment that is not safe (preoccupied/anxious attachment) and insecure, so she has an adequate representation and attention regulation system that is less functioning. Patients use existing stimuli as the basis for insecure sense of self. Fonagy termed this as an incoherent, disruptive "alien self" through controlling and manipulative behavior. The patient externalizes the alien self against the attachment figure. This externalization causes countertransference experiences in the therapeutic process that need to be appropriately managed by the therapist so that it can cause a feeling of coherence with the patient's internal world.[9] B often controlling and manipulative during therapy and makes therapist felt uncomfortable than therapist tries to understand why B did that way to understand her.
2. Identification of the non-mentalizing process
   At another time when asking for permission to meet a boyfriend but was not permitted by her mother, B cried blaming the mother who did not understand the needs of B. B could not understand why Mother could not see the changes in B self who was more able to socialize after meeting a boyfriend. B was angry about this so she can't sleep. At this time B was in a prementalization condition, a non-mentalizing process.
3. General stance
   a. Interventions are consistent with the capacity for mentalization
      B also has a diagnosis Axis II Borderline Personality Disorders. In specific conditions the mentalization fails so that attachment is ineffective, interpersonal interactions are disrupted and the patient feels very depressed. Fonagy calls it a prementalistic state characterized by the appearance of Borderline activity symptoms such as unstable emotions, self-harm, impulsiveness, and dissociation to paranoia.[7]
      For example when B performs singing without training first after giving tutor to a high school kid. B was exhausted and B's performance was judged poor. This resulted in her contract was not renewed. B realized that her mistake was lacking in preparation so that she sang poorly and accepted a singing contract decision that was not extended. At this time B can be well-mentalized.
   b. Monitoring the patient's affective arousal
      When asking for permission to meet a boyfriend but was not permitted by her mother, B cried blaming the mother who did not understand the needs of B. She could not understand why Mother could not see the changes in B self who could socialize after meeting a boyfriend. B was angry about this until could not sleep. At this time B was in a prementalization condition. B told this story in a therapy session, weeping. The therapist was a little confused with B who knows the mother's dislike of her boyfriend but needs her permission when meeting her boyfriend.
      Therapist: "*You know that your mother didn't like your boyfriend ... what made you ask for her permission last night to meet your boyfriend?*"
      B: "*Lately I talked a lot with mom, I think she listened more to me. So I tried asking for her permission when I wanted to meet my boyfriend ... but apparently my mother hasn't changed ...*"
   c. Focus on maintaining a therapist's mentalizing
      This is important in mentalization-based therapy. If the therapist is unable to mentalize, it is important that the therapist is aware of this and even stops the therapy session if necessary. In some initial therapy sessions, before the session ends B suddenly becomes more emotional because of missing a boyfriend. She will blame the parents who did not facilitate B to meet her boyfriend outside the town while crying. Sometimes this forces the therapist to extend the session. This happened several times until the therapist was irritated and had difficulty mentalizing with B. The therapist told B for the next meeting to discuss this. B did not realize this pattern, B did not want the therapy to end soon so she made the pattern. After the discussion, B pattern before session ends was stopped.
   d. Therapist's openness and explicit identification of therapist's feelings towards the patient's mental status
      The next meeting the therapist interprets that B wants to be with her boyfriend every time B will demand her parents to have to fulfill B's wishes, including financing B to meet the boyfriend. If this did not happen then B will speak badly of her parents, hate her parents and refuse to listen to her parents' advice. The therapist said "*I'm confused, you said that you hated your Mother but demanded your Mother to give you some money to meet your boyfriend...*"
   e. Beware the disconnection of mentalizing
      In one session B told of her sadness because in the parable there was a flood her Father chose to save Mother first because among them only Mother could not swim. B didn't like her Father's choice, but suddenly says he will take Mama

to the bag shop to pick a good college bag for B. The therapist sees discrepancy in B story and clarifies "*B says sadly when Father says he chose Mother first, but suddenly B plans to take Mother to the bag shop, try to explain about this ...* "

4. Not knowing stance
   The therapist needs to work authentically and accept patient experience even if the therapist did not understand it.
   If the therapist didn't understand what B is talking about, the therapist would say ... "... *I don't understand, can the story be repeated* ...?"
5. Identification of the mentalization pole
   B was angry when the nurse said B session started 15 minutes late. On therapy B said that she disliked having to wait 15 minutes, B focused on B's internal self. The therapist tried to balance B's internal self-focus with others' external focus by apologizing that the day's sessions were delayed by 15 minutes because the therapist was late. Not because the therapist gives more time to the patient's previous session. B can accept that and didn't angry anymore.
6. Therapeutic sessions: Implementation of interventions includes validation of empathy to explore, clarify, and confront by identifying effect and focus on impact for the mentalization of relations and contra-correlation.
   In the last few meetings B began to refrain from issuing rude and angry words. For example when her boyfriend didn't open his small fried chicken shop because he forgot to buy a basket even though he's been shopping for chicken, then blames B for not buying the basket until the chicken rot. B wants to say the boyfriend was "stupid" for shopping for chicken when it's not certain when to sell. But B knew the boyfriend was pressured by his actions which made a loss so that she didn't say the word to the boyfriend. B remembers when her sister lost her wallet and B said her sister was "stupid" and made her sister even more depressed. So she decided not to nag a boyfriend for fear of making him even more depressed. The therapist validates empathy for B and compliments B's wise choices that don't nag at his boyfriend.

After doing the six steps above, it appears that a safe base has begun to form within B in the past month. When the boyfriend says he didn't want to listen to B's complaint about B's parents because he feels dizzy enough to think about his own parents, B feels shocked, but trying to fulfill her boyfriend's wishes. It turns out that B can fulfill her boyfriend's desires so B who had to call her boyfriend every night, can be reduced to just 2-3 times a week. It can be seen that the patient's mentality ability has improved along with the establishment of secure base attachment, patients are better able to do self-soothing and regulate emotions properly.

Mentalizing is resulting from the development of representations of the infant's psychological mind and this capacity called Reflective Function.[10] B was asked to fill in the Reflective Function Questionnaire. The result was RFQu (hypomentalization) = 0.7 (the greater the number the more hypomentalization, the cut-off value 1.22). RFQc (hypermentalization) = 0.125 (the greater the number the more hypermentalization with a cut-off value of 1.09). B tends hypomentalisation, unable to understand the thoughts, feelings and behavior of self and others but is not significant. Hypermentalization tendencies, namely assumptive and projective tendencies, do not exist. So the impression of an approach to B is more to reconstructive psychotherapy especially one that enhances the patient's mentality.

B with her early attachments failure has developed her capacity for coherence, collaboration, reflection and mentalization.[11] In working with patients who temporarily lose mentalization capacity, it can help bring the patient back to a psychological frame of reference. When the patient has regained the capacity to mentalize, patient can reflect on thoughts and feelings in a fluid meaningful manner, therapist then can engage patient in an analysis on the defensive reaction that was involved in their temporary loss of mentalization.[4]

Limitation of MBT

Mentalization-based therapy provides long term positive outcomes with the therapist need to be mindful that therapist mental state color their understanding of the patient mental state. The therapist needs to release countertransference experience in Mentalisation-based therapy, which is sometimes difficult for therapists who understandably worry about violating therapeutic boundaries. Sometimes therapist wants to talk their personal problems and express feelings they might have in session, Mentalisation-based therapy did not suggest this. The therapist need to share openly current therapist experience of process therapy to make patient aware that their mental process affects others mental states.[7]

CONCLUSION

Feelings of security that children get from relationships with caregivers help them develop emotional regulation in dealing with various life experiences. Failure to form secure attachments has a significant effect in relationships as adults. Mentalisation-based therapy develops with the importance of establishing attachment relations with patients. Mentalisation-based therapy focuses on internal mental processes that occur in the therapeutic process that actively improves the patient-therapist relationship.

AUTHOR CONTRIBUTIONS

Wardani and Suromo designed the study; Wardani wrote the first version of article; Wardani and Suromo managed patient data. Suromo reviewed this article.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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ETHICAL STATEMENT

All participant had received signed written informed consent regarding publication of this article in medical journal.

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