The background of the cover is a dark, deep purple to black gradient. It is filled with numerous bright, multi-colored light streaks that radiate from a bright white point on the left side, creating a sense of motion and depth. The streaks transition through colors like yellow, orange, and red before fading into the dark background. There are also several distinct lens flare effects, appearing as bright, multi-pointed starbursts, scattered across the upper portion of the image.

MENTALIZATION-BASED GROUP THERAPY (MBT-G)

A theoretical, clinical, and research manual

SIGMUND KARTERUD

OXFORD

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Impression: 1

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Preface

This manual is a somewhat expanded and modified English version of a text that was published in Norwegian in 2012 (*Mentaliseringsbasert gruppeterapi*; Karterud, 2012). It is modified since the original text contained multiple references to my textbook “Group analysis and psychodynamic group therapy” (*Gruppeanalyse og psykodynamisk gruppepsykoterapi*; Karterud, 1999) which has not been translated into English. These references served to anchor mentalization-based group therapy (MBT-G) in the theoretical and relational matrix of group analysis and psychodynamic group therapy. The textbook describes the cultural, philosophical, psychoanalytic, and pragmatic roots of group analysis through a detailed history of its founding fathers, first and foremost Sigmund Freud, and of its institutions. The grounding concepts of group analysis are thoroughly explained, as well as the unresolved tensions in theory as well as therapeutics. I argued that group analysis needs a similar modernization as that of psychoanalysis, although group analysis has always been more relational than its individual counterpart. However, the grounding theory of man, *Homo sapiens*, social to the core of its existence, had to be liberated more profoundly from the (individual) psychoanalytic (outdated) concepts of the psychic apparatus and the drive theory. I argued that self psychology contained resources which could vitalize group analysis, a view which I shared with the group analytic pioneer Malcolm Pines (Pines, 1996a, 1996b). In the same vein as Heinz Kohut regarded narcissistic personality disorder (PD) as a paradigmatic disorder for the understanding of the essence of the self and the corresponding necessities for a healing psychoanalytic practice, I shared with Malcolm (Pines, 1990) the view that borderline personality disorder (BPD) was a key condition for the understanding of group dynamics and its healing powers. In the United States, a similar conceptual and therapeutic development was taking place, and I was fortunate to have Walt Stone as a companion in explorations of group dynamics and the self (Karterud & Stone, 2003; Stone & Karterud, 2006).

In this attempt to merge group analysis and self psychology, it was important to emphasize that both disciplines contained theoretical ballast that portrayed a polarized (and flawed) view of the nature of man. Group analysis harbored a metaphysical drive theory while self psychology resorted to a one-sided kind of “pure” hermeneutics, discarding any contributions to the understanding of the

mind coming from the natural sciences (Kohut, 1959; Karterud, 1998). I argued that modern hermeneutics, as construed by Paul Ricoeur (1981a), transcended these seemingly antithetic attitudes. Hermeneutics, says Ricoeur (1981b), does not anchor a split between the natural sciences and the humanities. There is a certain nature behind hermeneutics, which makes it a possible enterprise, in the same way as there is a nature behind language. Hermeneutics is the main tool of psychoanalysis, asserted Kohut, and he was right in this first wave of hermeneutic psychotherapy. However, a next generation of researchers took a bold step forward, by asking, with Ricoeur, what was the nature of hermeneutics itself. What are the very elements of interpretation, how do they develop, and when do they coalesce as true self-understanding? Ricoeur, in *Oneself as Another* (1992), argued, from a philosophical stance, that self-understanding (and thereby the “self”) developed as the capacity to turn the look upon the world, onto oneself, with the acquired conceptual and cultural wisdom developed by the world. In other words, the understanding of the world (others) comes prior to understanding oneself.

In “Group analysis and psychodynamic group psychotherapy” (*Gruppeanalyse og psykodynamisk gruppepsykoterapi*; Karterud, 1999), I elaborate on the implications of this view for the business of group analysis. I regret that this theoretical-practical work is not available for the English reader, although the English references in the preceding paragraphs contain the main ideas, scattered in different locations.

Since the time of publication of my group analytic textbook, there are signs that indicate that group analysis has entered a phase of stagnation, although the Scandinavian version might be more active than in the rest of Europe. When I turned to the theory and practice of mentalization, I found, in contrast, a field full of energy and vitality, with new and refreshing concepts, an empirical stance, and new ways of doing therapy. And, above all, that the matter of interest concerned the heart of hermeneutics: How does it develop, this very capacity for interpretation, the means to understand others and oneself, and do individual differences in this capacity, which was now labeled mentalization, play a significant role in psychopathology? These questions have been dealt with extensively in the rich literature on mentalization during the last decades (Fonagy et al., 2002). It concerns the conception of PDs in general, but in particular BPD (Bateman & Fonagy, 2004). By defining the capacity for mentalizing as the key element of personality pathology, it also carries with it important implications for the practice of psychotherapy. And most important for scientific reasons, the phenomena of mentalization/interpretation (hermeneutics) were now grounded in an evolutionary frame of reference. By that, a whole new set of

approaches and experiments were subsequently applied to the study of thinking and understanding of mental phenomena, for example, comparisons of mentalization among chimpanzees and children. The results have far-reaching consequences for our understanding of the individual–group relationship (Tomasello, 2014). The above mentioned developments, an evolutionary and mentalization-based conception of PDs, were the backdrop for our textbook of “Personality psychiatry” (*Personlighetspsykiatri*; Karterud et al., 2010) which has been significant for Scandinavian readers.

Being in charge of a unit for PDs, later expanded and titled as the Department for Personality Psychiatry, it was natural for me to contact Anthony Bateman who I had known since 1992. Anthony had already launched mentalization-based treatment (MBT) at St. Ann’s Hospital, London. He was recruited as a lecturer and supervisor at our department in Oslo, and we soon gathered together a Nordic group for MBT.

The MBT program in Oslo was opened in August 2008. This resulted in the former day hospital, with its roots in therapeutic community and group analytic theory and practice, being closed down and the staff had to be retrained. At that time there existed practical guidelines for MBT (Bateman & Fonagy, 2006), but the field lacked a more comprehensive manual. Both for our local purposes and also for the field at large we then, in cooperation with the Nordic group, developed the “Manual for mentalization-based treatment (MBT) and the MBT adherence and competence scale. Version individual therapy” (*Manual for mentaliseringsbasert terapi (MBT) og MBT vurderingsskala. Versjon individualterapi*; Karterud & Bateman, 2010). Thereafter followed the “Manual for psychoeducational mentalization-based group therapy” (*Manual for psykoedukativ mentaliseringsbasert gruppeterapi (MBT-I)*; Karterud & Bateman, 2011). Unfortunately, these manuals have not been translated into English; however, crucial parts, including the MBT adherence and competence scale (MBT-ACS), are available at different websites (e.g., <<http://mentalisering.no/index.php?page=English>>). A thorough description of the MBT-ACS as well as a study of its reliability are also published in *Psychotherapy Research* (Karterud et al., 2013).

This third (group) part of the manual trilogy refers extensively in its Norwegian version to the previous two manuals. Since these sources are not available in English, I have expanded the current text somewhat.

This manual has, like most other psychotherapy manuals, three major purposes. The first is to serve as a tool for training. The second is to make possible quality control, by assessing the degree of adherence and quality according to the manual. The third is to promote research.

A psychotherapy manual should specify guidelines for how to practice a particular type of psychotherapy aimed at a particular type of patients. Luborsky and Barber (1993) have defined treatment manuals as a professional literature genre that consists of the following three elements:

- 1 A presentation of the guiding principles which steer the therapeutic techniques
- 2 The techniques themselves, illustrated by relevant examples of therapeutic interactions
- 3 Scales and instruments that can identify the skills of therapists who perform the treatment.

This manual satisfies these criteria.

A therapeutic group, as a “stranger group,” is a unique place for exploring one’s mentalizing abilities as it unfolds in interaction with others. It is radically different from the intimate and controlled situation of individual psychotherapy. It is also radically different from the situation of family therapy, where the protagonists are bonded to each other through a shared past history and might live together in daily life. A therapeutic group is closer to ordinary life than individual therapy, and because the participants normally do not share any past history or come into contact with each other in daily life, the therapist is freer to construct the essence of the group. I hold the opinion that therapeutic groups are ideal places to become aware of, understand, and transcend one’s mentalizing failures. However, I believe we have barely begun the work of cultivating groups for these purposes.

Groups are complicated work tools. In the first chapter of this manual I describe how group therapy with seriously disturbed patients might become a very bad experience. In order for the mentalizing-enhancing potentials of the group to unfold, the therapist has to construct the group in a certain manner. This manual provides a range of recommendations for this construction. By these measures, MBT-G stands out as being radically different from psychodynamic group therapy, from which it arose, for example, by constricting free group associations. On the other hand, it is highly dynamic, in the sense of taking into account multiple motivational levels both for the individuals and for the group as a whole and the need for cultivation and development of the group as a whole, by stimulating spontaneous interaction in the group and utilizing here-and-now events for mentalizing purposes. By these dynamic elements, MBT-G is radically different from dialectical behavior therapy (DBT), skills training groups, or cognitive behavioral groups. Similarities and differences compared to other group therapies are discussed at the end of Chapter 2.

I emphasize that MBT-G is a highly flexible kind of group therapy and discuss this aspect in Chapter 2. With poorly functioning patients in high turnover situations, as in psychiatric inpatient units, MBT-G might be constructed quite strictly and be imbued by psychoeducation. With highly functioning patients in group analysis, the MBT structural elements may barely be visible, since they will be integrated as part of the group matrix. For those for whom it is designed, borderline patients, MBT-G should stand out as a mode of group therapy clearly different from its psychodynamic siblings as well as its more distant relatives of the cognitive type.

Working with this manual, I have had the privilege of having enlightening discussions with a wide range of colleagues. First and foremost is Anthony Bateman who has been a stimulating partner in a continuous dialogue. Then there are members of the Nordic MBT group, such as Carsten Rene Jørgensen, Morten Kjølbye, Sebastian Simonsen, Kirsten Aaskov Larsen, Nana Lund Nørgaard, Kraka Bjørnholm, Ann Nilsson, Kirsten Grage Rasmussen, Per Sørensen, Francisco Alberdi, Henning Jordet, Bjørn Philips, Anna Sten, and Niki Sundstrøm. From the MBT program of the Bergen Clinic Foundation there are Kari Lossius, Nina Arefjord, Fredrik Sylvester Jensen, Turi Bjelkarøy, Randi Abrahamsen, Helga Mjeldheim, Brita Leivestad, and Katharina Morken. From the Department of Personality Psychiatry, discussions involved Øyvind Urnes, Elfrida Kvarstein, Theresa Wilberg, Christian Schlüter, Siri Johns, Bendik Høigård, Turid Bergvik, Bendikte Steffensen, Åshild Jørstad, Jean Max Robasse, Gunn Ingrid Ulstein, Merete Tønder, Kjetil Bremer, Kristoffer Walter, and Espen Folmo. Participants in courses in MBT-G during the years 2011 to 2014 have contributed with demonstrations and discussions of video recordings from their ongoing groups. Warm thanks also go to hundreds of patients who have agreed to allow their therapy sessions to be videoed.

The clinical examples in this manual are based upon real therapies, although they have been disguised somewhat in order to preserve anonymity. Special thanks go to the therapists and the patients in the group who allowed publication of a full transcript of one of their sessions, which is presented in Chapter 5. This is quite unique in the literature of group psychotherapy. The readers will here get an undisguised explication of what MBT-G is all about and a demonstration of how the MBT-G adherence and quality scale works.

This English version of the manual has been partly translated by Paul Johanson, Elfrida Kvarstein, and Espen Folmo, and partly by me. Parts of Chapter 1 and the text on items 10–19 are written in collaboration with Anthony Bateman. Jeremy Holmes has provided useful commentaries when reviewing the text. I have realized that writing directly in English is different than translating a Norwegian text, even my own text. Due to economic constraints, I did not

have any professional translation assistance. The language flow is not always optimal and I hope the English-speaking audience will bear with my “Norwegian-English” style.

Finally, I would like to thank the Norwegian Association of Professional Writers and Translators (NFF) who supported the Norwegian manual with a grant and the University of Oslo and Oslo University Hospital for their general assistance.

Contents

- 1** Historical and theoretical background for mentalization-based group therapy *1*
 - Introduction *1*
 - Mentalizing, failures of mentalizing, and borderline personality disorder *2*
 - Is group therapy good treatment for patients with borderline personality disorder? *18*
 - Group dynamics and evolution *26*
 - Challenges with borderline patients in groups *37*
- 2** Main principles for mentalization-based group therapy *43*
 - Introduction *43*
 - The group as a training ground for mentalizing *44*
 - Focus on interpersonal transactions *50*
 - Continuity and coherence of meaning through the therapists “minding the group” *50*
 - Regulation of group phases *53*
 - Balanced (mentalizing) turntaking *55*
 - What counts as an “event?” *56*
 - Clarification of events *58*
 - Identification of failures of mentalizing *60*
 - Engaging the group members in mentalizing events *62*
 - Identifying and working through of events in the group *64*
 - The closing of sequences *68*
 - Starting the group *69*
 - The treatment course and termination *72*
 - Coordinating and mentalizing meetings between all involved therapists *74*
 - MBT-G in different contexts *77*
 - Similarities and differences between MBT-G and other types of group therapy *79*
 - The group as a whole: Constructing and mentalizing the matrix *87*
- 3** The mentalization-based group therapy adherence and quality rating scale (MBT-G-AQS) *91*
 - Introduction *91*
 - On rating scales for group therapy *91*

Selecting items for the MBT-G-AQS	93
Rating procedures for the MBT-G-AQS	95
4 The items of the MBT-G-AQS	99
Introduction: The mentalizing stance	99
Item 1: Managing group boundaries	104
Item 2: Regulating group phases	106
Item 3: Initiating and fulfilling turntaking	109
Item 4: Engaging group members in mentalizing external events	115
Item 5: Identifying and mentalizing events in the group	120
Item 6: Caring for the group and each member	123
Item 7: Managing authority	128
Item 8: Stimulating discussions about group norms	131
Item 9: Cooperation between co-therapists	133
Item 10: Engagement, interest, and warmth	136
Item 11: Exploration, curiosity, and not-knowing stance	138
Item 12: Challenging unwarranted beliefs	142
Item 13: Regulating emotional arousal	144
Item 14: Acknowledging good mentalization	149
Item 15: Handling pretend mode	151
Item 16: Handling psychic equivalence	156
Item 17: Focus on emotions	161
Item 18: Stop and rewind	166
Item 19: Focus on the relationship between therapists and patients	167
5 Transcript of a mentalization-based group therapy session	175
Introduction	175
The transcript	176
Notes on the ratings	197
Ratings of each item	199
Overall rating	205
References	207
Appendix 1 Rating scale for mentalization-based group therapy	217
Appendix 2 Rating scale for mentalization-based group therapy quality	219
Index	221

Historical and theoretical background for mentalization-based group therapy

Introduction

In this first chapter, I provide a short account of the theoretical rationale for defining mentalizing failures as being the pathogenic core of borderline personality disorder (BPD), and the significance of a carefully designed treatment system that might serve as a holding environment for the kinds of interactions and experiences that we advocate as a means to enhance mentalizing capacities. Thereafter I sketch the historical and theoretical background for mentalization-based group therapy (MBT-G). By that I want to highlight that we are situated in a long professional tradition. Group psychotherapy for patients with personality disorders (PDs), and particular BPD, has been practiced for more than 50 years. There is a rich literature, while there is also an alarming lack of controlled trials that can provide evidence for beneficial effects. This state of affairs was changed around the turn of the millennium when both mentalization-based treatment (MBT) and dialectical behavioral therapy (DBT), which both contain a crucial group component, were shown to be more effective than treatment as usual in several randomized trials (Linehan et al., 1991, 1993; Bateman & Fonagy, 2001, 2009). Group therapy for patients with BPD, as part of, for example, MBT or DBT, has therefore been recommended by health authorities (NICE, 2009).

Thereafter, since therapists have a tendency to underestimate the mentalizing difficulties that BPD patients encounter in group situations, I discuss group dynamics from the perspective of evolution and attachment. Being advanced primates, we, as *Homo sapiens*, carry a rich genetic baggage which helps us to instinctively follow basic group rules as well as to take on collective emotions. Thus it is possible to be member of a group, as a more silent group member, or as member of an engaged subgroup, without performing much mentalization. BPD patients are likely to oscillate between excessive engagement and withdrawal.

Chapter 1 ends by discussing the challenges the above themes represent for the BPD patient and for the task of developing and maintaining the group as a good “training ground for mentalizing.”

Mentalizing, failures of mentalizing, and borderline personality disorder

BPD is by definition a diagnostic category within the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) (and within the tenth revision of the International Statistical Classification of Diseases (ICD-10) under the label emotional unstable PD). However, this category is by no means unambiguous. According to the diagnostic rules, one needs at least five (out of nine) criteria to have the diagnosis. Since none of these criteria are either compulsory or necessary, there are 256 different ways of being borderline (Johansen et al., 2004)! Things are further complicated by the fact that patients diagnosed with any PD category, have even more maladaptive personality traits located “outside” their diagnostic label. Patients with a BPD diagnosis (with any “comorbid” PD diagnosis) have on average around 15 maladaptive personality traits, when assessed by the Structured Clinical Interview for DSM-IV Axis II disorders (SCID-II) (Karterud et al., 2010). This implies that as many as ten personality traits might derive from other than the borderline dimension. If we take these supplementary personality traits into account, the heterogeneity becomes enormous. It becomes even more complex if we add the different symptom disorders that often accompany the disorder. We might encounter BPD patients bordering on psychoses, with strong paranoid features and post-traumatic stress disorder; or BPD patients with antisocial features and substance use disorder; or BPD patients with avoidant features and eating disorder. In addition, things are further complicated by a severity dimension. Broadly speaking, the more PD criteria that are met, the more serious is the condition (Cramer et al., 2007). The number of criteria is linearly correlated with social dysfunction and lower quality of life. This relation is also captured by the Global Assessment of Functioning (GAF) scale. The more criteria fulfilled, the lower the GAF score (Pedersen & Karterud, 2012).

When we use the term BPD in this manual, it is therefore a heterogeneous group of patients we are referring to. And to complicate the case even further, we will, on some occasions, refer to BPD “in a broader sense.” By this we mean patients that do not surpass the threshold of five BPD criteria, but who can display three to four BPD criteria and exhibit other significant personality pathologies (e.g., histrionic, narcissistic, antisocial, or avoidant traits) and present with a clinical condition of “typical borderline style” with unstable relations,

identity disturbance, and emotional dysregulation. Such patients may also benefit from MBT.

“The borderline group” was first described by the American psychiatrist Adolf Stern in 1938. Since then, the market has been filled with an enormous clinical, theoretical, and research literature and there have been countless meetings, seminars, and conferences. Many prominent colleagues have their names inscribed in the history of psychology and psychiatry because of their engagement in the continuous dialogue on the nature of the borderline pathology. This strong engagement is likely to be connected to the fact that what we label borderline pathology touches something more than a delineated psychiatric disorder. It concerns fundamental questions of existence for modern humans.

Definition

MBT is grounded in the theory of mentalization. Mentalization is both self-reflective and interpersonal (“the problem of other minds”). It refers to the act of understanding the experiences and actions of oneself *and others*, in terms of mental phenomena, for example, assumptions, feelings, attitudes, wishes, hopes, knowledge, intentions, plans, dreams, false beliefs, deceptions, etc. The alternative to a mentalized understanding of self and others is to conceptualize a person as driven by outer forces, by simple stimuli–responses, by coincidences, by crude drives and instincts, by disease processes, etc. Mentalizing can be so simple and obvious that we overlook it, but it can also be a very challenging business. It presupposes the ability to direct one’s attention to relevant aspects of intrapsychic and interpersonal phenomena, and for the most part it is implicit and automatic. In daily life we mentalize each other constantly by attributing intentions to each other, consciously or unconsciously. Explicit mentalizing means that we engage in a conscious reflection upon our own and others’ motives and self-states. Because of the very nature of our minds, it will often be the case that our mentalizing endeavors will “fail” in the sense that we often misunderstand ourselves and others. We can never be absolutely sure of what other people are thinking or feeling, and our own thoughts and feelings are also often vague and unclear. The less proficient we are in mentalizing, the more often we misunderstand.

Historical roots

The concept of mentalization belongs to a tradition within French psychoanalysis, understood as the process whereby drives and affects are transformed into symbols (Bouchard & Lecours, 2008). There is also an important link to the British psychoanalyst Wilfred Bion’s theory of thinking (Bion, 1970). However, the main contributors to the modern content of the concept are Professor Peter

Fonagy and coworkers (Fonagy et al., 2002). The epicenter has been in London, at the Anna Freud Centre and University College London, but the ongoing discussion about mentalization in the literature has engaged a wide range of researchers and clinicians (Leuten et al., 2012). The concept is embedded in a theoretical network containing elements from evolutionary theory, attachment theory, developmental psychology, psychoanalysis, neurobiology, group dynamics, and personality pathology, to mention the most important. Historically, it is closely connected to John Bowlby's theories (1988) concerning "internal working models" in the mind of young children, contingent upon internal representations of their attachment experiences. Fonagy and coworkers constructed a general theory of self-development which is rooted in the attachment relationship (Fonagy et al., 1991, 1996, 1997, 2002). The theory argues that the attachment relationship among *Homo sapiens* is expanded in scope and function. In addition to providing a system for dealing with fears that can threaten the security and survival of children, it has become the most important arena for developing the self and the ability to reflect upon mental states.

Mentalizing, self-development, and attachment

The theory of self-development and mentalization is thoroughly explained in the volume *Affect Regulation, Mentalization and the Development of the Self* (Fonagy et al. 2002). Basic questions concerning self-development are discussed: How is the self—which is the prerequisite for subjectivity and self-reflection—constituted (e.g., the experience of being separated from other people and things, to be the origin of one's own actions, to be the agent and owner of one's own thoughts and affects, to be able to reflect upon these affects and thoughts as one's own)? The most important thesis is that the attachment relationship is an arena where the child's mental states are experienced, interpreted, and mirrored/reflected by an empathic other, and by being immersed in a benign sociocultural culture where people are "minding" each other, the developed mindreading capacities will eventually turn toward the self, leading to self-understanding and self-consciousness. A considerable body of research demonstrates that insecure attachment relationships are associated with a diminished ability to understand the intentions of others and leads to a generally lower level of social competence (Karterud et al., 2010). In particular, disorganized attachment in childhood is associated with psychopathology in adulthood.

The general theory of self-development is in a process of expansion. One important contributor is the Hungarian psychologist György Gergely, who has been particularly interested in the problem of how the core self (which is found among other primates as well) develops into the humane reflective self (Gergely

& Unoka, 2008). This development is closely linked to the formation of object representations and later to self-representations, and to the integration with primary emotional systems. In order to be able to reflect on oneself and others (objects), the self and other (and the *relationship* to important others) must be represented in the memory system. These representations must be retrievable in the working memory and being linked to the past, present, and future, to feelings and relevant options. Moreover, a consistent self requires there to be a unified agent who directs the various self-representations, object representations, and affect states. Without a reflexive distance, the individual risks being “lost in emotions.”

Mentalization theory describes how an individual—through interaction with a mentalizing other—achieves such a reflexive dialogue with himself/herself. The individual learns social tools that permit him/her to transform pressures arising from activation of the primary emotional systems into culturally sanctioned forms of understanding and expression. It is a theory that integrates self-consciousness with temperament.

Concepts from developmental psychology that are important to be familiar with (because they are also used in the clinical literature) include teleological understanding, psychic equivalence thinking, pretend mode, prementalistic thinking, and representational thinking.

Starting at the age of approximately 9 months, children develop the ability to differentiate goals from the means to reach the goals, adapt actions to new situations, and select the means (among various options) that most effectively lead to the goal. One can speak about *the self as a goal-oriented (teleological) agent*. The capacity for goal-oriented action does not require the capacity for cause-effect thinking or the ability to understand intention as cause, but it links the action to a goal. The term “teleological” is also used about the mode of thinking in regressed mental states when patients have difficulties believing anything else than concrete goal-oriented actions: “I won’t believe it until I see it . . .” and “If you care about me, then you will . . .”

From the age of about 2 years, the child develops the ability to understand that others can have intentions (wishes, needs) that can lead to action, without having to experience the action in real time. For example, the child is now able to contribute in relation to others’ preferences and to comfort others. We are now talking about *the self as an intentional agent*. This ability to think in mentalistic terms is also called “a naive theory of mind.” The child is now able to attribute generalized intentions to others, but is governed by a principle of mental coherence, that is, he or she still does not grasp the concept that others can contain contradicting intentions. At about this time the child establishes a concept of “me.” Action impulses, thoughts, and feelings become more and more

“mine.” However, consciousness is extroverted and “online.” It deals with targets in the world and is bound to prevailing situations. Offline abstract thinking is not yet possible (Bogdan, 2010).

The theory of prementalistic thinking is central to the developmental model. Initially, thinking is assumed to be at the level of psychic equivalence, which means that the child is unable to differentiate between the inner and outer world (or between fantasy and reality). These perspectives are yet to be acquired. One route is through pretend play. The nature of play is to simulate contrasting perspectives on reality. In play, the child imagines that others are different from what they really are. Through pretend play, the child learns to juggle between fantasy and reality. It is most exciting when the two are quite close and when it is difficult to differentiate fantasy from reality, for example, when daddy is *almost* like the evil troll. When the ability to differentiate fantasy from reality is not properly developed, the individual continues to alternate between psychic equivalence thinking where the world might become “too real,” and a pretend mode thinking which is too separated from reality.

From about the age of 4 years, there occurs a cognitive revolution (Bogdan, 2010). The child develops a more mature “theory of mind,” meaning that intentions are understood as parts of a *complex network of representations of self and other*. Enhanced executive functions (among other mechanisms) allow the child to perform metacognitive operations, that is, to understand the essence of representations, that they represent something, for example, the *aboutness* of thinking. Metacognition is thus a prerequisite for self-consciousness, for example, by knowing that the thought (Peter is hungry) is created by me, belongs to me, and may be false (as a representation about Peter’s mental state). The self enters the stage as a representational actor and it is not until this stage that children have the capacity to mentalize explicitly. Infantile amnesia (prior to the age of 3 to 4 years) is due to the inability to code personal experiences as uniquely personal events, that is, that happened to “me” in an autobiographical sense. Before this age, there are only scattered episodic memories, devoid of any narrative texture. From now on, the mentalization capacity is growing quickly. *The challenge is to be able to differentiate fantasy from reality in even more sophisticated manners and contexts, realizing that thoughts and feelings are representations of reality and not reality itself.*

The autobiographical self (from around 5 to 6 years) is based on the self as a representational agent. The transition from episodic and procedural memory to declarative memory (“it happened to me”) expands in scope and complexity. Now one can construct more realistic and coherent stories about one’s own actions and experiences. This ability, however, presupposes the capacity to maintain multiple representations of self and others so that time sequences and

causal and meaningful relations can be established between them. In general, one can say that the developmental course has as its goal the establishment of the structures and abilities that are the preconditions for a representational and autobiographical self. The sociocultural challenges that face the child, being thrown into a world of complex sociocultural practices, exert a constant pressure to install mentalizing capabilities in order to construe this world as meaningful and understandable. The emotional interactions between the child and attachment figures are crucial means to reach this goal.

Mentalization theory emphasizes mentalizing ability (including metacognition) as the most important aspect of the self. It provides the self with cohesion. Without mentalization, the individual would be subject to changing and inconsistent self-states constantly at the mercy of inner and outer events, and devoid of self-consciousness. Mentalization provides meaning and context to these changing self-states. It puts them in the perspective of one's own life history and one's impressions of other people, ongoing interactions, and the future. The ability to mentalize is genetically grounded, but must be realized through others in order to become manifest.

Mentalization and personality disorders

Mentalization theory is closely associated with the concept and theories of BPD. This connection reflects the close working relationship between Peter Fonagy and Anthony Bateman in London, both analysts and active clinicians who treat and carry out research on difficult-to-treat borderline patients. Together they developed MBT (Bateman and Fonagy, 2004). It is, however, important to emphasize that impaired mentalization ability is something that characterizes all PDs. To a certain extent this is self-evident since one of the general criteria for a PD is that the person suffers from maladaptive thought patterns, for example, a tendency to distort and/or interpret interpersonal events in a rigid manner. Mentalization theory explicates what characterizes distorted and rigid interpretational patterns. The focus is on "prementalistic" thought patterns: psychic equivalence thinking and pretend mode. Psychic equivalence thinking is schematic, concrete, black-white, and insisting. The reality it refers to is "too real." There is no room for other perspectives. In pretend mode, the relationship to reality is diffuse. Thought (and speech) is vague, metaphoric, and emotionally flat. Cognitive theory describes distorted and rigid interpretations as maladaptive cognitive schema. Mentalization theory emphasizes the importance of emotions, context, and attachment more strongly and with different therapeutic consequences. But the main point is the same: in all PDs the ability to properly interpret interpersonal events intersubjectively is impaired to a clinically significant degree.

An individual suffering from paranoid PD will, for example, interpret other people as more evil than they actually are, and themselves as more vulnerable to a conspiracy than which is actually the case. This can be seen as a consequence of the person's impaired mentalization ability. But the theory goes even further. It also refers to "unmentalized affects." In the case of paranoid PD, there is a chronic narcissistic rage, an "alien self" and projective identification (Fonagy et al., 2002). An individual suffering from paranoid PD is preoccupied with every manner of humiliation without ever being able to forget them. Total irreconcilability is at its heart and the individual's thoughts revolve around the theme of vengeance. It is this interwoven complex of self-representations, affects, and representations of others which is poorly mentalized. This means that when the individual experiences new or old humiliations, he/she quickly resorts to psychic equivalence thinking and becomes rigid, unreasonable, and insisting on his/her own version of reality. Previous humiliating experiences and the resulting rage take center stage and block out nuanced intersubjective thinking. Accordingly, mentalization-based treatment will necessarily also focus on affects.

Mentalization theory emphasizes the general phenomenon which the example of paranoid PD illustrates: that thinking is influenced by one's emotional state. If one is interested and curious, then one is likely to have optimistic thoughts. If one is depressed, one is likely to have sad and distressing thoughts. If one is manic, one has lofty and unrealistic thoughts. If one is scared, one may have disconcerting thoughts, and if one is angry, the focus may be on revenge. Mentalization theory integrates both a "bottom-up" and a "top-down" perspective. Emotions influence us from "below" in a way that can make us lose a more overall perspective on reality. The ability to mentalize allows us to approach emotions "from above" and put them into perspective. Mental health depends on a balance between the two extremes: "lost in emotions" or "lost in cognition."

Dimensions of mentalizing

Mentalizing is a multidimensional construct and breaking it down into dimensional components is helpful in understanding MBT. Broadly speaking, mentalization can be considered as four intersecting dimensions: (1) automatic versus controlled or implicit versus explicit, (2) internal versus externally based, (3) self- versus other-orientated, and (4) cognitive versus affective processes. The dimensions are probably grounded in different neurobiological systems (Luyten et al., 2012).

None of us manage to integrate all components of mentalizing all the time and nor should we. Normal people will at times move from understanding themselves and others according to their perceptions of what is in the mind, to explanations based on the physical environment—"if they behave like that they

obviously want to spoil everything.” This is particularly the case in powerful affective states when our cognitive processes decompose in the face of a wave of emotion. So, personality pathology does not simply arise because of a loss of mentalizing. It occurs for a number of reasons.

First, it matters how easily we lose it. Some individuals are sensitive and reactive, rapidly moving to non-mentalizing modes in a wide range of contexts.

Second, it matters how quickly we regain mentalizing once it has been lost. Bateman and Fonagy (2004) suggest that a combination of frequent, rapid, and easily provoked loss of mentalizing within interpersonal relationships with associated difficulties in regaining mentalizing and the consequent lengthy exposure to non-mentalizing modes of experience is characteristic of BPD. Individuals with BPD may be “normal mentalizers” except in the context of attachment relationships. They tend to misread minds, both their own and those of others, when emotionally aroused. As their relationship with another person moves into the sphere of attachment, the intensification of relationships means that their ability to think about the mental state of another can rapidly deteriorate. When this happens, prementalistic modes of organizing subjectivity emerge, psychic equivalence and pretend mode, which have the power to disorganize these relationships and destroy the coherence of self-experience that the narrative provided by normal mentalization generates.

Third, mentalizing can become rigid, lacking flexibility. People with paranoid PD often show rigid hypermentalizing with regard to their own internal mental states and lack any real understanding of others (Dimaggio et al., 2006). At best, they are suspicious of motives and at worst, they see people as having specific malign motives and cannot be persuaded otherwise. The mental processes of people with antisocial personality disorder (ASPD) are less rigid than those found in paranoid people. Their mentalizing shows flexibility at times but when uncertainty arises they resort to prementalistic ways of organizing their mental processes and how they understand the world and their relationships.

Finally, the balance of the components of mentalizing can be distorted. Patients with narcissistic personality have a well-developed self-focus but a limited understanding of others. In contrast, patients with ASPD may be experts at reading the inner states of others, even to the point that they misuse this capacity to coerce or manipulate them, while being unable to develop any real understanding of their own inner world. In addition, they lack abilities to accurately read certain emotions and fail to recognize fearful emotions from facial expressions. This implicates dysfunction in neural structures such as the amygdala that subserve fearful expression processing. Marsh and Blair (2008) in a meta-analysis of 20 studies showed a robust link between antisocial behavior

and specific deficits in recognizing fearful expressions. This impairment was not attributed solely to task difficulty.

Implicit versus explicit mentalizing

Among the dimensions of mentalizing, the implicit versus the explicit mode plays a superordinate role. Most of us mentalize automatically in our everyday lives—not to do so would be exhausting. Automatic or implicit mentalizing allows us to rapidly form mental representations based on previous experience and to use these as a reference point as we gather further information to confirm or disconfirm our tentative understanding of motivations. This is reflexive, requires little attention, and is beneath the level of our awareness (Satpute & Lieberman, 2006; Kahneman, 2011). If it does not seem to be working we move to more explicit or controlled mentalizing which requires effort and attention. It is therefore slower and more time-consuming and most commonly performed by inner (or outer) speech. Our capacity to manage this controlled mentalizing varies considerably and the threshold at which we return to automatic mentalizing is, in part, determined by the response we receive to our explicit attempts to understand someone in relation to ourselves and the secondary attachment strategies we deploy when being aroused and under stress.

Behavioral, neurobiological, and neuroimaging studies suggest that the move from controlled to automatic mentalizing and thence to non-mentalizing modes is determined by a “switch” between cortical and subcortical brain systems (Arsten & Goldman-Rakic, 1998; Lieberman, 2007) and that the point at which we switch is determined by our attachment patterns. Different attachment histories are associated with attachment styles that differ in terms of the associated background level of activation of the attachment system, and the point at which the switch from more prefrontal (controlled) to more automatic mentalizing occurs (Luyten et al., 2012). Dismissing individuals tend to deny attachment needs, asserting autonomy, independence, and strength in the face of stress, accompanied by attachment deactivation strategies. In contrast, a preoccupied attachment classification or an anxious attachment style is generally considered as being linked to attachment hyperactivating strategies (Mikulincer & Shaver, 2007). Attachment hyperactivating strategies are associated with the tendency to exaggerate both the presence and seriousness of threats, and frantic efforts to find support and relief, often expressed in demanding, clinging behavior. Both adult attachment interviews (AAIs) and self-report studies have found a predominance of anxious-preoccupied attachment strategies in BPD patients (Fonagy et al., 1997; Levy et al., 2006). In borderline patients, there is a characteristic pattern of fearful attachment (attachment-anxiety and relational avoidance), painful intolerance of aloneness, hypersensitivity to social environment, expectation of

hostility from others, and greatly reduced positive memories of dyadic interactions (Fonagy & Bateman, 2008; Gunderson & Lyons-Ruth, 2008).

An important cause of anxious attachment in BPD patients is the commonly observed trauma history of these individuals. Attachment theorists, in particular Mary Main and Erik Hesse, have suggested that maltreatment leads to disorganization of the child's attachment to the caregiver because of the irresolvable internal conflict created by the need for reassurance from the very person who also (by association perhaps) generates an experience of lack of safety. The activation of the attachment system by the threat of maltreatment is followed by proximity seeking, which drives the child closer to an experience of threat leading to further (hyper)activation of the attachment system (Hesse & Main, 2000). This irresolvable conflict leaves the child with an overwhelming sense of helplessness and hopelessness. Congruent with these assumptions, there is compelling evidence for problematic family conditions in the development of BPD, including physical and sexual abuse, prolonged separations, and neglect and emotional abuse, although their specificity and etiological import has often been questioned (Zweig-Frank & Paris, 1991). Probably a quarter of BPD patients have no maltreatment histories (Goodman et al., 2003) and the majority of individuals with abuse histories show a high rate of resilience and no personality pathology (McGloin & Widom, 2001). Early neglect may be an underestimated risk factor (Kantojarvi et al., 2008), as there is some evidence from adoption and other studies to suggest that early neglect interferes with emotional understanding (Shipman et al., 2005) and this plays a role in the emergence of emotional difficulties in preschool (Vorraia et al., 2006) and even in adolescence (Colvert et al., 2008). One developmental path to impairments in mentalizing in BPD may be a combination of early neglect, which might undermine the infant's developing capacity for affect regulation, with later maltreatment or other environmental circumstances, including adult experience of verbal, emotional, physical, and sexual abuse (Zanarini et al., 2005), that are likely to activate the attachment system chronically (Fonagy & Bateman, 2008).

BPD patients who mix deactivating and hyperactivating strategies, as is characteristic of disorganized attachment, show a tendency for *both* hypermentalization and a failure of mentalization. On the one hand, because attachment deactivating strategies are typically associated with minimizing and avoiding affective contents, BPD patients often have a tendency for hypermentalization, that is, continuing attempts to mentalize, but without integrating cognition and affect. At the same time, because the use of hyperactivating strategies is associated with a decoupling of controlled mentalization, this leads to failures of mentalization as a result of an overreliance on models of social cognition that antedate full mentalizing (Bateman & Fonagy, 2006).

This has important clinical implications for MBT. The therapist needs to develop strategies related to excessive demand and dependent behavior as well as ensuring an ability to manage sudden therapeutic ruptures, often characterized by dismissive statements about the therapist's inadequacies with the accompanying danger of leaving treatment.

Internal versus external mentalizing

The dimension of internal and external mentalizing refers to the predominant focus of mentalizing (Lieberman, 2007). Internal mentalizing refers to a focus on one's own or others' internal states, which are thoughts, feelings, and desires; external mentalizing implies a reliance on external features such as facial expression and behavior. This is not the same as the self/other dimension which relates to the actual object of focus. Mentalization focused on a psychological interior may be self or other oriented. Again, this distinction has important consequences for MBT. Patients with BPD have a problem with internal mentalizing but they also have difficulties with externally focused mentalizing. Inevitably both components of mentalizing inform each other, indicating that borderline patients are doubly disadvantaged. The difficulty is not so much that patients with BPD often misinterpret facial expression, although they might sometimes do so, but more that they are highly sensitive to facial expressions and so tend to react rapidly and without warning (Lynch et al., 2006). Any movement of the therapist might trigger a response—glancing out of the window, for example, might lead to claiming that the therapist is obviously not listening and so the patient might feel compelled to leave; a nonreactive face is equally disturbing as patients continuously attempt to deduce the therapist's internal state using information derived from external monitoring. Anything that disrupts this process will create anxiety, which leads to a loss of mentalizing and the re-emergence of developmentally earlier ways of relating to the world.

A reduced ability to arrive at an emotional understanding of others by reading their facial expressions accurately exaggerates a compromised ability in BPD to infer mental states from focusing on internal states. To maintain or repair cooperation during social/interpersonal exchange and interaction, we have to understand social gestures and the likely interpersonal consequences when shared expectations about fair exchange or social norms are violated by accident or intent. To do this we have to integrate external mentalizing with an assessment of the underlying internal state of mind of the other person. The importance of this interactional process in the pathology of BPD has been creatively demonstrated experimentally. Using a multiround economic exchange game played between patients with BPD and healthy partners, King-Casas and colleagues (2008) have shown that behaviorally, individuals with BPD showed

a profound incapacity to maintain cooperation, and were impaired in their ability to repair broken cooperation on the basis of a quantitative measure of coaxing. They failed to understand the intentions of others—an internally based task. They expected their partners to be mean to them and they were unable to change this understanding even when evidence suggested it was incorrect, for example, when their partner was generous. In other words, they were unable to read the intentions of their partner and to alter their own behavior reciprocally. This gradually led their partner in the game to become mean, suggesting that they were provoked to become the very person they were being seen as. Analogously, therapists working with patients with BPD must bear in mind the risk of being provoked into becoming the very therapist that their patient accuses them of being

Self versus other mentalizing

Impairments and imbalances in the capacity to reflect about oneself and others are common and it is only when they become more extreme that they begin to cause problems. Some people become experts at reading other people's minds and if they misuse this ability or exploit it for their own gain we tend to think they have antisocial characteristics; others focus on themselves and their own internal states and become experts in what others can do for them to meet their requirements and we then suggest they are narcissistic. Thus excessive concentration on either the self or other leads to one-sided relationships and distortions in social interaction. Inevitably this will be reflected in how patients present for treatment and interact with their therapists. Patients with BPD may be oversensitive, carefully monitoring the therapist's mind at the expense of their own needs and present what they think the therapist wants them to be. They may even take on the mind of the therapist and make it their own. Therapists should be wary of patients who eagerly comply with everything said to them. Such compliance may alternate with a tendency to become preoccupied and overly concerned about internal states of mind, leaving the therapist feeling left out of the relationship and unable to participate effectively.

Cognitive versus affective mentalizing

The final dimension to consider relates to cognitive and emotional processing—belief, reasoning, and perspective taking on the one hand and emotional empathy, subjective self-experience, and mentalized affectivity on the other (Jurist, 2005). A high level of mentalizing requires integration of both cognitive and affective processes. But some people are able to manage one aspect to a greater degree than the other. Patients with BPD are overwhelmed by affective processes and cannot integrate them with their cognitive understanding—they

may understand why they do something but feel unable to use their understanding to manage their feelings; they are compelled to act because they cannot form representations integrating emotional and cognitive processes. Others, such as people with ASPD, invest considerable time in cognitive understanding of mental states to the detriment of affective experience.

Mentalization measured as reflective functioning

An operationalized measure has been developed for mentalization: reflective functioning (RF) (Fonagy et al., 1998). RF is scored on the basis of a transcript of the AAI on a scale from -1 (negative or bizarre mentalization) to $+9$ (sophisticated mentalization). It is possible to achieve good reliability when scoring RF, but it requires long training. Since scoring is quite time-consuming, the RF scale is primarily a research instrument and not suitable for everyday clinical use. Efforts are underway to make RF scoring easier. Based upon the work of Perkins (2009), self-report scales have been constructed, both as a long (RFQ-54) as well as a short version (RFQ-18). Meehan and coworkers (2009) have tested a rating scale containing 53 items (“Reflective Function Questionnaire”), which can be used in various contexts, such as psychotherapy sessions. Low RF has been found for a range of mental disorders, for example, BPD, ASPD, and anorexia nervosa. Other studies have found that low RF in young mothers predicts insecure attachment patterns for their children (Fonagy et al., 1991). Borderline patients who received transference-focused psychotherapy were found to increase their RF score in the course of treatment (Levy et al., 2006).

MBT and mentalization-oriented psychotherapy

MBT is grounded in the theories of mentalization, PDs, and psychodynamic treatment. However, the MBT approach is relevant not just for PDs, but also for the treatment of depression, anxiety disorders, post-traumatic conditions, eating disorders, and substance abuse disorders (Rudden et al., 2006; Skårderud, 2007; Allen et al., 2011). MBT is a psychodynamic approach in the sense that the main instrument of change is the intersubjective transactions taking place between therapists and patients. It is therefore possible to modify different psychodynamic practices to increase the focus on mentalizing, as kinds of “mentalization-oriented psychotherapies.” Bateman and Fonagy (2006) suggest that all psychological therapies exert their influence through their effect on the patient’s ability to mentalize. MBT cultivates this focus. Even though MBT in the following sections will be described in a specialized format, many of the principles presented here might be integrated into everyday psychodynamic therapeutic practice.

MBT as day hospital treatment

Guidelines for MBT exist in two formats: as a long-term day hospital treatment program and as an intensive outpatient treatment program. Originally MBT was created as a day hospital treatment (Bateman & Fonagy 1999, 2001). The study that documented the effectiveness of treatment was small with respect to number of patients, but the treatment results were impressive. In all, 42 low-functioning borderline patients (mean GAF score = 35) in London, United Kingdom, were randomized to either experimental day hospital treatment or to the control condition (treatment as usual). The day hospital treatment program lasted up to 18 months and was followed by outpatient group psychotherapy twice a week for a further 18 months. Treatment as usual consisted of consultations with psychiatrists, pharmacological therapies, crisis teams, visits to emergency wards, admission to hospitals, or other type of day hospital treatment. After 18 and 36 months, major differences between the groups became evident in a wide range of variables: suicide attempts, self-injury, hospital admissions, depression, anxiety, general symptom distress, interpersonal functioning, and use of medication. Over the long term, the treatment also proved to be cost-efficient (Bateman & Fonagy, 2003). In a long-term follow-up, the differences between the experimental and control groups were maintained at 8 years after randomization (Bateman & Fonagy, 2008). A study in the Netherlands (Bales et al., 2012) has also showed excellent results for MBT day hospital treatment.

Guidelines for MBT day hospital treatment are available in publications from Bateman and Fonagy (2004, 2006). The treatment focus is upon attachment behavior and mentalization skills and consists of a well-choreographed collaborative effort combining individual therapy and group therapies. The group therapies are arenas for “mentalizing in practice.” Experiences from the groups and from the treatment program in general, as well as from external life, are discussed in more detail in individual therapy sessions. The treatment framework is an important element. Crisis plans are developed and close contact is maintained with families and health service professionals. Pharmacological treatment is followed up closely by a psychiatrist. In addition to the mentalization-based interactional group therapy, patients also attend expressive group therapy sessions (psychodrama, creative group therapy, or group art therapy). More informal interaction takes place in connection with activities and excursions. A psychoeducational mentalization group has been added recently.

MBT as intensive outpatient treatment

There have been claims that the treatment results by Bateman and Fonagy (2001) are not necessarily attributable solely to the mentalization component

of the complex day hospital treatment. Eighteen months of day hospital treatment involves a large number of potential change mechanisms. The precise content of the treatment technique has also been unclear. In response to this criticism, an attempt was made to purify MBT to an intensive outpatient treatment program. The treatment components included individual therapy for 1 hour a week and MBT group therapy once a week, for a period of 18 months. The treatment started with psychoeducational MBT group meetings weekly over the course of 2–3 months. The treatment technique is described in Bateman and Fonagy (2006).

MBT as an intensive outpatient treatment program was tested in a randomized study with 134 borderline patients where the control group was given “structured clinical management.” The results showed that patients in both treatments improved, but that the MBT group experienced a more rapid and significant improvement on variables such as suicide attempts, hospitalizations, symptoms, and social adjustment (Bateman & Fonagy, 2009). Outpatient MBT has a higher potential than the more costly intensive MBT day hospital treatment program, which is meant for patients who score below GAF = 40. Most borderline patients function on a somewhat higher GAF level. As long as patients have some modicum of structure in their lives, for example, a place to stay, some social network, not being involved in self-destructive, ongoing addiction behavior, being able to adhere to a treatment agreement, and collaborating on a crisis plan, then outpatient MBT will usually be sufficient. MBT requires a specialized team and is well suited for mental health centers.

Recently we have replicated the study of intensive outpatient MBT (Kvarstein et al., 2015). Sixty-four borderline patients treated in the MBT program (since 2008) at the Department of Personality Psychiatry, Oslo University Hospital, were compared to 281 borderline patients treated (from 1993 to 2007) in the previous psychodynamic day hospital program. Patients in the MBT program did better on all variables. The effect sizes on symptoms, interpersonal problems, and social functioning were nearly twice as large in the MBT program. Moreover, the dropout rate was extraordinary low, that is, 5% during the first 6 months, compared to 42% in the psychodynamic program. This study was also the first study to include MBT adherence ratings of the therapists, which were found to be satisfactory.

Personality assessments, dynamic formulations, crisis plans, and treatment structure

MBT requires the administration of customary personality assessments to map the type and scope of personality pathology, for example, by SCID-II interviews. During assessment, a MBT dynamic formulation should be developed in order

to consolidate the focus and therapeutic alliance. Patients at risk of self-mutilation or other kinds of gross self-destructive behavior (or violence toward others) should be provided with a crisis plan. Moreover, one should carefully design the treatment structure in order to enhance its overall containment capacity. This is of crucial importance for more poorly functioning patients. The treatment structure should be easy to understand and it should convey predictable responses. The components are usually the following, although treatment length may vary according to local conditions:

- 1 Assessments
- 2 Enhancing motivation and alliance, for example, by mentalization-based case formulations
- 3 Supportive measures, for example, crisis plans
- 4 Mentalization-based psychoeducational group therapy, 12 sessions
- 5 Individual MBT, 1 hour weekly for 1–2 years
- 6 MBT-G for 2–3 years
- 7 Consultations with a psychiatrist on pharmacotherapy
- 8 Once a week (video-based) supervision for individual and group therapists
- 9 Staff meetings and meetings of individual and group therapists
- 10 Information (psychoeducation) for relatives
- 11 Information and meetings with cooperating health personnel
- 12 Follow-up treatment/consultations after termination of the MBT program.

These issues are dealt with in the manuals by Karterud and Bateman (2010, 2011) and they are discussed at length in the practical guidelines for MBT by Bateman and Fonagy (2006). Since these issues do not directly concern the theory and practice of MBT-G, we will not elaborate on them here. However, it is important to emphasize the importance of these elements as crucial parts of the larger group/institutional matrix which holds and contains MBT-G as a specialized endeavor.

The group component of MBT has until now received less attention than the overall principles and principles for MBT individual therapy. Useful discussions are to be found by Bateman and Fonagy (2004, 2006) and by Karterud and Bateman (2012). The group therapy component is not any instant invention. It can be seen as an outgrowth of the common psychodynamic tradition of the Western world and in particular by the group analytic tradition in England/London. Group psychotherapy for borderline patients has always been a controversial issue. We will therefore proceed with a short historical account.

Is group therapy good treatment for patients with borderline personality disorder?

The literature on group psychotherapy and BPD is divergent. It is often emphasized that treatment of interpersonal problems constitutes the very strength of group psychotherapy. Since such problems will show up in the here and now of the group, they can be explored and be worked through in a direct manner. Patients with BPD have gross interpersonal problems and for those reasons alone, group psychotherapy should be well suited. It has also been claimed that a two-person relationship tends to be too “hot” or “tight” for borderline patients due to rapid arousal of transference and countertransference (cf. discussion on attachment arousal in previous paragraphs). Accordingly it might be an advantage to “dilute” the transference by spreading onto multiple persons. Another argument has been that borderline patients, due to their authority conflicts, have more difficulty in accepting a confrontation from a therapist as opposed to peers. Groups therefore may have the capacity to contain the contradictory inner representations of borderline patients and facilitate therapeutic transformation.

On the other hand, a psychodynamic group is an unstructured situation where suddenly unexpected and dramatic events may arise and where the therapist has less control than in individual psychotherapy. Borderline patients are emotionally unstable and often easily offended. They easily get captured by emotional waves in the group or in subgroups which they identify with. Their mentalizing ability rapidly declines during emotional arousal and they risk ending up in destructive or meaningless exchanges with other group members, including therapists. Therapists get caught up in the dilemma of how much time and attention should be devoted to that particular patient relative to the needs of other patients and the group as a whole. Moreover, borderline patients also have a tendency to act on latent antagonisms in the group and promote and perpetuate destructive splitting between persons and subgroups. Another scenario is that borderline patients get strongly emotionally activated, but hide it and sit in the group with strong unmentalized and chaotic emotions which perpetuate after the group and require a lot of energy in the aftermath. At worst, patients find no other solution than destructive acting out.

The clinical literature has discussed these dilemmas for more than 50 years, gradually being supplemented by research. We find colorful narratives on “the difficult patient in groups” (Roth et al., 1990). It is difficult to arrive at a clear overview of this literature since different problems are often conflated. The most important are: Do we focus on groups containing one or two borderline patients but otherwise composed of patients with higher levels of personality functioning? Or do we talk about groups where everybody or most of the patients have a

BPD (in a wide sense)? Do we talk about group psychotherapy as a stand-alone treatment (Verheul & Herbrink, 2007), or as a part of a more comprehensive treatment program?

The early clinical literature dealt with borderline patients who participated in ordinary psychotherapeutic groups. It soon became apparent that many of them needed “something more.” Different therapeutic schools have come up with different responses to what this “something more” should consist of. Group analysis, developed by the pioneer S.H. Foulkes and other colleagues in post-war London, was purist in the sense that the response to “too little therapy” was “more group.” To establish cooperation with other (individual) therapists was considered a defeat for the group in the sense that the group thereby only “exported” problems that it did not dare to approach itself. Group analysis therefore advocated twice-weekly group sessions, while one session a week was considered standard. Regrettably, there is no comparative research on this matter. We therefore do not know the effect of a twice a week format compared to alternative treatment strategies.

Here, as elsewhere, the Americans have been more pragmatic. They are traditionally less concerned by ideology than “what works.” Patients are obviously different. It might not be that *all* patients in a group needed more, but that some did, and perhaps not for the entire treatment course, but for intensive periods. Then it would be more appropriate to add something different, like individual therapy to the more vulnerable patients, rather than an extra group session each week. How should one construct such a concurrent treatment?

Concurrent group and individual therapy appeared in the literature through the work of Wender and Stein in 1949, when they described their experiences from an outpatient clinic in New York. Since this publication, two books on concurrent psychotherapy (Ormont & Strean, 1978; Caligor et al., 1984) have been published, as well as a number of articles summarized by Karterud et al. (2007).

According to Porter (1993), concurrent group and individual therapy is an effective and specialized treatment form that has its own indications, contraindications, therapeutic mechanisms, developmental stages, and technical requirements. When the therapy is conducted properly, there should be a synergistic effect since the two components complement each other and address different needs. Group therapy is particularly suited for exploring interpersonal problems, while individual therapy is better suited for exploring intrapsychic phenomena. Early on, concurrent therapy was viewed as being especially appropriate for treating borderline patients (Stein, 1981). However, there is always a danger of a split developing between the different therapists and the different formats, and this has been a central theme in the literature (de Zulueta & Mark, 2000; Kegerreis, 2007).

The terms “combined” and “conjoint” psychotherapy are commonly used for this type of therapy. It is customary to refer to combined psychotherapy when the same therapist conducts both the group and individual therapy. In conjoint psychotherapy, different therapists are involved. The risk of developing a split is a strong argument for combined therapy, in which the same therapist maintains full control. In practice, however, conjoint therapy is the most common pattern. One reason for this is that not all individual therapists are likely to master group therapy and vice versa. There are also good arguments for sharing the therapeutic burden when treating demanding patients. There is no research that has investigated differential effectiveness between conjoint or combined therapy programs.

In conjoint psychotherapy, collaboration between the therapists is a critical factor. The collaboration requires a fundamental respect for the unique elements of the different therapies and a personal and professional respect between the therapists. Many patients will, over shorter or longer periods, devalue one of the components and have a tendency to idealize the other. Even as therapists, we all have remnants of unmentalized narcissism that tempt us to accept, implicitly or explicitly, such a split if we are so lucky to be the idealized party. In practice, group therapy is most often the component to be devalued because it is the most complicated dynamically and puts larger demands on the patient’s mentalizing ability. In groups, each patient has to share the attention and devotion of the therapist(s) with other group members. Another reason is that insulting and humiliating episodes are more likely to occur in group therapy sessions than in individual sessions. In combined treatment processes, we recommend that the individual therapist asks about recent group experiences at practically every session. The therapist must also go closely through episodes in which the patient has felt himself or herself misunderstood, overrun, ignored, or poorly treated. These episodes are grist for the therapeutic mill. It is indeed by working through such episodes that the patient’s mentalization ability may be challenged, stimulated, and improved over time. The patient’s experiences in group therapy must be a central focus of the individual therapy, on an equal footing with relationships to other attachment figures.

Even if there is a rich clinical literature on concurrent psychotherapy, there is scarce evidence for the claim that it is better than one modality alone, even for borderline patients. To our knowledge there is only one study that has compared concurrent versus individual treatment with the same approach. Ivaldi and coworkers (2007) compared outpatient combined (same therapist) individual- and group therapy according to guidelines for “cognitive-evolutionary therapy” for patients (N = 85) with PDs (whereof BPD was in majority) with

individual “cognitive-evolutionary therapy” alone ($N = 24$). The results favored combined therapy on a range of outcome measures, like attrition, GAF scale, symptom reduction, quality of life, and self-harm. However, one cannot make any firm conclusion from this study. The patients were not randomized and there might have been systematic differences between those who were recruited to the different treatment modalities. On the other hand, this study indicates that concurrent psychotherapy, when conducted according to certain guidelines, may have some advantages for borderline patients.

What about group psychotherapy as a stand-alone treatment? The evidence here is also divergent (Verheul & Herbrink, 2007). It is important to distinguish between groups where all patients have a PD and groups where only some have a PD. Lorentzen and coworkers (2004) found that patients with mild to moderate PD (measured by GAF, Symptom Checklist-90-Revised (SCL-90-R), and Inventory of Interpersonal Problems (IIP) scales) had a good outcome by group analytic psychotherapy. However, 40% of the patients in those groups did not have any PD. Many clinicians contend that those patients are key actors with respect to group cohesion. They argue that it is the patients with little personality pathology that contribute the most to the culture of the group, to the benefit of patients with more serious pathology who are thereby contained and helped to explore their pathology in a group atmosphere which is more benign than their own inner world.

There is some evidence for this argument. Piper and coworkers (2007) compared the effect of different types of short-term group psychotherapy for patients with different quality of object relations (QOR). The QOR will most probably correlate strongly with mentalizing ability (or RF). Piper and coworkers (2004) had earlier found that QOR was a moderator for treatment effect, implying that patients with high QOR gained the most from insight-oriented psychotherapy while patients with low QOR gained the most from supportive psychotherapy. However, when they analyzed the material across groups, they found that *mean QOR on the group level*, regardless of what kind of group, was significantly associated with outcome. Clinically this indicates that every kind of well-functioning group needs some patients with fairly mature QOR because it most probably promotes higher-level group processes. This is in accordance with general wisdom among group therapists. When adding a new member they will prefer someone with higher personality functioning. According to the findings of Piper and coworkers, this will be for the better for all patients since it will raise the mean QOR in the group. And conversely, if there is a high mean QOR beforehand, the group can afford to add a patient with lower QOR, since it will have a low impact on the mean. In other words, stand-alone group psychotherapy may be beneficial for some patients with PD if most of the other

patients are healthier. According to this logic it is counterintuitive to develop a psychotherapy group with PD patients only.

The work by Piper and coworkers (2007) is suggestive. However, to prove it would be very difficult. A persuasive study would need 15–20 well-functioning groups that were willing to include two to three patients with more serious personality pathology of borderline type. It is possible, but difficult to see where such a study could be undertaken or how it could be funded. For these reasons, naturalistic studies and in-depth case studies need to be taken seriously.

It is mainly such other evidence which is highlighted when authors of major review articles emphasize the positive aspects of group psychotherapy for patients with PDs. Piper and Ogrodniczuk (2005) maintain that research evidence indicates a positive effect of group psychotherapy for all categories of PDs, except paranoid, narcissistic, and ASPD. They assert that groups are used too seldomly in the treatment of patients with PD. The contributing authors of the prestigious *Gabbard's Treatments of Psychiatric Disorders* (Gabbard, 2007) also have a general positive attitude to group psychotherapy. A much-cited study concerning BPD is that of Munroe-Blum and Marziali (1995). Time-limited interpersonal-oriented group psychotherapy (which is described more extensively in Chapter 2, in 'Similarities and differences between MBT-G and other types of group therapy') was compared to dynamic individual psychotherapy. Both therapy conditions displayed about the same good effect on dysfunctional behavior, symptoms, interpersonal problems, and social adjustment. Wilberg and coworkers (2003) also found good results from group psychotherapy for borderline patients in a follow-up treatment after day hospital treatment. Budman and coworkers (1996) found good effects for a diversity of PDs. In addition, there are meta-analytic studies of psychotherapy (including group psychotherapy) which convincingly display significant effects for PDs (Leichsenring & Rabung, 2008).

A reasonable conclusion of the above mentioned findings seems to be that somewhat better functioning borderline patients (e.g., GAF score > 50) most probably benefit from participating in groups where the majority of the patients have a higher level of personality functioning. However, it is still unclear if such treatment is better or worse than individual psychotherapy.

Psychotherapy is for most patients and conditions an efficient mode of treatment. However, like other potent remedies, psychotherapy may also have side effects and it may be harmful. Borderline patients are more emotionally reactive than most other patients and this makes them also more vulnerable to negative effects of treatment. They risk being victims of "iatrogenic harm" ("caused by the doctor/iatros"). Their high drop-out rate is most likely a reflection of this vulnerability. In published studies, their drop-out rate varies between 17% and 67% (Hummelen et al., 2007).

In order to explore this, we (Hummelen et al., 2007) performed a qualitative research study at the Department for Personality Psychiatry, Oslo University Hospital, on dropouts from groups where all patients suffered serious personality pathology. We conducted in-depth interviews of eight (out of 29 patients who dropped out during the years 2000–2003) female borderline patients and their therapists according to the qualitative research principles of Kvale (1997). The patients' (and therapists') responses were organized in ten themes: for example, "difficulties during the transition from day hospital to outpatient group psychotherapy," "the group therapy stirred up too much distress," "group therapy alone was insufficient," "the patient was unable to benefit from group therapy," and "poor motivation for change." The most frequent reason for drop-out was variations of the theme "group therapy stirred up too much distress." All patients reported "activation of strong negative emotions" and seven out of eight reported "too much rumination" in the aftermath of the group sessions, meaning that they were left alone with feelings that were difficult to digest. The therapists reported the vulnerability of patients as the most frequent problem. The patients described their emotional problems as "tough and difficult" and being associated with anxiety, anger, vulnerability, sadness, irritation, being humiliated, guilt, powerlessness, shame, disappointment, rejection, frustration, and contempt. The anger most often concerned the therapists and was related to their experiences that the therapists seemingly did not take seriously their difficulties in life in general and within the group. The interviews revealed that the therapists often were somewhat surprised when they later realized the magnitude of the patients' negative emotional experiences.

The patients displayed considerable problems with how to benefit from the group therapy format. They found it difficult to describe any meaningful purpose for the group and how they could make use of it for working with their personal problems. They found it difficult to disclose personal matters, often due to a fear of disappointment and rejection and being overwhelmed by own emotions, or because they were afraid that other group members, towards whom they harbored strong and ambivalent feelings, would be overwhelmed or hostile. Some were afraid to make other patients suicidal and that they would carry such fears the whole week until next group session. Some considered fellow patients as too vulnerable or too superficial or having no motivation for change. They often experienced themselves as outsiders and had little or no sensation of being part of a meaningful collective project, that is, their sense of group cohesion was low or absent. They had seldom reflected on their own contribution to low group cohesion, for example, that they on average showed up at only every second group session.

Overall the patients experienced the therapists as too passive and too little engaged. They expressed a wish for:

- 1 therapists that were more helpful in explaining *how* one could benefit from group therapy
- 2 therapists that were more humble, for example, that could admit own errors and shortcomings
- 3 therapists that clearly signaled that they had noticed the distress of the patients and who did something to alleviate the pain.

The patients clearly reported more and stronger negative emotional reactions than the therapists had realized. They described experiences and consequences of “mentalizing collapse” which the therapists had overlooked. The therapists had experienced several of the patients as “well functioning” and “quite mature” and had been somewhat surprised when some of them dropped out. In hindsight, they realized that they had been deceived by the “mask” which some of the patients carried.

This study demonstrates, in its condensed format, how borderline patients frequently activate negative emotions and negative self-states in dynamic groups; that these emotional reactions often are not sufficiently mentalized; that therapists tend to overestimate patients’ mentalizing capacities; that patients may enter a negative spiral of feeling neglected, misunderstood, and not belonging; and harbor an increasingly skeptical attitude and poorly articulated critique that together cause a therapeutic breakup. In such a negative interpersonal spiral, withdrawal will carry an aspect of self-protection. However, such ruptures also represent tragic repetitions of previous relational breakups, which are then enacted in the interpersonal field of the group, including the therapist. However, to blame the patients is too simple. Professional treatment of patients with BPD should have at its disposal strategies that can process such enactments and counteract their destructive spiraling effects. Such strategies should be embedded in the structure as well as the content of the treatment.

Most of the literature which has been referred to in this chapter concerns patients with moderate or even mild borderline pathology. More chaotic patients with little or no social network, being out of a job and homeless, with frequent episodes of self-harm and suicidal behavior, drug addiction, violence, and other kind of acting out, have not been regarded as suitable candidates for group psychotherapy. This was surely one reason why therapists started to experiment with other approaches. The prospects were so poor that there was nothing to lose. During the 1990s, there surfaced radically new ways of treating borderline patients. The results were remarkably good (Linehan et al., 1991, 1993; Bateman & Fonagy 1999, 2001).

Dialectical behavioral therapy (DBT) was developed by Marsha Linehan and coworkers (Linehan, 1993a, 1993b). DBT was initially designed for self-harming females with borderline pathology in an outpatient format. However, it has been expanded to include a range of disorders, for example, bulimia and drug addiction, and the format has been adjusted to inpatient treatment as well (Linehan et al., 2007). DBT is a concurrent treatment consisting of an individual and a group component. It is thoroughly manualized and patients receive psychoeducation and home lessons according to cognitive behavioral principles and a defined schedule. For our purpose, we should note that the group therapy component of DBT is not based upon free group association, but construed as a “skills training group,” with a program which is closely integrated with the treatment as a whole. Patients are exposed to a program of emotion regulation and the development of interpersonal skills. As described in Chapter 2, DBT skills training groups are radically different from MBT-G.

MBT also evolved during the 1990s. While DBT was the response from the cognitive behavioral field to the challenges posed by the borderline pathology, MBT was the response from the psychodynamic tradition. Both therapies are combined therapies. Other common features are a concise theory of the essence of borderline pathology, a structured treatment program that is consistent with this theory, clearly expressed treatment guidelines, treatment designed as teamwork, as well as guidelines for therapist cooperation and supervision. All the available evidence for groups as a treatment modality for BPD has been scrutinized by professional and state quality control agencies in the United States and United Kingdom (American Psychiatric Association, 2001; NICE, 2009). The conclusion is that group therapy is recommended as part of broader treatment programs for BPD. The effects of DBT and MBT weigh heavily in the data.

Compared to psychodynamic group therapy, MBT-G is a more structured modality. In MBT-G, one installs strategic measures in order to counteract aggressive escalation and collective group regression, influenced by the fact that emotions are contagious. Measures are also implemented to facilitate verbal exchange with all patients and to reflect upon the experience of sequences that involves different patients. This aims to counteract the problem of patients leaving group sessions with unmentalized emotions. Moreover, MBT-G has a clear focus for the treatment (enhance mentalizing abilities) and prioritizes exploration of interpersonal encounters. MBT-G evolved in London, United Kingdom, the hotbed of group analytic psychotherapy (Foulkes, 1948, 1964, 1975). It was shaped by the needs of long-term (18-month) day hospital treatment for extremely poorly functioning patients. Later it was modified by experience and the needs of intensive outpatient treatment of somewhat better functioning patients, but still in the serious realm (GAF score = 40–50). It was

further modified when being exported to other countries, like the Scandinavian countries, which this manual testifies. However, the core group analytic elements remain. Compared to group analysis, the main purpose with the therapeutic modifications were (1) to obtain more control of the group processes, (2) to maintain a focus on mentalization, and nevertheless (3) benefit from spontaneous interpersonal transactions.

Dynamic group psychotherapy is by essence “psychotherapy through the group process” (Whitaker, 1981). In addition to knowledge about personality pathologies and their treatment, one needs thorough knowledge about group dynamics and in particular the phenomena of group belonging, collective group regressions, why emotions are “contagious,” and an understanding of dominance, social withdrawal, and subordination. This volume is not a textbook or manual for group psychotherapy in a general sense. However, since an evolutionary perspective most often is lacking in other volumes, we find it necessary to take a detour before we dive into the details of BPD and MBT-G.

Group dynamics and evolution

Group scholars often contend at the beginning of their volumes that man is a “herd animal” (Bion, 1961) or “social to the core of its being” (Foulkes, 1975). There are seldom references to evolutionary evidence or specific animal studies. However, such evidence was to a large extent lacking when Bion and Foulkes constructed their theories. What exactly does it mean, that man is a thoroughly social, herd animal? The last decades have witnessed exciting new evidence and a series of conceptualizations which ought to have a significant impact upon our understanding of the fundamentals of group dynamics. The most important contributions concern:

- 1 group affiliation among social animals and in particular higher primates (Cheney & Seyfarth, 2007)
- 2 primary emotion systems (including attachment) among all mammals (Panksepp, 1998) and the mirror neuron system (Rizolatti & Arbib, 1998)
- 3 the evolution of thinking (Tomasello, 2014) and modes of mentalizing among higher primates, young children, and children older than 4–5 years and their consequences for self-consciousness (Bogdan, 2010), culture (Tomasello, 2014), self-cohesion, and identity (Fonagy et al., 2002).

Group behavior in itself, for example, individuals as being observed in a group setting, tells us little about the current mentalizing level of the protagonists. It is fully possible to behave in an inconspicuous manner in a group without mentalizing that much, as well as being engaged in what goes on. In a therapeutic

group, it is easy to overestimate the current level of mentalizing among its members. In the following we will try to explain why that is so.

Basic modes of social behavior are linked to the primary emotions. As explained in the manual for mentalization-based psychoeducational group therapy (and taught to patients in MBT programs) (Karterud & Bateman, 2011), primary emotions concern (1) *SEEKING* (interest, appetite, and exploratory behavior), (2) *FEAR*, (3) *RAGE*, (4) *LUST* (sexual), (5) *CARE* (and love), (6) *SEPARATION DISTRESS* (including sadness), and (7) *PLAY* (joy) (Panksepp, 1998). These are behavioral programs coupled with modes of subjective awareness (feelings) which are found among all mammals. Basically we do not need any ability for mentalizing in order to engage in and exploring the surroundings, to protect ourselves against predators, to attack rivals, or to find sex partners. However, within complex societies it helps a lot if these behavioral programs are modified by mentalizing!

Among *Homo sapiens*, group membership may be based upon rational deliberations alone. One does not need to be particularly fond of others in order to cooperate in a scientific committee. However, therapeutic groups exploit the mammalian ability to stick together and care about each other through emotional bonds.

Among mammals, social complexity increases with the different species of primates until one reaches the chimpanzees and it culminates with *Homo sapiens*. Even among *Homo sapiens* it is the emotional bonds that ultimately keep most groups united. These bonds are most probably derivatives of the attachment system which underpins qualities such as friendship, group loyalty, and group cohesion, abilities that transcend pure rational deliberations. Attachment evolved originally as kinds of transactions between mother and child, but was gradually extended to include other family members, as well as friends and clan members (Hrdy, 2009). Attachment bonds are founded in rather simple behavioral programs where fear signals and distress calls from the child elicit attachment behavior from the mother. Mothering behavior is mediated by the neuropeptide oxytocin (Panksepp, 1998). Successful attachment behavior is coupled with positive emotions, like well-being and calmness following stress regulation, coziness, and love, which are emotions that involve the neurotransmitter dopamine and the reward system. When the attachment bond between child and their caregiver develops and expands in scope and significance, their inner (object) representations of each other will become associated to the reward system so that merely the thought of the attachment figure may promote experiences of well-being.

The social anthropologist Sarah Hrdy (2009) suggests that *Homo erectus* (around 1.5 million years ago) extended care and raising responsibilities of infants to other family members and their allies and thereby started the journey

towards “it takes a village to raise a child.” Evidence suggests that men during this period became increasingly monogamous. There are reasons to believe that the presence of several attachment figures will enhance the ability to establish emotional bonds to other than core family members, thus paving the way for group cohesion in a more general sense.

However, cohesion in groups that extends to small family groups or small alpha-male colonies, involves more than positive emotional ties. Higher primates, such as chimpanzees, who may live in groups counting 50–70 animals, will most often adopt a social structure that is highly hierarchical. Lower-ranked individuals are regularly exposed to harassment, offered only remnants of food, and have to accept the poorest areas of land. The alpha male, on the other hand, can enjoy the glory of recognition, sex monopoly, the best food, and access to the most resource-rich regions of the territory. Selfish, demanding attention, harassing, and arrogant—this is probably the origin of narcissism (Karterud, 2010). What, then, connects lower-ranked and harassed animals to these groups? After all, when necessary, they react to the same alarm calls, to flight signals, and assemble in the group and participate in the periphery of the group’s undertakings. The most likely explanation for the participation of lower-ranked individuals in the group concerns the requirement for a basic need of safety (de Waal, 2009). To belong to a group provides a survival benefit which outweighs the drawbacks of living in the resource-poor sections of the community. In the group, one is above all safer with respect to predator attacks. There is more food due to rudimentary cooperation and some modicum of sharing despite social rank. In addition, there are social needs to be met. If rhesus monkeys are forced to choose between food and company with other monkeys, they choose the second option until the hunger becomes severe. They’d rather be hungry in company with others, than satisfied alone!

Male aggression is a major challenge for larger primate groups. Male rivals may kill or mutilate each other or kill offspring that they have not fathered. This must be mitigated lest it threaten the very existence of the group by chaos, anarchy, and fragmentation. Social norms are therefore necessary as well as a way of maintaining “laws” and mechanisms for promoting reconciliation. Monitoring aggression (as well as subordination) is learnt during upbringing, for example, through rough and tumble play (Panksepp, 1998). Alpha males may guarantee law and order, while elderly females of high rank often initiate conflict resolution through reconciliation (deWaal, 2009). A hierarchical albeit “unjust” social system seems better than chaos and anarchy.

It turns out that individuals in a group of 50–70 primates can identify each other. Moreover, they can also detect the social rank of others. Notwithstanding social rank however, they react towards strangers in quite different ways

compared with encountering fellow group members. Stranger fear seems to have evolved as a significant mode of protection. A basic survival skill is to be able to distinguish strangers from group mates.

Group cohesion is thus a composite phenomenon. It concerns attachment, but also safety, power, social dominance, and subordination.

Field studies of higher primates during recent decades have disclosed surprisingly sophisticated group behavior (Cheney & Seyfarth, 2007). However, it is still unresolved whether, or to what extent, they mentalize. Since chimpanzees (and baboons) can identify each other and have some kind of knowledge of which family individuals belong to, and their social rank, it must imply that they have inner (object-) representations of each other. However, what is the nature (or quality) of these object representations? In the language of John Bowlby, what do a chimpanzee's inner working models of the mind look like? Are the object representations invested with a mental life of their own in terms of desires and needs? Or are they more like images of some kind of functional organisms who occupy a social space and who can be manipulated with simple means? Within the "Theory of Mind" tradition, there are tests ("false belief") on the ability to conceive that another mind has its own representations, separate from one's own, that is, that there is an independent mind out there with its own perspective on the world (Baron-Cohen et al., 1993). There are specialized versions of these tests, adapted for different animals. The matter is still controversial, but most scholars favor the opinion that chimpanzees, for example, do not accomplish this, implying that their images of others (inner object representations) do not include "mental functions" in the sense which humans attribute to others.

However, there have been extended discussions on how to understand the phenomenon of cheating. Cheating has often been observed among primates, so there is no doubt that this is a kind of behavior they can manage. On the "YouTube" website, there is a video-recording of a low-ranked rhesus monkey who has caught a (delicious) fish and who seems to fear that higher-ranked members of the flock will confiscate the fish if they become aware of the catch. The monkey then releases a false predator alarm call which causes the rest of the group to flee in panic. Alone with the fish, this previously ill-treated monkey can enjoy a gourmet meal in peace and quietness! The question now is if our monkey friend harbored inner representations of group mates as beings who become afraid when they hear alarm calls, or if there are representations of beings that are inclined towards a certain behavior given certain stimuli. Most scholars agree that cheating behavior in itself does not presuppose mentalizing. It presupposes an ability to predict some kind of behavior among others, but not necessarily "mind-reading."

However, there are several mental operations that primates do master and which can be conceived as precursors or preconditions of cognition and mentalizing. They are summarized by Baron-Cohen and Belmonte (2005), who also suggest their brain localization. Primates seem to harbor an “*intention detector mechanism*” which premier job is to differentiate living creatures (with intentions) from not-living organisms (e.g., to differentiate between a snake and a branch), and to identify the most typical intentions (e.g., friendly, hostile, going for sex?). Moreover, Baron-Cohen and Belmonte suggest an “*emotion detector mechanism*” which can differentiate the most common (primary) emotional states among other animals. Primates are aware of *gaze direction* of other animals and have an ability for *shared attention* which is a precondition for cooperation towards joint goals. Furthermore there is a *system for empathy* which is supposed to facilitate more advanced social systems. The faculty of empathy seems to be connected with the *ability for self-awareness*. This ability is present among chimpanzees (as well as dolphins and elephants) (deWaal, 2009). These animals recognize themselves in a mirror and they are curious about their mirror image. Chimpanzees also have the *capacity for interpreting* certain types of intention among other animals, in a situation-bound manner. For example, female chimpanzees may understand when male apes are in the process of “pumping up” for a fight. They seem to interpret correctly the reluctance for reconciliation among male rivals and they might in such situations behave like mediators, something that benefits the group as a whole. However, this capacity for interpretation is situation-bound and by this they are different from individuals who possess a Theory of Mind in a more general sense, meaning harboring an inner working model of the mind of others. They might therefore better be described as “naive behaviorists” than “naive psychologists” (Bogdan, 1997, 2000). Chimpanzees understand certain goals and intentions of others, but not the phenomenon of false beliefs. Summing up the state of the art of Theory of Mind research, Call and Tomasello (2008, p. 187) write “Our conclusion for the moment is, thus, that chimpanzees understand others in terms of a perception-goal psychology, as opposed to a full-fledged human-like belief-desire psychology.”

However, even naive behaviorists are thinking behaviorists. Based upon a range of empirical studies, experts on primate cognition conclude that chimpanzees perform mental operations that have to be accepted as cognition (Tomasello, 2014). They seem to possess mental images that are processed with respect to goal attainment. What qualifies for the label “cognition” is that the process contains the following elements: 1) schematic cognitive representations, 2) the ability to make causal and intentional inferences from these cognitive representations, and 3) monitoring oneself during the decision-making

process. The entire process concerns the ability to reach thoughtful behavioral decisions which goes beyond the ability to perform “offline” simulations of potential perceptual experiences. Primates communicate with gestures and sounds. However, what chimpanzees seem to lack, according to Tomasello (2014), is *shared intentionality* which goes beyond the capacity for shared attention, that is, attending to the same object. Shared intentionality lies at the heart of the extensive collaboration which characterizes subjects of the *Homo sapiens* species. It evolved probably around 2 million years ago (*Homo erectus*) as a selection of capabilities that favored collaborative foraging. Shared intentionality is a crucial step in the evolution of *Homo sapiens*. It implies the advent of a “we” and later of collectivity. In shared intentionality, “we” “is” the agent. When we do things together, joined by shared intentionality, we have come to terms by a mutual agreement where I know that you know (and vice versa) that the nature of our project is basically cooperative, from planning through execution to sharing of outcome. Such kinds of projects presuppose the capacity for intersubjective (and thereby self-) monitoring, for example, the need to know when we have agreed upon something, if we have agreed upon the same project, and where you are and where I am in relation to you (intentionally and emotionally) during the execution.

When group theorists speak about humans “being social to the core of his/her existence,” they mostly refer to phenomena that belong to the faculty of shared intentionality, for example, related to emotional attunement and implicit mentalizing. One cannot help being affected by other subjects and one cannot help interpreting others (and consequently monitoring oneself). These abilities belong to the fabric of the human self.

Shared intentionality presupposes communication (vocalization and gestural signs), but not verbal language. Verbal language evolves, according to Tomasello (2014), in concert with (group) cultural practices that depends upon *collective intentionality*. Collective intentionality concerns matters of interest for the group as a whole, not only for two (or a few) persons collaborating around foraging. Verbal language evolves as a tool for handling communal and political (group) affairs. Language is the common agreed-upon and culturally sanctioned set of signs, metaphors, and inference rules that come to represent the “common ground” of the group. Since language rules are culturally sanctioned, and are not the invention of any particular subject, verbal utterances may acquire the appearance of “objectivity.” Inferences made according to the group’s standards for rationality makes it possible to assert “how things really are.” In Tomasello’s words (2014, p. 108):

And so with modern human such things as intentional states, logical operations, and background assumptions could be expressed explicitly in a relatively abstract and

normatively governed set of collectively known linguistic conventions. Because of the conventional and normative nature of language, new processes of reflection now took place not just as when apes monitor their own uncertainty in making a decision, and not as when early humans monitor recipient comprehension, but rather as an “objectively” and normatively thinking communicator evaluating his own linguistic conceptualization as if it were coming from some other “objectively” and normatively thinking person. The outcome is that modern humans engage not just in individual self-monitoring or second-personal social evaluation but, rather, in fully normative self-reflection.

Fully normative self-reflection is another word for explicit mentalization. When did it enter the historical scene? Estimates are obviously highly speculative, but genetic data (from the *FOXP2* gene) suggest that brain structures that are essential for language can be traced back to around 300,000 to 200,000 years before present time (BPT) (Coop et al., 2008). However, language in the pragmatic sense of Tomasello (and Wittgenstein) developed slowly in concert with developments in group cultures. There are reasons to believe that due to general development and evolution, migration, and climate change, complexities of group living took a new turn around 35,000 BPT among settlements of *Homo sapiens* (the Gravettian culture) in the Caucasian region (Finlayson, 2009). These developments in language and cognition might be the seeds of the Indo-European language. The next event that took language and cognition to new levels and sophistication was the invention of *written language* which took place around 5000 years BPT in the Middle East region of Euphrat and Tigris that hosted the agriculture revolution.

When does the individual acquire the ability for explicit mentalization? As outlined in the first chapter, it occurs through the “cognitive revolution” of ages 4–6 years. With the capacity for explicit mentalization, that is, being aware of different mental perspectives on the same phenomena and by that being able to consider oneself from the perspective of another, the (representational) self is born. The faculty of imagination is an extension of this capacity for offline self-reflection. Through imagination the subject is capable of considering multiple future scenarios in the light of the past and present and choosing the most appropriate path.

One can also question *why* do individuals develop the ability for explicit mentalization? Is it a preprogrammed genetic script that just unfolds independently of the environment, like the anatomy of the heart? Radu Bogdan (2013) makes a strong case that it is not. Human children begin their life in *sociocultural captivity*. And they cannot help but try to find out the rules and meaning of their sociocultural surroundings in order to master it and becoming informed members of it. The greatest challenge is to come to an understanding of the sociocultural as a matrix of mental states and mental processes. To do so, they activate

their innate capacity for intuitive psychology (implicit mentalizing) and mental rehearsal. By pretend play they engage in sociocultural learning of adult roles and games (mother–child, doctor–patient, fighting in wars, etc.). “Children *cannot* help but imitate adults (they are imitation machines), and once stimulated, *cannot* inhibit the action schemes inspired by the adult behaviors, especially in novel sociocultural contexts” (Bogdan, 2013, p. 119). However, more complex group dynamics call for sociopolitical strategizing. By around the age of 4–5 years, most children are mentally and neurobiological ready for a larger world and will adapt to the pressures of juvenile sociopolitics.

Strategizing means:

mentally figuring out and metamentally rehearsing offline how to handle the thoughts, attitudes, utterances, and actions of others, and in response, one’s own. Differently said, strategizing is metamentally rehearsing offline how to reach one’s goals by means of the *mental* states and actions of oneself, either altruistically, cooperatively, or with ulterior selfish motives. It is primarily the mental states of others and oneself used projectively as means to ends that define strategizing, and in turn foreshadow Imagining.

Examples of strategizing, so construed, include: rehearsing what to say and what to do, thinking how others think of you; planning how to relate to others and how to react to their reactions; deliberate and planned lying or obfuscation; gossip, including self-involving gossip; elaborate stories or communicative exchanges mixing reports of one’s mental states with those of others; justifying publicly one’s motives, reasoning, and actions; autobiographical recitations; fantasizing about what one could do in the future in relations to others; self-evaluation and criticism as well as self-advertising; defending one’s opinions; interpersonal diplomacy; and many other exploits along the same lines. (Bogdan 2013, p. 176)

By not adapting, or adapting poorly, to this world of juvenile and later adult sociopolitics, one’s capacities for explicit mentalization will stay behind. “A training ground for mentalizing” is the major slogan for MBT-G. This will be explained in detail later. Let it suffice here to alert the reader to the references to the natural course of self-development. In childhood, there are sociocultural grounds for pretending and imagining, as well as (training) grounds in the surrounding social matrices. Group therapy has to offer a similar ground and stimulate and cultivate the desire for entering this ground in a renewed attempt to develop the capacity for explicit mentalizing.

According to Tomasello and Bogdan we are fundamentally group beings by the fact that our BrainMind (Panksepp & Biven, 2013) is shaped by the group from the very beginning and that the tools we use (language and reason) have their origin in groups. Tomasello and Bogdan are less concerned by the emotional part of the story. As well as being predisposed for rational group behavior by being explicit mentalizers, we are equally disposed for primitive group behavior by the fact that we are carriers of the apparatus for primary emotions.

We cannot help but react emotionally to our surroundings. Moreover, we cannot help but be affected by the emotions of others in a group.

It always make a strong impression when one witnesses a flock of several thousand birds taking off almost simultaneously as a flight reaction because of perceived danger, or when a huge herd of grazing antelopes suddenly sets off. The fear that generates the flight spreads like lightning through the flock. Partly it will depend on a shared reaction to the same alarm call. However, we also assume that mirror neurons (or their precursors) are involved. Mirror neurons were initially detected among rhesus monkeys by di Pellegrino and coworkers in 1992 and evidence strongly suggests that they also exist among humans (Rizzolatti & Arbib, 1998). Mirror neurons in one's own brain fire when one observes certain behaviors executed by others, as if the actions were one's own. The theory suggests that mirror neurons subsume the immediate emotional resonance that occurs between people and that they are essential for intersubjective transactions. Imitation starts literally at birth—an infant just a few days old can mimic movements which the mother performs with her mouth and tongue. We witness here an innate program at work. Comparable emotional resonance is thought to be a major cause of emotional contagion in groups.

The group literature contends that the contagious effect increases with the size of the group. Panic in large crowds is an example. The prime tool of Hitler in his fight for power in Germany during the 1930s was carefully designed mass rallies. One gets a taste of it when being in the midst of supporters during a football match. It is difficult to remain untouched. Viewed from outside it is as if people in an excited crowd are hypnotized. An important topic in the group literature is the question of what causes such mental states. Freud (1921) objected to the view that it could be explained by (mass) suggestion. He contended that when members of a group/crowd took the one and same object as a leading figure (the group leader or the leading idea), which he labeled ego ideal, the group members would thereby identify with each other and so become more open to external influence. Today the pendulum has swung more in the direction of mirror neurons. However one conceptualizes it, a major argument for including working with large groups in the training of group therapists is that the candidates will experience the emotional power of such groups and what it does to one's mentalizing capacity (Karterud, 1999).

However, the same mechanisms are also operating in small groups. That is the main thesis of Bion in his classical text *Experiences in Groups* (1961). Bion observed that group members' rational efforts at figuring out what happened between them in the here and now were systematically undermined by collective forces in the group. He labeled these forces "basic assumptions." The reason

for this label was that therapeutic groups often seemed to behave *as if* they had come together for quite some other purpose than expanding their understanding and insight. It was as if they were gathered in order to:

- 1 fight or flee from something, or
- 2 be taken care of by an omnipotent leader, or
- 3 devote themselves to enthusiastic dreams about future salvation from all pain and distress.

The three basic assumptions were therefore labeled:

- 1 fight-flight
- 2 dependency
- 3 pairing.

According to Bion, there is no need for any special knowledge or education in order for people to “cooperate” on basic assumptions in groups. Group members are victims of mechanisms that operate on a “proto-mental” level. However, individuals differ as to how easily they get caught up in the basic assumption function. Some are more readily recruited to the fight/flight group (e.g., borderline patients), while others are more disposed to the dependency group. In Bion’s terms: individuals have different valence for different basic assumptions (Karterud, 1989).

These are realities which all group therapists have to take into consideration. Group therapists can through structural actions (e.g., time, space, contracts, and group composition) and their technical abilities counteract the tendencies towards basic assumptions and facilitate the rational “work group” aspect of the group (Karterud, 1999).

However, Bion’s theoretical web needs modernization. He leaned on Melanie Klein’s version of psychoanalytic theory of early human mentation. This theory has not survived empirical evidence from modern infant and child research, either with respect to cognition or emotions. The strongest current theory of emotions is Jaak Panksepp’s neuroaffective theory, mentioned earlier in this chapter. There is evidence for seven primary emotions among mammals. One could possibly add dominance/submission for higher primates and *Homo sapiens*. Bion singled out three “proto-mental” motivational categories while there are at least seven. So how does the basic assumption theory look in the light of modern knowledge and concepts?

Firstly, the fight/flight group: the problem here is that “fight” and “flight” are conceived as equal phenomena and belonging to a higher-order unity. When one starts to measure fight and flight, one soon finds out that aggression in groups is fairly easy to identify, while flight is a vaguer concept which occurs in all types of

group modes. The phenomena that Bion described is better characterized as collective RAGE (in Panksepp's notation). Borderline patients have a strong valence for rage groups (Karterud, 1988). They are attracted by rage groups and promote rage groups.

Flight is a mostly caused by FEAR. Groups composed of members with predominantly avoidant PD, will often resort to collective fear and flight strategies. These groups are fear groups, not fight/flight groups.

Secondly, the dependency group where people are passive and wait to be fed by an omnipotent leader. This is a constellation which is often seen in the public mental health services. It occurs when leaders and group members act reciprocally upon the primary emotions of SEPARATION DISTRESS and CARE. In other words, the attachment system is activated by both parties. The patients experience themselves as small, vulnerable, abandoned, and unable to take care of themselves, while the therapists/leaders occupy a caregiver role where they give advice, support, empathy, and consolation. Dependency groups are therefore better labeled as care-separation groups.

Thirdly, the pairing group where the members behave with an optimistic belief in future salvation. The aristocracy was Bion's favorite prototype of a pairing group. For different reasons it is less frequent in the mental health services (Karterud, 1989). It seems to require a certain level of personality functioning, while rage, fear, care, and separation distress are more archaic. Bion noted that breeding and sex played a crucial role in the pairing group, as well as a cheerful atmosphere. The entertainment industry is the modern group formation that capitalizes on the pairing group. Sex and romance and illusions and flight from reality flourish, and the industry attracts people with narcissistic features who also have charismatic and messianic qualities. The pairing group is a complex group formation. It exploits the primary emotions of SEX and PLAY. People's hunger for sex and play in Western societies seems insatiable.

There is no group mode that capitalizes primarily on SEEK. The reason is that seek is a more basic primary emotion which fuels the others. Seek is the primary energetic directedness towards the world, in other systems conceived more narrowly as novelty seeking or exploratory behavior. It is more like libido in the Freudian sense. Seek is involved in all group modes.

One should probably add dominance (and subordination) to the list of primary emotions as well (Karterud, 2015). It is not predominant among all mammals, but seems to be an innate feature among higher primates, that is, highly social animals.

Conceived this way, groups can be dominated by all primary emotions, be it rage, fear, sex, care, separation distress, play, or dominance. Whether they undermine the group's work with its primary task or not depends on the intensity of

the emotions and to what degree they are collectively shared. When strong enough, individuals will lose their mentalizing capacities and resort to prementalistic modes of cognition, in particular psychic equivalence. In groups, they tend to reinforce each other in this respect and the group as a whole will regress.

Summing up, we can conclude that as members of the species *Homo sapiens* we have in our genetic heritage a range of dispositions for group behavior. We are programmed to attach ourselves to others, but also to fear strangers, to be empathic towards others, to cooperate in groups, to dominate or to subordinate, to follow group rules, to identify with “ingroup” and be skeptical towards “outgroup,” to imitate others, to march in line, and to be infected by others’ emotions, to mention the most important. That we are genetically programmed does not mean that all individuals of our species have these properties to the same degree. There are considerable variations between individuals and groups (Karterud, 1988) and the inclinations are shaped by socialization and culturalization. However, when joining a group these forces are set in motion, at a “proto-mental” level as Bion’s preferred term, beyond our will and conscious awareness. To become a member of a group does not in itself require sophisticated mentalizing abilities.

It follows that group behavior in itself, either by complying with group rules or being engaged by sweeping emotions in the group, does not tell us much about the individual’s level of mentalizing. I emphasize this because therapists seem to have a tendency to overestimate patients’ mentalizing capacities. It has to be challenged before we can say anything valid about it. In MBT-G this is done in a controlled and systematic manner.

Challenges with borderline patients in groups

As explicated in the previous section, it comes naturally to humans to be members of groups. Or to be more precise, groups are man’s natural habitat. We are evolutionary designed for it and we become socialized and cultured for it. However, psychotherapeutic groups have some crucial features that are different from more natural work groups.

The following components are special and they might arouse fear:

- 1 It is expected that people will talk about the most shameful aspects of themselves.
- 2 It is expected that people will involve themselves in a group discourse about these aspects, which is not customary in other social situations (i.e., commonly used social strategies might no longer be valid).
- 3 In the beginning it will therefore be quite unclear how people “do their job” in the group.

On the other hand, these fears will likely be counterbalanced by:

- 1 more acceptance of shameful experiences than is customary
- 2 relief when a despised part of oneself becomes accepted and understood
- 3 consolation by the observation that such a risky project is directed by professionals who are experts in group dynamics and group therapy.

Once the process has started, powerful curative factors of group therapy will slowly do their job: installation of hope, the realization that one's own problems are not unique but similar to others (universality), psychoeducation, altruism (the experience of being helpful towards others), corrective emotional experiences, acquiring social skills, and learning by copying other's strategies (imitation) (Yalom, 1995).

In general, one can say that borderline patients come with similar problems to other patients, but to a stronger degree. But note that groups can exaggerate crucial mental phenomena. Groups with borderline patients are comparable to a sound system where the switch for the loudspeakers is turned too high. There is a risk that everything becomes too intense, too loud, and too fast. The main reasons are the emotional instability and identity problems of borderline patients. Generally they are more easily triggered than others, react more intensely with a subsequent decrease of their mentalizing capacity, and probably take longer to resume mentalization. This applies to all emotions, although anger and separation distress are the most volatile (Karterud et al., submitted). In groups, this implies high levels of stranger anxiety. It might take a long time before borderline patients are able to trust other group members, and new members may be met with suspicion. Above all, the anger is stronger and the ability to control it is weaker. Feelings of shame are often high, not least feelings of helplessness and despair which can be an ordeal for the group when associated with suicidal thoughts and threats. Envy and jealousy may be prominent and connected to issues of who "gets most," be it attention, care, or love from the therapists. Opinions on these matters, and whom is preferred and how, are often asserted with firm convictions of representing the truth (psychic equivalence).

Primitive defenses are often prevalent, such as denial, splitting, and projective identification. Patients will often tell the group about external events shaped by such mechanisms. It is more troublesome when it happens in the here and now of the group itself. Enactment is a well-known phenomenon in psychotherapy and thoroughly discussed in the group literature (Roth et al., 1990). Roles and behavior in others will be induced through projective identification to correspond with the protagonist's inner world. Mild and moderate versions may, when identified and worked through, open up avenues for change. Malignant versions

may in the worst case lead to negative therapeutic reactions and therapeutic ruptures. Often there will be victim scenarios where the protagonist denies his/her own contribution. In combined psychotherapy, a common type of splitting is idealization of the individual therapist and devaluation of (part of) the group. However, the reverse can also happen when the individual therapist is characterized as “hopeless,” “remote,” “an old pig,” “immature,” “uninterested,” etc. This too will be presented in a psychic equivalence manner, as something that represents the truth rather than being an opportunity for exploration. Other group members may be targets for idealization or devaluation as well. All such phenomena challenge therapists’ ability to handle their countertransference, as will be discussed in later chapters.

Insecure attachment patterns will play a dominant role. Patients with a disorganized pattern will have trouble in finding a suitable role in the group, often resulting in poor attendance. Poor attendance may also be found among patients with a dismissive attachment pattern. Absence is a way to regulate intimacy and distance. Such patients, and particularly when they harbor narcissistic traits, do not easily understand that their frequent absence has a negative impact on the other group members and the group as a whole. Overinvolved patients, on the other hand, have difficulties in differentiating themselves from others. The problems of other patients, the feelings of others, and in particular their despair and helplessness and corresponding reproach towards the therapists for not providing enough help, quickly become their own. They tend to take these problems home with them and might later complain that it is too burdensome to be in the group as “there are too many problems there” or because there are “too many sick people” (Hummelen et al., 2007). Overinvolved patients may in addition be locked in a “help-rejecting complainer” role which is a deep-seated ambivalence towards attachment figures (Yalom, 1995). They can loudly voice their complaints but simultaneously reject all offers of help and soothing. One can imagine an original scenario when an initially reluctant attachment figure eventually rushes in to help the child, being rejected, however, with the implicit message that “now it is too late.”

Pseudomentalizing is possibly the most common type of collective disavowal in therapeutic groups in our times. We write “possibly” since there is no research evidence for this claim, and own observations come mostly from groups with PDs. The inclination for pseudomentalization is probably linked to changing ways of social expressions in the Western world. When therapeutic group analysis was developed in the aftermath of the Second World War, it represented something novel with respect to free and open communication. It turned out to be possible to talk to other people about issues that were taboo in the surrounding repressive culture. Today people are bombarded with intimate confessions

in mass media and agony aunt columns flourish where “experts” of different persuasions tell people about the significance of feelings, relations, and openness. School and youth cultures encourage a different sort of discourse: people Twitter about everything and nothing and uncover their bodies and intimate secrets on Facebook. To talk to others, even strangers, about oneself and one’s mental sufferings is no longer unique and sensational. In fact, our borderline patients have often taken on roles as helpers in their particular circle of friends and may look upon themselves as particularly insightful. In addition, they may have quite a lot of previous psychotherapy experience. The effect of all these factors together is that many patients bring with them a kind of understanding and discourse style which resembles psychotherapy and counseling and insight and which they try to practice in the group, but which will fail because it often is replete with mannerisms and undigested words and expressions which do not capture the essence of ongoing intersubjective transactions. If the therapists “buy into” this discourse style, the result may be endless sequences where patients talk in a seemingly insightful way about themselves and others and involve themselves with ostensibly insightful commentaries to fellow group members, but without any real progress.

Notwithstanding the problems discussed above, borderline patients also bring with them positive aspects which engage therapists’ interest and curiosity. Many therapists experience this work as exciting and rewarding, although tough. Groups with borderline patients are seldom boring, unless they have developed a pseudomentalizing culture. Borderline patients are above all relational. They approach you, are curious and engaged, and often creative. It is not only its severity which results in the countless articles, books, meetings and conferences on the condition. Borderline pathology also touches something profoundly humane which everybody can recognize as fundamental to existence. Above all, it is rewarding to therapists, and it might be deeply moving, when one witnesses therapeutic progress that helps the individual out of destructive confusion towards a stronger identity, meaningful prospects for the future, and an ability to thrive in love relations.

There are some complicating factors which have to be mentioned here, but which transcend the scope of a group therapy manual (Karterud et al., 2010). These concern the fact that borderline patients who are referred to specialized treatment typically carry the burden of additional disorders. Almost everybody will have suffered a major depressive episode. Some may be depressed at admission and others will acquire a depression during treatment. Some border on psychosis and some may turn psychotic. Some have a comorbid bipolar II disorder and become hypomanic. Some have attention deficit hyperactivity disorder (ADHD) which burdens the person with additional attention problems.

Some have serious anxiety disorders; many will have substance use disorders and some will have eating disorders. These additional symptom disorders may in some instances qualify for concurrent pharmacotherapy. In addition to group therapy there might be a need for parallel psychiatric consultation. However, it is my clinical experience that many colleagues exaggerate the need for concurrent pharmacotherapy. Patients usually come to our clinic at Oslo University Hospital with a terrible cocktail of medicines. The main task for the psychiatric consultant is to make a plan for terminating the medication. In principle, MBT is a medication-free treatment.

The main message in this chapter is that when treating borderline patients, feelings and relational issues will rapidly become extreme, and that this tendency easily becomes augmented because fellow group members share the same tendencies. The process might get out of hand and the treatment may turn destructive. The alternative is stagnation. Therapists need to tread a tightrope between chaos and stasis. They need strategies to help counteract such collective (group) regression. When mastering this dynamic, therapists may be able to also help borderline patients benefit from reflective discourse on intersubjective transactions. How to accomplish this is covered in the next two chapters of this manual.

Main principles for mentalization-based group therapy

Introduction

All types of psychotherapy aim to enhance mentalization in one way or other. MBT is a kind of therapy that *specifically targets* failures of mentalization and where the therapist prioritizes *certain strategies* in order to engage the patient in a dialogue with the *explicit* aim to enhance mentalization. The principles for these strategies and the mode of dialogue are described in the individual MBT manual (Karterud & Bateman, 2010).

In MBT-G, the aim is the same: to engage patients in a dialog that fosters mentalizing. The therapists use many of the same active ingredients as in individual therapy, but since the therapeutic setting is radically different, the practical methods have to be different. Although MBT-G may invite longer individually focused sequences than what is usual in psychodynamic group therapy, it is important to emphasize that the goal is not “individual therapy in group.” *MBT-G is a dynamic group therapy in that it has a dynamic approach to the group processes.* The group is not merely a backdrop for individual exploration or for conveying knowledge, as is the case for structured cognitive behavioral groups or psychoeducational groups. Just as in psychodynamic group therapy, the aim is to develop the group as a norm- and culture-bearing system (matrix) where the individual attributes of each member can be played out and where important events, either as reported from outside life or as manifested in the here and now, are subjected to collective reflection.

But this is done in a more controlled way than in ordinary psychodynamic group therapy. The rationale for this is given in Chapter 1 of this manual. Put briefly, groups composed of people with severe psychopathology, when left to themselves with regard to means and ends, tend to alternate between chaos and pseudomentalizing. Group members will quickly descend to psychic equivalence and lose any reflective perspective on what is going on. They will often be emotionally overwhelmed and either become very demanding or retreat to defensive and nonproductive positions and tend to drop out of treatment. This

means that the space for thoughtful reflections on mental states will be undermined and a lot of the therapist's time and attention will be spent on "putting out fires."

One way to gain more control is to create a structure, that is, a favored working method, which differs from the usual principle of free group associations of group analytic psychotherapy. It is our strong opinion that free group associations require members with a good mentalizing capacity in order to be productive. Free associations in psychoanalysis and free group associations in group analysis have their historical roots in a time when the individual was inhibited by a suppressive family and societal culture. The therapeutic community in psychiatry was a reaction to a similarly repressive treatment culture (Karterud, 1989b). In the therapeutic community, the idea of free and open communication was adopted, and from it group analysis was born (Karterud, 1999). Seen in a historical context, it was perhaps mainly a liberation project for the middle classes. Many therapists felt freer with this way of working, as did some patients with a somewhat higher capacity for mentalizing. It is not certain, however, that the therapeutic community was equally liberating for less well-functioning patients.

Thus, MBT-G is not set up for free group associations in the group analytic sense. Instead, the group therapist takes control of the group and strives to make way for what we label *the group as a training ground for mentalizing*. This includes an increased focus on *emotionally charged interpersonal events (scenes)*.

In clinical practice this means:

- ◆ that patients are informed about the group's emphasis on interpersonal events and that they should cooperate in exploring these events in a mentalizing way
- ◆ that therapists organize the group in such a way that it provides enough space for the exploration of important events
- ◆ that therapists utilize interventions aimed at promoting mentalizing, both in their structuring endeavors, as role models and dialogue partners, and the way that they stimulate group members to collectively explore important events.

All of these points will be described in more detail in the following sections.

The group as a training ground for mentalizing

Just as in other kinds of group therapy, we differentiate between two basic therapist roles: (1) dynamic administrators *of* the group, and (2) dynamic therapists *for* the group.

As dynamic administrators of the group, the therapists make sure that:

- ◆ the practice is carried out within the boundaries of the law, and in accordance with norms and rules of the society
- ◆ time boundaries are clearly defined, for example, duration of each session, duration of each patient's treatment, holiday breaks, etc.
- ◆ the criteria for group membership are clear, that a maximum group size is defined, as well as whether the group is closed or slow-open
- ◆ the physical space for the treatment is clearly defined and suitable (clean, orderly, comfortable, chairs are arranged, etc.)
- ◆ the routines for payment are clearly defined
- ◆ a record is kept for each patient and the events taking place in the group
- ◆ the group is conducted in a professional manner, meaning that the therapists have the necessary skills, have access to supervision, and cooperate professionally with their colleagues
- ◆ it has been clarified how and under what circumstances therapists may be contacted outside of sessions
- ◆ the therapists administer notes between members and the group as a whole
- ◆ the therapists recommend norms for patients' relations with one another outside the group
- ◆ the therapists take action when something interferes with the group, be it noise from the adjoining room or if one member is threatening another.

The above items are rather noncontroversial and easily understood.

More problematic is the *purpose* of the group, and which methods should be used in order to reach its goal. This is problematic for several group therapies. It is easier for people to understand the purpose of task groups, for example, a football team or a bridge club. The purpose of a bridge club is simply to facilitate the playing of bridge by the members, at a certain level, and the methods in order to achieve this goal are not hard to understand. Psychodynamic therapists, however, have had difficulties in expressing the purpose of their treatment. Is it to make the patient "well," whatever that might mean? Or is it to give the patient more "insight," "self-understanding," to become more "integrated," "a more whole person," or "symptom free"? Or to become themselves, to lead a fuller life, to make use of happiness and to avoid adding too much further suffering to their miseries, as S.H. Foulkes used to express it? Since the purposes have been somewhat unclear, so have the methods to achieve the goals, including the role and tasks on the part of the patient. Is the goal achieved simply by attending the group meetings?

Are the patients expected to associate freely? Are the patients expected to contribute to solving other group members' problems?

Questions about this will arise in every group. It is not unusual to hear patients say "I don't understand what this group is doing" or "I have no idea how to behave here." These questions can be quite timely. Therapeutic groups are often doing things that have little to do with psychotherapy, and members are often behaving in ways that are far from promoting the goals of the group. And when goals and methods are poorly defined, it is not easy for therapists to answer these questions constructively. Answering using therapeutic clichés, like "What do you think?" are likely to produce nothing but pseudomentalizing.

For MBT-G the answer to the question of purpose is as follows: The purpose of the group is to increase the members' ability to mentalize in close relationships.

What "increasing the members' ability to mentalize" means, has been explained to patients in the psychoeducative component of MBT programs (Karterud & Bateman, 2011). They have been educated about bad versus good mentalizing, about the role of fuzzy contexts and emotions, and that close relationships are especially problematic. If the question arises again in the dynamic group, the therapists can ask other members for their opinions. They are expected to have some thoughts about it, and everyone may benefit from recurring discussions about this theme.

The next question is then, "How do I set about increasing my and others' ability to mentalize?" Or, "What do I do?" or, "What is my role?" The answer to this, for new group members, can be summarized in five points:

- 1 You have to be willing to talk about relevant experiences from your own life, that is, take the initiative to bring in events that are connected to your problems with mentalizing.
- 2 You have to be willing to explore these events in a mentalizing manner.
- 3 You have to make an effort to relate to others in the group in a mentalizing manner.
- 4 You have to make an effort to find out what is happening in the group and between group members in a mentalizing manner.
- 5 You have to make an effort to attach to the group and its members.

In the interview which therapists conduct with patients prior to group therapy, they should emphasize that none of this is easy—and if it were, they might not need to be there in the first place—but that patients will be helped by the group and the therapists to work on and practice these issues. This is the reason why the others are there too—to help one another reciprocally. It should not be difficult to highlight the first point with examples from the patient's life. Nor should it be

difficult to find resonance for the word “resistance” in this context, for example, that it can be difficult to bring in sensitive things from one’s life, because of shame, fear of being judged, and so on. Points 2–4 are also straightforward to go through with patients once they have understood what a mentalizing stance is about. Of course it will be more difficult to actually practice this. The last point, about attaching to the group, will prove more problematic for some. This is especially true for patients with a dismissive attachment style. “It’s OK to be in group therapy, but does one really have to attach to the others? And what does that mean, actually?” Whether the attachment pattern is dismissive or overinvolved/ambivalent, it gives the therapist a good opportunity to talk about the importance of attachment.

It is important that the therapists convey the importance of “caring.” This is what attachment is about. In a therapeutic group, one is not indifferent to others’ suffering and worries. The other is not a stranger. *There is an implicit contract of reciprocity in a therapeutic group.* In the same way that I expect to be heard and receive a positive engagement, others expect the same from me. And it is expected that one cares about the group as a whole. Being a group member implies a commitment to attend every time and to give priority to the group once per week, at the expense of most other things. And this commitment is not merely an abstract principle. It is founded on the fact that it matters for the group as a whole, for its work and success, that everyone attends. What the therapists are implying by this is a kind of ethics of communication (Habermas, 1989). Communicative cooperation comes with an ethical obligation.

What this means for each individual will naturally differ. Some will have problems attending regularly; others will never miss a session. Some will be overly involved in other members, while others barely think about the group once they’re out the door. A therapeutic group is not a disciplinary machine aimed at conformity. It is not behavior as such that matters. The ideals of caring and committing are important primarily in a normative sense, meaning that these ideals serve as something which patients’ motives and considerations can be measured against. Consolidating these kinds of ideals as part of the group’s ethical code, owned and practiced by key members, will typically occur during the so-called norming phase in the development of the group and it will be a recurring theme in slow-open groups, often brought to light when new members enter (Karterud & Stone, 2003).

In light of this, we argue that MBT-G has an educational advantage compared to other psychodynamic groups, and that this helps therapists, patients, and supervisors. When the “work group,” as defined by Bion (1961) is reasonably well defined, it becomes clearer what is *not* “work,” that is, when the group is doing things outside of its primary task. In practice, this often means the group gives way to “basic assumption functioning,” for example, that suspiciousness,

hostility, and quarrelling takes over, or the group descends to passivity and dependence, expecting to be fed by the therapist, or to endless clichéd babble that is leading nowhere.

In order for the group to function as a training ground for mentalizing, one must make clear to the patients what is expected from them. Just as important is that the *therapists organize the group*. This involves both mental work and concrete, practical work. The practical side has been described already. Mentally, it concerns the work the therapists do by digesting and organizing the experiences from the last session. When the therapists meet after a session they sum up the events in the group and each member's contribution, seen from a mentalizing perspective. Their comments are recorded and rehearsed at the meeting before the next session. Here, a strategy for opening the upcoming meeting is formulated. We strongly recommend that therapists start the session with references to the last session and use this as an introduction to the present. By this mental work on the group *between sessions*, the therapists create an explicit continuity in time for the group. The way it is practically handled also ensures that each member is mentioned (and remembered) and that the group is reminded of its purpose. The slogan is: *The therapists are minding the group*.

Taken together this is assumed to strengthen the group cohesion and to provide a sense of membership and clarity of the purpose of the group. We emphasize these three factors because borderline patients most often struggle with these issues ("I don't understand the purpose of this group"; "I have no idea what I'm supposed to do here"; "I don't feel attached to anyone here").

The next element that may optimize the group as a training ground for mentalizing is that therapists *encourage turntaking* during the opening phase of the group. This strategy makes MBT-G different from other psychodynamic groups which most often start sessions by following the patients' own initiatives and deal with whatever may follow in the spontaneous group process. It has to be emphasized that turntaking in MBT-G is not some rigid portioning out of time and attention to each individual patient. What we recommend is for therapists to ask who wants space for discussion of events, while at the same time reminding the group who has been given and who has not been given attention in previous meetings. This way, *attention and relevance of events becomes a theme for the group* and each member is repeatedly reminded about their role and responsibility.

Moreover, the therapists are active, in collaboration with other group members, in the *clarification of events*. The process of clarification (where, when, who, how?) may in itself contribute to mentalizing, in that the group member is helped in sorting out thoughts and feelings in a sequence of events and helped to be able to formulate a relevant scene. Some patients are, at the beginning of treatment, incapable of formulating a relevant narrative. When a scene is

clarified, the stage is opened up for a general *exploration of the sequence of events*. This is “mentalization training” in a narrow sense. How can one understand the actors who are involved in the scene? Which emotions were involved and how were they handled? What is it about the event that indicates problems in mentalizing (or good mentalizing) for the narrator? How long should one work on such scenes? When is the understanding “saturated?” When has the main character understood something new? In this phase it is important that therapists keep their opinions in check and stick to a curious “not-knowing” mentalizing stance. The therapists’ task is not to do the mentalizing job on behalf of the member in focus or the other group members. The therapists’ main task in this phase is to stimulate and contribute to an engagement of all group members in the exploration and mentalizing of the emotionally charged scenes at hand and try to formulate some kind of summing up when the sequence moves towards a closure. This formulation should be framed in a kind of language/discourse that conveys the general mentalization-based perspective on BPD applied to the specific intersubjective experience for that particular patient.

During the process schematically described above, there is a continuous interaction between the participants. This interaction is of course also characterized by emotions and thoughts in the here and now which reflect varying levels of mentalizing. This is rich material, but when and how should therapists address this? It is difficult to give exact answers. But generally, *therapists should intervene when something happens that can be assumed to have a significant impact for individuals and the group as a whole*. For example, if a polarization flares up between individuals or subgroups. Or when group members react in ways that are striking: “Can we stop here for a moment? It seems that you, Kristin, reacted to something here. Is that right? What was it?” Events here and now are potent material for exploration and mentalizing. They happen while they are being talked about, all actors are present as well as many witnesses, and the emotional temperature is often moderate or high. This will be a challenge for most people, and especially for borderline patients. *The greatest challenge for group therapists is to switch between mentalizing external and internal events in ways that feels meaningful while the same time preserving the wholeness and flow in the group*. If this manual was only about opening with a report from the last meeting, arranging a queue of group members who wish to bring something up, clarifying and working on it, and then moving on to the next member, MBT-G would soon turn into a mechanical exercise. What makes MBT groups alive and exciting, is that therapists constantly seek out a mentalizing perspective, stimulate metacognition, “supervise” a working through of difficult interpersonal events that members recognize from their external life, and connect those to emotionally charged events in the here and now of the group itself.

We consider it especially important to *develop participants' capacity for meta-cognition*. Several interventions facilitate this, for example, the initial encouragement and reflection about turntaking. Again, this is not a question of arranging a queue. Each member is repeatedly posed questions that force them to think about the following: Has something important happened in my life recently? What is it with that experience that is important? Shall I talk about it in the group? How should I describe it? What if I do not reveal it? And so on. Likewise, when therapists ask whether the work has been successful (“Did we get anywhere?”) or about time dilemmas (“What do we do now, there are 15 minutes remaining and Terje, Petter, and Linda have all said they want to bring something to the group?”).

In conclusion, therapists in MBT-G take a number of steps to optimize the group as a ground for mentalizing. These include clarifying roles and tasks of the participants, doing summaries after sessions, writing reports, minding the group, preparation for upcoming meetings, cooperation with participants on turntaking, repeated reflections on the way the group is working, clarifications and invitations to mentalizing events in ongoing life, and invitations to mentalize events in the here and now. In the following sections we will go through the latter points in more detail.

Finally, it is important to emphasize that we are talking about group therapy as part of a combined treatment. In combined treatment the therapists don't have to do “everything.” They can lean on the whole MBT structure, and especially the psychoeducative group and the parallel individual therapy. Thus they can concentrate on that which groups are especially suited for: exploring interpersonal transactions.

Focus on interpersonal transactions

The focus on interpersonal events has an organizing function for MBT-G. It has significant implications for both therapists and patients. Patients are asked to be vigilant, to notice significant events in their daily lives and in the ongoing group therapy, and to bring them into a focus of exploration. The therapists must ensure that these events can be processed in the group. We will now go through in more detail how therapists can do this.

Continuity and coherence of meaning through the therapists “minding the group”

In MBT-G, the therapists take more responsibility for the group processes than in analytic groups. Among group analysts one can often hear the slogan “leave it to the group.” This is not legal tender in MBT-G. In MBT-G, it is the group

therapists who take primary responsibility for the group's continuity and coherence. In particular, they create a context and continuity through their thinking about the group. This happens continuously throughout the group meeting and is summarized and reflected upon in the therapists' meeting before and after the session. It is formulated in a written form which the therapists continue to have in their minds and think about between sessions. It is further processed in group supervision. In this way, meaningful contexts are created that tentatively integrate each group member's process (e.g., what topics are most urgent, what is their most important challenge with regard to mentalization, is the patient new, well established, or approaching termination?) with ongoing interpersonal processes (e.g., alliances and conflicts) and processes in the group as a whole (e.g., well-established norms and cooperation versus collective resistance and formation of subgroups). These meaningful contexts give rise to working hypotheses that the therapists bring to the group, try out, and modify by new experiences. Thus there is a dialectic between the dynamic group that exists in the mind of the therapists and the living group that meets in real life.

Each session starts with a preparatory meeting and ends with a closing meeting between the two group therapists, lasting for 10–15 minutes. The work being done at these meetings is unfortunately not covered by the MBT-G rating scale (which is explained later in this manual) because it cannot be observed routinely on video recordings. However, every group session is influenced by these meetings. At the closing meeting the group as a whole and each group member is commented on from a mentalizing perspective. Was the group meeting good/average/poor? How were the phases handled? What can be said specifically about the participation of each member? What should be written in the records? What should the therapist be aware of for the next meeting? Did the therapists have a shared understanding of the processes? Were there any countertransference reactions, and if so, were they commented on? At the preparatory meeting the therapists go through the minutes from the last meeting. They have now had a week to think through the meeting and during this time they may also have had inquiries from or about individual patients. At this meeting, the last session is brought up, and the therapists discuss whether in the upcoming group there is anything in particular they should be aware of, prepared for, or take the initiative about.

Example: At a preparatory meeting, the therapists comment that the last meeting was OK. The group has several new patients, but it seems that things are "moving along." The last arrival, Laila, is on board, but she has a bit of an expressionless face and talks a little too cleverly and pseudomentalizes in a way that makes it difficult to know how the group is affecting her. The therapists agree to see how this develops. Concerning another patient, Hilda, it has recently been discovered that she has a serious substance abuse problem. The

therapists agree that this must be addressed again. Trude has been absent twice, and this should be mentioned. Furthermore, there have been major changes to Kari's life situation and the group must be updated on how things are going. Trine has put her problems at work on the agenda and can be expected to bring these in again. Hege is on leave from the group due to the birth of her child. Sonja has cancelled because of fever. The therapists use most of the time for discussion about the relationship between Trine and Berit. Therapist A has heard from Berit's individual therapist that Berit brings up the relationship to Trine in her individual therapy and that there seems to be some tension between them. The therapists discuss what this may be about, but conclude that neither of them will take the initiative to bring it up. They will, however, be more vigilant with regard to this relationship than they otherwise would have been.

At the subsequent after-meeting, the therapists agreed that the meeting was quite good. The group seemed to develop well. This was perhaps most evident for Berit, who had her best meeting ever. She brought up a difficult event regarding her friend, an event she thought was very typical, and talked about it quite coherently and about her own emotional reactions and subsequent reflections. She was open and invited comments from the others, discussed these in an open manner, and utilized these in her further reflections. She displayed a genuine and moving despair over her own difficulties in mentalizing and how difficult it was for her to accept this. She reaped genuine sympathy from the group and her capacity for mentalizing here and now was praised by both patients and therapists. Furthermore, her reaction to these acknowledgements was commented on (her ability to accept validation). Therapist B expressed his own understanding of the story in light of Berit's attachment pattern, said something about his own countertransference (he was moved), and that the individual therapist should be informed about her work in the group.

Kari was also praised by the therapists at the after-meeting. While she previously had been extremely avoidant and her mentalizing ability used to collapse whenever the focus was on her in the group, it was as if she now was trying to be more genuinely rooted in herself. She discussed an upcoming date where she also involved and engaged the others on what she expected to get out of it, what emotions she believed would be set off, how she could cope with them, what this meant for her, and so on.

Hilda's substance abuse was addressed for nearly half an hour, a little too long, but probably necessary in order to get the group involved. The therapists agreed that Hilda's level of mentalizing was very low, actually leaning towards the negative. In the group, Hilda had expressed that her substance abuse was nothing to discuss and that she didn't have anything else to bring up either. Therapist B was able to use his countertransference in a constructive way ("I get a feeling now that I'm almost nagging at you"—"Yes you are!") which also incorporated the other members of the group. The dilemmas for Hilda and the group were discussed at many levels. The therapists noticed that she later spontaneously engaged in Kari's story. The therapists concluded that Hilda's substance abuse should be addressed at every meeting in order to monitor the development, but that it should perhaps be more limited in the future.

Trine brought in her theme about difficulties at work, as expected. This time the emotions were stronger than ever, and more clearly articulated. However, it was painful to hear (countertransference) how she was locked in a psychic equivalence mode in the events she brought up, and also to witness her psychic equivalence in the here and now. On the other hand the other group members managed to challenge her in a constructive

way. The therapists were not sure what Trine learned from the meeting, if it would help her to endure at work, or if she would give up and quit.

Trude said that she still was not well. She participated in the work of the others in a constructive way and she brought up a theme of her own that the group agreed would be the first one to be addressed at the next meeting.

Laila had hesitantly announced a theme at the beginning of the session which she later withdrew without protests from the others. The therapists agreed to focus more on her next time.

It seemed obvious that Trude and Laila should be in focus next time, as well as more stuff from Trine about the drama at work. The members would probably hear about Kari's date, and at least the therapists would be looking for any development in Hilda's motivation to deal with her substance abuse.

Along these lines, a note would be written in each patient's record. The notes should be glued together as a group note and reviewed before the next meeting.

Regulation of group phases

Group meetings have their typical phases and these must be handled in ways that optimize the primary task of the group. Broadly speaking, groups have three major phases: the opening phase, the middle working phase, and the termination phase. Many psychodynamic group therapists leave phase regulation to the group so that the group as a whole is held responsible for how it is handled. In a well-functioning dynamic group, this will become a part of the group culture. In MBT-G, it is recommended that the therapists take more responsibility. The group therapists should not just sit down in their chairs and await what happens. The therapists should start, after saying hello, by passing on messages from those who are absent, and comment on patients that are not present, but have not left a message. There may also be messages on video recordings, from the clinic about changes in routines for payment, or information about meetings for the relatives of the patients, etc. The therapists also comment on the presence of patients who have been absent several times. The meeting is then open for comments on these initial messages.

The next task for the therapists is "building bridges" to the previous meeting. Every patient should be mentioned, so it will appear like a round when the therapists disclose their views on the last meeting with regard to individual patients, themes, focus, completion of mentalizing work, allocation of time, group issues, and so on:

"Last time we worked pretty thoroughly with your themes Kari, and yours Henrik. Kari—you were concerned with disturbing thoughts about something alien growing out of your body. You've never told this to anybody before. Our impression was that it felt a relief to be able to talk about it and that it became less scary.

Are we right? You Henrik talked about the relationship to your parents, condensed in an episode last Tuesday. Is there anything that should be brought up in connection with that? Maybe we didn't quite finish with Jonas, for several reasons, we think. Partly it was due to time running out, but perhaps it wasn't quite clear what your main problem was, Jonas. The group was concerned with your relationship with your father, but were there other issues there as well? Hilde said she would like to wait until today to talk about something and maybe it is still relevant? Then we thought that what you brought in at the end, Eli, should be followed up today—what do you think? And then there's you, Bente, who we haven't heard anything from for a while, you should probably be given the opportunity, are you up for that? Any other things we need to be thinking about?"

In this way, the therapists bring continuity to the group and communicate that they have been thinking about it and the respective members since the last session ("holding the group and its members in mind"), while their reflections also are presented as topics for discussion in the group. The round serves to organize the group, and at the same time it is a recurrent reminder that each member should be given attention in the group, that time is limited, that it must be allocated, and that balance must be created between the members. This is something the members have to relate to in the opening phase. They are forced, so to speak, to take a metaperspective. The therapists notice who takes initiatives and who is more withdrawn and use this as observations that can be brought up along the way:

"Bente, you were a little hesitant when we initially discussed who had something to talk about in the group. It now seems apparent that you really had something that was very important for you. What do you make of that?"

The round can be summed up and closed in different ways. One way is that the therapists come with a suggestion:

"OK, what if you start, Hilde, and after that maybe you should continue Bente, and there's you two, Jonas and Eli?"

Another way is for the therapists to let the group decide:

"OK, there are several themes here. Where should we start?"

In practice, group members tend to lose their perspective of time along the way. Once group members start getting involved in a story, they will bring their own associations, their own agendas will appear, and things will happen in the group here and now which call for comments and engagement. Thus, it is not difficult to fill a group meeting of 1.5 hours with material emerging from the event of one group member. In regular group psychotherapy, this usually happens. There is no initial organizing. The group typically starts after an initiative from one of the members and after that it develops and unfolds through its own

dynamics. MBT-G is different. At some point the therapists must remind the group of the reality of time:

“We have been through Hilde’s story and yours is perhaps coming to an end, Bente? Jonas and Eli also have things to bring in, and then there is you, Turid. So how do we handle this?”

Again, the members are “forced” to take a metaperspective. Are we now “finished” with Bente? What does it mean to “finish” something? What is most urgent among the other issues? And so on.

In the same manner, the therapists should comment on termination. They should remind the group of how much time is remaining. What is most important during these minutes?

“Are we going to finish with Jonas? Or do we have to leave some of it until next time? How is Hilde now? Has she calmed down? What will it be like for her to leave today? And the others? And, how was it? Did we get anywhere? Did we move forward?”

Again, metacognition is encouraged. The interventions convey a concern for the members’ self-state at the same time as they serve as a reminder of the fact that people are here to work. Has this work been successful? It encourages metacognition since it is not the cognitive content of the members’ thoughts about a subject matter that is the focus. Members are asked about their thoughts about their own and others’ thought and feeling processes.

Balanced (mentalizing) turntaking

As noted previously, in the section about regulation of group phases, MBT-G encourages a kind of turntaking, implying that group members take turns being at the center of the group’s attention. Turntaking is for many psychodynamic group therapists a big No-No. They want the members’ relational difficulties to be manifested in the here and now, spontaneously by the group processes. They also allow, even encourage, themes to flow back and forth freely in an associative exchange of experiences, thoughts, and feelings. In an analytic group, no single member “owns” a theme. In a well-functioning group, this can be productive even if it comes at the expense of the possibility of detailed working through of crucial events. In MBT-G, things are different. Here, we want and encourage detailed accounts of interpersonal events that are experienced by the individual members. Consequently, we must also safeguard the individual members’ thematic “property” against comments that take the attention over to something else. If in-depth exploration of interpersonal transactions is favored, there is no way around turntaking in some form or other.

Turntaking can be practiced in a number of ways. In groups with low group cohesion, we recommend that therapists take the initiative to structure the group in the opening stage by way of a consensus on two to four members that have something in particular to bring in. Each group member is then expected to be in focus at least once every three meetings. However, this is not meant to be a strict rule. In better functioning groups, it can be natural to start off with a theme from the last session, or perhaps someone starts with a group-relevant theme that appeals to most members. But even if a group starts off in this way, it is our experience that meaningful themes will appear along the way that should be given individual attention. We then get a more spontaneous form of turntaking. In MBT-G, there will be interplay between these forms and we label this as “balanced” turntaking. It should be emphasized that this goes beyond the structural element of everyone being put on the group’s agenda. Adding the word “mentalizing” to the heading for this section means that what each member brings to the group *will be subjected to mentalizing group work*. The main elements in this are (1) clarification, (2) mentalizing in a more limited sense, and (3) closing.

What counts as an “event?”

The words the therapists use in the opening phase when referring to the patients’ “material” are important. If the therapists say “Who wants some space today?” this is an open invitation to get involved. It’s an invitation to talk about “whatever.” We may alternate between that kind of question and “Does anyone have *an event* they want to discuss?” Both are useful. Many patients don’t know what to bring in, what is relevant, and cannot single out episodes of mentalization failures. As some patients say: “How am I supposed to know that, it’s like that for me all the time, more or less?” It should be made clear, explicitly and implicitly (through the work that is actually carried out), that it is OK to bring in “anything,” as long as when discussing “anything,” something will emerge that turns out to be of importance for the patient’s mentalizing ability, and that this is what the therapists and the group will focus on. *In most cases this will be an interpersonal event and in most cases emotions will have been involved which have impacted the involved parties.* This is where the group should concentrate its efforts. It doesn’t need to be close relationships, but often it is. Groups are especially well suited for exploring interpersonal events and relationships because they can utilize events here and now as concrete examples of the same themes. In this regard, we are in line with Yalom (1995) who is the greatest spokesperson of our time for group therapy as “interpersonal psychotherapy.” Groups are less suited for exploration of the intrapsychic. Here individual therapy has an advantage.

Nevertheless, patients who bring in a more well-defined event often also report them in ways that needs clarification. *To present a consistent and*

coherent story, with a beginning, middle, and an end, with comprehensible actors involved, each with their different qualities, leading up to an emotional climax that puts the mentalizing ability to the test, is a work of mentalizing in itself. Many patients will therefore struggle with this throughout their treatment. It is a goal in itself to be able to present a coherent narrative. In practice, one will encounter not only unclear stories, but also unclear motives for storytelling. Nor can one assume that the story is being told with an ambition to mentalize. It may just as well be motivated by a desire to recruit support for what is felt to be unjust treatment, or to distract the listeners from more urgent matters.

Which events are relevant for the group? It should be made clear that it is not only interpersonal events in life outside the group that exemplify failures of mentalization. It can also be events from the past or worries about future events. It can be events that have been challenging, but also those where one has coped well, for example, where good mentalizing has been evident. And not least, it can be events from the ongoing group therapy. Especially important are events that strengthen the group morale by confirming the purpose of therapy: "It helps!"

Example: Henrik (37) has a dismissive attachment style. The people in his life have been there for him to manipulate. According to him, they manipulate him too. To trust others by assuming they have good and friendly intentions is naive in Henrik's worldview. He has never leaned on anyone. These attitudes are related to experiences of always having felt "dirty," and convictions that others won't touch him because of that. This idea exploded when he was diagnosed as HIV positive. After around 2 years in the group, when discussing an episode at work, he spontaneously begins telling the group that he has noticed a change in how he regards others, and he thinks this is due to his experiences in the group. He is less wary. He is more spontaneous and talkative with others. He relaxes more when he's around people. Sometimes he tells himself that he "simply likes others." He now feels it is OK to be in the group, and he is looking forward to the meetings. The other group members listen intently. The therapists focus on the here and now: "What is it like to hear Henrik say this?"

Events can also be in the future. It can be situations that one is dreading and worrying about and would rather avoid.

Example: Marianne asks for time in the group. She tells how she has become more aware that she has a problem of tolerating being alone and that she has had to admit both to herself and her individual therapist that in situations like that she numbs the anxiety with alcohol and that she often drinks too much and that this has created a lot of problems. Now the Easter holidays are approaching, and her daughters are going away skiing with her parents while her partner has to work out of town. Marianne wonders whether she should have herself admitted to the psychiatric ward for the Easter period. The therapists acknowledge her frank account of her problem of being alone and drinking to calm her anxiety. But why doesn't she join her parents and daughters on the skiing trip? She asserts that is because "We can't be in the same room" and because "We cannot talk together." This

becomes the focus for exploration in the group. What does it mean to be together in the mountains during Easter? What normally happens? What does this, in turn, do to Marianne? What happens with her parents? How do they interact? The other group members get engaged and come out with many questions and comments. What was originally unthinkable for Marianne—to go on holiday with her parents—seems to become a possibility through the thought experiments in the group. She wants to think about it some more, and discuss it further with her individual therapist.

Being a new member in a group is a major event for the individual as well as other members and the group as a whole. New members should be allotted time for self-presentation at their first meeting. Often they will behave in quite a reserved manner: “My name is Linda, I’m 26 and I live downtown. I have quite a lot of problems, but I could perhaps talk about that later on?” Yes, that is perfectly all right to say in the group. Later on when Linda (and other new members) feels more comfortable in the group, she should be given space for her *life story*. The focus here is not on any “events,” but a kind of life narrative that gives everybody, including the protagonist, a feeling of the rough contours of the person.

Clarification of events

Therapists should be active with regard to clarifying events. The more one can engage the other group members in this, the better. It can be interventions like “Hold on a second, I don’t quite follow.” “Where were you?” “Can you repeat what she said, as precisely as you can?” “What came first . . . ?” “Was this after you . . . ?” “Does everyone follow this?” Therapists should monitor their own activity and comments from other group members. Strategically they should aim to establish a workable scene rather quickly, within, say, 5–10 minutes. It takes some discipline when comments from other group members will vary from “Oh my God, I can’t believe it,” “If that had been me, I would’ve punched him in the face,” “People who drive BMWs are assholes,” “I’ve been through exactly the same and it sucks, it was the time when I . . . ,” where the one commenting is about to grab center-stage, to a more supportive “I think you’re brave” and “Good that you got to say just that.” What is often striking for the therapists is how quickly other group members identify with the one telling the story, or with other actors or parts of the story and comment just as if what has been told is a piece of hard reality. It is as though they’re being sucked into the story itself. For the one telling it, this may partly be a good thing. It can give the person telling the story the necessary support and encouragement to carry on. For the group therapists, it is different. They seek a metaperspective which they want others to share. This metaperspective means that they cannot dwell for very long on content at this stage that has a low level of mentalizing and which

they otherwise would comment on (e.g., “Bente, you say that everyone who drives a BMW is an asshole, I’m not sure how to understand that . . .”).

Unless the subject of discussion is quite clear, the therapists may after a time make a kind of summary:

“Ok, if I understand you correctly you were pretty annoyed with some fellow students at the seminar who displayed a negative attitude, and that you didn’t find any way to express this, and, on the way home, when you got off the bus at the petrol station you were almost hit by a BMW, and you “blacked out,” and shouted at the driver and let him have it and gave him the finger and almost dented the car. Does that about sum it up?”

When it comes to patients that don’t have anything in particular to bring to the group, but who are on the “agenda,” one must show respect and patience, but not too much of the latter. Sooner or later patients have to get down to business. The most important task for the therapists and the group is then to help the patient define a theme that is relevant and workable. It is OK, to start off with, that someone has “been depressed” for the last week, or “everything has been bad.” But the group cannot work with “been depressed” or “everything is bad” in other ways than simply to listen, accept, comfort (“I’m sure it’ll pass”), or give advice (“Why don’t you try getting out of the house more often?”). *The focus must be shifted from the person as a victim of negative emotions (depression, all-bad feelings), to the person as an accountable agent in the world.* The challenge is to find an interpersonal event that is relevant and meaningful for the patient and which is connected to the relevant emotions. It can be a telephone call from their mother, or a letter from a former partner, or a meeting with the neighbor, that “made me even more depressed.”

In general, we assume that patients who don’t have anything in particular to bring, are displaying some sort of defense or resistance in a psychodynamic sense. Some patients also react to the word “event”: “There’s nothing happening in my life, I don’t have ‘events’ like other people to tell you about.” The resistance can be maintained even after the word “event” has been clarified and there is an explicit invitation to “talk about anything.” This is more common among new members than well-established group members. The therapists may then make what is happening here and now, the refusal itself, into the event for that particular member, and invite the group to take an interest in this and try to find out more about it. How do we understand that someone doesn’t have anything to talk about? Does absolutely nothing happen in the person’s life? Maybe it is difficult to talk about something *here*? But the good news is that the patient is coming to the group. Perhaps he or she is uncomfortable with the way of working here? Or maybe he/she is not so sure about the others? Or has become unsure about what he/she wants help with? How can the group help with this?

Notice here that we encourage therapists to actively engage the group in exploring these themes and put a bracket on theories about denial, projective identification, dismissive attachment styles and the like. Whatever the reasons are for the reluctance to get involved, the aim is to try to get the group engaged in attempting to find out. The therapists may, however, explore the resistance after successfully having completed a turn:

“After this, I’m left wondering, Henrik. You said beforehand that you had nothing in particular to bring to the group. It then turns out that you have had a really uncomfortable experience that really got a hold on you. How do we understand this? Did you think that it was no big deal? Or that it was embarrassing to talk about it in the group? Or are there other things that made it difficult for you to tell us this straight away?”

If the therapists aren’t wide awake, potential events risk disappearing in a flood of words and emotions that serve more as tools for “emptying” oneself, rather than as a means towards new understanding. This is demoralizing for everyone and a misuse of the group.

Example: Lise (29), with BPD and ADHD, is ending group therapy after the next session. Lately her functioning has declined again. Her attendance in the group has been very irregular. This time she is half an hour late. Another theme is just being closed and thereafter the therapists ask who has something they want to talk about. Another member comments that “Lise looks tired” and this leads to a long tirade from Lise, with a lot of details and shifting themes, centering on her boyfriend who is suffering from varying maladies and is being a pain, but whom she can’t seem to get rid of. The others do their best to follow. It is like they’re being pulled into an unreal world. When something appears a little clearer, something else and strange appears. The therapists try to structure the process, but they too become seduced into following each new theme that appears. After a while the therapists abdicate from their roles as authorities for the group. The fact that she is about to terminate the group next week is not mentioned.

In this case, seen from a mentalizing perspective, there is only one event to deal with: The fact that Lise is ending therapy after the next session. Everything else is unimportant. When Lise herself can’t make this a theme, the others must do it for her and help her in sorting out her thoughts and feelings around this upcoming event. In the session referred to in the example, everybody got confused and the therapists became overwhelmed by their own countertransference—perhaps not wanting to face the limitations of their effectiveness—and lost their MBT perspective.

Identification of failures of mentalizing

In working with events, the most important factors are the therapists’ own perceptions of what constitutes good versus bad mentalizing, their ability to clarify fuzzy events, and their ability to recruit the other group members for conjoint

explorations. Firstly, the therapists must identify the core issue, then they have to reveal and articulate it, and then they have to arouse curiosity in others—let's find out what this is about! And at the same time this must be done using language that everyone understands and with realistic intentions. The therapists shouldn't invite the others to hazardous escapades, but rather to stay within areas where they have reasonably good oversight.

Listening actively to a story does something to you. To use the words of Foulkes, *the story creates a resonance in you*. What kind of resonance this is will vary from person to person. Different memories, moods, and emotions are activated, giving rise to specific thoughts here and now. In a freely associating group, the task is to express these experiences. Naturally, this makes for a rather unpredictable course. In MBT-G, the course is being directed. The other group members, apart from the most experienced and sophisticated, will tend to say anything that comes to mind out of their own spontaneous resonance. And this may have nothing to do with the failure of mentalizing in the protagonist. Furthermore, in a longer story there will be many different, bigger or smaller examples of mentalization failures. What to choose? It will be in the spirit of MBT to have an open discussion about this. What is "good news" in the story and what is the most problematic? The therapists have to wonder about this openly, and in the group discussions to take what can be labeled a "normative common-sense position": It is sensible to think before you act, to pay attention to your feelings, to have understood the other in a reasonably correct way, to weigh different perspectives, not to think in terms of black and white, and so on. At the same time, it is sensible to be tolerant and nonjudgmental, to convey understanding of the fact that stupid mistakes are often made, that misunderstandings of one self and others often do happen, that it is difficult to pull oneself together, and so forth. From this perspective, how can we understand what happened in this event? What is suitable for further exploration in the group of course also comes down to the current mental state of the member and the therapeutic alliance with the group and therapists.

Example: Terje says hesitantly that "There's something I perhaps should talk about in the group . . ." He starts off with a kind of conclusion that "he messed it up again." The story is about him going for dinner last Sunday with his girlfriend and her mother and stepfather. He was a little nervous beforehand, but not too bad. Then something happened as he entered the house, and "he freaked out," had a couple of drinks and then some more until he was "totally pissed," but he managed to get out without causing any major scene. He went to town where he met some old mates and they had more to drink and things got out of control. But he did manage to stop himself before he vandalized something and went to the police station asking to be placed in the drunk tank. The other members ask questions along the way and someone says it was good of him to voluntarily turn to the police for help. In the past he had fought them. Terje recovers somewhat by the group exchange, but then he leans forward and puts his head in his hands and says "My God" when the

therapists ask what happened as he entered the house. He just can't bear to think about it. The situation in the group is now that he is (1) talking about an episode with a grave failure of mentalization, and (2) clearly expressing a current collapse in the here and now. Feelings here and now come first. Therapist: "It seems that there is something here that is pretty hard for you. What do others in the group think, what should we do?" "Leave him alone." "Don't push him." "But it's something he needs to talk about." "Maybe he needs to calm down a little." "Maybe he can say something about it later." In the course of this exchange Terje gets a new hold of himself. He stutters some additional information that signals that he's on his way. "It's just so damn shameful." "What, ending up in the drunken tank?" "No, the fucking thoughts." "What kind of thoughts?" Then gradually the story about how his suspicion towards his girlfriend's stepfather comes to light. Terje believes the stepfather gets too close. "He looks at her in a certain way." Terje is sure that if given the opportunity, he would make a move on her. Terje gets both upset and angry, and those emotions came over him when the stepfather stood there with his smug grin and welcomed them to the house. Terje is not sure whether it is his mind playing tricks on him, or if the stepfather really is a "fucking pig." It is this uncertainty that is tormenting, and he is too embarrassed to talk to others about it, so he just wants to sink through the ground. As the meeting progresses, Terje becomes able to join the exploration of what happened in the crucial moment in that house, and what is going on inside him in relation to the others here and now.

Engaging the group members in mentalizing events

As previously noted, the mentalizing ability of group members and the patient currently in focus may be enhanced by the very clarification of a significant event. However, direct work with the event itself is at least as important. If we go back to the previous example of reactions to "negative fellow students" and the rage against the driver of the BMW, it is the task of the therapists to engage the group members to explore this scenario. The therapist can ask an open question such as "What do you make of this?" It is then opened up for comments of all kinds and the therapists are advised to stay in the background. They observe what direction the group discussion takes. This discussion is a mentalizing exercise not only for the "owner" of the event, but also for the others. The group therapists eventually join in with their repertoire of techniques: exploration based on a not-knowing stance, regulation of emotional temperature, adjusting to the level of mentalizing, challenging unwarranted beliefs, focusing on emotions in the event and emotions here and now, on the interpersonal context of emotions, on striking transference manifestations in relation to the therapists or the group as a whole, on the therapists' own countertransference, and so on. This is often an engaging and lively phase of the group meeting. *The most important rule is that the therapists should not do the mentalizing work for the protagonist or the group as a whole.* This sets MBT-G apart from other therapies that utilize various forms of "individual therapy in groups." The therapists' main

task is to promote the protagonist's and the other group members' ability to perform an integrated cognitive and emotional understanding of important events in their lives and what is going on between people and oneself in the here and now.

Example: Beate has attended the group five times and has mostly commented on others' material. There have only been disparate and limited pieces of information about herself. On this day the group gets a message from Beate's individual therapist that she might not come to the group. Then there comes a message to the contrary and right after that another one yet again with the opposite information. It is obvious that Beate is not doing well. Beate arrives around 10 minutes late, at the end of the opening phase. She is welcomed by the therapists who comment that they have received different messages, and that it was good that she came. Beate gives a brave smile, but is breathing with constraint and says that it has not been easy. The therapists say that it is obvious that she is struggling with something emotional so perhaps it is best if she can go first? The others think this is a good idea, but Beate is hesitant, she stutters and says she can hardly talk, that she doesn't know what to say, that her head is all foggy, and that she is terribly ashamed. With a little help from the therapists she manages to tell bits and pieces of a love story, enough to give the other members something to ask about and soon more people are involved in the exploration of the event. It concerned her relationship with a man from Colombia. He was in prison for drug-related crime, and in a way it was OK that he was "inside," because then she knew what he was doing, since she was terribly jealous, but soon he would be released and this meant a huge dilemma for her with regard to what she should do. He didn't have a residence permit, but that was likely not to be a problem since he would simply "go underground." Should she take him back, or build up the strength to end it with him? The thing was, she really cared about him and she couldn't bear the thought of being alone. The worst thing here and now was that she was so ashamed to have got herself into this situation.

At this point, when Beate has told this much of her story, her mentalizing ability is significantly improved. Her head is no longer "all foggy." She is more coherent and is looking straight at the person she is talking to. The other group members are strongly engaged in her story. It has been clarified for all, and at the same time it is clear that simple advice like "Get a hold of yourself" is no good here. In a long sequence, they discuss the shame here and now ("I understand that, but we've all been there, and you're wrong if you believe we despise you"), people say it is good that she came to the group and told her story, that she managed to sit through it, instead of running away, and she is praised for how well she told her story. But why does she have this belief that she cannot be alone? What is that about? And what is it about this man that attracts her? Does she forget all that is bad about him when he looks at her in certain ways? Doesn't she really deserve better? Why do her relationships with men so quickly turn destructive? In a long sequence, these themes are explored in concert with the other group members. The sequence has no conclusion, but Beate is far more composed than when she came and she ends by thanking the group for listening to her, and she says she now has a lot to think about.

In this example, there are no problems in engaging the group members in the exploration of the event and its ramifications. The problem lies perhaps more in holding them back so they don't get overly eager and take over, trying to solve

the problems for Beate. The function of the therapists here is to remind the group, in different ways, of the mentalizing stance. What Beate needs is food for thought and stronger anchor points for her fleeting value system.

In the next example, there are also no problems in engaging the other members. It is about a patient, Kristine, who has been in the group for two and a half years and is one of the veterans, but who has been a bit stagnant in her process and is still hanging on to a good deal of black-and-white thinking.

Example: Kristine brings in an event that has to do with her father. He moved in with her a while back when she wasn't doing well, and he has stayed there. Recently Kristine has suggested that her boyfriend's sister, together with her two children, should stay in their apartment for a week, because she is being harassed by her ex-husband who is threatening her. Kristine's father, however, has put his foot down, and said no to this. Kristine has never seen her father so determined and is taken aback by this. Consequently she has now moved in with her mother and doesn't want to have any contact with her father. This sets off a lot of activity in the group. Many of the members have thoughts and comments. Some of it concerns clarification of the circumstances. And a lot is about identifying the failure of mentalization. What is the problem here? Obviously there are many problems. The boyfriend's sister is in trouble. How much should you help your family? And what about the father? "Good of him to move in with you when you needed help, but why didn't he move out again?" After some time the group is focusing on Kristine's relation to her father. "Surely he has some rights too, as he has continued to stay at hers?" But why didn't Kristine and her father agree on how to handle this situation? Kristine comments that she "has never been turned down by her father before." He never "puts his foot down." Never put his foot down? Other group members wonder about this. Why is this so? "Fathers normally put their foot down! What kind of relationship do you two have?" "You must have been spoiled, in a way?" "Real bummer! So that's why you moved in with your mother?" There's a lot of involvement and wondering and Kristine is progressively taking in what is being said, with more and more curiosity and reflection. In this sequence, the other group members do a lot of work, and Kristine finally thanks them for all their dedication and says she has a lot to think about.

Identifying and working through of events in the group

In a psychotherapy group, the members will be in constant interaction with each other, verbally as well as nonverbally. They will inevitably interpret each other implicitly as well as explicitly. Most of this flow of intersubjective transactions will occur outside of the members' (including the therapists') awareness. The therapists should rarely intervene or comment as long as the communication serves the purpose of the group. However, each group meeting will present events that need special attention because they signal problems with mentalizing here and now. Emotional reactions should always be commented on. If none of the other group members do it, the therapists should take the initiative. In the same way, misunderstandings or unwarranted beliefs

should be commented on and challenged. In a well-functioning group, the participants will deal with events like this on their own. The therapists should support this by an attentive presence and contribute in clarifying and working through the events. However, often the therapists must take the initiative and bring here-and-now events into focus:

“Wait a minute; it seems to me that Lise, who brought this theme in, has dropped out of the discussion. Is this true Lise? Did something happen that made you withdraw?”

Psychodynamic group therapy traditionally focuses on the here and now. MBT-G actually has a stronger invitation to members to bring in external events than most other group therapies. Nonetheless, MBT-G strives to achieve a dynamic interplay between “there and then” and “here and now.” Events here and now provide especially potent therapeutic opportunities because they (1) often illustrate what is being talked about “there and then,” and (2) demonstrate in real life what is likely to happen in the problematic “external” transactions that members talk about. Good therapists are able to make use of the here and now in creative ways. As we will see, this is especially true when it comes to therapists using the relationship to themselves and their own feelings in the therapeutic process.

The most common reason for addressing an event in the group is that it is accompanied by an emotional reaction. This gives it a natural and immediate character of a here-and-now phenomenon that needs to be explored. The task is partly to *understand* the emotional reaction. Is it shame, guilt, envy, irritation, sadness, or what? The reader is referred here to the item on the MBT-G rating scale that concerns focus on emotions, about emotion awareness, tolerance for emotions, conceptual understanding of emotions, and ability to express emotions. Why are patients reacting as they do? Note here that the therapists should maintain their not-knowing stance and explorative attitude, even if it may seem obvious what it is the patient has reacted to. We recommend interventions such as: “I can see that you are sad, Grethe. What, of the things you’ve told us, are you most sad about?” What makes emotional reactions natural here-and-now phenomena to be explored is that everybody is bound to react to it, and that each does so in accordance with their specific predispositions.

Example: Hanne has asked for time in the group. When there is an opening, one of the therapists turns to her and invites her in. She turns away, while making a face that is difficult to interpret, but that indicates that she is upset in some way, and she mumbles something about “Now is not the time . . . I can’t speak.” The therapists firmly advise her to say something on what this is about. Stuttering and disconnected, she tells the group that during the meeting she has become so annoyed with Eva that everything else has been lost to the background. But it’s only her own fault and she doesn’t want to burden

Eva with this, so therefore . . . Now she has caught the attention of not only the therapists. The other group members engage and more than one say that they understand the dilemma very well, but that it would be wrong to just stop here and sweep this under the rug. The therapists ask whether they can find out whether Eva (who was the main character in the last sequence), can endure Hanne's feelings. Hanne looks squarely at Eva, who smiles (bravely) and says that "Sure, I can handle that." Hanne calms down a bit and says that it's the same thing she has reacted to before, that Eva pisses her off, because Eva does so many stupid things and gets so self-destructive, and that she recognizes this pattern so well from her own life. During this elaboration, Eva changes, her expression alters, and somebody comments on this. Eva, who is now struggling to hold back tears, says that "It's always like this, there's something wrong with me. Someone always reacts to me and gets cross with me, that's why I stay away from ordinary people." Hanne is even more upset now and says "Yes, right, she can't take it, I torment her. I also create a mess with others all the time." The therapist now comes in to say that he "can't see that Eva can't take it. Eva is still in the group, but she's reacting emotionally and emotions are what the group is about." The attention is now turned towards Eva and her emotions. One member points out "But Eva, right now you're doing what is most difficult for you. You're sad and you're letting other people see that." Eva: "Yes, and it's horrible, I've been on my way out the door." Therapist: "But you've stayed in your chair." Eva: "Yes, I don't know why." Eva now joins in the reflection of her handling of sad feelings, of how she deletes them before she feels them, like when her father died, but that it has become more difficult lately. But she is just beside herself now, she says, and feelings surge about how useless and hopeless she is and she should just go and hang herself. Some of the other members nod, recognizing such feelings, and encouraged by some comments by the therapists, they talk about tolerating feelings and how difficult it is. Eva says that the first reaction, like how she reacted here, "Oh yes, it's no problem at all," comes automatically. That's how she's always reacted. That is the nice and compliant doll. After dwelling on this, the therapists again turn to Hanne. What does she think now, after hearing how important this theme is for Eva and how Hanne actually helped bring it out into the open? Yes, Hanne understands that, but nonetheless it is hard for her. Hurting others is the worst thing she knows. "What is so bad about that?" the therapist asks. Well, she thinks it's awful and it is nearly unbearable to think that others should suffer nearly as much as she does. The therapists ask for the other members' thoughts on this. Different aspects are brought to light, but the most strongly felt is that Hanne ("like most of us in this group") seems to take too much responsibility for others' emotions. The significance of personal boundaries is also discussed. "It's as if you don't separate yourself from others, so that the suffering of others becomes your own." Eva is now actively engaged and connects what happened in the group between her and Hanne and what seems to be a general problem when relating to other people. The mentalizing ability, which collapsed at the beginning of the sequence, is now reestablished and she participates in exploring important aspects of her own feelings, own self-regulation, and boundaries towards others.

Variations on the "event" above will occur in all therapeutic groups. What is important is that the therapists identify the event, stop and explore the experiences of all involved members with regard to current emotions and

interpersonal transactions, determine what significance the event has for the involved members and for the group as a whole, consider the ramifications for the protagonists, and involve the other group members in this endeavor.

The outcome is not always as good as in the preceding example. The following is another example from a group where an external event set off an internal event that was so overwhelming that the group didn't manage to explore the external one.

Example: Berit has told the group there is something she "just has to talk about." The previous week she found out that her boyfriend had been called to the police station for questioning and that this had to do with him having sexual contact with girls he met through the Internet, some of whom were minors. The theme had many ramifications and implications. Most of the group members participated in the exploration, but not Lisa, who seemed absent-minded. The therapists were aware that Lisa had a tendency to dissociate in the group and they addressed her and asked her where she was in relation to what was being discussed. Lisa says that she has "switched off" and that she can hardly breathe. She asks for permission to go and get some water. When she comes back she says she can't handle this theme and asks to leave the group meeting. Lisa's reaction is now the center of attention. The therapists try to engage the other patients in an exploration of what is going on, but Lisa simply states that she can't handle the theme and that she has other important things to do this afternoon and that she can't ruin her day. Berit now feels guilty for bringing the theme in to begin with; especially bringing it up without first briefing the group on what it was about, and the focus from the others is now on how Lisa is doing. Berit finally gives praise to Lisa for being so outspoken with her boundaries. The theme of Berit gets lost.

In this session, the purpose of the group is sacrificed. Lisa is praised for "being so outspoken with her boundaries," but it has come at a high cost. The cost was a blocking of the group's collective mentalization ability. Lisa blocked it by making a certain theme taboo. At the same time, Lisa revealed, by her incipient anxiety attack, that she had serious difficulties in dealing with this theme. This is a very complicated situation for the therapists and the group as a whole. Looking back we might say that the therapists should have dwelled longer on the dilemma of the group as a whole, for example, its main method of free and open communication versus Lisa's needs and her anxiety. If Lisa persisted with her ultimatum to the group after a thorough discussion, it would probably have been better if she left the group so that the group could do its job. The content of her thoughts and emotions, including her reaction in the group, should be worked on in Lisa's individual therapy. It is important to underline that in MBT-G, unlike traditional group analysis, "the group" is not idealized or made sacrosanct; it has a job to do and must be allowed to get on with its work, even if it means Lisa dropping out, at least for this session.

The closing of sequences

A whole group session can easily be filled with just one event and what it sets off in the others and in the group as a whole. But within the MBT-G model, events have to be closed in order to make space for other events. When should the therapists start thinking about closing? It depends on many things. One is the graveness of the event. Groups like this do sometimes deal with questions of life and death. A serious suicide act demands more time and attention than a quarrel with a friend. Another factor is the relevance of the event for the protagonist, and for the group as a whole. Sometimes trivial matters are brought up. Other times, themes will represent core conflicts and hold opportunities for significant changes. Or it can be a conflict in the group that has a large impact on the group's ability to mentalize in a collective sense. Therapists must take such broader implications into consideration and adjust the timing accordingly. It is also of importance at what point during the meeting the sequence takes place. There is more time at the group's disposal at the beginning than at the end of a session. How many members there are who are "waiting in line" is also of importance.

To what degree a sequence has engaged the other members also counts. With a highly engaging sequence, where many participate, where the temperature is high, but not too high, and where there are still interesting comments, one is normally hesitant to close. However, it is the concern for the member in focus that counts the most. Even if the sequence is for everyone, one should make sure that nobody "steals the scene." This can easily happen. Someone else may relate to the story being told, and bring in a similar, but more "juicy" story that catches all the attention. The therapists should therefore protect the main actor's "ownership" of the scene. A turntaking sequence is approaching its end when it has been "saturated" with perspectives. It is when people start repeating themselves and nothing new is really emerging and when the temperature is dropping. And not least when the main actor has declared that he/she has "absorbed" the comments and seems "satisfied."

The beginning of the end of an "ordinary" sequence can be that the therapists say to the protagonist something along the lines of: "We've been discussing this for a while now and looking back at this event, what do you think about it now?" This type of question is beneficial in itself, as it appeals to the member's metacognitive ability. The answer will indicate whether the sequence is reasonably finished. If the member says "Well, I'm still just as pissed off with this BMW guy" or "I don't know what to say, I'm pretty confused" there is still some distance to cover. It's different if the answer is something like "I've got a lot to think about now."

Every now and then therapists may feel that the sequence hasn't brought about any changes in the main actor. A lot of time and attention has been spent but it is as if it hasn't led anywhere. In this case, this should be said: "How is it Irene, have you learned anything from this?" Irene: "To be honest, no!" Therapist: "It was important that you said so. Then we have a problem. But what is the problem? It is apparent that we've been doing something that didn't quite work for you. What could we have done differently?" Notice that this intervention also stimulates metacognition.

Starting the group

MBT-G can start in different ways. It can start from scratch, it can start as a psychoeducational group and subsequently adopt a dynamic mode, or it can be an existing group that redefines its foundation.

At the Department for Personality Psychiatry, Oslo University Hospital, we chose the last option. MBT was formally implemented in August 2008, but not all elements were ready at that moment. The retraining of the therapists was not complete and the groups continued for some time in their former psychodynamic mode. However, inevitable tensions arose in the nine different groups of the program when new patients were admitted who had been exposed to 3 months of MBT group psychoeducation. They arrived with expectancies that were not fulfilled. After a while, the head of the clinic marked the "formal" transition to MBT-G by a letter to all group therapists and former group members which explained why MBT had been implemented and what consequences this implied for the dynamic groups with respect to structure, content, and commitment for the patients. Some groups encountered more problems than others. Not all patients (or therapists) embraced the changes. However, by and large the message was well received. In most groups, there was lively discussion on what this would imply for the group as a whole and for each group member. Naturally it took a long time (several months) before the new structure and new mode of thinking and relating were settled.

When implementing the MBT program at the Bergen Clinics Foundation (a drug addiction clinic in the Norwegian town of Bergen), the group started as a psychoeducational group and transformed itself to a dynamic MBT group after eight sessions. This route has different kind of problems that must be addressed. Redefining a psychoeducational group might be more difficult than redefining a dynamic group. In a dynamic group, there is a focus on group dynamics from the very beginning. Members learn about interaction, process, and the significance of spontaneous involvement. A psychoeducational group is closer to a school class. It is possible to attend without being emotionally involved and

therapists do not dig into events or their manifest and latent conflicts. On the other hand, patients in psychoeducational groups may become eager to get the “real thing” when they learn about dynamic MBT groups. The transition depends also on the motivation and level of personality functioning of the participants. We have witnessed both smooth transitions and strong resistances. The transition for the group in Bergen was troublesome. The members were females with BPD and drug addiction. Most of them were distrustful and adopting a mentalizing stance was not their favorite remedy for coping with other people. Listening to therapist experts was far easier than engaging in mutual exploration of shameful experiences.

The easiest way is to start the group from scratch. However, one should note that there is no shortcut to MBT-G. Like any other dynamic group it has to develop through the typical phases that encompass the members’ need to get to know each other, developing trust in each other and trusting the therapists, to agreement on basic group rules and learning the MBT mode of group work. The struggle with these themes will gradually materialize as a certain kind of group culture. This manual will not cover such basic issues of group psychotherapy. Readers are referred to general textbooks, for example, part 9 of “Group analysis and psychodynamic group therapy” (Karterud, 1999). The author has no experience of starting a MBT group from scratch. However, he has supervised several such groups. The impression is that a well-established group culture is reached somewhat faster than is most often the case with group analytic psychotherapy. We would suggest around 6 months compared to around 1 year for group analysis. Group culture formation in MBT-G is facilitated by therapists who are more explicit with respect to goals, means, and working procedures.

Therapists should not be too obsessional in defining and working through mentalizing failures during the formative phase of the group, or when integrating new members. Members need to get to know each other. A good way is to ask for facts which contextualize events, such as “Where did you live then?” “Have you additional siblings?” “So you started quite early with self-harm” and “Did you complete the high school?” The therapists can gradually sharpen the interpersonal focus and educate members through concrete group experiences into how the MBT-G model works.

Most often MBT-G will take the format of a slow-open group. New members are admitted when existing ones leave. New members will experience processes similar to what other members have gone through. Becoming a new member in a formal sense is far from being a committed member based upon personalized meaning and profound experiences of group cohesion. Every new member has his/her own trajectory from being a curious (but typically skeptical) newcomer,

maybe through a period as outsider, to the role of a committed member that has internalized the value system of the group.

Example: Anne, in her fourth meeting, expresses some disappointment and criticism of the group. She finds it somewhat slow and passive and asks for “more direct feedback.” Kristin seems to be an eager listener. She has attended the group for around 3 months, although with some absences. She has been mostly listening with only sporadic and short narratives from her own life. The last session was the first one where she talked about herself in more depth, in a sequence lasting around 40 minutes. The main theme in her family history concerned over-involvement from others and vague self-boundaries. It concerned who was the proper owner of themes, conflicts, and emotions in the family. Kristin: “I just want to say, Anne, it takes time. I was also a kind of frustrated, a kind of outsider here. But I want to tell you that since the last session, the stuff I told about my mother and my cousins and everything they struggle with, it continued in my head through the week, but then it struck me, and I thought that the group agreed with me, that I should keep more distance, and I felt that the group were with me in a way, I didn’t feel alone, I thought I’ll do the best I can and that there are people here that agree with me, so I didn’t feel alone.” Lise: “Well, great! We’re lined up. Wow!” Kristin: “Yes, I felt strong support when we talked about it last time and it made a difference. I realized that much of it were their problems, my mother’s and the others. I got some kind of distance from it.” The therapists acknowledged her experience of enhanced mentalizing with smiles and commentaries: “It is clear that last session was important for you and that you got something that made it possible to reflect in another way and thereby think other kinds of thoughts about the matter.”

To become a group member in this more profound way seems to be linked to this phenomenon of having told one’s story and having experienced acceptance, engagement, and curiosity around it. Before such an experience of mutual involvement it might sound artificial to present isolated events and fragments of one’s life.

Example: During the opening phase, the therapists address Hilde and say that she got started with something last session, but seemingly did not get to the end, so they wonder if the group should just take up the thread. It is her sixth group meeting. She mumbles “Yes, well . . . it’s OK if you think so,” but adds that there isn’t any news from her side. Basically she is rather bewildered with respect to the group. Today, for example, she didn’t feel like coming. Actually she doesn’t know what she is doing here or what people expect from her. Other group members ask curiously if she perhaps has not been in therapy, in particular group therapy, previously. “Oh yes, I have,” and they get a history of frequent hospitalizations on a mental health center support ward, adding up to around 1.5 years, because of repeating self-harm. Through this story, group members learn about her parents and her boyfriend and not least about the “power struggle” which emerged between her, her family, and the health authorities. She hated being controlled, but at the same time she provoked it by repeating self-destructive acting out. When there was no control regime around her, she felt abandoned and alone. There was not much treatment in those years, she said, but she was cared for. She had noticed that things are different here. This is somehow her own project. She had noticed that nobody controls her here. However, in some strange manner, this has increased her bewilderment.

The sequence lasts for around 45 minutes. The other members listen intensely to this dramatic but also sad story, and they ask simple questions so that the story can unfold in detail and relevance. People say that the story makes them understand her bewilderment with respect to what she might say or do in the group. In addition, it seems good that she now has come to a place where people will be concerned about her, but not in any controlling way. She might be helped to find out what is her own genuine project on the road towards liberation.

The treatment course and termination

Groups have their typical developmental phases (Karterud, 1999). Most scholars speak about an orientation phase, a conflict phase, a norming phase, a working phase, and a termination phase. The group as a whole has reached its goal when it has established a mentalizing working culture (phase). There is no developmental stage beyond that. When the group has reached this stage, the task is to maintain it, repair it, and renew it. It can be compared to democracy as a form of government. When it is established, there is no “higher” stage beyond it (Fukuyama, 1992). However, democracy have to be cared for, magnified, and realized in all areas of society. It must be maintained, repaired, and renewed.

An established group (and an established democracy) is a vulnerable organism. The members’ lives and the life of the group itself never stand still. Some terminate and new members arrive, some enter critical states, the therapists may get ill or may themselves terminate. Such occurrences can push the group back and therapists will encounter new (but presumably shorter) phases of conflicts about goals, meaning, and norms.

Most MBT groups will last for several years. However, the individual members have only limited time. There is no gold standard for how long this time should be. At Halliwick Hospital in London, the birthplace of MBT, the treatment length of the regular MBT program is limited to 18 months. Thereafter one can have some kind of individually tailored aftercare, but no regular and systematic psychotherapy. At the Department for Personality Psychiatry, Oslo University Hospital, the upper limit for the group part of the program is 3 years. However, mean treatment time is around 2 years (Kvarstein et al., 2015). There is as yet no empirical knowledge on what “is best”—18, 24, or 36 months. It is an open question if group treatment beyond 18 months increases treatment effects. For patients with disorganized and dismissing attachment patterns it may take a long time, often around a year, before they become reasonable stable and committed group members. It doesn’t feel right then to rush into a termination phase. All parties have invested a lot in the attachment process. Only now is there time to “dig out the gold,” or, using another economic metaphor, to “harvest the gain from the invested capital.”

The individual trajectories are of course different from person to person. Some drop out or terminate early in cooperation with their therapists.

Example: Turid (22) used to drop out of all kinds of relationships. She had dropped out of school, of all kind of jobs, and had cut connections with all former friends. She lived at the family home, but the contact with other family members was sparse and superficial. Most often she was on the run. She used to be picked up by strangers at bars, ending up at some party, taking drugs or being doped, and couldn't remember much of what had happened when she woke up after some days in an unknown place. Then she would flee home, spend a couple of days recovering, and was off again. She hated it when people asked her how she was. The group became a nightmare for her. She became dizzy and sick and clung to the group chair in order not to faint and she was unable to provide any coherent narrative to the individual therapist when he asked about what happened in the group sessions. Her drug misuse escalated. One day she arrived drunk at the group meeting. Meetings between her and her different therapists did not help. She was unable to follow any crisis plan. After 4 months with frequent absences it was decided to stop the group treatment for Turid. She continued in individual therapy with the same therapist and expressed her gratitude for not just being dropped. Slowly she got control of her drug and alcohol problems and managed to take on a suitable job which she held for years while she simultaneously completed high school.

The above example illustrates a “controlled” premature termination. A few patients are unable to cooperate and have to be thrown out of the group. We refer to the example in item 7 in Chapter 4: “Managing authority.”

However, most patients stay the course. And when is it completed? Having achieved control over self-destructive acts is one indicator. For example, when drug misuse is under control, when acute hospitalizations are no longer necessary, when self-harm has gone, or when suicide attempts and suicide thoughts are minimized. Other indicators include being stabilized in school or employment. However, such behavioral indicators should be coupled to clear signs of enhanced mentalizing abilities. It will typically express itself in (1) the quality of the stories that patients bring to the group, and (2) the ability to partake constructively in the ongoing mentalizing discourse, in particular around here-and-now events.

The narratives that are told in the group become more articulated, focused, and relevant, indicating that the individual has internalized the group discourse style. There is less need for clarification through the group. The protagonist has done the clarifying (and mentalizing) job by her/himself. The narratives are also more complex and above all they will contain a reflective perspective.

Example: “Yes, I have something I will tell you. It happened a couple of days ago. We visited my parents-in-law. I guess you remember how scary my father-in-law has seemed to me. It used to make me feel dumb somehow, and I have been nervous to talk about it with my partner. Well, there was a whole bunch of people there. Then it struck me how avoidant my mother-in-law was in setting limits for the children. They were allowed to mess

around. However, I stopped them when they started to tamper with our PlayStation. I just said no, plain and simple. The most important thing was that I experienced my father-in-law quite differently. He should have supported his wife, but he was absorbed in talking about himself. I believed I listened better this time, and it struck me that what he talked about was rather trivial. And partly untrue, I believe. I have never before had such kind of thoughts, but thought them then, like “You are rather self-preoccupied.” It’s strange to think such thoughts, me who has been scared to death by him. I discussed it with my partner afterwards. Not to criticize, I said, but it struck me that your father just lets things happen around him, as with the children, as long as he gets attention on himself, and honestly, what he talks about is not that interesting. I chose my words carefully because I know my partner hates criticism towards his parents. However, this time, strangely, he nodded and then we talked about it. I believe it is the first time we have managed to talk seriously about them and us.”

Example: Berit (34) has had leave from the group for about a month. She has visited the homeland of her boyfriend, for the first time, and met his family. The group members were eager to hear about the tour. “Well, by and large it was fantastic. However, there were some real bumps along the way. You can imagine. The family was huge. Quite different from here. Aunts, uncles, and cousins everywhere, and neighbors. And lots of food, and wine, and laughter and dance. A real hubbub. We moved around, staying with his parents, siblings, and uncle. And me, not really speaking the language very well. How could I understand when they joked? And they did most of the time. By the third day I was tired out. I woke up and just started to cry. Do you know what happened then? Strange really. I began to think about the group, about all of you, and I started to talk to you. Someone said this and someone said that, and I got hold of things in a different way. I decided to talk with my boyfriend and told him that I needed a break, not because I didn’t like his family, but I had to breathe, I had to breathe together with him, and then we did things that day, just the two of us, and I got grounded. It was as if we found an outlet together; we realized that I, we, needed space to breathe, and then it was quite OK with the huge family, and slowly I mastered the language better. It was an immense experience.”

Both of these examples, coupled with signs of social stabilization, indicate that for those people, group therapy is approaching an appropriate ending. Most patients terminate without any follow-up, while some get sporadic individual sessions for a limited time.

Coordinating and mentalizing meetings between all involved therapists

MBT contains several treatment formats and several therapists. A precondition for good treatment is that the therapists are informed about their respective roles, that they coordinate their initiatives, that they have a reasonable consensus on the psychodynamics and the personality of the patient, that they respect and tolerate the diversity of different treatment formats and different therapists, for example, that one and the same patient may have different kind of transference to different therapists and may evoke different countertransference.

Accordingly it is important to have regular meetings for coordination and reflection between all involved therapists. This entails team meetings, supervision meetings, ad hoc meetings, and meetings every 6 months for evaluation of treatment progress. The following clinical examples will illustrate these points.

The patient who evokes different kind of countertransference in different settings:

Else (24) is a self-destructive and self-harming woman who fulfills eight of nine borderline criteria. She has dropped out of schools and jobs and lives a marginal life around a gang of addicts. She drinks habitually, in heavy doses, often through night and day and can perform “crazy things” in order to gain higher status in the gang.

By admission to the MBT program she “agreed” that her drinking habits “were alarming” and had to be moderated. Once started, it was not that problematic any longer. However, fellow group members were shocked when hearing her drinking stories. It does not impress Else. She believes that “all the mess in the group about the drinking” is due to bourgeois and moralistic group therapists. She doesn’t care and by the way “she actually has not so much to tell the group.”

During the first months her mentalizing level was around zero. The group therapists had to handle their countertransference aroused by denial and rejection and an experience of meaninglessness and no prospect of progress. However, the therapists in the psychoeducational group reported on a different side of the same patient. She attended regularly and looked interested and motivated. The individual therapist could also report on a greater sense of alliance. The alcohol excesses did worry the patient, although she fluctuated. She had agreed to be referred to a detoxification unit. A fifth therapist had been engaged for that project.

In a meeting between all therapists they agreed to stick to the alcohol focus, they acknowledged that the alliance can increase, and that a main issue in this first phase of treatment should be to “hold and contain” the contradictory parts of her. One part seems to realize that life is too hard and that she needs to be taken care of, while another part could not care less and may perform spectacular and dangerous things that demonstrate that she doesn’t give a damn. The group therapists became more relaxed and trusting about the effect of the treatment system as a whole.

The patient who frustrates the group therapists with surprisingly poor functioning:

Fredric (23) is referred because he has dropped out of work and isolated himself from family and friends. He gets a diagnosis of mixed PD with paranoid, borderline, avoidant, and obsessive–compulsive traits. In better functioning periods he hangs out with a socio-cultural subgroup. In the MBT group he becomes “totally blocked.” He can hardly utter a word and he “gets sick.” The group therapists are surprised by his poor functioning and wonder if the assessment has been appropriate. He has indicated that he periodically “hears voices” and the group therapists believe he at least fulfills criteria for a schizotypal PD, if not schizophrenia.

Fredric talks about his group experiences with the individual therapist. There are people in the group who he ordinarily would not socialize with. The manner of speech is strange. Things seem just to float around. Nobody sticks to “the topic.” And people

interrupt each other. There is no respect. Fredric had tried to indicate with his hand that he wanted to say something, but was overlooked. However, in his individual therapy he also displays interest in this strange way of being together. Many hours are devoted to these themes. Being informed about the focus in the individual part of the treatment, the group therapists calm down. “It’s OK. We can contain him in the group while you work with his experiences. Maybe he slowly can get along.” After some months, Fredric is able to endure the group without clinging to the chair. He starts to make sense of what it is all about and slowly manages to comment upon the discussions in a rewarding manner.

The patient who exploits “sleeping” group therapists and recruits the group in a frontal attack on the individual therapist:

Rita (30) is an immigrant from a Latin American country and brings with her strong traumatic experiences. In Norway, she has had to flee from several abusive men. She has been referred from the rehab program of the local crisis center.

In her individual therapy she reacts with strong disgust at the male therapist. She has the opinion that he is “an old pig that is after her.” She talks about this several times in the group and succeeds in recruiting a subgroup that supports her views that “it is like an abuse to be exposed to such a therapist.” She wants another one. She asserts this strongly to the individual therapist, saying that the whole group supports her request for a new therapist. Anything else would just be abusive, “and I assume that the system here cannot just be protected to any cost.” Needless to say, the situation is not easy to handle for the therapist. He witnesses psychic equivalence to an almost delusional degree. What strikes him as most curious is the reference of support from “the whole group.” He contacts the group therapists to get their side of the story. Yes, they admit that perhaps they were “not alert enough” last session and that Rita was not challenged in her criticisms against the individual therapist. They could not give any good reasons for their passivity but promised to raise the matter in the next group session. It turned out to be a lively and emotional meeting. Rita and her subgroup were challenged and the seemingly united campaign against an external enemy collapsed. Rita’s emotions and thoughts about the individual therapist continued for a while. However, the “solution,” with the support of the group, was abandoned. Gradually it was possible to reflect upon several sources of these painful emotions.

The patient who devalues the group and the individual therapist who encourages the group therapists to “carry on carrying on”:

Reidar (33) became seriously depressed when his father died and literally tried to drink himself to death in the aftermath. He didn’t succeed, but developed chronic pancreatitis. Since then he had lived a cumbersome and marginal life of drug abuse and occasional jobs far below his potential. He had “lost all illusions,” thought “civilization is a great lie” and he was tired of “this lousy life.” There were some short affairs, but he could not sustain any intimate relationship. He knew a lot of people, but had no close friends. The social rehabilitation office referred him for treatment: “Otherwise, nothing will happen to him. He’s just drifting.”

Reidar liked the individual sessions. They had an intellectual aura that appealed to him although he was disappointed by the fact that the therapist would not discuss the content of the many fascinating books he noticed on the book shelves. But the group was “a

nightmare.” The therapists were “passive and seemingly disinterested” and the fellow group members were “lazy and stupid.” They clung to modes of existence which he had long since left. He just “would be dragged into the mud by them.” When the individual therapist asked him to be more concrete about his experiences of individuals and events in the group, he responded with resignation that “it was too boring.” The others just made him feel low. He regarded it as ridiculous to open up for such a bunch. They just hadn’t anything to give. He preferred people at the cafés downtown.

No wonder that he hadn’t got the “energy” to attend the group regularly. On average, he turned up at every second meeting. His absences were addressed and explored repeatedly, but to no avail. The group therapists complained to the individual therapist who assured them that he was “working on the case.” However, when asked, Reidar had nothing to say about the group except for general devaluating phrases. It was as if he was not mentally present in the group. The group therapists wanted to throw him out and several meetings were held to discuss this. Each time he promised to do his best (he appreciated the individual therapy), but his behavior did not change. All this changed when he found a new and better functioning girlfriend. His own problems with intimacy could not be denied any longer and he found a new motivation for psychotherapy (which he had previously experienced as a request from the rehabilitation office). Now he turned it into his own project.

Approximately 1 year had passed when the individual therapist asked his customary question, “And how was the group last week?” and got the surprising answer that “Oh yes, it was fine.” Reidar had presented a relational problem with his girlfriend, received engaged commentaries and questions, and then he was hooked. A long and meaningful group sequence followed. This was a quite undramatic, yet highly significant turning point. From then on, he hardly missed a group session.

MBT-G in different contexts

In this manual, we outline the principles of MBT-G for its most common format, which is intensive outpatient treatment. But MBT-G may also be used in other settings, for example, as part of short-term or medium-term inpatient treatment, or as group psychotherapy in private practice. It is inherently flexible. The degree of group cohesion, degree of psychopathology, and alliance will guide the amount of control the therapists should have over the group. In a psychiatric short-term ward, one is unable to build substantial group cohesion because the patients come and go in quick succession, and because their current mental disorders put demands on concentration and attention. This implies that group therapies should be highly structured. MBT-G allows for this and makes it possible for the therapists to have good control. In practice, this will mean a synthesis between psychoeducative and dynamic MBT-G. In one and the same session one can oscillate between psychoeducative and dynamic sequences. A good starting point would be the four meetings about mentalizing, failure of mentalizing, emotions, and emotional regulation, as described in the MBT psychoeducation manual (Karterud & Bateman, 2011). One may

rotate between these themes and spend more time on discussing the different participants' own experiences. If it is to be used in short-term, specialized wards for people with a higher level of functioning than what one will find in more crisis-ridden, psychiatric short-term wards, one may add special group exercises designed to promote mentalization (Allen et al., 2011; Karterud & Bate-man, 2011).

In intermediary and long-term wards, the structure and technique will depend on the type of clients. Modifications will of course be needed if most patients have schizophrenic spectrum disorders. If treatment of addiction is the target, the group therapy could be a more structured version of what is described in this manual. In institutional treatment, events in the milieu will have a strong priority besides external events and events in the group (Kibel, 1987).

In institutions, one should also take advantage of the interchange between weekdays and weekends. Some wards may even be closed over weekends. It is useful to establish "before- and after-weekend groups." In Friday's "before-weekend group" the participants take turns in discussing which mentalization challenges they will face during the weekend, for example, containing anxiety or depression, resisting ideas about suicide and drinking, meeting one's family or neighbors, or coping with loneliness. The therapists should keep an interpersonal focus. Which interpersonal encounters or situations might increase the weight of the symptoms and which might ease them, and why would that be? What can patients do to find out more about this and handle it satisfactorily? In Monday's "after-weekend group" the participants go through their experiences. What happened? What does the protagonist think about what happened? What do the others think?

Mental health centers (MHCs) are key organizational structures for mental health services in most European countries. They run a number of group therapies, often directed by specialized group units or group clinics for outpatients. Many of these group units have developed from previous day wards. In modern mental health services, the boundaries between a psychiatric day ward and an intensive treatment program in a group unit are vague. Modern developments favor intensive outpatient treatment programs and MBT-G has its natural place in such programs which should exist in every MHC. MHCs face many patients with different kinds of personality pathology, as well as varying degrees thereof, without the substantial identity problems and self-destruction that is part of borderline pathology. Many of these patients would still struggle with making use of conventional psychodynamic group therapy. For these patients, MBT-G represents a clear and structured alternative, with or without parallel individual therapy.

In private practice groups, the participants often have a higher level of functioning, being able to fulfill basic educational, work, and family life roles. Self-cohesion and identity will be more robust, the attachment patterns will be more secure, object constancy will be firmer, emotional regulation better, and way of life will be less destructive. Nonetheless, these people also have problems with self-esteem, work performance, and relationships. In such higher-functioning groups, a strong group cohesion will more easily develop and it will be a natural part of the group process to regulate time and attention for each individual participant and problematize the reasons for any asymmetrical distribution. Usually this does not happen in a structured way to begin with, as this manual recommends. Any degree of turntaking that might take place also happens more spontaneously. Can “ordinary” psychodynamic group therapy still make use of anything from this manual? In our opinion, yes—in several ways. Therapists will benefit from recognizing and differentiating in a clearer ways between good and poor mentalizing. They should know about psychic equivalence and pretend mode. Also within psychodynamic group therapy therapists should stop aggressive escalation, take control over the group when necessary, and make use of techniques that are appropriate in order to promote mentalizing in irreconcilable participants. Furthermore, therapists should help groups out of collective pretend modes, assist patients and groups to clarify interpersonal events, and assist in a collective exploration of such events, focusing on what kind of mentalizing failure, if any, is involved. However, in well-functioning groups this does not need to be as structured as is recommended in this manual. In well-functioning groups this will unfold more spontaneously from the group process, almost “on its own,” although there is of course no such thing as “on its own.” In reality, this apparent spontaneity happens as a consequence of a long-term and fertile interplay between the group therapist’s theories, imagination, and practice, and the resonance this invokes in the group. The therapist’s discourse ideal tends to be established in the group’s matrix if he/she is clever enough.

Similarities and differences between MBT-G and other types of group therapy

Cognitive group therapy

There are several varieties of cognitive group therapy. They have the following in common:

- ◆ a clearly defined (cognitive) goal
- ◆ the therapists take a clear and authoritative role as leaders, both regarding content and process

- ◆ a pedagogical focus with regard to (didactical) learning and skills training
- ◆ short inserted “lectures” by the therapists
- ◆ the group dynamics should facilitate the above-mentioned intent and interpersonal events here and now are not exploited, or to a very limited extent, as therapeutic material
- ◆ the therapy is supported by rather extensive work books which explain cognitive theory and also serve as note pads for individual (home)work
- ◆ specific recommendations for individual homework.

Most variants of cognitive group therapy, often called “cognitive therapy in groups,” are more similar to psychoeducative group therapy than psychodynamic group therapy. A particularly thorough variant by Michael Free (*Cognitive Therapy in Groups*; Free, 2007) serves to illustrate this. This is a manual for a time-limited therapy set within 24 meetings. The content of every meeting is meticulously defined and the text is accompanied by 150 pages of forms and PowerPoint illustrations which are presented to group participants. In this way, the participants have to relate to a massive theoretical corpus. Compared with this therapy, mentalization-based psychoeducative therapy is actually quite dynamic.

There are few resemblances between cognitive group therapy and MBT-G. If any, it would be that the therapists of both formats seek to define the group goals as clearly as possible, and that the therapists are actively engaged in making the group structure support the goals. Another common denominator is emphasizing so-called chain analysis. We will discuss this in the next paragraph. Cognitive group therapy and MBT-G are otherwise widely different genres. MBT-G is a kind of therapy that activates the group members here and now in a collective dynamic discourse where intersubjective transactions are in focus. Cognitive therapy in groups is more like a school class or a course where you are given justified recommendations for working at home with the curriculum that is elaborated at school.

Groups for skills training in dialectical behavior therapy

The first year of DBT is defined as combination treatment. The group component is a premise for the individual therapy, and vice versa. The individual therapist, however, is defined as the “primary therapist.” Marsha Linehan (1993a, p. 103) writes that:

skills training with borderline patients is exceptionally difficult within the context of individual therapy . . . The need for crisis intervention and attention to other issues generally precludes skills training.

The treatment is therefore divided into two components where skills training is ascribed to the group component. In DBT, the word “skills” is used synonymously with “abilities,” and “includes in its broadest sense cognitive, emotional, and covert behavioral (or action) response repertoires” (Linehan 1993a, p. 329).

The skills in focus are associated with the following main categories: (1) mindfulness, (2) tolerance for affect, (3) emotional regulation, and (4) interpersonal skill/capability/competence. The treatment is strongly oriented towards problem-solving and behavioral mastery. There is a skill defined for most things and half of the book *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993b) consists of different handouts and forms supporting the identification, practice, and strengthening of the skills in question, or the identification and restraint of unwanted skills. As an example, “crisis survival skills” are defined as consisting of “distracting skills” and “self-soothing skills,” and the manual describes what this implies.

The skills training groups in DBT are usually slow-open groups. They can consist of two to eight members. They meet weekly, and the meetings last for about 2–2.5 hours, usually with a break in the middle. Linehan characteristically labels the therapist “the skills training therapist,” not “the group therapist.” Structurally, these groups adhere to manuals for cognitive group therapy and do not relate at all to dynamic group therapy, for example, like MBT-G. The group component in DBT is essentially psychoeducation combined with skills training where the therapists take advantage of the fact that many patients are gathered, to support their experiences of recognition, identification, learning from each other, and mutual support.

In this way, the group therapies of DBT and MBT are widely different. Technically, though, DBT and MBT share some common ground. One example is so-called chain analysis. In DBT, the focus is on problematic behavior, and as soon as a relevant piece of problematic behavior is identified, one seeks to develop an exhaustive and step-by-step description of the chain of events which lead up to and succeeded unwanted behavior. In individual therapy this will fill a considerable part of the treatment:

The essence of conducting a chain analysis is examining a particular instance of a specific dysfunctional behavior in excruciating detail. Much of the therapeutic work in DBT is the ceaseless analysis of specific instances of targeted behaviors. (Linehan, 1993a, p. 258)

Linehan writes that both therapists and patients often tend to overlook the significance of this. Linehan does not define as explicitly as in MBT that the focus is interpersonal events, but in practice this will often also be the case in DBT. A DBT chain analysis is at least as detailed as in MBT, but the focus on

mentalization as “target behavior” is not as consistent. In DBT, one will find repeated “Socratic questions” beginning with “who,” “what,” “when,” “where,” “how,” etc. In chain analysis, Linehan recommends an attitude which is quite similar to the not-knowing stance in MBT: “Rather than understanding the connections in the chain, the therapist should play the part of the naive observer who does not understand anything and who asks about everything” (Linehan, 1993a, p. 259).

In DBT, detailed chain analysis is first and foremost a task for the individual therapist. In MBT-G, chain analysis (in a simplified version) focusing on mentalization and intersubjectivity is one of the main tasks. This manual contains detailed instructions on how patients can be trained in this skill through “practice” within the group. The rationale is that when this ability is internalized and used outside the group therapy room, both regarding self-understanding and interpersonal transactions, it will enhance self-cohesion and interpersonal competence.

Group analytic and psychodynamic group psychotherapy

MBT-G developed from, and therefore shares many points of resemblance with, group analysis (GA) and psychodynamic group psychotherapy (PG). Group analytic and psychodynamic group psychotherapy belong to the same therapeutic “family.” Group analytic psychotherapy is the British version taught at a number of European institutes for group analysis and which follows the tradition of S. H. Foulkes (1948, 1964, 1975). Psychodynamic group psychotherapy is the American version, described in textbooks like that of Rutan et al. (2007). For our purpose, the similarities between these forms of therapy are greater than the differences. The most important common feature of these therapies and MBT-G is that they are all based upon an active use of the group dynamics, that is, what happens here and now through the intersubjective transactions in the group. The relations to fellow patients, the therapists, and the group as a whole are at the center of exploratory attention. The most important differences are the following:

- ◆ MBT-G has patients with BPD (in a wide sense) as its target group. GA and PG have broader indications, and they would be cautious in having several borderline patients in the same group. GA and PG strive for “balanced” membership.
- ◆ MBT-G is a time-limited kind of treatment (1.5–3 years) while GA and PG are quite often without a predefined time-limit.
- ◆ MBT-G is usually combined with individual therapy. GA and PG are usually stand-alone group therapies.

- ◆ The purpose of the group, the role of the patients, and the group's manner of working are more clearly defined in MBT-G than in GA and PG.
- ◆ GA and most PGs rely on free group associations. MBT-G does not.
- ◆ MBT-G therapists start the group in a particular way and issue invitations for balanced turntaking. This is not done in GA and PG.
- ◆ MGT-G has interpersonal events as a privileged focus to a stronger degree than in GA and PG.
- ◆ MBT-G therapists are more active and this is especially true for their role in (1) structuring the group, (2) exploring events, (3) engaging other group members in explorations, and (4) regulating arousal in the group.
- ◆ Therapists in GA have a greater tolerance for turbulence and chaos and are working according to principles of "Leave it to the group" and "Trust the group."
- ◆ MBT-G therapists make far less use of group interpretations than in GA.
- ◆ MBT-G therapists make less use of individual interpretations than in PG.
- ◆ MBT-G therapists are more open (transparent) than in GA and openly explore their own contribution to events in the group, and use this as a model for a mentalizing stance.

Interpersonal group psychotherapy

In our comparison with different types of group therapy, we will allow some more space for interpersonal (group) psychotherapy (IPT) since IPT is not as well known as general psychodynamic therapy, and since this tradition incorporates a form of group therapy sharing a number of similarities with MBT-G.

Interpersonal psychotherapy is founded by the work of the American psychiatrist Harry Stack Sullivan and professionals following in his wake. Irvin Yalom has influenced several generations of group psychotherapists, and his renowned textbooks are strongly informed by interpersonal theory and practice (Yalom, 1995). His own personal version of interpersonal group therapy is inspired by his interest for continental existential philosophy (Yalom, 1980). Yalom is not only extremely interpersonally oriented in groups, he also strives to be as authentic, open, honest, and present a therapist as possible in a therapeutic group. He promotes an ideal of being as transparent as is humanly possible with regard to his own thoughts and feelings. Moreover, he strongly emphasizes the here and now and calls for the therapist's creativity with regard to "catching the moment." Yalom is also an exceptionally skilled writer. MBT-G therapists can learn a great deal from Yalom when it comes to (1) interpersonal focus, (2) authenticity, (3) openness about the relationship between therapists and patients, and (4) creative use of the here-and-now interaction.

Interpersonal psychotherapy has over time developed a more manualized and evidence-based form. It started with time-limited, interpersonal psychotherapy for depression, and subsequently included other disorders, especially bulimia. Myrna Weissman has been central in the modern shaping of interpersonal psychotherapy (Weissman et al., 2000). Technically we notice the use of the so-called communication analysis:

The therapist invites for a detailed account of an important conversation or a row with the partner, for multiple purposes: It is both to achieve an understanding of what the transaction means, and to understand the way the couple communicates. The therapist listens to the details of the communication and halts in order to understand the patient's feelings and motives on critical points: What did you say next? . . . What did you feel then? (Weissman et al., 2009, p. 115)

There are clear similarities with chain analysis in DBT and the exploration of interpersonal interactions in MBT. However, IPT lacks the theoretical rationale and purpose embedded in MBT. Compared with psychodynamic psychotherapy, the authors claim that IPT is focusing:

more on the actual situation than precursors in childhood; it focus on the patient's life outside the therapist's office and it does not interpret dreams or transference. IPT deploys a more structured and pragmatic stance in order to change interpersonal patterns, as a means to diminish symptoms of an affective syndrome or some other psychiatric condition. (Weissman et al., 2009, p. 132)

Before IPT received its modern design through the works of Weissman and colleagues, the Canadian psychologists Elsa Marziali and Heather Munroe-Blum (1994) developed an "Interpersonal group psychotherapy for borderline personality disorders" (IGP). This is thorough empirical work, both in the development of guidelines, training of therapists, and measuring of treatment effects. It concerned time-limited closed groups, lasting for about 1 year (30 group sessions). The technique was especially adjusted to borderline patients and it has many similarities with MBT-G:

- ◆ Avoid interpretations and confrontations in the way which has been recommended by Kernberg (1975). Marziali and Monroe-Blum (1994) recommend a "noninterpretative, emphatic feedback approach."
- ◆ Show interest and engagement in the patient's subjective experiences and way of communicating. Use explorative questions.
- ◆ Abstain from the role as expert when it comes to the patients' (unconscious) inner world; admit and tolerate your own insecurity and confusion and find ways to communicate this: The therapist "models for the patient tolerance for anxiety and ambiguity while various solutions to the dilemma are considered. In this model of treatment, it is the patient who has control over the

dialogue, and it is the therapist who communicate uncertainty and confusion while maintaining a sharp interest in each patient's narrative" (Marziali & Monroe-Blum, 1994, p. 71). We recognize here many of the elements in MBT's not-knowing stance.

- ◆ Actively regulate the "temperature" in the group to avoid overexposure or defensive emotional flatness.
- ◆ Focus on here-and-now interaction in the group, but do not interpret events as enactments or repetition compulsion.

Compared with a psychoanalytic interpretative technique, IGP:

primarily focuses on the acquisition of new learning by observing and experiencing the "here and now" interpersonal dialogue, whereas the former emphasizes the acquisition of new knowledge through understanding and integrating the content of what is communicated. In the IGP model of treatment, change is more due to the experience of interactions in the group and less to the acquisition of insights about the genesis of internalized conflicts. Thus, the context of knowing is more important than the content of what is known. This reflects the belief that for the borderline patient the context has been historically imbued with debilitating levels of painful emotions that block effective cognitive processing of new information; thus when the context (member-to-member and member-to-therapist transactions) are well understood and adequately managed by the therapists, the borderline patient's inherent capacity for information processing is enhanced. (Marziali & Monroe-Blum, 1994, p. 74)

Today we would state this more simply and clear, but the essence remains the same: Training in understanding and handling of interpersonal transactions here and now will increase one's mentalizing ability.

As for therapeutic technique, there is a focus throughout on the interaction between the group members and between the members and the therapists. The therapists should devote special attention to how the following themes play out in the group (because of the borderline pathology):

- ◆ Searching for boundaries (for themselves, in cooperation, and for the group as a whole)
- ◆ Attack and despair (quick activation of the fight/flight response, projective identification, and ruin of relations)
- ◆ Grief processes and repair (as natural tendencies that are liberated in treatment)
- ◆ Integration and self-control.

In IGP, there is a special emphasis on "intersubjectivity and the management of group derailments." It concerns intersubjective consciousness and competence within the therapists, how they can handle projective identification in the group and how they can understand when the group derails, their own possible

contributions to this, and how they can get the group back on track again. Summing up:

Distinguishing group dialogue that is “stuck” from dialogue that advances the work of the group is another important approach with IGP. For example, when patient dialogue becomes polarized, the therapists are alert to the fact that an intervention is needed. Their aim is to restore the balance of a give-and-take dialogue that advances interpersonal process within the group. When the meanings of the “stuck” dialogue are misunderstood by the therapists, derailment occurs. The therapists are again alerted that an intervention is needed. Mending the derailment may have the greatest therapeutic impact on the patients because they witness the effects of the therapists’ confusion and suspended capacity for processing both their own and the patients’ emotions. However, contrary to the patients’ experiences with managing explosive emotions, the therapists are able to produce a balanced response and process the meanings of the derailment. As the therapy progresses, the patients are increasingly able to address the derailments in the interpersonal dialogue. These patient “interventions” are manifestations of the integration of self-control that is the ultimate aim of IGP. (Marziali and Monroe-Blum, 1994, p. 99)

The above mentioned quotes capture the essence of the “group as a training ground for mentalizing,” and they correspond with our claim that the “process is more important than the content,” that it all depends on the quality of the dialogue, and the emphasis on the therapists as models for good mentalization. IGP is therefore the group therapy mode which is most closely related to MBT-G. IGP and MBT-G also share a positive relation to empirical data and studies, while GA is more skeptical about the value of quantitative measurements. IGP was developed through a synthesis of borderline theory (available at that time) and experiences from the testing of different group techniques. There is a standardized program for skills training in the education of IGP therapists, and the treatment effect has been tested in a randomized controlled trial where the control condition was individual psychotherapy (Munroe-Blum & Marziali, 1995). The effects turned out to be roughly the same for the two treatment formats, but the group therapy mode was more cost-effective.

When we compare IGP with MBT-G, we may say that there are many similarities, but that MBT-G on most points has gone some steps further. The theory is more thorough and grounded in a number of supporting disciplines (evolution, genetics, neurobiology, developmental psychology, psychopathology, treatment theory, etc.) related directly to therapeutic techniques. MBT has a larger degree of evidence supporting its efficiency for borderline patients. IGP describes guidelines for group therapy, but does not, strictly speaking, have a manual comparable to MBT-G. The manual for MBT-G is more theoretically consistent, systematic, and comprehensive than IGP, and it contains moreover a rating scale which makes it possible to evaluate therapists’ competence.

The group as a whole: Constructing and mentalizing the matrix

Since MBT-G strongly emphasizes the therapist's leader responsibilities, does it neglect the significance of the group as a whole? The answer is no. In the following section, this short answer will be elaborated with reference to the group analytic concept of *matrix*. This concept has a foundational role in group analytic theory and practice. It was launched by the founder of group analysis, S. H. Foulkes, early in his career, but not explicated extensively until his second textbook, *Group Psychotherapy: The Psychoanalytical Approach* (Foulkes & Anthony, 1957). The matrix can be thought of as an invisible web which influences people in a concrete ways. It is also a theoretical web. The very concept links with other theoretical elements of group analysis. The concept presupposes a theory of the relationship between the individual and the group while at the same time it represents a crucial building block for such a theory.

Foulkes expressed himself in such ways as "Man is primarily a social being, a particle of a group" (Foulkes & Anthony, 1957, p. 234). The conception of *the isolated individual*, as a kind of solipsism, is a historical phenomenon which gained support during the nineteenth century. Foulkes was strongly opposed to this. He believed that man's "groupishness" is embedded in the genes, having evolved through millions of years (cf. the earlier section on "Group dynamics and evolution"). Bringing strangers together in a group, as one does in a group analysis, will arouse fear of an antagonistic kind, but this will be overshadowed, claimed Foulkes, by:

an overwhelmingly strong impulse, amounting to an absolute and irresistible need, to make contact and to re-establish the old and deeply rooted modes of group behaviour. We think indeed that as soon as the group takes hold and the formerly isolated individuals have felt again the compelling currents of ancient tribal feelings, it permeates them to the very core and that all their subsequent interactions are inescapably embedded in this common matrix (Foulkes & Anthony, 1957, p. 235)

When people come together, they are compelled to communicate with each other. The communication might be silent, but never nonexistent. In a therapeutic group, verbal communication is a *sine qua non*. One gets together simply in order to talk to one another. One comes to the group in order to understand *more* of oneself, and perhaps *differently*. In order to understand more and differently, based upon interpersonal transactions, one has to expand one's own communicative repertoire. One has to immerse oneself in a process which has communicative diversity and self-reflection as its very purpose. Symptoms, which represent *distorted communications* as well as private, secret, and shameful fantasies and needs, have to be translated into a realm of commonly

accepted public communication. The therapist's skill resides in his or her ability to understand distorted communication and assist in this translation process. Communication, which includes the process of making the un/pre-conscious conscious and the process of verbalizing, is the essence of group analysis.

The concept of matrix refers to the communicational network that will establish itself in a group. It is the communicational structure (role assignment, norms, relations, discourse style, etc.) which has materialized during the history of the group. Matrix is not a static phenomenon. It has a significant process feature since structure and content will continuously become modified through the group's ongoing "negotiations" (Whitaker, 1981). Foulkes emphasized that the interpersonal relations that constitute the matrix, as well as all events in the group, literally happen *between* two or more persons. A lot of the communication that flows in the matrix takes place at a nonverbal or unconscious level. The forces in the matrix:

may be conceived as passing right through the individual members and may therefore be called a transpersonal network, comparable to a magnetic field, The individual is thought as a nodal point in this network, as suspended in it. (Foulkes & Anthony, 1957, p. 259)

In the article "The group as matrix of the individual's mental life," Foulkes (1973) distinguishes between a *foundation matrix* and a *dynamic matrix*. The dynamic matrix is what we perceive at a phenomenal level in a given group. We have a tendency to overlook the foundational matrix since we all are a part of it. It operates more silently in the "bottom" of the group. It is what unites us by the fact that we belong to the same species, we have the same biological makeup with respect to perceptions and language, we belong to the same language community, to the same culture, and so on. In short, we share a common genetic design and are socialized through a network of common values and norms and communicational styles. Such are the silent preconditions for our speech acts in the group.

Group analytic theory contends that symptoms are repressed unsymbolized affects which have not been transformed by communicational processes in the individual's primary group (the family). The group can be conceived as a resonance box, meaning that experiences that have been "homeless," that is, devoid of a communicational community, now may find resonance in other people in the group, or in the group as a whole. By this, there may be initiated a symbolizing and communicative process which lends words and meanings to experiences that previously were devoid of words and meaning. The main task for the group analyst is to facilitate these processes of symbolization and communication. A major tool in this respect is free group associations.

Matrix is a phenomenon which is not reserved for analytic groups. Foulkes emphasizes that he speaks about communicational networks that will become established in all kinds of groups. Certain features by this matrix will be shared by many groups (foundation matrix), while specific groups will own their specific dynamic matrices. *Group therapists face the task of constructing, or designing, the matrix in order for it to serve the primary purposes of the group.*

It is not the case that the “natural matrix” of group psychotherapy is the one which is founded upon free group associations. Free group associations are the group analytic counterpart to free associations in psychoanalysis. It was a technical tool which Freud created in order to counteract the repression barrier. He contended that free associations will loosen up the repression mechanism and thereby facilitate the process of making the unconscious conscious. However, today few would seriously claim that borderline pathology is due to repression. There is far more evidence for the theory of deficient psychic structure (lack of consolidation of self and internal objects) (Karterud et al., 2010). Accordingly it seems rather strange to maintain that the tool for building psychic structure should be an unstructured treatment situation. According to classical literature, it is individuals who have “too much structure,” for example, the old “neuroses,” who might benefit from lack of structure.

Just as free-associative group analysis therapists create their own group culture, therapists who follow MBT-G guidelines will create their own species of matrix. The question is not which kind of matrix is “best,” but rather whether they suit their purposes in a constructive manner. In this manual, we try to outline in detail what kind of dynamic processes we stimulate and why they are appropriate for borderline patients.

Group analysis and MBT-G construe different kind of matrices. The therapies are also different with respect to how they understand and respond to the dynamics in the matrix (“mentalizing the matrix”). Group analysis recommends group interpretations, such as:

“Yes, mothers can surely be frustrating. However, I wonder if the current group discussion creates a kind of assumption that most sources of pain reside outside the group. According to that, it may make sense to consult each other on how to cope with all frustrations out there. But a deeper cause seems to be the fact that there are two new members in the group. Talking about mothers implies shutting one’s eyes for what is frustrating here and now.”

This kind of interpretation, close to a statement of what is “actually” going on in the group, and which implies that the therapists have some particular abilities to “see” such things, is not recommended in MBT-G. To understand group dynamics in itself is not a high-ranked goal in MBT-G. Even if group dynamics

represent contextual factors here and now, which several people might benefit from exploring, such an understanding is subordinate to the higher-ranked goal of enhancing mentalizing ability through reflection on intersubjective transactions. Group interpretations in MBT-G should be short, descriptive, aimed at evoking curiosity, and avoid references to unconscious processes. They should be used in order to point at something going on here and now, something which prevents constructive group work: “It is rather quiet here today, isn’t it?” Many will not even label such an utterance as an interpretation. It is more like an open wondering about an obvious group phenomenon. Interpretations in a classical sense should convey a hypothesis about a causal connection, as in the earlier example where the therapist postulates that the conversation about mothers is “caused by” frustration created by two new members in the group.

The fact that regular group interpretations occur rather seldomly in MBT-G does not imply that MBT-G therapists ignore the dynamic matrix. As outlined in the introductory chapters of this manual, the principles of MBT-G are constructed with constant reference to group dynamics. In addition, there is in Chapter 3 an item (number 8) which concerns “stimulating and assisting the group in discussions of group relevant themes.” Through such discussions group members will slowly come to “own” a project which was initiated by the therapists and presented in an abstract manner. When the norms and rules have been negotiated in the group, and internalized, the members will begin to feel at home in a matrix which they have co-created.

The mentalization-based group therapy adherence and quality rating scale (MBT-G-AQS)

Introduction

The principles for MBT-G have been outlined in Chapter 2. In this chapter, these principles will be operationalized through nine group-specific items. We recommend that the reader consults Chapter 2 when reading Chapter 3 and 4. In addition to the nine group-specific items, the manual includes ten items that are modified from the manual for mentalization-based individual therapy (Karterud & Bateman, 2010). Altogether, the complete manual for MBT-G consists of 19 items.

These items can be rated on the MBT-G adherence and quality scale (MBT-G-AQS). The scale can be used for education, supervision, and research purposes. By using the rating scale, therapists may receive qualified feedback on their therapeutic style.

We will first discuss the place of this rating scale within the general tradition of (group) psychotherapy rating scales. Thereafter we describe the construction of the scale and the rating procedures. In Chapter 4, we will describe each item in detail. Readers who are not interested in the science of group therapy ratings can skip Chapter 3 and go directly to the item descriptions in Chapter 4.

On rating scales for group therapy

Manuals and rating scales have been controversial issues in the field of psychotherapy (Karterud & Bateman, 2010). Rating scales have been developed primarily for research purposes, in order to provide measures of the degree to which the therapists stick to the proscribed guidelines for the treatment in question, that is, for measuring so-called treatment integrity. Manuals and rating scales were initially developed for behavioral therapy (Wolpe, 1969), soon followed by cognitive therapy, interpersonal therapy, and various psychodynamic modes. The tradition is by now well established in individual psychotherapy and there is a rich literature on the technology of such rating scales. The

overriding questions concern validity and reliability: The items which are chosen should reflect the most prominent features of the treatment, and independent raters should be able to reach a high degree of agreement as to how therapists actually perform with respect to the proscribed guidelines.

The MBT adherence and quality scale (MBT-AQS) for individual therapy consisted of 17 items. A reliability study showed that the reliability of these items varied considerably. Some were rather easy to agree upon, others were more difficult (Karterud et al., 2012). However, the overall rating was found to be good enough for scientific purposes. Later on, we established a MBT quality laboratory at the Department for Personality Psychiatry, Oslo University Hospital. It turned out that the reliability improved considerably through more extensive training and in concert with more elaborated rules and procedures for rating. During 2013/2014 the reliability of MBT-AQS has been around 0.90 (ICC-2) at this laboratory. This is a high degree of agreement. There is no doubt that MBT can be assessed in a reliable manner.

Within the field of group psychotherapy, the situation is different. The question of treatment integrity has, by and large, been ignored. It is true that there exists a tradition which can be traced back to Bales' (1950) *Interaction Process Analysis*, which rates the activity of group leaders, and to systems that rate member–leader interaction (Mann et al., 1967). However, these ratings were part of general process analyses (Beck & Lewis, 2000). They did not concern how therapists adhered to specific and manualized guidelines. There has been considerable concern as to this state of affairs, for example, by Chapman and coworkers (2010, p. 15):

One of the most neglected areas in group research literature has been that of leader effects on groups . . . Accordingly, a recent review of the current status of group psychotherapy research by Burlingame, MacKenzie, and Strauss (2004) issued a call for the development of leader measures as a next step in the group treatment literature.

A notable exception is the Group Psychotherapy Intervention Rating Scale (GPIRS), developed by Sternberg and Trijsburg (2005). GPIRS is a scale developed for group psychotherapy in general and accordingly does not lean on any particular treatment manual. The items, amounting to 48 (!), are designed to comply with empirical research norms. Each item should represent “specific interventions with established effectiveness in enhancing group therapeutic factors” (Burlingame et al., 2002). The items are organized in three higher-order domains:

- 1 *Structuring the group.* This domain includes interventions that promote group norms, that define therapist and patient roles, that implement group exercises, and so on.
- 2 *Facilitating verbal interaction.* This domain includes interventions that aim at facilitating verbal interaction, openness between members, mutual feedback, and so on.

- 3 *Creating and maintaining a therapeutic emotional climate.* This domain includes interventions that aim at a safe group milieu, decreasing anxiety, hostility, and uncertainty in the group, and so on.

These higher-order domains seem valid for most kinds of group therapy: structure, verbal interaction, and a safe emotional climate. As will become apparent, all items in MBT-G are easily located in such a scheme. GIPRS contained 48 items. They should be rated for occurrence (yes–no) and quality on a 1–4 Likert scale (poor–adequate–well done–excellent).

However, it is well known that reliability declines when the number of items increases. Ideally, the fewer the better. It is hard to decide exactly which item out of 48 is appropriate for a certain intervention, especially when such decisions are undertaken in rapid succession, following the flow of the group dialogue. It comes as no surprise that a validation study of GIPRS, based upon 71 group sessions, revealed that only 26 of the 48 items were actually rated. It is regrettable that this study did not adequately report on the reliability of these 26 items. Current knowledge (Karterud et al., 2013) indicates that rating scales should contain fewer than 20 items.

The Mindfulness-Based Relapse Prevention Adherence and Competence Scale is another recent example of rating scales for group therapists (Chawla et al., 2010). This rating scale is, in contrast to GIPRS, founded upon a highly specialized manual. The groups in question are conducted according to cognitive behavioral principles, for example, by a high degree of structuring, focus on the individual, and use of group exercises. It is easier to achieve high reliability for therapists in such groups since interventions are structured according to a preconceived plan and follow stricter rules. As such, they have less relevance for process-oriented groups like MBT-G.

In conclusion, when designing MBT-G-AQS there were few relevant previous scales on which to base our approach.

Selecting items for the MBT-G-AQS

The MBT-G-AQS consists of 19 items. Nine items are group specific, while ten items are modifications of items originally belonging to the rating scale for individual MBT (Karterud & Bateman, 2010). When designing the group scale, it was important, as explained in Chapter 2, to end up with a total number of items that was fewer than 20. Within this boundary we wanted to achieve a fair balance between group-specific items and items indicating MBT in a general sense. The easiest task was to define items that indicated MBT in a general sense, since we could benefit from the experiences gained by the work with the individual scale. Of the 17 items that originally were defined as indicative of MBT, we removed the following seven. The reasons differed;

some items seemed to be superfluous, while others had low reliability (Karterud et al., 2012):

- 1 *Adjustment to level of mentalizing.* This item is now defined as part of a general mentalizing stance.
- 2 *Stimulating mentalizing through the process.* This item is also now defined as part of a general mentalizing stance.
- 3 *Focus on emotions and interpersonal events.* This item is covered by several group-specific items. It is the bedrock of MBT-G.
- 4 *Validating emotional reactions.* This item turned out to be used quite infrequently. It is now included in the more general item “Focus on emotions.”
- 5 *Focus on transference and the relation to the therapist and Use of countertransference.* These items are collapsed into one item: “Focus on the relationship between therapists and patients.”
- 6 *Checking one’s understanding and correcting misunderstandings.* This item used to have low reliability. The content has been integrated in the items “Exploration, curiosity, and not-knowing stance” as well as “Stop and rewind.”
- 7 *Integration of experiences from concurrent group therapy.* This item is of course superfluous in MBT-G.

The remaining ten items from the individual MBT-AQS have been modified for the MBT-G format. It concerns their theoretical position as well as their practical applications. The clinical examples which illustrate these items in this manual are all sampled from group therapies. It concerns the following items:

- 1 Engagement, interest, and warmth
- 2 Exploration, curiosity, and not-knowing stance
- 3 Challenging unwarranted beliefs
- 4 Regulation of tension level
- 5 Acknowledging good mentalization
- 6 Handling pretend mode
- 7 Handling psychic equivalence
- 8 Focus on emotions
- 9 Stop and rewind
- 10 Focus on the relationship between therapists and patients.

The nine group-specific items are the following:

- 1 Managing group boundaries
- 2 Regulating group phases

- 3 Initiating and fulfilling turntaking
- 4 Engaging group members in mentalizing external events
- 5 Identifying and mentalizing events in the group
- 6 Caring for the group and each member
- 7 Managing authority
- 8 Stimulating discussions on group norms
- 9 Cooperation between therapists.

The nine group-specific items were identified and operationally defined through a project that started when the manual for individual MBT was finished. Also this time there was collaboration between the present author, Anthony Bateman, and the Nordic MBT group. The criteria for selecting items were (1) that they should reflect significant motives for group psychotherapy interventions in a more general sense, and (2) that they also reflected treatment needs according to the theory and practice of MBT. A larger criteria pool was assembled and critically reviewed. Those that survived the scrutiny were further defined and clarified through clinical trials. We studied video recordings of group sessions from Norway, Sweden, Denmark, and the United Kingdom.

The items relate to the domains defined by Chapman and coworkers (2010) as follows:

- ◆ *Structuring the group*: Managing group boundaries; regulating group phases; and initiating and fulfilling turntaking.
- ◆ *Facilitating verbal interaction*: Engaging group members in mentalizing external events; identifying and mentalizing events in the group; exploration, curiosity, and not-knowing stance; challenging unwarranted beliefs; acknowledging good mentalization; handling pretend mode; focus on emotions; stop and rewind; and focus on the relationship between therapists and patients.
- ◆ *Creating and maintaining a therapeutic emotional climate*: Caring for the group and each member; managing authority; stimulating discussions on group norms; cooperation between therapists; regulation of tension level; and handling of psychic equivalence.

Rating procedures for the MBT-G-AQS

Rating of occurrence

Scoring sheets and detailed procedures can be downloaded from the websites of the MBT quality laboratory or the Norwegian Institute for Mentalizing. The Google search engine will provide correct website addresses by searching for

“MBT kvalitetslaboratorium” or “Institutt for mentalisering.” Go to the English tab on the website.

Each intervention which complies with the item definition should be marked by a short line in the appropriate item box on the scoring sheet. An intervention is defined as an utterance which is delineated by an utterance from another person or by a longer pause. We do not differentiate between short and long interventions. However, short utterances should convey a meaningful and relevant statement. Short statements like “Hmm,” or “Uh,” or “Well . . .” do not count. A short statement like “Yes” will count if it is a response to an item-relevant answer from a patient: “Are you frustrated by me?” “Yes.”

One and the same intervention may be rated as valid for several items. Example: “it is unclear to me what kinds of feelings were evoked in you Lise, when Peter just spoke. Perhaps it is clearer for others in the group?” This intervention should be rated as exploration, focus on emotions, and engaging group members in mentalizing events in the group.

The following items are not rated for occurrence: Care (6), Authority (7), Engagement (10), Regulating arousal (13), and Pretend mode (15).

The rating for each item is equal to the sum of recorded interventions for that item. Number of ratings per item will typically vary between 0 and 30.

There will be several interventions that do not comply with item definitions. These interventions do not receive any rating. For example, “Where did he live?” “What is the name of your boyfriend?” “Shouldn’t you speak with the rehabilitation authorities about this?” “Do you use any medication these days?” There is nothing wrong with such interventions. However, they are generic constituents of any kind of clarifying discourse and not specific for MBT. And most importantly, they do not address mental states. MBT interventions should by definition address mental states and interpersonal processes.

The fact that only certain interventions qualify for a MBT-G-AQS rating imply that the absolute number of rated interventions is an indication of compliance to the treatment model. We discuss this below when addressing the overall rating.

Rating of quality

For this purpose, we use a 1–7 Likert scale where 1 is “very poor” and 7 is “excellent.” A zero denotes “not applicable,” for example, that the intervention was not observed.

It will often be the case that *relevant phenomena occur* (e.g., unwarranted opinions about self and others), but that the therapists do not comment upon them. In such cases, the item should be rated 0 for occurrence. One might argue that there should be no rating for quality in such cases, as one cannot qualify something that does not exist (i.e., therapist interventions). However, the fact that the therapists do not intervene attests to poor competence with respect to

the item in question. Therefore: *No intervention when relevant phenomena are displayed should be rated by low quality (e.g., 3, 2, or 1), dependent on the seriousness of the omission.*

The rater judges the quality according to the guidelines for each item. Three quality levels 1–3, 4, and 5–7 are described for each item. The descriptions are item specifications that are adjusted to the following general scale constructed as a continuum from very poor to excellent:

0	Not applicable	The intervention was not observed
1	Very poor	The therapists handled the item content in a very poor way
2	Poor	The therapists handled the item content poorly (e.g., by significant lack of expertise, understanding, competence, engagement, timing, or unclear language)
3	Acceptable	The therapists handled the item content in an acceptable way, but poorer than average
4	Adequate	The therapists handled the item content in ways typical for an average “good enough” therapist
5	Good	The therapists handled the item content in ways that were somewhat better than average
6	Very good	The therapists demonstrated significant skills and expertise in handling the item content
7	Extremely good (“excellent”)	The therapists demonstrated very high levels of skills and expertise in handling the item content

MBT-G will often be conducted by co-therapists. The therapists may display a markedly different style. Should they be rated separately? According to this manual they should not. This is a rating scale for MB group therapy, not for MB group therapists. One should rate the conjoint efforts of the therapists. Co-therapists often develop a kind of cooperation based upon (conscious or unconscious) sharing of tasks. Raters usually have no information about what kind of (if any) deliberations have been undertaken between the therapists with respect to role differentiation. In any case, raters may observe a practice which is asymmetric, for example, that one therapist is more active than the other, or that one therapist performs more of a certain kind of intervention compared to the other. Such differences might be important and relevant for many research questions, but they are outside the scope of this manual. *The purpose of the MBT-G-AQS is to measure the actual interventions that are delivered to patients in a given group, regardless of whether they originate from the one therapist or the other.* The raters cannot have any sound opinion about how the individual therapists would behave if he/she conducted the group alone.

Rating of overall occurrence and quality

In addition to ratings on each item, there should be overall ratings for occurrence and quality. The overall rating should be based upon a global comprehension, that is, it should not be an arithmetic mean. The rating scale is not constructed in a way which gives each of the items an “equal weight.” The therapists should demonstrate an active and engaged therapeutic style which is coined by a mentalizing stance (cf. the first section in Chapter 4). The raters should therefore ask themselves the following question: *Is it the case that the therapists by and large focus on the mental states of the group members; do they stimulate the participants to explore these states and do they do it in a warm, yet authoritative way which is adjusted to the participants’ level of mentalizing, and do they in this process challenge unwarranted opinions, pretend modes and psychic equivalence and strive to keep an optimal emotional temperature?*

Here there is less reliance on the formal features, for example, if there is organized turntaking, since well-functioning groups can be excellent training grounds for mentalizing without this particular feature. However, if one observes chaotic and poorly functioning groups, the absence of phase regulation and organized turntaking should count in a negative way.

Rater training and reliability

In Norway, we have established a MBT quality laboratory which rates and comments on MBT sessions performed in established MBT programs. Raters in the lab are practicing MBT therapists, having been trained by the Norwegian Institute for Mentalizing. Accordingly they are well versed in the theory and practice of MBT before they are trained in rating according to the MBT-AQS. We have performed two formal reliability tests. The first displayed moderate agreement (Karterud et al., 2012), while the second yielded high reliabilities, in the range of 0.90 (ICC-2). Raters need a couple of hours of instruction in rating procedures. Thereafter they rate two verbatim transcripts and their ratings are compared to a gold standard. Good enough reliability is usually obtained after rating of eight to ten video recordings.

A reliability study of the MBT-G-AQS is underway. We have trained raters who already are reliable with respect to the individual scale. All raters are practicing MBT group therapists with a good command of the theory and practice of MBT-G. The procedure is the same. After discussions of rating procedure, they rate two verbatim transcripts of MBT-G and their ratings are compared to a gold standard. The formal reliability test will include 16 group sessions. The results so far are most promising and will be published during 2015.

The items of the MBT-G-AQS

Introduction: The mentalizing stance

MBT-G is a therapeutic approach where the therapists seek to enhance the patients' ability to mentalize through the therapeutic process, more specifically, through the group discourse, including the relationships between patients and therapists.

The actual process is therefore more important than “the content” (what patients in the group talk *about*). This does not mean that such content is unimportant. The main themes for MBT are those which involve a person's own mind, other people's minds, and the person's relationships to other significant people. MBT does not emphasize “insight” in such matters if “insight” implies something like the following:

“I have low self-esteem.”

“I have low self-esteem because I was harassed and treated badly when I grew up.”

“I have a problem with aggression.”

“I often have a depressive way of thinking. I was left to fend for myself when I was a child and then I lost all hope.”

“My mother neglected me because she drank.”

The main issue for MBT is *how* a person thinks and feels about their own and about other people's backgrounds, about their own and other people's minds, and about how social processes influence all involved parties. In MBT-G, the therapists are interested in experiences of self and others and engage each member and the group in exploring such issues. “The process” is the way in which this is done.

The most important sign of a successful MBT group session is when patients become engaged in a mentalizing group dialogue. What characterizes such a dialogue is firstly the content of the subject matter. That is *what* the group is talking about. The group should be talking about mental states. Secondly, there is *the way* of talking in the group. In a good mentalizing dialogue, images, constructs, feelings, or intersubjective transactions will be dealt with in ways that lead to new, sometimes surprising and refreshing perspectives. An observer gets the impression that something new has happened to the group members through this kind of group discourse. Mental phenomena are thought about a

little differently. In contrast, we have supportive group therapies where members listen to, acknowledge, support, and encourage each other, but where new thoughts about mental processes are seldom developed. Low MBT adherence implies that therapists do not actively explore mental phenomena, but concentrate on, for example, problem-solving, behavioral management, and psychosocial support or engage in interpretations to facilitate pseudomentalizing “insight.”

“To enhance mentalization through the process,” was a separate item in the rating scale for MBT individual therapy. In MBT-G, we consider this element so central and overriding that representing it as a separate therapeutic-technical item among several others, would be misleading. It is woven into a general therapeutic attitude which permeates all items. This attitude should be expressed as a general strategy in and for the group. Besides, all interventions from the therapists should, in principle, have two aims. On one hand, they should address a certain issue (which might be a single-member phenomenon). At the same time the therapists must be aware that everything that is said in a group influences the group process. Optimally, an intervention should highlight both a member’s state of mind and *at the same time* make other members curious about such a state of mind and its implications.

High MBT-G competence implies that the therapists pose relevant questions which are formulated (using simple, straightforward, and “ordinary” words) so that they stimulate further reflection and afterthought, and that this is followed up in longer sequences which optimally contain thoughts, notions, feelings, relations, intersubjective transactions, and “here-and-now” phenomena. Indicators that patients are engaged in a mentalizing process can be utterances, for example:

“Well, possibly . . .”

“When I think about it . . . it might well be that . . .”

“I have never thought about that before, but it makes sense in a way . . .”

“It strikes me when I’m listening to you, that I experienced something similar recently when my sister . . .”

“Could it be that you were afraid of hurting him?”

“But tell me, what exactly went on in your mind when . . .?”

“Your story makes me feel sad, in a good way actually.”

“Wait a minute, could it be that . . .?”

If patients seem reluctant to engage in group explorative dialogues, the therapists’ interventions should be carefully scrutinized. Are the interventions not open or inviting enough? Are they properly attuned to the patient’s level of mentalizing (neither too “sophisticated” nor too elementary)? Or are the interventions in themselves appropriate, but does some overriding group issue block the process?

When rating therapists' overall adherence and quality, the extent to which the interventions are imbued by such a general mentalizing stance which stimulates the group process, should be taken into account. It is therefore important that the therapists do not themselves do the job of mentalization on behalf of the patients!

We mentioned earlier that a mentalizing stance should take into account and adjust to the patients' current level of mentalizing. The term "level of mentalizing" refers to the reflective function (RF) scale which is an operationalization of mentalization. RF scores are based on the AAI (Fonagy et al., 1998). A patient's level of RF is rated repeatedly throughout the interview on a -1 to +9 scale. Level 5 is considered "good enough." For most people, RF will vary depending on the themes which are elaborated in the attachment interview. Scores along the interview may vary between, for example, 3 and 7 and in such a case the patient's (average) mentalizing level would be around 5. The average mentalization level for patients with BPD has been found in several studies to be around 2.5-3 (Fonagy et al., 1996; Gullestad et al., 2012). In addition to normal everyday fluctuations around one's average level, the level might decline considerably during emotional arousal and involvement in interpersonal conflicts. The therapists must therefore adjust to each patient's typical style and in addition be prepared for further adjustment when emotions get high.

One should also consider the treatment phase of the patient. In an early phase, the therapeutic alliance might be vulnerable, and the patient can at this stage be unaccustomed to the special discourse of MBT-G. Merely being in a group (which focuses on mental states) might be provoking. Many patients will initially be in a "fight-flight" mode, where emotional outbursts are easily triggered.

Therapists should have an opinion about the patient's approximate current level of mentalizing. It is useful to have the RF scale in mind. A simplified version for clinical purposes can be downloaded from the MBT quality laboratory homepage.

At level -1, patients have bizarre beliefs about themselves or others, or they dismiss psychological perspectives with threatening hostility. At level 1, patients are characterized by non-mentalizing beliefs and attitudes. Behavior and social events are attributed to mechanical and nonpsychological factors instead of intrinsic motives. At level 3, patients have an understanding of the relationship between behavior and motives, but this relation is often implausible, excessive, clichéd, peripheral, incomplete, and so on. At level 5, patients have an adequate, but rather simple, understanding of the relationship between behavior and motives. At level 7, it is sophisticated, and at level 9, it is exceptionally good. A high level of mentalization is characterized by beliefs that behavior is being

caused by different and complex motives which again are influenced by personal history, family and cultural background, and current interpersonal, familial, and sociocultural contexts.

Adjustment to the patient's level of mentalizing implies being "in tune" with the patient. Therapists can overestimate their patients and speak above their level of comprehension, talk "over their heads." Therapists can also underestimate patients. Examples of the latter include being excessively supportive, not challenging enough, or even being infantilizing, "talking down."

Therapists most often tend to be too "sophisticated." In the initial phase in particular, interventions should be short and concise. Lengthy explanations, use of complicated language, and references to unconscious phenomena should be avoided. When the therapists to some extent do embark on more extensive explanations, they should check carefully with the patients that they are being understood. Many patients will often pretend that they understand—partly in order not to disappoint the therapists and partly not to appear "ignorant." Another variant is that the patient has acquired a strategy of pseudomentalizing where words have a life of their own, detached from feelings and the depths of the mind. The patient "understands" in a more superficial or theoretical way. Furthermore (especially in the initial phase), therapists should be careful in using metaphors, allegories, and symbols.

Adjustment to the level of mentalization also implies an adjustment to the group as a whole. The therapists' level of activity should be related to how well the group is acclimatized to the MBT group structure and discourse (the maturity of the group). How much can the group as a whole regulate itself? Does the group take responsibility for a reasonable allocation of time and attention between members? Do the patients share relevant events spontaneously?

To be aware of and correct misunderstandings is part of the mentalizing approach. In addition, therapists should, if they are uncertain, check whether they have been understood. As previously mentioned, it is a central premise of MBT that mental phenomena are opaque, and that it requires a sort of mental work in order to bring mental phenomena into verbal discourse, whether it concerns the patient's inner sensations or conceiving the minds of others. Mental states are not visible to the naked eye. Mental states have to be interpreted.

Interpretation of mental states can be more or less precise (or correct, adequate, apt). Misunderstandings can happen at any time. It is a hallmark of good mentalizing that the person is sensitive to inner and outer signs which indicate such misunderstanding, that he/she checks if this is the case, and that he/she is able to readjust if his/her interpretation did not correspond well with the subject matter. This ability corresponds to what we conceive as capacity for reality testing.

All therapists make mistakes and they misunderstand from time to time. This raises questions about what should be done when something goes wrong and about what has caused the misunderstanding. Therapists' mistakes vary of course, from minor errors to the more serious. Here, we limit our topic to a discussion of "minor" misunderstandings, omitting severe boundary violations. Therapist errors offer opportunities to re-explore the event in question and to learn more about the context, experiences, and feelings which affected all parties during the therapeutic process. Handling misunderstandings are thus excellent topics for "training in mentalizing." In MBT-G, therapists should be good role models for the patients by checking their own perceptions and correcting their misunderstandings. Such incidents also allow for "corrective emotional experiences." Borderline patients usually have in their baggage a lot of memories from rigid and unpleasant encounters, where no honest attempts occurred to clarify the transactions.

The group format has several advantages over individual therapy, for example, that witnesses are present in the group. When misunderstandings happen, therapists should "rewind" and involve fellow group members. What happened exactly? How did you fellow members interpret it? This is an excellent exercise in mentalization and it requires that the therapists are thoughtful and unpretentious.

Therapists with a poor allegiance to the mentalizing stance usually make no or only superficial attempts to check if their interpretation of a patient's state of mind corresponds with the patient's experience. Even when there are signs of a misunderstanding, it is not explored or corrected. On the contrary, therapists may insist that their understanding is the correct one, and that disagreements reside in deficient "insight" on the part of the patient. A mentalizing stance implies an openness to one's own fallibility, a willingness to explore and seriously consider comments from others who have witnessed the events in question.

Example: The group has reached the last third of the session. Grethe has shared a sequence with her sister which has caused much amusement. Åse seems to be in a world of her own. She is looking down and shaking her leg. The sequence with Grethe is brought to an end and the therapists turn to Åse. Åse covers her face with her hands and says she cannot bear to think. She says she can barely manage to breathe. A brief silence follows, in which the group has to shift gear from vitality, joking, and laughter in order to attune to Åse who is struggling to keep control. The therapist asks gently if her reaction has anything to do with something in the sequence with Grethe. No! Does it have anything to do with the fact that the group session is approaching the end? No, not that either. "It was that you [the therapist] misunderstood what I said at the beginning of the session." The therapist "rewinds" and involves the other group members in recapitulating what had happened. After a sequence of recap and exploration, the therapist sums

up by saying that it is possible to understand that what he had said might be interpreted in the way Åse did, but he emphasizes that he in no way had any intention of characterizing Åse as a racist. Åse recovers herself in the course of this sequence and becomes able to participate in the group conversation again in a more constructive way.

Item 1: Managing group boundaries

This item is not specific for MBT, but is included because it concerns fundamental preconditions for conducting group psychotherapy in a professional manner. Failures in this area are likely to influence the group dynamics and inhibit mentalization in the group. As previously mentioned, the group therapists are responsible for arranging *the physical framework* in a good way. This includes the group therapy location, that it has good enough light, is clean and tidy, has a comfortable temperature, and that the correct number of chairs are in place. It also includes *circumstances outside the group room*, for example, that the entrance door is open, that the reception is available, that payment systems are functioning, and that messages are passed on to the therapists. Furthermore, the group must be informed about forthcoming boundary events *within the group*, such as the arrival of a new group member, that group sessions are to be videoed for supervision or research purposes, that one of the therapists will be absent next time, and so on. It also concerns therapists starting and ending group sessions punctually. Therapists do not need to comment upon the group's boundaries when all this is functioning properly and when no out-of-the-ordinary incidents crop up.

The most common boundary violation is that one or more group members are absent. All groups should have a system to ensure that therapists receive messages before the session starts. Patients' compliance to their obligations of notification will of course vary. In MBT-G, it is quite common that one or more patients are absent. Some will have notified the therapists and given a reason, some may have left a message that was not received, and some will not have given any notice. These seemingly trivial transgressions have to be addressed.

When a situation arises which concerns the group boundaries, the therapists should comment on it, clarify their own responsibility, and explore the significance of the event.

An example of good management:

It is the first group session with a new co-therapist. She shakes hands with group members who she does not know from before. The other therapist comments that this is an important group event. They should set aside time for talking about what this means. Otherwise, the therapist conveys information to the group from two absent members who had left messages. One of the messages is commented on briefly. Thereafter, the therapist says that Lisa and Hilde were absent last time. The

reasons are repeated and commented on. The therapist asks if there is anything Lisa and Hilde should be informed about from the previous session. There is a short discussion about what happened last session with special reference to Kari who was “in the limelight.” Kari talks a little about her experience in the group and what happened afterwards, but adds that she might elaborate on this later on. Basically it had been OK but now would other topics perhaps be more important?

An example of poor management:

The group has five members. The therapists sit in the group room, having a pre-meeting there and are drinking coffee. Four minutes ahead of time, Else arrives and enters the room. The therapists seem a little surprised, but say hello, turn towards her and ask how things are going. They continue drinking coffee. Else tells them that she has had a lot of trouble with different people and services. Five minutes late, Grethe now enters the room. She rapidly updates herself on Else’s experiences and takes on a dominating role of questioning and consulting Else. After 15 minutes, Hanne comes in. It takes a while before she becomes included in the conversation. There are no references to the last group session and no comments about latecomers or discussion about what this means for the group as a whole.

Guidelines for rating of occurrence

Boundary-relevant events need not occur in a group session. If so, occurrence is rated with no intervention. If the boundaries are functioning properly (in the background) it indicates that the therapists have done their job “silently” and they should be given a quality rating = 4 (good enough). If there are relevant events which the therapists address, each intervention should be marked on the rating sheet. Examples of relevant interventions are:

“You were absent last time, Einar. We didn’t receive any message so we are curious about the reasons.”

“Nice that you came today, Elsa, even if it was 20 minutes late. We’re curious to know what held you up.”

“We have a new patient starting next time. Are there any thoughts or feelings concerning that?”

“I’m sorry it is so hot in here today, but we can’t get the window opened.”

“Next time we will video a session again. Any comments on that?”

“Next time I will be absent and the co-therapist will conduct the group. Are there any comments on that?”

Guidelines for rating of quality

Low (1–3): Clear boundary relevant events are observed which the therapists do not address, for example, people are arriving late, the wrong number of chairs have been set up, and there are missing group members. The therapists do not take responsibility for group boundaries or minimize and convert clear boundary problems into psychological problems of some group members.

Adequate (4): The group is functioning smoothly with respect to boundary issues. The therapists identify boundary-relevant events and comment and deal with them in ways which seem appropriate and clarifying for the group as a whole.

High (5–7): The therapists address the event(s), acknowledge their own responsibility, explore the significance of the event(s) for the group as a whole or for especially involved patients in ways that facilitates mentalizing, and give the event(s) the attention which is appropriate according to its severity.

Item 2: Regulating group phases

This item is about therapists taking explicit responsibility for (1) the opening phase, (2) the middle phase, and (3) the closing phase.

As previously described, the opening phase is influenced by the therapists' reflections immediately after the previous group session, the writing of a group session summary, their processing during the week, and their meeting and planning immediately before the current group session. Managing group boundaries is an issue of the opening phase, but it has also been singled out as a separate item. The opening phase covers more than boundary regulation. It is about the dynamic management of the continuity of the group and structuring of the upcoming session. It concerns minding the group and its members. The therapists convey thoughts about what happened last time, with references to each member, and, in this light, the challenges that might be expected in the current session. This can seem demanding for some therapists. We have observed a tendency to skip this part. Some therapists take a more supportive stance by initiating a kind of round where group members report on "how they are doing." Consequently the opening phase tends to become overtly long. This qualifies for a low rating. Others go directly to the structuring part: "Do we have any topics?" It seems more difficult to convey what the therapists have been thinking since the last session.

The therapists should convey their thoughts in ways which invite commentary and supplementing perspectives and which engage the members in a discussion of priorities for the present session. The opening phase should also result in a conclusion about who, or which theme, one should start with and who/which theme has to wait. There are many considerations here and the therapists must make sure that the group members get engaged. As always, complicated words should be avoided. One example of difficult words (in Norwegian!) could be: "What is on the *agenda*?" One must remember not to start exploring the different themes in this phase. The therapists must also be disciplined and not let this phase last too long—about 5–10 minutes is usually thought to be sufficient.

In the middle phase, the group should work in accordance with the guidelines described in Chapter 2. It concerns external events that the patients have suggested in the opening phase, external events from earlier sessions(s), and

current internal events, happening as the group proceeds. We underline that events from previous sessions are regarded as *external* events. Current events are happening in the here and now. The therapists should display the ability to round off sequences and start up new themes.

At some time-point in the middle phase, inevitable time limitations will become noticeable and problematic. The therapists should comment on this and invite the group to reflect upon this fact.

Finally, the therapists should assist the group in finding an appropriate way to close the group session.

An example of a fair regulation:

The therapist opens the session by accounting for the absence of Eva. The group has five members and Vera asks if any new group members have been scheduled. The therapist answers "No," but adds that there most probably will be some new members within a month or two. Kine asks if they are soon "going to get on with this session." The therapist comments that it sounds like that she has something she needs to talk about. "Yes!" The therapist acknowledges her initiative, but adds that perhaps one should start with the disagreement (or perhaps a conflict) from the last session between Irene and Beate. "I wonder if this is something we should talk a bit more about." Silence. "What do you think?" Again, some reluctance. Irene then confirms that she has thought a lot about this since the last session, and that she has had a very difficult week. In the following 30 minutes, the conflict is recapitulated and clarified. This includes thoughts and feelings which the other group members had after the last session. Then Kine breaks in and says that her ex-boyfriend makes her "mad." The therapist nods and conveys his understanding but adds that he would like firstly to know if the conflict from the last session has been reasonably reviewed and worked through. Group members nod and seem to agree and say they are ready to hear more about Kine's problem with her ex-boyfriend. Several have a similar kind of trouble and would like to hear what this is about. A long and engaged sequence follows on a fairly high level of mentalizing. The therapist inquires after a while: What do the group members think? Should they carry on with this theme to the end, or are there other things which should be given attention? "No, no, now we are doing what we really should have been doing for a long time. This is important!" By the end, several commented that it had been "a very good session." The therapist largely shared this point of view, but was a little uncertain concerning his own role. He became quite passive while the group proceeded. The group did most of the job on its own. He thought he mainly provided some space, but was this maybe good enough?

An example of poor regulation:

Four members are present, and it is the first time for one of them, Mona. Three are absent and two have not left any messages. The co-therapist is also absent. The therapist opens the group by wishing Mona welcome and adds some brief comments on the aim of the group, the structure, and the group rules. There are no

references to the previous session. Åse is obviously uneasy and says impatiently that there is something she has to talk about. She tells, in a somewhat breathless and fumbling way, that she had a nasty kind of attack during a concert last week. Trine responds by becoming very engaged and quite dominating. She explains partly theoretically, partly based on examples from her own experiences with panic attacks, what panic attacks are about and how they can be managed. Trine is also a fairly new member. It is her third group session, and the therapist says afterwards that she was not sure how vulnerable Trine was. The therapist is therefore initially reluctant to intervene while Trine insists on her kind of "individual therapy in the group." After a while, the therapist comes in again and takes over the lead. She helps Åse explore some of the background for her reaction. At the same time she has to manage Trine who, it turns out, carries with her a considerable traumatic baggage. The therapist runs the rest of the group by her more standard version of "individual therapy in group."

Mona, who is new, has not said a word. When there are only a few minutes left, the therapist turns to Mona and asks how the group has been for her. "Well, hard, but also interesting." The therapist adds then that she forgot to say anything about the three absent members, but that Lena had left a message saying she has caught a cold.

In this case, the group gets too carried away with itself. The therapist gives away control and leadership, regains it after a while and keeps it in a rigid individual therapy-type manner. She is constantly lagging behind because she has not organized the group in the opening phase and does not take the event of having a new group member seriously enough (which might be relevant to Trine's agitation).

Guidelines for rating of occurrence

The observer notes all explicit phase regulatory interventions. Interventions which count for this item are, for example:

"Since the last group session, I have thought . . ."

"Last time you, Nora, talked about the relation to your mother and how difficult it was for you to state your own opinion, and you Peter . . ."

"You, Eric, were not here last time and have therefore missed a lot of things. What can we do about that? . . . Should Eric be updated in any way?"

"What do we have on the schedule today?"

"It seems like many of you have something on your minds today, how shall we deal with that?"

"OK, shall we start with you then, Knut?"

"I wonder if we should stop there, or what do you think? We have several other things we also should talk about."

"What do we do now, we have 25 minutes left. Terje and Kari have things they want to talk about. In addition, we have the issue about how directly we can speak to each other here."

“There is now only a couple of minutes left, how does it feel for you now, Tone, to leave the group after what you have been through?”

Guidelines for rating of quality

The quality concerns the therapists’ abilities to report on their own reflections, to handle here-and-now disturbances and to mentalize the members’ current motivations. It should be done in a flexible way while also inviting the group members to join in the considerations of group regulation. It also has to do with timing and relevance and a consistent mentalizing stance.

Low (1–3): There are no or too few explicit phase regulatory interventions. Interventions are too technical or too bound to the written manual at the cost of stimulating greater responsibility and metacognition about commitment and group membership.

Adequate (4): At least two phases are addressed in a way that engages members to reflect upon the possibilities and choices they have.

High (5–7): The therapists are sensitive to the members’ comments around phase issues and give their contributions and reflections on time and impact. At the same time, the opening phase does not end up as a pseudo-democracy. The therapists take active responsibility for organizing the session. During the middle phase, the therapists stimulate reflections on the group’s and some members’ dilemmas concerning time, attention, and conflicting priorities. During the closing phase, when the group meets its final boundary, it is marked by the therapists, who allow for a new round of reflections.

Item 3: Initiating and fulfilling turntaking

This item is about taking the initiative in stimulating as well as facilitating mentalizing turntaking. Thereby interpersonal events are given the highest priority in the group, and particularly the emotional aspects of such events. This item therefore replaces the corresponding item in the manual for MBT individual therapy, “a focus upon emotions and interpersonal events.”

The present manual emphasizes not only that emotions are important, but that they have a special function as “steering elements” in the continuous process of interpersonal interactions. A high capacity for mentalizing implies being able to let oneself be influenced by emotional reactions. To relate authentically and flexibly to other people requires an openness about one’s own emotional reactions while at the same time having cognitive control, in contrast to losing oneself by having to pretend, subdue, or not heed one’s feelings.

Patients will often report that they feel “miserable,” “depressed,” or “out of balance,” that they have more symptoms again, being on the verge of self-mutilation,

having more suicidal ideation, and so forth. It is a challenge to link such “unexplainable” emotional reactions to interpersonal events.

Through the therapeutic discourse, patients are trained to attend to, explore, feel, understand, and manage previously unnoticed or denied emotional intersubjective interactions.

Mentalizing turntaking is an important part of the organizing principles of the group. It directs the focus towards problematic interpersonal interactions and ensures that all members are considered in this respect, for example, by being explicitly thought about and discussed with regard to their process and group participation. The therapists should take initiatives so that each member has the possibility of sharing their own personal issues. In practice, this does not annihilate differences between members’ level of activity in the group. Some members will notoriously be more dominant and some more subordinate. However, it ensures that the theme of responsible participation is continuously on the agenda as well as the inevitable group theme of justice: Who is getting the largest part of the pie? The principle of turntaking guarantees to some degree that dominant members don’t exploit every meeting and that the subordinate ones don’t stay in the shadows forever. However, it does not block the interpersonal style of the individual member. It does not cover up significant tendencies in dominant behavior. There will remain more than enough material to work on.

The therapists’ initiatives make it clear to everybody that the main task of the group concerns exploration of interpersonal transactions, and there is an invitation for each member to engage him/herself in this process. However, the interpersonal focus must not be handled in a mechanical way. Although interpersonal themes have precedence, they should not be at the cost of relevant intrapsychic themes. Thus patients will often be concerned with thoughts set in motion by experiences from previous sessions. Needless to say, these are highly relevant, not necessarily for a deeper understanding of the precipitating event, but as tools for expanding one’s capacity for imagination (Bogdan, 2013).

When somebody in the group has “got on stage,” the therapist must take care of the initiative and protect the space. How much attention each member takes up (and receives) varies a lot. Some have issues that only need a short time and can be rounded off after 5–10 minutes, while others can keep going for the rest of the session. The most important “steering principles” for the therapist are:

- ◆ that the patient gets a feeling of “owning” a sequence
- ◆ that other members are not allowed to “steal” the person’s position as the center of the group’s attention

- ◆ that therapists and patients hold on to a mentalizing perspective on the issues that the member brings up
- ◆ that the sequence is closed in a marked fashion.

Closing comments can be something like “Is it OK to round off here?” “Shall we stop there, is that ok?” “How is it, was this helpful for you?” or “We have to move on, Peter has also announced that he has something to share, is that OK now?” Patients often take initiatives to round off themselves. The therapists must then decide whether this should be taken at face value, or if they should explore the sequence further based on the hypothesis that the patient is withdrawing defensively.

The optimal time for closure is dependent on whether the members of the group have “done their job.” One part of this is to organize turntaking so that a group member gets time and attention in the group to talk about something that concerns him/her, and thereafter leave the scene for another group member. What matters more is what the time and attention are used for. Carrying out the principle of turntaking should be done in a “mentalizing way.” As previously mentioned, this requires that the group is interested and engaged in clarifying a sequence of events (creating a narrative). Thereafter, the object of concern is to find out which mental state was problematic, and how this was influenced by the social context and the interpersonal transactions which occurred. Which feelings were involved and what happens with the understanding of the situation while talking about it here and now?

This item is about giving space to the individual patient, ensuring that this space is protected, and that the space is used for a mentalizing exploration. The other group members’ presence and engagement is an inherent part of the whole process. How the therapist should proceed to engage other members is a separate item. In well-functioning groups, the therapist does not need to take such a firm grip on the group structure as described in these first three items of this manual. Well-functioning groups will be more self-regulating. The patients take more appropriate initiatives and the regulation of time and attention can be integrated in the ongoing group process. If the therapists do not believe it will be at the expense of other important themes, they can leave the group free to start by its own initiative. The therapists’ adherence to the principles of MBT-G will then depend on how they follow up the patients’ own initiatives by focusing on emotions and interpersonal transactions, by integrating this focus with the here-and-now dynamics and by engaging the other group members in mentalizing explorations.

An example of a well-carried out turntaking:

Several of the members have announced personal themes in the opening phase. Grethe is one of them. After the group has updated a member who has missed two group sessions and thereby included her in a way, the therapist asks: “Well, several

of you have announced yourselves, what do we do?" Some of the group members point at Grethe and say it is her turn. Grethe starts crying and says that she has started to stammer again, and that it is really awful. Several group members engage in clarification: "What has happened?" "How did you notice it?" "When did you notice it?" "Did you stammer before?" Grethe explains the current circumstances, about an encounter with a former girlfriend at the tram. She also tells about a difficult period with considerable parental neglect when she was a child, when the whole thing started. She receives sympathetic comments about the tough time as a child when she had nobody to turn to—it is not surprising that she stammered. The therapist asks for more details about the stammer and says that it was a bit surprising to hear as there now seem to be few signs of such problems in her way of speech. "Should it, strictly speaking, be described as stammering?" "No, not really, it is more like stuttering." Several other members nod and say they can recognize that one can stutter when one is having a tough time and is not feeling safe. Therapist: "Could we return to that situation you just described on the tram? Could you tell us what happened in more detail?"

Several patients participate in the exploration of the situation, about the former girlfriend she met on the tram, what Grethe thought and felt, what was at stake, what happened inside her, and so on. Grethe finally takes the initiative to speculate on why this insecurity turned up again now. Could it have anything to do with the fact that she had got so much better, and was "heading full speed back to the world again," but that this at the same time was frightening? More explicitly, that it was easier to hide behind a wall of depression and binge eating and that she now encountered a kind of performance anxiety in herself, when meeting that girl? The group engaged in a round of good reflection about these issues. Grethe closed the sequence by saying that "It's OK, it's been useful. Earlier on, such incidents would have put me out completely, but now I am more able to see how things can be related to each other and that things have meanings and then it's not that frightening. I don't think I will be stuck in this, I think it will pass."

An example of poorly carried out turntaking:

Bente says she has something she would like to talk about. It concerns last week. Her mother was going to receive an award and a lot of friends and relatives would be present. Bente turned up at the ceremony, even though she would have preferred not to go. She noticed that she was very tense, had raised shoulders, felt stressed and agitated, but really made an effort to be nice. What she in fact wanted to talk about in the group was that she noticed she became very suspicious: What did other people think about her now, did they think she was odd, did they notice that she was struggling to keep up? That somebody did this or that, was it because of her? She got through it all in some way, until after the formal dinner. Then things went a bit off the rails. No catastrophe, but she drank too much. Started out chattering too much and ended up falling asleep in a chair.

Bente described the situation adequately, with far more details than reported here, and the therapists finally had to interrupt her by saying "Shall we now hear what the others think about this?"

The other group members are reluctant. One says that “I also become suspicious in that way. It’s hard.” And another confirms this by nodding. There are a few other comments. Bente expands her story a bit, but mainly by adding details that do not bring in anything new with respect to her mentalizing problems. The therapists comment: “One thing is a general tendency of suspiciousness, but what about the circumstances here, the context with mother and lots of family and friends?” For some reason or other, this comment did not interest or engage the group very much. None of the usual interest, enquiry, and exploration developed in the group. Usually group members might ask questions like “What does your mother do?” “What was the award for?” “Did you think it was well deserved?” “What did you think in advance?” “Was there anything you were especially afraid of?” “Was your boyfriend there as well?” And so on. The therapists tried some questions in that direction based on the knowledge (that also was known to the rest of the group) that Bente’s relationship with her parents was quite difficult. But no group member followed up. The sequence became rather static, approximating a kind of individual therapy in group. The sequence was closed by reference to the fact that other themes also should be given space. Bente felt it was “OK that others had similar experiences.”

The therapists were later told that the same event had been worked through in her individual therapy an hour before the group started. Bente had not mentioned this. At the team meeting, the therapists discussed that perhaps the sequence was an effort to “be a good patient.” She “did her lesson,” that is, brought up a relevant incident, but did it in a submissive way. This was only vaguely perceived by the therapists during the session. They had noticed the low level of engagement in the group (which they had not commented on) and retrospectively, they now wondered if the group’s lack of engagement could be connected to Bente’s way of reporting the incident, for example, without any really desire to explore it. They thought that a comment like “Bente, what is it in this story, that you want to find out more about,” might have been helpful. At a later time point, this could have been followed up by a comment including the individual therapy: “Have you discussed the same incident in the individual therapy? If so, is there something you did not finish there, something you feel you need to find out more about here in the group? What then?” This might have stimulated a meta-reflection and could possibly have brought her and the group into a more vital discourse. The sequence reminded the therapists that encouraging patients towards mentalizing turntaking also has pitfalls. It can stimulate dismissiveness and a striving to be a “good patient.”

Guidelines for rating of occurrence

This item might cover a great deal of the therapists’ activity if they follow this manual. It concerns interventions which directly invite members to take turns, interventions that clarify and search for a workable scene, and interventions that close the sequence. Practical trials have demonstrated that the reliability is high for rating interventions that invite turntaking and for interventions that close it, but not for interventions that facilitate the turntaking process. Raters simply

cannot agree to a sufficient degree on exactly which interventions during a sequence actually *facilitate* a mentalizing process, and which do not (or are “neutral”). We therefore have come to the conclusion that occurrence and quality for this item should cover somewhat different terrains. Ratings of occurrence should be limited to the initiating and closing remarks as well as the (few) interventions that clearly define the scene, while quality should concern the sequence as a whole, that is, to which degree the sequence in question actually followed MBT principles. It is quite possible, and actually it happens quite often, that therapists organize (and terminate) a turntaking sequence, without focusing on mental states and intersubjective transactions. If so, they might achieve a reasonable occurrence rating, but a low quality rating. The opposite might also happen. If the group is well established and active, it will organize itself and spontaneously work with interpersonal sequences that unfold in turns. The therapist will then receive a low rating on occurrence, but might be rated high on competence if he/she behaves according to MBT principles during the sequence. As for occurrence, interventions that count are along the following lines:

“Is it a long time since you have brought up something in the group, Erik?”

“OK, shall we start with Knut then?”

“Erling, you had something on your mind last time, which we did not find time for. How are you today?”

“You brought in something last time, Peter, which I got the impression that we did not finish. How is it going?”

“Is that something which you might explore now?”

“Yes, I think that is a fine topic, just go ahead.”

“How is it, Turid? Has this sequence been useful for you? Is there anything that has been especially important?”

“Is it OK for you if we close this now and proceed with other things?”

Guidelines for rating of quality

According to the clarification above, quality concerns *the way* the therapists conduct the turntaking sequence. The following examples give some indications:

“I don’t really know if I have quite understood what happened, what it was that X said to you?”

“You were quite irritated then, is that how it was? . . . When did it start? . . . So it was the meeting in the corridor with group member Y that provoked you . . . What happened between the two of you? . . . You felt she ignored you, did you? . . . What did she do or not do that made you feel that way? . . . How did you react then? . . . Do you have any thoughts about why she behaved as she did?”

“I suggest that we go through this episode from yesterday morning in more detail. Tell us what happened right from the beginning . . . All right, you were talking to each other on the phone. . . . Then your mother made the remark ‘but, surely, you do know that’ which made you react. . . . As far as I understand, this really upset

you, made you feel irritated, disappointed, and hopeless . . . a lot of different feelings. Such feelings used to make you withdraw, but this time, you confronted her. How was that? What was different this time?”

“You tell us that it is hard to bear the thought that others are irritated or angry with you. What does that thought do to you?”

“If I have understood you correctly, you got the feeling of being mean? . . . Let’s go back to what happened between you and your brother last Monday. Can you tell us more about what happened?”

Low (1–3): The therapists take little or no initiative for turntaking. When the group’s attention towards a single member prevails over time, the therapists contribute very little to ensure that the focus is on emotions, mental states, and interpersonal interactions. The therapists take little responsibility for the development of the sequence and construction of scenes that can be worked with. The closure of the sequence is somewhat arbitrary, lacking a distinct marking or any attempt to summarize how it has been for the protagonist.

Adequate (4): The therapists themselves take the initiative and they also follow up patients’ initiatives for turntaking. They contribute to the unfolding of the story and identification of relevant scenes, intervene in ways that facilitate a comprehensive narrative and keep a focus on emotions, mental states, and interpersonal interactions.

High (5–7): The therapists are especially creative and skilled in facilitating a mentalizing exploration of sequences which become elaborated in the group. They facilitate the narrative, explore which scenes are the most relevant, make pertinent comments about the significance of the event for the protagonist in light of current knowledge about his/her personality problems, and terminate the sequence in a thoughtful and respectful manner.

Item 4: Engaging group members in mentalizing external events

The therapists’ most important tasks are to maintain the group’s structure and dynamic focus, and then, to engage the group members in a mentalizing exploration of events brought up in the group. Events can be external or internal. External events are of the “there and then type.” Internal events are “here and now.” Events from previous group sessions are by definition classified as external events. Item 4 is a crucial item. Without it the group process would relapse into “individual therapy in group.”

With the structure we recommend, there is a permanent risk for such a relapse, and therapists must therefore take precautions. After all, we clearly recommend that therapists speak directly to individual group members (not self-evident within group analysis), and we also recommend turntaking.

How then can we avoid a development in the direction of individual therapy in group, and so creating a dependency group where all knowledge and skill resides in the therapists? Firstly, therapists have to be extremely aware of this issue and it should continuously be discussed between the therapists in their meetings before and after group sessions. Secondly, therapists should cultivate a therapeutic style where interventions have a “double message,” remembering that when speaking to a single group member they also speak to the group as a whole. Because of this reality, that when speaking to the one, all members are simultaneously addressed, interventions towards single members should also contain an implicit invitation to the other members to join the dialogue. At any time point, the other members should be encouraged to respond. MBT-G might well contain long sequences with many verbal exchanges (e.g., five to ten) between one member and the therapists. This does not matter as long as the other group members feel free to participate. It becomes problematic if the therapists want “ownership” of such sequences, and find it disturbing if other members join in.

An example of good engagement:

Relapse of substance abuse is a typical event. Reidar tells the group, a bit nervously, that he was absent last group session, that he also had difficulties coming this time, that he did not go to the last individual appointment either, and that it all had to do with his first relapse in 2 years. It happened last Friday afternoon. He felt restless, simply picked up his mobile, called a dealer, and then had it going on. A few short questions clarified the circumstances. Therapist: “Ok. Let’s go back to that Friday. What happened inside you?” Reidar: “I don’t know. I was uneasy, somehow.” Therapist: “What do the rest of you think? Friday afternoon, uneasiness, what can that be?” Erik: “I don’t know either, but if it had been me, I might have been feeling lonely.” Reidar: “Yes, probably something like that. The old boys, you know, they’re gone. I know people here, though, but not in the same way. Yes, I suppose I probably was a bit lonely.” The members exchange experiences and thoughts about loneliness. Therapist: “Last time you were here in the group, you talked about things that had been really tough for you, and there was some talk about how things you had endured on your own. Could that have made you feel lonely in some way?” Reidar: “Yes, when you say so. Thought about it afterwards, how much I have struggled with thoughts and things, much distress, and then sometimes I just can’t bear it anymore, got to have a break, somehow, but that just made things much worse, I got into vicious circles.” Erik: “But last time, there were a lot of good things after a while, you remembered good things.” Reidar: “Yes, but I wonder if it only made it worse. Can’t really understand it, but when somebody is kind to me, it’s as if an alarm goes off. Had some things going on with girls, lately. But when they say something nice, and show that they’re quite keen on me, I just back out.” Hilde: “That’s odd. Why do you do that?” Reidar: “I’ve had some funny explanations, but I don’t really get it.” Therapist: “It’s important to find out more about this, what do you others think?”

The therapist is here siding with the other group members, taking an overriding “scenography” position. He first addresses Friday night and invites the group to reflect upon the mental state of Reidar that afternoon. Then, he addresses the therapy process, through the last session, and thereafter, the phenomenon that Reidar backs out when somebody is affectionate and interested. The other members are well attuned. Comments from the therapist and the group members alternate and complement each other, focus on Reidar’s mental states, and succeed in activating his own interest in the perspectives raised by the group.

An example of poor engagement:

Brita is quick to take an initiative, starting before the opening phase has finished, before all members have had a chance to briefly present their issues. She insists on speaking at once. She wants to talk about several things, but especially the event last week which upset her. Last week she came to the department and left a message saying that she was not able to attend the group session because something had happened which required her presence. It was the way the group therapist had responded to her, when she met him in the corridor, which upset her, and which was aggravated when the department sent her a bill for not having shown up. Yes, she had been very agitated, but the therapist did not show any understanding or concern.

In the group, the therapist tries to clarify what had happened and their different experiences, in a calm and questioning manner, but as Brita continues by presenting new issues and new reproaches, one after the other, the therapist becomes more defensive, by giving overly detailed explanations and partly by apologizing. Comments from the other group members do not change the process. Brita does not accept explicit and implicit invitations to reflect or try to see things from different perspectives. The group atmosphere grows tense and Brita takes on an offended, irreconcilable stance. After three-quarters of an hour, Sissel becomes increasingly uneasy. This is addressed and she leaves the room. The co-therapist goes after her and persuades her to come back in again. The group situation has reminded Sissel of persisting rows and relentlessness back home when she was a child. This is worked on in a good way and after a while Brita assures Sissel that she is not “dangerous” and that she “does not attack people.” However, nobody comments any more on Brita’s rigid psychic equivalent position. It remains in the group as an unclosed gestalt which everybody avoids.

Plausible reasons for this development are (1) that Brita was allowed to highjack the group by aborting the opening phase and thereby overriding the other group members, and (2) that the therapist took too much responsibility for handling the offended group member, Brita (because the other group members already were devalued?). The dialog became “too intimate” and the therapist was dragged more and more into Brita’s narrow, rigid way of thinking (psychic equivalence), and lost the ability to maneuver out and create a space for reflection. There was too little focus on the here and now, on current affects, and the therapists did not manage to engage the other group members efficiently to work on the events which took place both at the department last week and in the present session.

Another example of poor engagement:

Hilde is talking about her job in the opening phase. She says she wants to talk about a few small incidents at her workplace, "and then there is also a lot of poor mentalizing going on in relation to a man I am seeing." When it is her turn in the group, she continues: "Yes, I have started dating again, but I am really very uncertain. It is so tiresome. He lives in Hamar [a Norwegian city 150 km north of Oslo] and that does not make things any better, it means a lot of phone calls, text messages, and e-mails. Molehills become mountains. Oh, it's like swinging from heaven to hell. I can be completely ice-cold, as if I couldn't care less, and then I can be warm, my heart is beating loudly, and I really want him to be here all the time. I'm really crazy. Should I just switch off?" The group responds with several practical questions, why Hamar, how often do they meet, and so on. Hilde answers briefly, and then she adds that a girlfriend of hers has been very supportive, saying that it's always like that in the beginning. This is confirmed by Trude: "Yes, aren't all crushes like that really, if they mean anything?" Kristian: "I think you seem very reflective about this, actually. And these things take time. You are coming here to try to change your ways of thinking about things, but I think you're getting on well." Hilde then gives an example from a telephone conversation where she had reacted strongly. "But the next day, I understood how outrageous I had been, the things I had said, really . . ."

"Astri: "But that's good, Hilde. You see your own part in it. Otherwise, I don't think you should excuse yourself as if you were weak or ill. Just be yourself." Sigrid: "Take your time, at your own pace. I think you are doing very well." Therapist: "It is through the meeting with others that one's own personal issues come up again and relationships are difficult, you know. But, now you have a fine opportunity to work on it. It is important how you manage this and that you don't act out." Hilde: "Yes, well, OK . . . Well, then, I think I've finished, that's enough for now."

The problem with this sequence is that the therapist resigns. Initially, the group does its job, finding issues and taking turns, and Hilde brings in an extremely relevant event and this is explored a bit, but then the process comes to a halt. The group members lapse into supportive statements and the therapist says that "she has a fine opportunity to work on it." The problem is that it is exactly this work which is missing. The process lacks a transition from support and declarations about what the group is meant to do, to doing the actual job. In short, there is no effort at exploring the details of the transactions. Nobody tries to identify the obvious failures of mentalizing. What does they consist of? It has to be specified. What was actually said in the telephone conversation which Hilde referred to? What did she say, what did he say? Why? How did she understand it? And how did she understand him? When such exploration of subjectivity is lacking, one is left with general information and risks lapsing into pseudomentalization. The therapists' task is to lead the group members on, when the process ends up in a supportive stance. Support is fine, but in this case it blocks a further understanding of Hilde's inner scenarios.

The therapists' dilemma is that in a group setting, they should not do the job of mentalizing by themselves in dialogue with the protagonist. They should try to identify the failure of mentalization, but at the same time hold back the impulse

to go into it fully and instead attend to how the other group members manage the situation and help them to practice a mentalizing stance. The example illustrates how a supportive group psychotherapy style implies avoidance of this vital task.

Guidelines for rating of occurrence

Technically we recommend that interventions have frequent references to the group as a whole, by using “we” and “us” about those present. This means that the therapists define themselves as part of the group:

- “Have we understood this?”
- “What shall we do now?”
- “Shall we go on?”

The first task is to contribute to a clarification of events. Interventions which aim at engaging others in this clarification will be variants of the following:

- “This is a bit unclear to me; I think it is important that this aspect/sequence become clearer, what about the rest of you—do you agree with me?”
- “Do we understand what happened?”

When a narrative is reasonably clarified (who did what and when and what was the outcome?), one should choose a particular scene. Interventions that count are of the following type:

- “Which aspect of this story do you [the group members] feel is most important to address?”
- “Are feelings the main problem here, in that case, whose feelings?”
- “What do you think, Clara, about what was going on here?”
- “It seems like you become engaged by this story, Fred. What do you think about these feelings? Are they unclear, too strong, too weak, difficult to own, difficult to express? Are they reasonable?”
- “How do you others react to this story?”

As in all dynamic group therapy, when other members do this in a clarifying, explorative, empathic, and even a more challenging way, the therapists can stay in the background. In situations where the group members hold back, become passive, pursue issues which do not have anything to do with mental states, or give in to psychic equivalence or pseudomentalization, the therapist should intervene with the repertoire of interventions which are described later in the present manual.

Guidelines for rating of quality

Low (1–3): The therapists take over (too much) and lapse into individual therapy in the group, or do not contribute to clarifying the events so that the group has to deal with extremely unclear scenarios, or that they do not contribute to finding a focus which involves problematic mental states.

Adequate (4): The therapists invite the other group members, implicitly or explicitly, to clarify relevant events and engage members to participate in a collective exploration of the mental states involved therein.

High (5–7): The therapists display high level of expertise in engaging other members in clarifying the narrative, identifying appropriate scenes, and exploring with the members a wide range of perspectives on the scenes.

Item 5: Identifying and mentalizing events in the group

“Events” in the here and now are defined as an act by somebody that attracts attention because of its emotional content or latent significance. When ten people come together, lots of things will inevitably happen all the time. People react with the protomental/primary emotion core of themselves and they continuously interpret each other’s actions and mental states. The reactions are contextualized by the established group matrix, but most of these transactions take place outside awareness or are vaguely registered as sweeping thoughts that pass away. However, from time to time, tensions will surface. Somebody does or says something that provokes a conscious experience. When becoming more intense, it gets more difficult to hide and at some point, it gets noticed by others. When noticed by the therapists, they should act.

Formally, there is a clear distinction between external events and events which happen in the group here and now. However, in practice they are often interwoven. Any story about external events will evoke some kind of here-and-now response, such as interest, caring, acknowledgement, rejection, or irritation.

When should the therapist focus on the external story and when on the accompanying unfolding of the ramifications of the story in the here and now? It is not possible to state any firm rules about this because the context is so important, but generally, it might be said that one should “go where the temperature is highest.” This does not contradict the principle about keeping affects moderate when working through issues in the group. The therapists need to find out where and if the temperature is high, since “small fires” have to be tamed before one can deal with other issues. If an external event has evoked strong feelings in the group, these must first be worked through, before one goes back to “the story out there.” A skilled therapist will shift between “there and then” and “here and now.” What happens here and now is most often highly relevant to the understanding of the story being told from “out there.” It also concerns vitality and engagement. If the story is laden with feelings, stay there. If the story seems too composed, superficial, or “flat” (lacks feelings), then go to the “here and now.”

Working with events in the here and now has special significance for the phenomenon of projective identification, that is, the tendency to suck other people into (most often) malignant roles that correspond to (part-) object relations in

the inner world of the protagonist. It's hard to work on projective identification when it unfolds in real-life events since the protagonist will be identified with the innocent victim side of the story. In the here and now it is different. Distortions may be more easily identified and corrected and other perspectives may be introduced and accepted before the sequence escalates in a malign direction. We will return to these issues in "Item 16: Handling psychic equivalence."

Events in the here and now can be explicitly identified by the therapist "marking" something by stopping and commenting on it. Implicit identification means that somebody else in the group reacts in a way which changes the focus to here and now, and that the therapist tacitly accepts it.

Mentalizing an event means that it is talked about and explored with respect to its emotional meaning and intersubjective and systemic (for the group) implications. What happens can be that a story reminds a group member about something emotional from the past. Or it can be that he/she has identified with something in the story or reacts emotionally to the story teller:

"I can't stand listening to this, it's so destructive . . ."

"It reminds me of something I did myself, but I just can't bear thinking about it."

When working on events in the group, the full meaning of the group being a "training ground for mentalization" becomes realized. Something has happened in the here and now and has become a matter of interest. How? Who saw or heard what? How was it interpreted? Does this match the protagonist's own experience? Can different perspectives exist side by side? Is it possible to establish an exploratory dialogue about the event? Which feelings are involved and why? Is it possible to "stay in these feelings" and talk about them at the same time?

The following is an example where other aspects of the story than the actual content turned out to be important. The main person becomes engaged in the group process by telling a personal story and this involvement in itself becomes the here-and-now event which the therapists encourage the group to reflect upon:

Kari (23) has been a group member for approximately 4 months. She has a mixed (A/C) attachment pattern. She can become chaotic, overinvolved, and self-destructive in romantic relationships, but is critical and reserved in relation to authorities, like the therapists. She has been skeptical of the treatment program, as she is of health authorities in general. In her opinion, existence itself is meaningless. To her, this is a fact and not a personality feature (e.g., a consequence of a pessimistic attitude or of being depressive). In the group, she has taken on the role of being the skeptical listener, the outsider, and has only as a matter of duty participated in sharing anecdotal events from her own life. She has (perhaps) been a bit more active during the last few sessions.

At the beginning of the present group session she quickly conveys that she has something she wishes to talk about and that she would like it to be the first item. She then tells the group about a drive to her home town the previous weekend, and how they became involved in a rear-end collision. A car drove into them from behind and then just drove

off. The other group members listen attentively from the start, and their commentaries make the story move forward and expand into other stories (about negative experiences from the health services). The comments range from more technical questions about insurance matters, to how she coped afterwards emotionally. The therapists think that her story is being told quite ambivalently. She speaks rapidly, is rather unarticulated, difficult to understand sometimes, as if she wishes to be finished quickly, and that it really does not matter if she is understood or not. But, this does not seem to affect her slightly older, fellow group members. They ask a lot of questions and are obviously engaged by her, and also compliment her on how she handled the car crash situation.

The therapists thought that this here-and-now situation was important and filled in with some comments which helped keep the exploration going, but eventually became more interested in the actual group process. Their minds were filled with thoughts about the previous mutual suspicion in the group which was now less apparent, about a possible relief over this, about a wish to include Kari as a “real” group member and her wish to be included (although ambivalently), about mature women who take to a younger, delinquent member, that it might be easier for Kari to attach to peers than authorities, and so on.

After half an hour, one of the therapists comments that this was the longest conversation about Kari’s life which she could remember. “Yes, I am sure it is.” “And how has it been?” Several members exclaim that it had been very satisfactory. And for Kari? “Well, not bad.” “Not bad? How should we understand that?” “Not so bad is not so bad!” “It seems that you are a bit irritated now, is that right Kari?” “Yes!” “And what is that all about?” “You become so intrusive!” “OK. What do you mean?” After a while the other group members join in and a discussion about caring for others develops. Some say that “parents can spoil things by caring too much.” Sometimes, “one must be allowed to just do things on one’s own.” Kari nods and says that it was like that, it felt OK to talk about the car crash and afterwards about the hospital admission. But “when I was forced by the therapists to say it was OK, it all went wrong.” “The therapists wanting you to say it was OK? Where did you get that idea from?” “No, maybe it was more like, when one says that something is OK, then it suddenly isn’t OK any more. You suddenly realize what you’re up to.” Therapist: “Can it also be that as one says that something is OK, then suddenly things are no longer meaningless?” “Well, yes, possibly, no, it’s difficult . . .”

The group continued this discussion about how good things can be destroyed and if the therapists actually did that in this session, or if Kari had misunderstood, or if the therapists were not sensitive enough, or . . . The sequence lasted for about 1 hour.

For another example of good performance we refer to item 16, “Handling psychic equivalence.” The example concerns Grethe, who reacts to the therapists videoing the group session.

As an example of poor performance we refer to item 7, “Managing authority.” The example is about how Valborg, a patient, devalues the therapist.

Guidelines for rating of occurrence

This item concerns all kinds of interventions which aim to make group members aware of something happening in the here and now, and to help them

explore the phenomenon. Events may be marked by the therapists by interventions such as:

- “Can we stop a bit here? It looks like Jonas has reacted to something.”
- “Did something happen just now, between you, Petter, and you, Kari?”
- “It seems that something happens with you while you are telling this story?”
- “You seem quite uneasy today Jessica.”
- “Wait a minute, I haven’t got it. Was it when you, Kari, said X, that you, Rita, felt . . . ?”
- “Are there any thoughts about what just happened between Kari and Rita?”
- “This seems to engage you, Tom. What are your thoughts?”

Guidelines for rating of quality

General interpretations of the kind “It seems there is a lot of irritation going on in the group today,” can lead to concrete exploration, but can just as well lead to pseudomentalizing. The question here is how the therapists follow up such an interpretation. Interventions should be as simple as possible and mark identifiable occurrences.

Low (1–3): The therapists ignore obvious events in the group, or only comment on them superficially, or do not work consistently in engaging the members in a collective exploration.

Adequate (4): The therapists identify some important events in the group and engage group members in a collective exploration which seems meaningful and clarifying.

High (5–7): The therapists identify several important events in the group and engage members in a collective exploration which is profound both regarding relevance for the group as a whole and for the individuals. Therapists and patients are cooperating actively and vitally about the understanding of the intersubjective transactions in the here and now, about feelings which are involved, and about the implications for the involved subjects.

Item 6: Caring for the group and each member

The theory of mentalization is related to attachment theory. John Bowlby coined the metaphor “a secure base,” referring to the physical and mental home which takes care of the child’s needs for safety. Referring to both mentalization and attachment theory, we would say that for the group to become a good training ground for mentalization, it *requires that the group becomes, and is experienced as, a secure base*. Explicitly and implicitly, the group process activates the attachment system (explicitly: “You should try to attach to the group and its members”; implicitly: “You can share your worries and concerns in the group”).

Since the attachment system will become activated, one has to ensure that members' attachment behavior is met in a respectful and professional manner. This is most important for patients whose attachment is profoundly insecure or, in the worst cases, have a disorganized attachment pattern, which makes them confused in close relations. When the attachment system becomes activated, a lot of doubt and uncertainty will be aroused in these patients, as a consequence of their early poor attachment experiences. It is then even more important that retraumatization does not occur in the group.

The ideal about the group as a secure base has references to families as groups. Within a good enough family, feelings are regulated by parents and siblings, confirmed but also challenged; the family provides the members with opportunities to talk about life outside the family and about what happens within the family, in addition to playmates. Children who grow up in healthy families who have continuous and curious conversations about relations with other people, develop better social competence than children who grow up in insecure families with high levels of conflict (Gergely & Unoka, 2008). In a sound family, parents protect the family boundaries, respect the family member's integrity, teach the children healthy norms and social skills, contribute to solution of conflicts, and make space for play at the same time as talking and negotiating about how things should be understood and justified.

These ideals come close to the group therapist's care for the group. We notice that this item partly overlaps with taking responsibility for the group's boundaries and the regulation of the group's phases. It also overlaps somewhat with the item about turntaking which makes sure that all members get their share of time and attention. In addition to taking responsibility for turntaking, the group therapist should in each group session make sure that the attention is "balanced" so that it includes all group members. Everybody should be mentioned and commented on in the course of a meeting and if someone is conspicuously quiet, this is an "event." How come? What is it about?

The most important negative examples are related to destructive group behavior. This has most often to do with patients who treat other patients badly, here and now, or who in other ways behave destructively towards the group as a whole. *It is the therapist's duty to actively intervene and stop such behavior.* And to justify why. It is not only destructive for an individual to be harassed, threatened, and yelled at—it is harmful for the group as a whole if this is allowed. It undermines members' confidence in the group as a whole, the confidence that an authority, a parental figure, is watching out for them, looking after what is happening, and that he/she will intervene if necessary when somebody's feelings get out of hand. To take care of the group as a whole, it is sometimes necessary for the therapists to expel destructive patients who are unable to change.

An example of taking care of the group:

Lise had great expectations of the group therapy component of the MBT program, in particular because the group was conducted by an “expert.” From the start, she was talkative, dominating, almost a bit like a co-therapist. She was interested in other group members and gave a lot of advice and recommendations. Early on, she highlighted similarities between the therapist and her father, and at the same time she complained that her relationship with her father was “terribly difficult” because he had never “seen” her. It was difficult for the therapist to successfully stimulate any reflection concerning Lise and her contributions to the group. When the therapist said: “Lise, can we stop a little here and . . . ,” she replied, “now you are interrupting me again. It is terribly irritating, exactly like my father, I want to finish speaking.” If the therapist tried to say “Yes, but . . . ,” she interrupted again by raising her voice above his. When the therapist finally got a word in, she was quick to object and respond that it was actually the therapist who had a problem. For some reason or other, “he was after her.” The confrontations with Lise turned competitive, and Lise was always trying to get the last word. The individual therapist was informed and asked to work on this in her individual therapy. This, however, had no effect on her group behavior. The controversies intensified and after a while they came to dominate the entire group process, until the group therapist, after about eight sessions, decided, with justification why he could not have Lise in the group any longer. The treatment was unproductive. What was happening in the group was far from what could be labelled “therapy,” and for the group as a whole it was destructive. Lise continued in individual therapy. An attempt at reconciliation after some weeks failed and she was not taken into group again.

An example of taking care of a member:

Sissel had had an issue for a long time about a complicated court trial which was coming up. She was a central witness. She tells the group that she has been called in for cross-examination the next week. At the same time she rather inconspicuously adds that she is going to have an operation that same morning. The therapists stop and wonder if it is possible to have an operation and to be cross-examined as a witness on the same day. Sissel tells them that she just has to. “I have had to do worse things than that.” The other group members also realize the unreasonableness of the situation. In the following discussion, the therapists comment upon her childhood story of gross neglect. The theme of caring for oneself develops. Sissel finds that the issue of the trial is “peanuts” compared to what she has been through before, and that it is only a matter of “pulling oneself together.” In addition, there had been considerable pressure to bring this case to court as soon as possible. The group therapist says that she has difficulties with accepting this and offers to call the lawyer and explain Sissel’s situation to him. The other group members are obviously relieved. The issue of taking care of oneself becomes supplemented with the issue of parental care. Sissel starts to reflect on how she tends to completely disregard her own needs.

An example of a failed effort to explore group events:

In the opening round, the therapist says that he has been wondering if there is “some conflict going on between you, Erna, Knut, and Kari? Is something going on? There have been some small incidents lately, some disagreements, comments. Perhaps there is something we should look more into here?” Trine: “I find it really unpleasant that you mention this. I don’t know what this is about, or if anybody is feeling uncomfortable, but just now it is unpleasant.” Siri: “It is OK for me. I’m in my own world these days. I don’t really notice how others react.” Knut: “I think it’s quite difficult. But a lot of things have been hard lately. I feel as if I could explode.” After a round on Knut’s anger towards health authorities, the therapist returns to the conflict issue and Erna takes the floor: “Yes. I can start. When it came to the last session, I did not understand what Kari was talking about. Nor the session before. It was not a lack of interest, it’s just that I faded out, you know, and then I pulled myself together again. It is something with your manners, Kari, so many words, and I don’t really know if they hang together, and then you have some very strong statements within this fog of speech, which I don’t get, and then last time you suddenly talked about me, that you were convinced you could change me somehow, if you only got the chance, and then I thought, well, now . . . who are you and what do you know of me, to change me from the outside, when I have known myself from the inside for 35 years! I couldn’t just sit and listen to that, it was really quite cheeky, but I have learnt some things in this group, after all, I’ve been coming here much longer than you have, so I thought, I’ll answer that one. In the old days I just would have taken it in and kept silent, never dared to oppose, really. But I’m doing it now. I can’t put up with things in the same way any longer. It is feedback which is the main point in this group, so I did say to you then, exactly what I thought about such statements like yours.”

With some short comments from Trine, Knut, and the therapist, Erna keeps up her monologue for approximately 10–12 minutes, where she talks more about Kari than to her. Kari then says: “I’ve been listening to this for a quarter of an hour, and I must say that I am present in this room too, you know. I just wonder if you’re soon going to ask me a question, or what this really is about. There are limits to what I can take. I can see that you have taken up the sword, but I don’t like just sitting here receiving attack after attack from you. I knew at once when the therapist mentioned it, that I was the one to be ‘taken’ today.”

The same kind of “dialogue” continues, with plain offensive comments and more indirect hints, mutual insults, exaggerations, and misunderstandings. No unified understanding or reconciliation happens during the group session.

There is a lot to address here. On a superficial level, the therapist makes some “correct” moves. He mentions a group issue in the opening phase and says it should be talked about. Thereafter, a lot goes wrong. The therapist underestimates the emotions associated with the theme and he overestimates the mentalizing capacities of the group members. This allows Erna to overrule Kari. Most people would find Erna’s flow of words insulting. The therapist should have listened more to the

hints which were apparent from the beginning, hints about this being “really unpleasant,” and explored that. Kari had also felt that immediately: “that I was the one to be ‘taken’ today.” By finding out more about what the unpleasantness was all about, the current affect, one could have kept a more metacognitive stance later: “This is obviously difficult—how shall we deal with this?”

When this example is mentioned under item 6, “Caring for the group and each member,” it is because the main point is that the therapists let a patient overrule another member without intervening and stopping it. It is a scenario, where a member (Kari), is picked out and talked about derogatively over a prolonged sequence of time, while other members are listening. Erna appeals to the others, almost as if she is talking on behalf of the members in the group. It is a scapegoat scenario. Kari, however, is not necessarily an innocent part of it. She may have contributed to the scene by projective identification. She even says afterwards that she “knew” that she “would be taken.” Whatever the contribution of underlying mechanisms, such scenarios must be stopped. It has to do with caring for the group as a whole as for its members.

As mentioned, the therapists should try to live up to an ideal of caring for parents in a family which can accept that a lot is troublesome, but which try to mentalize together about things that are difficult and unpleasant. It is far from the ideal if a parent allows a member of the family to attack somebody else in the family without intervening. At some time point, this will result in a retraumatization, as yet another experience that nobody cares and that all in all, it is best to be on the lookout, offensive, and that in the end the only person one can trust is oneself. The right intervention in this case would have been a variant of “Hey, slow down there, Erna, this is going too fast for me, I can’t quite follow you. We’d better take it a bit more calmly. How is it for the rest of you? How are you doing, Kari?” Thereafter continuing with a more controlled exploration where each involved member is stopped if needs be, and made responsible for their unclear statements, feelings, and misunderstandings.

An example of a patient who experienced a panic attack in the group:

Louise (23) is an attractive young woman who has dropped out of secondary school and only just manages to make ends meet by working as a part-time shop assistant. She gets a lot of attention from men, but does not manage longer-lasting relationships, and is not interested in them either. She has a dismissive attachment pattern and keeps other people at an emotional distance. She has no close friends and does not feel comfortable when a person she knows asks her how she is doing. This kind of talk, and especially in groups, “gives her the creeps.” The group therapy component of MBT was therefore troublesome and quite provoking for her. She felt sick when she entered the group, and in the beginning, she only managed to give brief answers to straightforward questions. During the fourth group session, she had a panic attack and left the room. The group therapist followed her and found her sitting on a bench in the corridor, trembling and hyperventilating. He sat down beside her, held her hand, and talked calmly to her. After 10 minutes the attack was

over. She composed herself and joined the therapist back in the group. She explained that she had simply felt scared stiff in the group. She had appreciated that the therapist came out, that he cared, and that he managed to calm her down by staying with her. Later, in the course of treatment, when Louise had managed to adjust and use the group constructively, she often returned to this incident, saying how important it had been for her that the therapist took care of her and did not leave her on her own.

Guidelines for rating of occurrence

When therapists do their job in accordance with this manual, caring aspects will most often be implicit in the group dynamics. They do not stand out as separate phenomena, but are part of the foundation of the group. Since many interventions may have this implicit feature of caring, it is difficult based on “external” signs to operationalize what would characterize a caring intervention. This item is therefore not rated on occurrence. However, the rater should note on the working sheet when explicit caring interventions do occur.

In an “ordinary” group session, without particular positive or negative events, the quality is set to 4 (good enough).

Guidelines for rating of quality

Low (1–3): The therapists let group members treat one another in a derogatory or insulting way or they handle such situations superficially.

Adequate (4): At this level, the group process is on an even keel when it comes to care. The therapists seem to have an awareness regarding negative comments between group members and are quick to intervene in such situations.

High (5–7): The therapists are very well emotionally attuned to interactions between members and to issues that have to do with disappointments, insults, rejections, and withdrawals here and now, as well as failing abilities to care for oneself, and they are active in mentalizing seemingly “small” incidents in the group.

Item 7: Managing authority

The therapists should not only take care of the group and its members in the sense of caring, but also by their authority as the leaders of the group. This item marks a distinct and different attitude towards leadership as compared to group analysis. The latter defines a distinct leadership of administrative issues (the therapist takes responsible for time, place, and physical matters) but group analysis, as recommended by S. H. Foulkes, does not define the therapist as the dynamic leader of the group. The therapist is instead labelled a “conductor” (as in an orchestra). In MBT-G, we clearly define the therapist as the leader of the group. He/she not only has responsibility for physical arrangements, but he/she has also invited the group members to join a specially designed project with

specific aims and rules. Within group analysis, one can to some extent profess that the group members “own the group,” meaning that in many ways it’s *their* product. The group analyst should act more like the group’s “midwife.” Within MBT-G, group members are also active participants, but the terms and premises for the group are nevertheless decided by the therapist.

Managing authority implies that the therapists are active, that they explicate and model the goals of the group and ways of achieving the goals. They should explain the rationale and structure in a convincing way and demonstrate in practice what it implies. They should be open, curious, and explorative, but at the same time able to maintain consistent boundaries. The group should be a training ground for mentalization, not an arena for acting out personal aggression, self-destructiveness, or antisocial features. The therapist should monitor how the group keeps to its primary task and sensitively interrupt issues which do not belong to this setting. When the therapist’s authority is tested by devaluating and aggressive patients, it is important that they are able to handle their own countertransference.

In particular, one should be aware of potential conflicts between the obligation of managing authority and taking a not-knowing stance. Quite recently we (Inderhaug & Karterud, 2015; Karterud, 2015) conducted an observational study on three consecutive MBT-G sessions at a MHC in Norway. We found that the group dynamics were out of control. The main reason was that the therapists downplayed their authority role and overplayed the not-knowing stance. They appeared not-knowing with respect to knowledge about borderline pathology as well as group dynamics. The result was chaos. Readers should be reminded that the principle of not-knowing refers to the content of the mind in particular circumstances. We are not experts on *what* people are feeling and thinking in particular situations. However, we *are* experts on how to conduct MBT-G, in general, for borderline patients.

An example of good management: See the example about Lise in “Item 6: Caring for the group and each member.” Lise made repeated frontal attacks on the therapist who at first answered by ordinary therapeutic techniques. When this did not lead to any change, the treatment was terminated.

An example of poor management:

It had become acceptable in the group to speak to the therapists in a rude and derogatory manner without any consequences. In this session, the group used the first hour to say goodbye to Reidun who had been a group member for about 3 years. There was a lot of focus on how Reidun was feeling these days, and on her plans after ending the treatment. There was little focus on what it actually felt like, that this was her last group session, here and now. Reidun had improved and when asked what she thought had helped, she answered that it was probably the medication. Nobody in the group commented on this any further. Nobody asked how

Reidun thought the group might have contributed to her improvement. The therapist cringed, but he could not bring himself to say anything in this situation. This sequence of Reidun's last session became emotionally flat.

After this sequence, one of the group members commented that she had problems with Kine and Valborg in the group. It seemed to her as though these two were sticking together in some way. She felt a bit suspicious about what they were talking about, whether it was something critical, behind her back, and she thought she had to bring it up in the group. This led to a heated, quarrelsome atmosphere. People interrupted each other, were quick to feel attacked and to counterattack. The therapist tried after a while to stop this by saying something and moving his hand, but was overlooked and not heard. After a while, he tried again, but was overlooked once more. On the third attempt, he finally succeeded in capturing the group's attention. Although the therapist then said the "right" things—about an important issue and that the temperature had become a bit high in the group—it became somewhat drawn-out, and in the end he was interrupted by Valborg who turned to someone else and just continued as if the therapist's intervention had not taken place. The therapist let this happen. After a while, Valborg's rather weighty style is commented on by another group member and her interruption of the therapist is mentioned. Valborg then says "Well, yes, but therapist X just keeps going on and on. Usually nothing comes out of what he says, anyway. You're quite right, I do become impatient. But I think that's just healthy." Another group member comments: "You know, I think you're brave." The group continues and Valborg's devaluation is not mentioned again.

In the following example, the therapist did not manage to handle a hostile patient:

Bente had for a long time been very reluctant to speak about herself. In the opening phase in this meeting, the therapist turns to Bente and asks: "How about you, Bente?" The therapist has a Bergen accent [a Norwegian west coast town] and Bente answers in a mocking way, repeating her words using the therapist's accent. The therapist is startled and exclaims in a rather surprised way, "What was that?" She is answered in the same way, but now even more accentuated. The therapist feels humiliated and remarks, in an irritated way, that "Well, it's about time we get to hear something from you, now." Bente does not answer. Therapist: "No? OK then," and continues, turning her attention to the others. Bente does not say anything more in this session. During the next session, the therapist tries to bring up the incident again, but is not answered. Some weeks later, she gets a note from Bente, saying that both she and the group need a break from each other. During supervision, the therapist explains that she has for a long time felt almost "terrorized" by Bente and that this has made her avoidant and helpless. Retrospectively, it's easy to see that the therapist in this particular session should not have turned to the other patients, but kept to this incident and made it a main group issue for that session, talked about her own feelings, and asked her co-therapist and the group for help.

See also the example from Chapter 2 ("Clarification of events") where Lise arrives late for her last but one group session, when she more or less "empties"

herself, and talks in a flow of incoherent themes, where the therapists give in, abdicating from their role as authoritative group therapists.

Guidelines for rating of occurrence

This item is also difficult to operationalize at the level of distinct and explicit commentaries. Therapists manage their authority by a range of different means. This item is therefore not rated for occurrence.

Guidelines for rating of quality

Low (1–3): The therapists let derogatory comments about their characteristics and unwarranted beliefs and opinions about themselves pass by. They do not stand up for or defend the group's basic values as something inherently linked to their own role. The therapists seem unconfident or hesitant, or they manage their authority in an unnecessarily harsh or rigid manner.

Adequate (4): The therapists seem calm and confident as MBT-G therapists. In theory and practice they stand up for the group's basic values.

High (5–7): The therapists manage difficult challenges from individuals and from the group as a whole that have to do with the group's basic values. They do this in a convincing way, firmly determined when necessary, but at the same time keeping a mentalizing attitude.

Item 8: Stimulating discussions about group norms

This item is about the necessary discussion group members have to perform in order to make the group's generalized project concretely their own. It is mainly about establishing norms. Even if therapists in MBT-G repeatedly indicate the goals of the group, this does not necessarily mean that group members really get the point, internalize it, and make the group norms their own. The therapist's recommendations will necessarily be a bit general and abstract and not always straightforward or understandable. It is a major task for the group to find out what these recommendations mean for the practical week-to-week work of the group. This may account for procedures, such as *how do we receive a new member? Should members introduce themselves? What and how much should they say?* It may also account for *the opening phase. How long time should it take? Must everybody have something to say? What is an event?* But mostly, it accounts for principles about being open, frank, managing defenses and resistances, handling feelings, and principles about how active (or passive) one should be. *Is it right to push people? In that case, how much? How frank can one be? What about if people become hurt? Is anger allowed in the group? How active should the therapists be? If one keeps silent, should one then be asked?* And so on. For a more

profound introduction to the theme of establishing group norms, we refer to other literature (e.g., Karterud, 1999, p. 338).

The issue of norms turns up in all types of groups. Some groups regulate this by communicating a set of principles and rules as to what is allowed and not allowed with respect to content and ways of expressing oneself. In dynamic groups, where the establishment of norms is part of the therapeutic group process, the therapists should facilitate discussions about norm establishment. This is done by “marking” certain problems and making them topics for general discussions:

”It seems that you, Kristian, felt a bit devalued by Eva, just now. It seems that you got things straightened out, though. It brings out the question of how careful or conversely how persuasive or confrontational one can be towards each other in the group. Any thoughts about that?”

Norms which are accepted and shared after such conflicts have been termed “group solutions” (Whitaker, 1981). Group solutions can be restrictive or enabling. Restrictive group solutions aim at controlling anxiety. A restrictive solution to the above mentioned conflict could be the following: “Everybody in the group is really fragile and vulnerable. It’s important that we are very careful with each other and make sure we don’t hurt anybody.” Restrictive group solutions indicate high levels of anxiety. Therapists should not accept restrictive group solutions. However, at times the therapist might think that this is the most the group can manage at the given time point. In that case, the therapists should make a plan for how they can make the group develop in a more liberating direction. This is described in detail by Karterud (1999). An enabling solution to the above mentioned group conflict could be:

“Everybody in the group has inhibitory, anxious features which restrict life. To get on in life we have to challenge each other. It’s important to keep on discussing how this can be done.”

By this item we want to emphasize that the therapists should stimulate (1) by taking initiatives, or actively being engaged in group relevant discussions which spontaneously occur, in order to underline that this is important, and (2) by challenging restrictive group solutions and favor enabling solutions.

An example of a too directive leadership style:

Brita is a new member in the group. This fact probably accounted for some reluctance in the opening phase. The therapist saves the day by saying: “Well, then we usually introduce ourselves.” A better variant would have been: “Yes, now we have a new group member today. How are we going to handle this?”

As an example of poor performance on this item we refer to the passage about Berit and Lisa under “Item 5: Identifying and mentalizing events in the group.”

Lisa makes the group choose a restrictive group solution which the therapists do not challenge.

Guidelines for rating of occurrence

This item concerns interventions where the therapists take the initiative, support, and engage in discussions about issues that are important for how the group functions as a group:

“Being angry in the group is perhaps not so easy. How shall we handle that?”

“It is a dilemma when someone is getting on well with an event and we at the same time know that several others also have things to talk about. How shall we handle that?”

“This discussion about latecomers is important. How can we find a balance between making requirements about commitment without lapsing into military discipline?”

“Should things become a bit stricter now, by not allowing people to interrupt when somebody is talking?”

Guidelines for rating of quality

Low (1–3): The therapists are either too directive and try to make rules in an authoritarian manner, or they neglect obvious group conflicts so that these are not brought up for group discussions in order to establish enabling group solutions, or they do not engage in the discussions between patients on norms and the making of norms.

Adequate (4): The therapists take the initiative to norm discussions, engage in an interested way in spontaneous discussions, and try to modify restrictive group solutions which are being made, if these are not challenged by other group members.

High (5–7): The therapists are obviously sensitive to group conflicts, participate in making the group aware of these, and formulate them in words which seem relevant and vitalizing for the group. At the same time they give the issues meaning, in the context of the group’s main goal as a training ground for mentalization, and thereby help the group to negotiate group conflicts in enabling directions.

Item 9: Cooperation between co-therapists

A noteworthy difference between individual and group therapy is the presence of a co-therapist, which is frequently seen in group therapy. It is of course important that the different therapists cooperate in an efficient manner. In MBT-G, they should do this in a manner that models mentalizing dialogues. We have previously written about how co-therapists should cooperate before and after each group session to ensure meaning and continuity of the group

process. In the group, they have to assist each other. It is most important when the mentalizing capacity of one of the therapists has been weakened by something in the group. In such situations, co-therapy can demonstrate here and now how one can make use of other perspectives and regain mentalizing capacity. This requires that the therapists *speak to each other* during the group sessions. Instead of wondering what the co-therapist might have thought about a subject, it is recommended that therapists ask each other directly, and also, that therapists are open about feelings of uncertainty: “I must admit that I don’t quite know how to understand this. What do you think, therapist B?”

Talking directly to each other contributes to making the therapy process less obscure. An efficient cooperation requires free and open (transparent) communication. Being open demonstrates that therapists are not omnipotent and that they also sometimes mentalize poorly. On the other hand, they might become models for how it is possible to regain mentalizing capacity. Being open also models good parenthood. It is possible (and preferable) for parents to speak to each other frankly about difficult situations with the rest of the family present. Such frankness requires a confident relationship between the co-therapists. We do not encourage therapists to expose aggressive feelings or contempt for each other. If this is the case, it should be dealt with after the group session or in supervision. If co-therapists, over time, do not manage to achieve a confident cooperative relationship, they should not continue to work together. Patients rapidly perceive such tensions and if a bad co-therapist relationship was pointed out in the group, the co-therapists would be in difficulties. If they deny it, which might well happen, they undermine the project of MBT. Sensitive observations from patients are actually pieces of good mentalizing. To deny that would be destructive. On the other hand, if therapists should admit to a bad co-therapist relationship, this would open up a far greater transparency than most therapists can handle here and now in a group.

An example of good cooperation:

Therapist A made an intervention which was followed by total silence. Therapist B felt confused because she did not hear what had been said and wondered if the same had happened with the patients. Instead of leaving it to the patients to find out about this, she actively intervened. Therapist B: “While you were talking, I found it a bit difficult to understand what you actually meant. Could you repeat it please, or perhaps put it differently?” (An alternative intervention is to ask the group what the members have experienced, but then there is a risk that a problem which the therapists are responsible for becomes attributed to the group.) Therapist A: “Yes, I see that this was a bit fuzzy. Perhaps it was because I was not clear enough in my own head. I tried to say something about the group having trouble with listening. The way I talked, it seemed I made things even worse!” Therapist B: “Yes,

I was really struggling to follow you and to understand what you were saying. Is there anything in the group making you so vague?" Therapist A: "Good point. I think it may have to do with the disagreement last week between Truls and Katrine. We have not referred to it today, but I think it is important. I have been thinking a great deal about what happened and can't understand what really led to such a heated discussion. Assisted by therapist B's question, therapist A now points to a manageable issue for the group. It is time to round off the dialogue between the therapists and to open up exploration which includes the patients. Therapist B: "Has anybody else had thoughts about the disagreement last week? Perhaps you also became a bit apprehensive?"

In this manual, most of the examples of poor group processes are also examples of poor cooperation between therapists. When a therapist does something which has a bad effect on the group's development (or does *not* do something), it is the other therapist's duty to intervene in order to re-establish the group's collective capacity to reflect. It is understandable that one therapist temporarily loses some capacity for mentalization. It is more unfortunate if *both* simultaneously lose this capacity.

Guidelines for rating of occurrence

This item concerns all types of interventions where therapists talk to each other or refer to each other:

"Are you or I going to start, therapist X?"

"Now, I'm a bit uncertain, what do you think, therapist X?"

"In addition to what therapist X has said, I would like to add . . ."

"I just want to say that I feel a bit confused here. I don't know what this means. Do you understand, therapist X?"

It is possible for therapists to have a good and confident therapeutic cooperation without communicating to each other verbally. Interventions can follow each other smoothly and creatively without any explicit dialogue. It is therefore possible to have a low rating of occurrence (even 0) and at the same time receive an adequate score on competence.

Guidelines for rating of quality

Low (1–3): There is no verbal communication between the co-therapists. They also cooperate badly by not following each other's interventions, and pull in opposite directions. In the worst case, therapists contradict each other and show signs of irritation or dissatisfaction.

Adequate (4): There seems to be a confident relationship between the therapists, their interventions are complementary, and they communicate with each other with open, reflective comments.

High (5–7): The therapists have an open dialogue between themselves which functions as a model for mentalizing and contributes to clarifying difficult situations in the group.

Item 10: Engagement, interest, and warmth

This item is not unique to MBT-G. It is highly valued in most psychotherapies. The key terms engagement, interest, and warmth could be supplemented with the terms authenticity, empathy, and caring. Their opposites are cold, disinterested, uncaring, reserved, and distanced. This item is meant to reflect perhaps the most important general factor in psychotherapy. It refers to a therapist who “cares” and who is able to communicate this in a manner so that patients feel welcomed, respected, important, listened to, and taken seriously. This requires a far more active therapeutic style than is customary in group analytic psychotherapy. The therapist should be interpersonally “present” and take initiatives. He/she should not be distant with the individual members and wait for “the group to take the initiative.”

The item reflects MBT’s and mentalization theory’s roots in the attachment tradition. The ability to mentalize grows out of an experience of being understood. Through this experience the individual will find culturally acceptable verbal means of expressing his/her state of mind. The therapist’s role, as previously mentioned, is somewhat similar to that of a parent. It is a matter of “mind-ing minds.” It requires an interest in and involvement on the part of the parent/therapist to find out what is in the child/patient’s “mind,” an interest that is sustained by a desire to be helpful. For parents, this is a natural response in relation to one’s offspring and is linked to the emotional system of “CARE” (Panksepp, 1998). For the therapist, it is a cultivated response that is sustained by the emotional systems of care and SEEK.

The idea here is not of overwhelming warmth bordering on invasiveness, which is likely to be harmful to patients with BPD, but more about a balanced friendliness. It should be genuine, not superficial. Although this item is generic for the psychotherapies, the MBT version of it contains a specific quality of *authenticity*. The mentalizing therapist needs to make their mental processes transparent to the patient as they try to understand them, openly deliberating while “marking” their statements carefully. This requires directness, honesty, authenticity, and personal ownership that might seem problematic partly because of the dangers of boundary violations in the treatment of BPD. Our emphasis on the need for authenticity is not a license to overstep boundaries of therapy or to develop a “real” relationship; we are merely stressing that the therapist needs to make themselves mentally available to the patient and must demonstrate an ability to balance uncertainty and doubt with a continued struggle to

understand. This becomes particularly important when patients correctly identify feelings and thoughts experienced by the therapist. The therapist needs to be prepared for questions that put them on the defensive – “You’re bored with me,” “You don’t like me much either do you,” etc. Such challenges to the therapist can arise suddenly and without warning and the therapist needs to be able to answer with authenticity. If they do not do so the patient will become more insistent and evoke the very experience they is complaining of, if indeed the therapist was not already feeling it at the time.

The therapist need not like all aspects of a patient, but the patient must arouse a positive involvement on the part of the therapist. Positive involvement may be challenged and threatened by the therapist’s countertransference, but unless the therapist has an initial positive attitude toward a patient, then he/she should refer the patient to another therapist.

Engagement, interest, and warmth are factors that should pervade the therapy as a whole, and it is therefore less relevant to link this item to specific interventions. This is the reason why this item is not scored for adherence. It is more a sort of a precondition for the other interventions, such as “Exploration, curiosity, and not-knowing stance.” Even though it refers more to a general attitude than to specific interventions, but certainly involves nonverbal signals (e.g., smiling, a friendly facial expression, body language, etc.), a number of phrases clearly communicate interest and involvement, such as “I have thought about you since we last met” (“holding mind in mind”), or “I’m sorry to hear that” (empathy), or “Too bad,” or “That sounds good,” in addition to questions such as “How was it?” “What were you feeling then?” and “What did you think?”

Humor belongs to this item. Psychotherapists should have a good sense of humor. It testifies to an ability of having different perspectives in mind which might counteract the grave seriousness of psychic equivalence. It is easier to joke in group therapy and it is a fact that people do laugh more often in group settings. The therapists should be a part of this. However, the humor should be warm and inclusive, not cold or cynical.

Guidelines for rating of occurrence

This item is not rated for occurrence

Guidelines for rating of quality

Low (1–3): At the lowest level, the therapists appear cold, uninvolved, and uninterested, with a reserved body language. They give the impression of having little or no empathy. Questions are delivered in a mechanical manner. On a somewhat higher level, they do not appear directly cold and uninterested, but more reserved and distanced. The therapists act and react with little vitality and

spontaneity, and the therapeutic process seems slow and lethargic. At level 3, there are sequences in which the therapists seem more involved, but the overall impression is still one of reservation and distance. It is also possible to be overly involved and blinded by one's own therapeutic focus and thus overlook the patients' points of view.

Adequate (4): The therapists appear genuinely warm and interested in each member and the group as a whole. The rater gets the impression that the therapists care in a positive way. Several interventions and their stance indicate this.

High (5–7): The therapists seem definitely genuinely interested and involved, and they express their empathetic attitude in a natural and spontaneous way as well as a capacity for authenticity. At the highest level, the therapists' involvement is dynamic with flashes of disarming humor, but without this undermining the feeling of a genuinely empathetic stance.

Item 11: Exploration, curiosity, and not-knowing stance

This item also refers to an underlying attitude that should characterize the entire therapy process. It is a most crucial item for MBT. It may of course occur in other psychotherapies as well, but hardly as consistently. Earlier versions of the assessment scale differentiated between a not-knowing stance and promoting exploration and curiosity. Practice has shown, however, that these phenomena are so closely related that they practically never occur independently of each other. This is also consistent with a conceptual analysis. Exploration and curiosity arise out of a state of not knowing and of a desire to find out. Exploration and curiosity are linked to the primary emotional system SEEK. It is usually associated with a scrutiny of the surroundings, of unfamiliar others, and a search for food, resources, sex, and so forth. The unique aspect here is that it is applied for the exploration of the inner world. The starting point is that the patient has poor mentalizing abilities to find out about and understand mental phenomena, or that these abilities are temporarily shut down due to emotional hyperactivation. The essence in MBT is that patients need to develop their ability to mentalize through the therapeutic process. The therapist must therefore be consistent, clear, and pedagogical with respect to the following fundamental principles:

- 1 Even though mental states and mental phenomena are not transparent, they are not incomprehensible
- 2 They can be made more understandable via exploration
- 3 This type of exploration requires inquisitiveness and a not-knowing attitude.

The therapists' most important task is therefore to be tolerant companions in an exploratory process and not all-knowing experts who think they have privileged access to other people's inner worlds or to "what really goes on in the group." Like companions on a journey, the therapists should engage patients in common efforts to find out about certain phenomena. The therapists must communicate the attitude that they cannot simply see into the patient's inner world, but that they depend on the patients' assistance. Mental states are not transparent, but they can become apparent through dialogue. The therapists must accept that both they and the patients experience things only impressionistically and that neither of them has primacy of knowledge about the other or about what has happened. This is more easily said than done. Both patients and therapists may behave as if they are sure about what the other is thinking or feeling. The therapists should refrain from statements or interpretations that have a conclusive character in relation to patients' or others' mental states without having first arrived at a common understanding with the patient based on an abundance of information.

This item emphasizes the importance of awakening/stimulating patients' interest in mental states and motives in themselves and in others. An interest in other people's motives is a precondition for conducting the necessary work that is needed to find out other people's mental landscape and what drives them. The therapists must have activated their own seeking system and, by way of genuine curiosity for the patients' minds, they hopefully stimulate the patients' own curiosity.

The beauty of the not-knowing stance is that it reminds the therapists that they do not need to understand what patients are saying or to struggle to make sense of it within another framework such as a patient's traumatic past or their maladaptive cognitive schemas. MBT therapists eschew their need to understand. The therapists should not feel under obligation to understand the nonunderstandable. Patients with BPD become muddled as they talk about themselves and others when they become aroused, as do people in general. But feelings disrupt mentalizing more rapidly in patients with BPD and, as the mentalizing processes of the patient derail, the therapists are likely to understand less and less. This is a moment for the therapist to intervene, most simply by saying "I am not sure that I understand this. Can you, or someone else, help me do so"? The cardinal error under these circumstances is for therapists to take over the mentalizing and to try harder and harder to make sense of what the patient says and subsequently to deliver their understanding. Relieved of having to understand, the novice therapist is in a more confident position. It allows them to be less fearful of making errors.

Curiosity, exploration, and not-knowing stance concerns also the group as a whole as well as what happens between the group members during the session. Interpersonal transactions are usually spontaneous and fast. Interventions belonging to this item will therefore often be linked to interventions aimed at calming down, and stop and rewind: “Let’s go back and find out what happened.”

In the section on group-specific items we underlined how important it is for therapists to elicit how other patients understand what the group is talking about. It means that therapists have to contain and practice a kind of *double not-knowing position*! They have to be curious about what particular individuals talk about and how they enact their story here and now, and at the same time wonder how other group members interpret the same phenomena.

Low occurrence of this item means that the therapists are not particularly interested in understanding mental phenomena, but are more concerned about behavior, support, problem-solving, or, for example, manipulating mental phenomena with medication. The opposite of an open, seeking, curious, and non-knowing attitude is a closed, convinced, and assertive attitude. A therapist with a “closed” attitude often establishes an idea about what “really” is the patient’s problem, what he/she “really” is afraid of, what he/she “really” is feeling, or what the patient’s closest relations “really” have in terms of hidden agendas. Such a therapist’s objective is then to convince or persuade the patient to accept his/her view. The same attitude may prevail towards what happens in the group. These kinds of interventions are not covered by this rating system. The rater should still make notes on the worksheet about when and to what degree such interventions occur. It might be that the therapists in some sequences are assertive and persuasive and that in other sequences they are more open and exploring. In such a case, the persuasive section will decrease the quality score.

Most of the clinical illustrations in this manual contain interventions that comply with this item. In the example of “What counts as an event?” (Chapter 2), the therapists explore what is “impossible” for Marianne by staying with her parents over Easter. In the example with Grethe under “Item 3: Initiating and fulfilling turntaking,” the therapists explore the event that triggered her stuttering.

Guidelines for rating of occurrence

The target here is interventions that convey curiosity about motives and mental states and not curiosity about facts or systems. In the course of a 1.5-hour group session, a large number of people will have been mentioned and a lot will have happened here and now. Low occurrence implies that the therapists do not pose

questions about these people's mental states or motives and their intersubjective transactions. The patient's explicit and implicit perceptions and interpretations are quietly accepted. With high occurrence, many questions are posed that promote seeking and curiosity about the patient's own motives as well as those of others:

"What do you others think about this?"

"What kind of feelings do you get by listening to this story?"

"What do you think made her say that?"

"Why did he do that, do you think?"

"Yes, I hear what you are saying, but I wonder why you said it in exactly that way?"

"It is possible he said it to hurt you, but might there be other reasons as well?"

"Based on what you have told me, is it possible that your mother often overlooked you. Why did she do that, do you believe?"

"How is it for you, Elisabeth, to hear that the other group members do worry about you?"

"What has been in your thoughts about this matter since the last group session, Peter?"

"It seems like something is going on between you two, Eva and Louise. Can we find out what it is about?"

Guidelines for rating of quality

Quality concerns to what degree the therapists follow up questions like those above, in detail and depth:

"Yes, that makes sense, but how does it relate to X, do you think?"

"Is it possible to find out how Trudy reacted to your story?"

"Am I right in thinking from what you've been telling me that you believed she just was acting in order to deceive people?"

"Why? Are you suggesting that it was because Y was present?"

By way of similar questions, motives may become understood within broader interpersonal and social contexts.

In general, therapists should be careful in suggesting possible motives that may be driving patients or others, unless the case is explored in depth. MBT is not an insight-oriented therapy. The goal is to develop the patient's own abilities to mentalize. However, if one encounters mental blockages of any type of exploration, the therapist might make suggestions, such as in the following example:

"I understand that you have difficulties understanding why X behaved as he did. It is not easy for me to understand it either. I do not know him other than through what you have told me. But could he simply have been exhausted?"

The following are examples of low quality:

”You have been traumatized and that is why you can’t stand such situations.”

”You are doing this because of your unconscious guilt complex.”

Low (1–3): The therapists do not pose questions about mental states. Or, they make assertive claims about the patient’s or some other person’s motives. The therapist’s questions about motives are poorly formulated, mechanical, and superficial. They may also be poorly timed and appear like ruptures in the ongoing conversation. The therapists accept responses that sound like clichés. The therapists leave it to the group to explore narratives and interpersonal events. The therapists display little interest in the process of finding out and seem more interested in “causes.”

Adequate (4): The therapists pose appropriate questions designed to promote exploration of the patient’s and other’s mental states, motives, and emotions and communicate a genuine interest in finding out more about them.

High (5–7): The therapists pose adequate questions about the patient’s and others’ mental states, motives, and emotions. They are posed in a friendly and welcoming manner. The questions are followed up with respect to details and they invite an in-depth exploration of interpersonal and social contexts without relapsing into individual therapy in group.

Item 12: Challenging unwarranted beliefs

Patients often have unwarranted opinions about themselves and others and about relationships between people. Such unwarranted opinions are in themselves signs of poor mentalizing. They should be challenged, but in a friendly and sensitive manner; not in a categorical or unsympathetic manner, but consistent with a curious and not-knowing stance.

Typical unwarranted opinions about oneself have been well documented in the cognitive literature. Patients may describe themselves as dumb, ugly, less worthy than others, not deserving anything good, deserving punishment, or being helpless victims of bad life conditions. We also encounter the opposite, when patients state they are better than others, more intelligent, deserving of special treatment, and so on.

Unwarranted opinions about others often appear as fixed, rather clichéd-like ideas about others’ supposedly inflexible personality characteristics, for example, that others are dumb, lazy, ruthless, nice, envious, jealous, unsympathetic, greedy, bad, etc. It may involve attitudes about groups expressed in general terms: “Health system bureaucrats don’t care at all about us patients” or “Estate agents are just greedy.”

Or it can be about specific people: “She never cared about me” or “My mother was always nice.”

It may concern other people’s motives in specific contexts: “He did it to punish me” or “Yes, I hit her; she asked for it.”

It can also be about relationships between people: “My parents’ relationship was always good. Never an angry word was spoken between them” or “Yes, there is a lot of hitting, kicking, and arguing, but I don’t think the relationship between us is worse compared to most people.”

Therapists may suspect an opinion to be unwarranted when it is overly one-sided, rigid and fixed, global (applies to the entire person or everyone in a category of persons), lacks empirical proof, seems improbable, or seems overly exaggerated.

Guidelines for rating of occurrence

Interventions that belong to this item often take the following forms:

“I noticed that you described yourself as dumb, and I also heard that earlier. I wonder what you mean by that? . . . Any thoughts about this in the group?”

“You say that you experience yourself as less worthy than others. But last session you said that you felt OK. It seems like your self-confidence fluctuates. Do you have any thoughts about why your self-confidence may be down today?”

“A while ago you said that everybody at the unemployment office was an idiot. I am unsure about how I should interpret that statement; is it a manner of speech, is it because you were upset, or is it because you really meant it?”

“You said that your mother was always nice. I don’t know exactly how I should interpret this statement. Can you explain it a bit more?”

“Based on what you have told the group, it is quite possible that he did it to punish you; but could there be other reasons as well?”

“You say that she asked for it. For me it is difficult to understand how someone could want to be beaten up. It seems like Robert has some comments about this. What are your thoughts, Robert?”

Guidelines for rating of quality

When it comes to this item, it may be that unwarranted opinions about oneself and/or others do occur in the session, but that the therapists do not comment on it. The adherence rating will then be zero. Some would argue that there should not then be any rating of quality. One cannot assess the quality of something that does not occur. However, as explained in previous paragraphs, the fact that therapists do not intervene when the phenomenon actually is present indicates poor skills on the part of the therapists with respect to the item. *No reaction when appropriate target behavior in fact occurs should receive a low competence score (e.g., 2 or 1).*

Examples of low quality would be the following:

- “How on earth could you think that?”
- “That is the craziest thing I’ve ever heard.”
- “That sounds like an incredible exaggeration.”
- “I don’t believe that at all. You can’t mean that!”
- “What a load of rubbish.”

Low (1–3): The therapists do not react to obvious unwarranted opinions. The therapists confront patient in unsuitable manners. Therapists intervene rather superficially by accepting clichéd-like responses or abandon the topic without a more careful examination.

Adequate (4): The therapists confront and challenge unwarranted opinions about oneself or others in an appropriate manner.

High (5–7): High-competence interventions are formulated in a friendly and slightly provocative manner. The therapists do not accept clichéd-like answers, but find new ways to move on without seeming to be condescending. They find acceptable ways to end the sequence if the patient insists on his or her perceptions, for example, by accepting the patient’s view but at the same time clarifying their own position, as in the following: “I understand that you see this in a specific way. I see it a bit differently, however. How do you feel about us having different views on this subject?”

Item 13: Regulating emotional arousal

Treatment should take place in an atmosphere of optimal emotional arousal. As already mentioned in “Item 2: Regulating group phases,” therapists should work to prime and activate the patient’s emotional system for exploration/seeking/engagement. Often this will be accompanied by a feeling of vitality. With a friendly and caring attitude on the part of the therapists, one should expect that the patient’s fear system should gradually be downregulated. However, the therapists’ constant focus on emotions may likely activate fear. A range of emotions may be hard to accept and own and integrate. It concerns the primary emotions of anger, separation anxiety, lust, love, and joy, as well as more complex social emotions such as jealousy, envy, guilt, shame, and so forth. The therapists have an important task with respect to regulating the level of emotional arousal (corresponding to parents’ regulating function in relation to their children). The level must not be too high so that it overwhelms the patient (confuses him/her, puts him/her off, leading to uncontrolled emotional outbursts, seriously impairing mentalizing ability, etc.); nor should it be so low that the treatment becomes just words, that is, pseudomentalizing.

It is important to be aware that the treatment system by itself might destabilize patients’ mentalizing abilities by stimulating their attachment system. When

therapists explore and pose questions about emotions, patients may become anxious. Therapists as well as fellow patients will naturally come closer emotionally to a protagonist during a session. However, MBT therapists should monitor the level of mentalizing. When they see signs of decline, they should retreat and become more distant in order to curb the emotional arousal.

Here we encounter a clinically significant paradox. Just when therapists do have a natural inclination to be even closer, we ask them to retreat. Most people who speak with somebody who is about to lose control will display a tendency to become even more empathic and caring. They will likely speak more quietly and softly and try to demonstrate their understanding of the other's difficulties. However, this strategy might only provide extra stimuli for the attachment system and provoke even more decline of mentalizing ability. This is particularly valid for borderline patients who have a hypersensitive attachment system. Accordingly, we advise therapists to resist the natural inclination to become more empathic and caring when patients become emotional. When their mentalizing capacity is regained, therapists may involve themselves again, becoming more emotionally attuned. However, one should not be surprised to experience a new round when getting closer. Therapists should therefore have a vigilant focus on level of emotional arousal and do their best to monitor it. We do not recommend that therapists become careless and cold. However, we warn against care expressed through tenderness, worry, and sympathy in situations of strong emotional turmoil since it may fuel the fire and activate deep and unsatiated attachment needs. It might diminish patients' mental resources when they need to have them most urgently.

Therapists help regulate the level of emotional arousal in groups through their general attitudes (interest, warmth, friendliness, engagement, and focus on emotions), through nonverbal communication and through specific interventions. Typical challenges are "the agitated member," "the withdrawn member," "the quarrelling couple," and "the devaluating subgroup," when the group as a whole is in fight-flight mode, or the group is emotionally flat. How to deal with such group situations are described by the examples which accompany most of the items in this manual. Therapists have to use different techniques, adjusted to where the problems reside.

In MBT, therapists follow a general principle that the greater the emotional arousal of the patient, the less complex the intervention should be. Supportive comments, gentle exploration of a problem, and clarification require less mental effort on behalf of the patient and so are considered "safe" interventions during high states of arousal. In contrast, interpretive mentalizing and mentalizing the transference heighten arousal and so carry the danger of stimulating either hyperactivation, leading to over-arousal of the patient or deactivation, inducing pretend mode, both of which decrease mentalizing. We therefore suggest that

these interventions are used with care. They are likely to be of most benefit when the patient is optimally aroused, that is, able to remain within a feeling while continuing to explore its context—so-called mentalized affectivity (Jurist, 2005).

Groups with borderline patients will always exist on the brink of fight–flight mode. It is a vital competence of MBT-G therapists to be able to regulate this kind of dynamics. However, therapists (like patients) have different tolerances for emotional tension. If one is uncertain about the limits, one may well ask:

“How is it? Is it too hot in this group now, or is it tolerable?”

“How about you, Janet? Is this about to be too tough, or can you manage?”

The most important emotion in this respect is RAGE (anger and aggression). One should remember that the group should be a training ground also for this emotion. Patients have to express anger in appropriate ways and they should learn to handle anger from others, including group members. It is therefore important that MBT groups don't become organized around restrictive group solutions that forbid anger here and now. On the other hand, MBT groups should not encourage aggressive acting out.

It is important that therapists carefully monitor the level of anger in the group, for example, by interventions like those mentioned above. When therapists consider the “emotional temperature” to be too high, the first commandment is to stop the ongoing interaction. It might concern two or more members, it may pertain to the group as a whole, and may also include therapists. If therapists are part of the turmoil: stop challenging! Shift gear. Otherwise, one should go straight to the heart of the matter:

“Stop. This is going too fast/becoming too hot/getting too tough . . . I cannot follow it. We need to slow down . . .”

In such cases, it is important that the therapists have gained a position of authority in the group. Their words should be respected (Inderhaug & Karterud, 2015). It should not be necessary to shout in order to be heard. However, it is important to be stern and authoritative. When therapists stop ongoing interaction in this way, it is because they want to establish another mode of communication which is more reflective and containing. The main target for reflection should be: What happened since we got to the point where people started shouting at each other?

Too high arousal is of course not restricted to anger. Separation distress may also become overwhelming. Some patients will submit to grief and intense crying. Some will dissociate. And fear is often turned on. Sometime we witness panic attacks. We may succeed in regulating some patients while they stay in the group. At other times, patients have to leave the group. When they have calmed down, they should return and reflect upon what triggered the fear.

It may help to redirect the focus of the regressed patient, for example, from here and now towards the mind of another “out there.” The purpose of such a strategy is to help patients regain a modicum of mentalization by supporting their thinking about the motives of others, when the opposite perspective is too overwhelming, that is, thinking and reflection on one’s own mind. This strategy is labelled “contrary moves” (Bateman & Fonagy, 2012). It advocates moving “outwardly” when patients become overly self-focused and moving “inwardly” when they become overly focused on others. If self-reflection turns to repetitive and rigid bouts of negative, shameful, and self-derogative accusations, it might be better to turn the attention towards others:

“How do you think this affected him?”

“What do you believe made her do that?”

Patients may answer that they just do not have a clue and jump back to their unproductive preoccupation with own state of mind. Therapists may insist a little harder:

“You have to bear with me, but in fact I do wonder how you understood what happened to him since he responded in that way.”

Moving in the opposite direction might be necessary when patients are obsessed by understanding others, why they behaved as they did:

“But what are your feelings about this?”

“How do you understand your own reaction?”

The fact that many items contain examples which also could have been included in this item, illustrates the central position of “Regulation of emotional arousal.” We refer, for example, to the vignette about Erna and Kari in “Item 6: Caring for the group and each member” which describes poor regulation. Patients express fear prior to the subsequent confrontation, but they are overruled. Later Erna is allowed to ventilate her feelings uncontrollably and a reflective stance is not achieved.

Interventions that count as regulating emotional arousal are often as follows:

“Hey, wait a minute. I believe we have to stop. The one word triggers another and to me this does not sound constructive. How should we handle this?”

“Hey, Pete and Joan. It seems like things are getting rather heated between you. It might be wise to hear comments from other group members.”

“I see that you feel sad. We touched on a sensitive topic. Take your time . . . Are you doing ok? Is it still just as painful? . . . Is it possible to take a closer look at what it is exactly about this story that overwhelms you?”

“It’s clear that something is upsetting you. I am not quite sure what it is. It might be something I said or the very subject we are discussing. Maybe you need some time

for yourself before we try to find out about the reason behind your reaction, what do you think?”

“I understand that this makes you angry. How distressing is it for you? Are you furious inside? Is it OK to be where you are right now, or would it be better for you to take a moment and wind down a bit? Earlier it helped if you . . .”

“Hi, Trine. Are you doing OK? Did your thoughts wander off a bit just now? We have been discussing a difficult topic. Maybe you need some time to collect your thoughts?”

“It’s OK, John, to leave the group. It’s OK to calm down. Do you need someone to accompany you?”

It is more difficult for therapists to have to up-regulate patients who seem to have closed down their emotional states. Patients become monosyllabic, fail to respond to comments from the therapists by elaboration, and appear disinterested. Interventions that aim at raising the temperature might be something like:

“How are you doing, any feelings about what we’ve been talking about just now?”

“Earlier in the session I got the impression that you were really interested in what we were talking about. Now it seems you’ve lost interest. Did we lose focus or was it me who moved it away from the important things?”

“I am a bit unsure how important what we are talking about right now is for you.”

An example of low competence:

“I see that it really pisses you off. That’s an honest reaction. It’s important to get in touch with your feelings. Let it out!”

Guidelines for rating of occurrence

As the examples above indicate, it is perfectly possible to identify interventions that explicitly address the here-and-now emotional temperature. However, numerous trials have shown that therapists most often regulate the temperature through their general therapeutic style. We might thus encounter groups that are well regulated while at the same time do not contain many specific interventions. For this reason we do not rate occurrence for this item, just competence.

Guidelines for rating of quality

Low (1–3): Therapists do nothing (or little) to regulate the emotional arousal when one or more patients, or the group as a whole, become overactivated during the session and it results in strong emotional outbursts. In contrast, therapists may say or do things that fire up already excessively activated feelings. Alternatively, the session is emotionally flat, dull, and without emotional involvement from anyone, and the therapists do nothing to “raise the temperature.”

Adequate (4): The therapists play an active role in terms of maintaining emotional arousal at an optimal level (not too high so that patients lose their ability

to mentalize and not too low so that the session becomes meaningless emotionally).

High (5–7): In addition to skills described for level 4, therapists use a wide range of interventions which may partly be geared towards specific patients, and partly towards the group as a whole. Raters get the impression that emotional regulation is a domain of high priority and that therapists are quite conscious about their goals in this respect.

Item 14: Acknowledging good mentalization

The therapists should support and gently praise patients when they have dealt with a situation in ways that attest to good mentalization. It also concerns the group as a whole. It is important pedagogically, as an illustration of what the therapists mean by good mentalization. It will also strengthen the alliance, and it has importance for patients' self-esteem. They receive recognition for mastering an activity that is a valued objective for the joint therapeutic project. In addition, the therapists' praise has effects through positive reinforcement. For the group as a whole it implies acknowledgement when the group does its job in an exemplary manner.

Examples of good mentalization might be situations in which patients have mastered their emotional arousal through reflection, in contrast to previous reactions such as emotional outbursts, confusion, dissociation, withdrawal, self-destructive behavior, overeating, intoxication, or suicidal gestures. It may, for example, involve situations where patients deal with problems on their own, such as when they decide to "sleep on" an incident, instead of calling the boyfriend or girlfriend late at night and indulge in destructively arguing. Or it might be an interaction that is dealt with in a new and better way, a conversation, a constructive argument, an earlier unbearable feeling, or a sequence in therapy in which the patient has dared to address a sensitive topic without collapsing.

Acknowledging particular individuals in a group is a double-edged sword that should be used with some caution since it can provoke envy and jealousy. However, years of clinical experience proves that this seldom occurs when the item is practiced with care and consideration. Also, patients have the capacity to appreciate progress among fellow beings! This item is therefore significant for the curative mechanism of "installation of hope" (Yalom, 1995). However, one should take care not to favor particular patients. Regardless of their level of functioning, there should be moments of praise for everyone. It should be delivered as fairly as possible. One should acknowledge small steps among more poorly functioning patients, and not always acclaim "star patients."

Acknowledging good mentalization should be done in a “mentalizing manner.” This means that therapists check as they go along whether their evaluation is consistent with the patient’s own assessment, and that the therapists encourage patients to reflect about the event in the here and now:

“How is it for you now when you think back on it? . . . What was different this time, do you think? . . . How is it for you that we appreciate this?”

As an example, we refer to the vignette about Kristin in the section on “Starting the group” (Chapter 2). Kristin tells how she, with help from the group, has found different perspectives on her parents, their interaction, and the significance for herself. The therapists approve her reflections in a warm and smiling way.

Guidelines for rating of occurrence

This item concerns interventions where therapists acknowledge and give their approval not just with a smile or a confirmatory nod or “mm,” but also verbally. The following types of intervention count:

“What you are telling me about what happened yesterday evening is a bit new, isn’t it? . . . Isn’t it the type of situation where you previously would have done X? . . . It is perhaps an example of what we have been talking about in therapy, about trying to control your feelings and reflect on them and trying to understand things in new ways. . . . It seems that you dealt better with the situation this time. . . . How is it for you now when you think back on it?”

“It seems that the conversation that you had with your mother yesterday evening took a different path than the usual one between the two of you. If that’s the case, then it sounds positive. What was different do you think?”

“It seems that you enjoyed the encounters with your friends more on this trip. It seems as if you were more involved and enthusiastic. You have told us about similar trips before where you felt lonely, ignored, and unhappy. What was different this time?”

“That was good to hear. I am happy for you that it went so well. It meant a lot for you. It was a difficult situation, but you managed it without having to take any medicine or getting stoned or high. It seems that you were able to contain the painful feelings without collapsing and you managed to uphold your ability to think. It must have felt like a victory. Or am I exaggerating?”

There does not need to be several occurrences of this type of dialogue for it to count as an adequate degree of adherence. One occurrence is sufficient if it is of a reasonable scope. If there are obvious incidents that the therapist overlooks, however, then the absence of interventions should be scored as low quality.

Guidelines for rating of quality

Low (1–3): There are obvious examples of good mentalization that are overlooked, neglected, or misunderstood. Low quality also includes comments that

are short and delivered with little empathy or conviction, almost as if they are forced in order to adhere to the manual; or if therapists say something like “sounds good” without leaving an opening for reflection.

Adequate (4): The therapists identify and explore good mentalization and this is accompanied by approving words or judicious praise.

High (5–7): The therapists identify, explore, and support good mentalization in ways that are consistent with patients’ and the group’s mentalizing capacity and stimulate longer reflections that add further dimensions to the events and current group processes.

Item 15: Handling pretend mode

The expressions “pretend mode” and “pseudomentalizing” are often used as if they are interchangeable. There is a difference though. Pretend mode (or pretend play) is also the label for a normal and healthy way of being and thinking during child development, at its height during 3–4 years of age. Adults also need this ability to play and pretend, and “*Homo ludens*” is an ideal for many people. However, when we talk about pretend mode in adulthood, it is not this creative mode of being we are referring to. The word pseudomentalizing is more straightforward since it (“pseudo-”) refers to something negative or dysfunctional. Pseudomentalizing is also better suited for delineated utterances, while pretend mode refers more to a “mode” or mental state, not merely expressing oneself in a clichéd-like manner about a subject matter. This distinction is quite important for interactions in groups and that is why we prefer the expression pretend mode for certain phenomena that occur in groups. One will also often encounter statements that have a flavor of pseudomentalizing in groups. There is no need to worry about this. It is part of vernacular speech and life itself. The critical point is what other group members are doing with it. Is the statement accepted as a reasonable way of speaking and do other members follow in the same vein? If so, the group may enter the route of pretend mode and the therapist will need to prepare some kind of intervention. However, we often see that the statement is followed by responses which are more grounded in real life and imbued with more emotions and vitality which takes the conversation “back on track.” In that case, therapists do not need to intervene.

Pretend mode (and pseudomentalizing) is a mode of discourse in which patients speak about a topic in a superficial, emotionally flat, but often detailed way so that one gets the impression that it is “just talk.” It is a manner of dialogue with a monologue-like form where the person doesn’t check out whether what he/she is saying provides any meaning to the conversation partner, or where the person uses words and concepts that seem to have a psychological content, but

are used in an exaggerated, distorted, or clichéd-like manner so that the content is lost. In pretend mode, the patient's contact with social reality is poor. He/she is relating to a pseudo-reality consisting of words, concepts, and perceptions that are poorly grounded. The term intellectualizing covers part of this phenomenon. Other relevant associations are "The Emperor's New Clothes" and the term "bullshit" as it now is used within the social sciences (Frankfurt, 2005).

In pretend mode, the person is running on idle. No development takes place in pretend mode. It's wasting time here and now. However, for some patients it is a kind of discourse that is meaningfully based on that person's history. It is a way of relating to others that might make relationships possible, albeit in a distanced and abstract way. Pseudomentalization might work as a distancing strategy. The person may have many acquaintances, but no close friends. It is a poor strategy for intimacy with respect to feelings and being open to one's own vulnerability. The latter requires a mentalizing approach and not a pseudomentalizing manner of speech.

The following are examples of speech in pretend mode:

"Most people simply do not interest me. They have an aura reflecting an inability to process the complexities that exist between people. I need an input of energy that hits my chakra so that the totality of the existence may reveal itself in the shape of an immediacy that makes it possible to endure our world, which is on the verge of destruction."

PATIENT: "I realize that my problems were created by my upbringing."

THERAPIST: "Tell me more about what makes you say that?"

PATIENT: "Well, my relationship with my mother was good for some of the time and bad at other times. I became a sort of nonperson who was destined to be neurotic and the black sheep of the family. Yes, that is it. I was the black sheep of the family. The black sheep. So I became the person who was not going anywhere, without any direction, just drifting. I float around like a piece of flotsam in the ocean and never know what's going to happen next. It might have been my father too. He didn't give me a sense of being. I got no grounding which I could use for my development."

Pretend mode is often accompanied by typical countertransference reactions. When listening to empty and aimless talk, therapists will often experience boredom and lose interest. Listening to "bullshit" may also be irritating because of pompous exaggerations, or simply because therapists do not fathom what the patient is talking about. There is a risk that therapists collude with pretend mode, by joining the patient and the group in a kind of talk which provides masquerading "insight" into the patient's situation. Believing that the patient is making progress, therapists may continue this kind of discourse without realizing that it has no links with the patient's emotional life or reality. This might lead to endless inconsequential talk. In group sessions where pretend mode

develops and therapists are reluctant to intervene and let the group carry on, an assistant “therapist” from the rank of fellow group members is often recruited. Patients with histrionic features are particularly apt for such roles. They rapidly feel “close” to other people and their empathy is easily activated. One problem is that boundaries between self and others are often blurred: “I know exactly how you feel.” Such patients are very “understanding” and they will sometimes experience the same-sex co-therapist as a rival. In the group literature, such characters are known as “helpful Hannahs” (Bogdanoff & Elbaum, 1978).

Pseudomentelization poses many dilemmas for the therapists. A group session lasting for 1.5 hours will of course vary with respect to vitality and intensity. Some sequences are merely “transport legs” which carry the group from one theme to another. Some comments are superficial while others are more challenging. Some are more cliché-laden and intellectualizing while other come more “from the heart.” Therapists should tolerate troughs. Everything cannot be a peak. If therapists were to comment on all defensive utterances, the conversation would become so fragmented that the very life, the lush undercurrent of the group would get lost. We are now touching on the essence of a dynamic therapeutic group. In individual therapy, the patient and therapist might be in a constant intersubjective exchange where every speech act may be explored with respect to its meaning and implication. The other wonders, does not quite understand, gets touched or provoked, etc. In groups, all members relate to each other, to the group as a whole and to the topics in question. What does not make much sense for the therapists may be experienced as very meaningful for other group members. Foulkes used the phrase “resonance.” It connotes the reaction of each individual person in the group to what is being said and done. Each mind is a soundboard or resonance chamber for other minds. What people react to, the string that starts to vibrate inside them, does not necessarily concern the primary level of the speech. It might be a reaction to the “subtitles” (Gullestad & Killingmo, 2005). Such phenomena justify a more tolerant therapist attitude.

On the other hand, sequences will occur that clearly are superficial and which need to be challenged. Simple interventions may suffice:

“Are we a bit superficial now, and reluctant to dig deeper into the matter?”

Or:

“Are there some emotions in this?”

More troublesome are sequences of pseudotherapy in groups. That is, sequences where one or more members try to “solve” the problems of a designated “patient.” Such situations might be difficult to handle since the involvement often is well intentioned and since patients who offer themselves as problem

targets often feel understood and cared for. Therapists may feel uncomfortable when they intervene in such situations. They should find a plausible reason to call a halt. One could ask for comments from more passive onlookers, refer to the purpose of the group, or go back to what led to the sequence in question:

“Can we have a pause here? I wonder where the other members are.”

“I hear much advice and recommendations as to what you could do, Mary. But have we lost our focus on emotions and thoughts?”

“I wonder if we have got a bit away from what initiated this sequence, that you, Paul . . .”

The following example illustrates pretend mode at the group level:

The session has lasted for a while. A sequence emerges with somewhat general talk about “stress.” Veronica starts to say that she is stressed because of too little money. It’s awful and she feels down. She adds that her self-esteem is bound up with money. She feels miserable without or with little money, but feels great when it’s there. It also affects her lifestyle. She gets pissed off when having to worry about every cent and to reflect and plan carefully. Having money she might find herself in a kind of shopping euphoria. She loses control. It’s great when it’s happening, but she experiences a backlash afterwards.

The theme gets hold of the group. Other members join in and say how lousy it is to be poor and attest to the almost intoxicating feeling of having money in their hands. Irony and laughter fills the group. Therapist: “What is the connection between self-esteem and money?” The question leads to more of the same. Short episodes are being told which illustrate the theme, again followed by some laughter and jokes, and possibly a subcurrent of shame which is not explored. “The nice thing with money is that everything becomes available.” One member comments that “the pleasure is shortlived, then.” Another compares it with bulimia: “There is strict control and then suddenly it explodes in an orgy.” “Buying, eating, and forgetting everything.” The next person explains how he “is broke half of the month and have to borrow from people, and just now I have to sneak on the tube. When I get money I become like a devil. Hell, I also deserve some joy. Then I am broke again, and there is a new round.”

This conversation is not detached from reality. Hard realities are the very backdrop. The sequence is not emotionally flat—there is laughter and excitement. The problem resides in the very discourse. It’s unbinding. One short episode follows another, accompanied with nonsense comments about “short-lived pleasures.” However, the group does not really explore the events. Members do not penetrate the surface. General opinions and clichés are accepted and small sins are confessed. The (video) observer is reminded of Bion’s descriptions of the pairing group. It concerns a group mode where the main point is to sustain hope, but in a way that is remote from mental realities. In this case, it is money that evokes hopes of joy and permanent happiness. People tell their stories of being at the gate of heaven, having a glimpse of it, and the brutal experience of being thrown back. The whole

sequence is marked by pairing and pseudomentalization. The group is partly on the brink, and partly down in the mire. We note that the therapists have to take their own share of responsibility. To pose a question about the “connection between self-esteem and money” is to ask for pseudomentalization.

Guidelines for rating of occurrence

Group sessions vary in terms of involvement, interest, and vitality and the therapists must tolerate sequences of confusion and floundering. It is a question of judgment when such a rollercoaster ride takes on the form of clinically significant pretend mode. Nor is it the case that all therapy sessions are characterized by clinically significant pretend mode. When therapists notice this tendency, they should implement MBT strategies such as posing exploratory questions, adapting a focus on emotions, regulating the emotional arousal, and so on. If such attempts do not have the desired effect and patients continue with a flat or pompous style, then this should be challenged. In order for it to be rated, however, the episode must be long enough so that the observer becomes aware of it, which often means that he/she becomes a bit impatient and gets the impression that the group is wasting time or that the conversational style prevents exploratory mentalization. Examples of such interventions include the following:

“Earlier in the session I got the impression that we were rather focused on what we were talking about. Now it seems that some of that focus is gone. Have we lost our direction?”

“In the past 10 minutes it seems like we have jumped from one thing to the other, without really catching on to any one thing. Do you agree that it has been like that?”

“I am not quite sure that I understand what you mean by waves of energy between people. Is it possible to explain this by giving a concrete example?”

“I must admit that I could not follow you in your train of thought here. Earlier we talked about your tendency to use words and expressions that make it difficult for me to understand what you are talking about. I think we are in that mode of conversation now, or what do you think?”

Examples of poor competence include:

“The words are getting the better of you. It’s boring me.”

“These are just empty words.”

“Now you are intellectualizing.”

Guidelines for rating of quality

Low (1–3): The therapists ignore clear and clinically significant sequences of pretend mode. They follow up on patients’ pseudomentalizing mode of speech with seemingly interested questions and comments, and sequences take on a

character of pseudotherapy. Alternatively, the therapists confront patients in insensitive or humiliating ways.

Adequate (4): The therapists identify pretend mode sequences and intervene to improve mentalizing capacity.

High (5–7): The therapists point out pretend mode sequences in a friendly and sensitive manner, and do this by using various words and examples if the first intervention does not succeed. They invite a reflection on the phenomenon, for example, on when and why it started. If therapists do not succeed in obtaining a reflection on the pretend mode activity, they try other strategies (e.g., challenge) in order to establish a more meaningful dialogue.

Item 16: Handling psychic equivalence

Psychic equivalence is a term for a prementalistic form of thinking in which the individual has a tendency to equate mental phenomena with objective phenomena and vice versa. There is little difference between fantasy and reality. A perception about the world is mistaken for the world itself. Other people are supposed to think and experience things in the same way as that of the protagonist. Thinking about oneself and others is characterized by unwarranted generalizations and one-sided categories, such as “He is always bad” or “She is always good.”

Clinicians often characterize psychic equivalence as concreteness of thought: what is thought is real. Patients with BPD have an overriding sense of certainty in relation to their subjective experience. Experienced in the psychic-equivalence mode, even a passing thought feels real; no alternative perspectives are possible. Thoughts therefore have to be acted upon. Psychic equivalence suspends the “as-if” mode of experience. Everything imagined, sometimes frighteningly, appears to be “for real.” This experience can add drama as well as risk to interpersonal relationships, and patients’ exaggerated emotional reactions are justified by the seriousness with which they suddenly experience their own and others’ thoughts and feelings. The vividness and bizarreness of psychic equivalent subjective experience can appear as quasi-psychotic symptoms

As with pretend mode, this is a mode of thinking and relating that may characterize individuals to a greater or lesser extent, or it may be a mode that individuals resort to when feeling stressed or in an emotionally aroused state. In the latter case, interventions aimed at regulating psychic equivalence should target the emotional arousal level. In a state of emotional arousal, we all have a tendency to resort to psychic equivalence: “I am a failure . . .,” “Everyone is stupid . . .,” “Life is terrible . . .,” or “The entire world is just horrible . . .” Nuances, alternative interpretations, and the possibility of other perspectives are lost.

Similar to pretend mode, psychic equivalence is a position where no psychological development takes place. *Patients must therefore be helped to get out of*

this mode. This is easier said than done since psychic equivalence is a state governed by intense emotions. It is also a state of mind that can arise from—or approximate to—a psychosis. All therapists know that it is useless to challenge (in the sense of reality testing) a person in a state of paranoid delusions. Challenging psychic equivalence therefore requires great skill and empathy.

Psychic equivalence may be accompanied by attitudes of self-righteousness, absolute certainness, and arrogance that can be provoking. Therapists must be careful not to let their interventions be influenced by countertransference.

Psychic equivalence flourishes in therapeutic groups with poorly functioning patients and it is a major task to deal with this tendency appropriately. If assumptions based on psychic equivalence are not challenged, they tend to multiply or create more or less hidden alliances and subgroups. Taboos will develop. The group will behave as if there are catastrophes linked to certain individuals or previous events or themes in the group. Similar phenomena are described by Volkan (1998) for natural groups. They might carry a “chosen historical trauma” which becomes part of their identity formation. According to Volkan, the battle of Kosovo in 1389 carries such significance for devoted Serbs. Opinions about this battle are sanctioned. To challenge these opinions is a high-risk enterprise, not to mention the risk entailed in making caricatures of the prophet Muhammed. In therapeutic groups, it is as if group members know intuitively that certain phenomena are particularly rigid and guarded by vehement emotions and that one should better stay away from them. However, therapists should have the courage to approach the unspeakable and demonstrate that, when brought into the light of day, most episodes lose their power to scare.

An example of good handling of psychic equivalence:

Grethe turns up some minutes late. She realizes that the therapists have turned on the video camera for a recording for supervision purposes. In the opening phase, the therapists remark that Grethe in earlier sessions had signaled the need to talk in the group, but that other issues had been prioritized. Accordingly, she should have the first go. Grethe says yes, surely it's her turn, there are a lot of issues she had prepared herself to talk about, but now we should just forget it, it's impossible with the camera running. She displays pain and almost despairs, twists her body, waves her arms, and tries to cover her face. She catches the group's attention. Some fellow patients seem more comfortable with the routines of video recording. They acknowledge that it can be stressful, but they have accepted it and it has “to be lived with.” They wonder what the most difficult part is for Grethe. She answers “that is obvious” and “it's just impossible.” “It's impossible to talk when the camera is on.”

The therapists and other patients try, using different kinds of questions, to find out more about what this “impossible” is about. The therapists repeat previous information about video recordings and supervision and who the members of the supervision group are. Some patients say they understand how frustrating this is for

her since “she previously had given her time to others” and now was eager to get her share. One of the therapists says that she is tempted to turn off the camera. On the other hand, she says, the very purpose of the group is to understand and master strong emotional reactions to frustrating events in daily life. “And there’s where we are now, isn’t it? So, how can we understand it and help to master it?” Grethe responds, “No way!” The other therapist comments that Grethe is obviously in great emotional pain. However, it is as if she has got stuck in a corner, remains sitting there, and rejects all offers at help. He adds that there have previously been several similar scenes with Grethe in the group, and that it is important, not only for her, but also for the group, to find out what this is about so that she might be able to handle similar situations in the future in a better way. Grethe: “Yes, I’m like a 4-year-old. I’m stuck in my corner and I cannot get out of it.” Some other patients share experiences of being stubborn during their childhood and that they can recognize this rejection of others while at the same time just wanting to be included, to be in the warmth again, but that they could not manage it. “When that is the case, parents must not give in too!” someone says. Through listening to the experiences, images, and metaphors of fellow patients, Grethe seems to recover her ability to think and speak. She straightens herself up in the chair and gets engaged in the group discussion. After a while she takes the lead and starts to talk about her biggest problem with the group, which is her own strong reaction when perceiving signs from other group members that they aren’t listening to her, don’t like her, or don’t understand what she is talking about. By further exploration she explains that the main problem is not perhaps that she misinterprets other group members, but that she cannot accept different points of view, in particular if they have a “negative” valency. It’s “unbearable” that people might get bored while she talks. Therapist: “What is so unbearable about that?” There follows a lengthy discussion in the group with many illustrations from the group as well as to the video camera “which she cannot control.” The sequence ends by Grethe explaining, in different ways, that she has to train herself to endure the reality that other people can view things quite differently than herself and that they even may dislike what she is saying. She regards this session as some kind of “breakthrough” in this respect, “but it’s hard.” The sequence lasts for around 40 minutes.

In the example above, the other group members behaved as constructive “team players” with the therapists. At other times they may join ranks with “the weak” and express feeling such as “We should stop this; it’s just painful; can’t we just move on?” Or they can support a defensive maneuver, as in the following case:

Janet picks up on her theme of suspiciousness. There was a new episode this weekend. Somebody rang the doorbell at home and she believed it to be a friend of her son. However, it was a neighbor who was delivering the key to their joint bicycle shelter. She believed she was caught off-guard, talked too fast and strangely, and thereafter she thought: “Jesus, how stupid I was. Now he can see how far out I am and the neighbors will talk even more about me.” She describes a “bottomless” despair by having made a fool of herself once more, feeling hopeless and panic-ridden. In order just to do something, she

started to clean the floor violently. Later that night she asked her husband if they could not just move to their summer house for the season, it used to be so nice. When saying this she knew that she just wanted to escape from the neighbors.

Two group members acclaim: “Yes, that is a good idea, Janet.” “You are tired and need a break.” “Well,” the therapist comments, “it might be nice at the summer house during the season, but aren’t we talking about Janet’s emotional problems? Can we reach a better understanding of these problems here?” The group “stops and rewinds” and goes back to the scene at home: What happened exactly and why did Janet react as she did? The story gets more detailed and nuanced compared to previous episodes told in the group—the episodes that had provoked “unexplainable panic attacks.” The group members, as well as Janet, regard this as progress. Janet describes movingly how terrible it feels “to fall down in the cellar,” to lose the capacity to think and becoming beset by the thought of “getting away.” The other group members express their understanding and recognition and they discuss ways to tolerate and regulate strong emotions.

Another example of good handling:

Vera asks for attention. “I have an appointment with my individual therapist on Wednesday, but I have to talk about it here. I can’t stand it.” She tells a story, accompanied by a lot of tears and display of shame and guilt, about how she had made a fool of herself since the last session. Her main concern now is that she might encounter the people in question tomorrow, that they would see straight through her, and that everything would become public knowledge because she feels unable to do anything other than reveal her most secret thoughts. The therapists focus on the belief that other people might “see straight through” somebody and how terrible it might feel if one doesn’t have a private space inside, which is one’s own property and not available to others. The other group members get engaged and share similar experiences and Vera gets involved in a lively group exploration of such experiences and assumptions. Several group members emphasize their “right to own” their own mind and the importance of being able to contain and protect one’s most inner thoughts.

The most important factor for the destiny of psychic equivalence in groups is how the other group members respond. The wished-for course is that fellow patients, for example, in the aftermath of a therapist intervention, accept and empathize with the painful state of the protagonist, but challenge his/her accompanying beliefs. The last example illustrates such a course. On other occasions, we witness how fellow group members get recruited as supporters and allies in a crusade against some evil object or in a flight from an overwhelming danger. Theoretically we would then say that the protagonist has succeeded in engaging the group in a fight–flight mode (Karterud, 1989). If one studies such sequences in detail, one can often see how protagonists present a series of utterances about self and others, where each utterance is shaped by slightly unwarranted claims, which many would let pass, but which, taken

together, lead to conclusions with disastrous consequences. If one lets such a discourse develop, members might get trapped in a sort of conclusion which seems “natural,” based upon the (dubious) premises which have silently been accepted by the group. The previous example of Janet illustrates this. Several group members seemed to accept the premise that the neighbors were of the mean and gossipy kind, and that Janet “just had to get away.” The “natural” topic then became *how* she could get away. Group therapists have to deconstruct such discourses and, for example, return to the premises, preferably to concrete events. It should be said as simply as possible:

“Can we stop here? It seems that there is a big concern about how Janet can get away. However, the primary task for the group is to explore difficult emotions. Can we pick up this trajectory and go back to the situation where you, Janet . . .”

Guidelines for rating of occurrence

This item overlaps with item 12, “Challenging unwarranted beliefs.” All psychic equivalence involves unwarranted beliefs, but not all unwarranted beliefs are part of psychic equivalence. Some unwarranted beliefs are due to habitual thought patterns, lack of information, manners of speech, and so on, which make them easier to regulate.

Psychic equivalence can be reduced simply by having the patient calm down:

“Now I’m doing a bit better. I can see that I get rather one-sided when I get upset.”

Interventions that qualify for this item should be something more than the therapist’s ability to calm down patients. They should contain an explicit verbal statement aimed at a manifestation of here-and-now psychic equivalence:

“You say that no one in the group likes you. That’s strange. What do you base that impression on?”

“As far as I understood it, it was a comment from Linda at the student house that got you thinking that no one likes you. Is that right? . . . I agree with you that the comment, as you present it, sounds critical. But the fact that someone criticizes you, does that mean that they do not like you?”

“You seem convinced that the same thing will happen again so there is no reason to try. Can we look at this for a second? . . . Is it that you think you can’t handle situation X? Or that he will not be able to accept Y?”

“I hear that you say that it is impossible. Could you explain to me what the impossible is about?”

Examples of poor handling include:

“I must admit that this is wearing me out. I have suggested both X and Y and Z, but you just reject all of my suggestions.”

“I don’t know if I can help you. Whatever I say is wrong.”

“It doesn’t seem like we are getting anywhere with this. Maybe we should talk about Y instead?”

Guidelines for rating of quality

Low (1–3): There are clear signs of psychic equivalence functioning in the group, but the therapists deal with it as if it were the case, rather than accepting the painful emotions and challenging the adjacent beliefs. Alternatively, the therapists challenge psychic equivalence in a superficial or even condescending way.

Adequate (4): The therapists identify psychic equivalence functioning and intervene to improve mentalizing capacity.

High (5–7): In addition to level 4 competence, therapists keep to the key issues over time and devote much attention and energy to exploring the case by recruiting other group members. They intervene with tact, empathy, and creativity, and without signs of negative countertransference.

Item 17: Focus on emotions

All PDs are characterized by some kind of emotional dysregulation, and this is particularly the case with BPD. Emotion dysregulation concerns problematic emotional awareness, emotion tolerance, understanding of emotions, and the ability to adaptively express emotions. It is important to gain an accurate understanding of what the patient’s emotional problems are about. For some, it is about impaired access to emotions (awareness); for others, it is about the intensity of emotions, possibly combined with a poor tolerance. It could be that dysfunctional emotions are acted upon (e.g., intense feelings of jealousy or envy), that their inappropriateness is poorly understood, or there may be problems with finding a culturally accepted outlet.

In MBT-G, emotions are defined as a primary priority focus for the group. This is thoroughly explained in the psychoeducative group component, in the pre-group interview, and it is repeated explicitly during the course of the group. Every member should have received this message in different wrap-ups.

The item favors emotions here and now. “All” emotional reactions should be noticed, responded to, and explored when necessary. Group members do this intuitively much of the time. As we have emphasized in previous paragraphs, particularly significant reactions should be given the status of an “event” in the group.

We have also emphasized (cf. items 3 and 4) that emotions should be explored in their interpersonal context.

The item concerns the emotional “atmosphere” in the group. Sometimes this is clear to everyone, sometimes it is vague and beyond conscious awareness for

all participants. It is the task of the therapists to identify it and express it in words in order to make it available for joint exploration. Awareness of the emotional tone in a group depends on this double ability to read other minds appropriately and at the same time be aware of the resonance in one's own mind. Therapists may start to worry about certain group members, or about the group discourse, or about their own difficulties with thinking, without knowing exactly what this is about. Or there may be other kinds of experiences that alert the therapists and make them search for the underlying emotions. We do not require that therapists have nicely formulated hypotheses in their heads before intervening. They should express their own experiences, as something that belongs to their own mind and for which they take responsibility, but which nevertheless resonates with what is going on in other minds: "Let's try to find out together!"

Identifying emotions is an important step in MBT-G because it links general exploratory work, rewinding with clarifications, and challenge to mentalizing the transference. The aim is "to mentalize the emotions," that is, to give them a name, to bring them into a symbolized and reflective space, and to let them have an influence on the mind in a regulated way and in an intersubjective context.

Identifying emotions links to the concept of "marked response" in mentalization theory (Fonagy et al., 2002). Emotional confusion is ontogenetically rooted in flawed parental responses, for example, by neglect, incorrect attribution, or by being overwhelmed by the parental emotional reaction which, so to speak, "steals" one's own experience. By a "marked response," parents clearly point at the child's reaction and help in mentalizing it so that the child becomes able to own it as a proper emotional representation. The same should take place in MBT-G. The therapists survey the group process and halt and point to emotional events, if no one else does, and help in mentalizing what happened.

As for examples, we refer to the section "Identifying failures in mentalizing" (Chapter 2) where Terje becomes overwhelmed by emotions when he is helped to describe what triggered his feeling that "it went to hell." See also the example with Beate in the section "Engaging the group members in mentalizing events" (Chapter 2). Beate's experience of shame was so pervasive that it could hardly be owned.

Guidelines for rating of occurrence

Examples of interventions relevant for awareness of emotions include the following:

"What did you feel when X . . . ?"

"Did this generate other feelings as well?"

"It seems like you are reacting to what we are talking about. Tell me what you are feeling? . . . Is it difficult to say something about it? Is it primarily a type of

restlessness? . . . Try to concentrate . . . where do you feel it? . . . What do you associate with this feeling?

“It seems to me that something just happened between you two, Eva and Ruth. Is that so?”

Examples of interventions relevant for a tolerance of emotions include:

“What does that emotion do to you? . . . Does it make you nervous? . . . Afraid that it might overwhelm you? . . . What would happen if it became very intense? . . . You perhaps wonder how people in the group would react?”

“It seems to me that there is a connection between the fact that you were feeling X last night and that you started drinking. What was it about X that was difficult for you to accept?”

“How much of your emotions do you believe we can take, here in the group?”

Examples of interventions relevant for understanding emotions include:

“It seems like sadness is a feeling that you try to avoid. It’s as if you quickly have to get rid of it when you notice it coming over you. You have talked about how it does something to you that you don’t like. That you feel pathetic. Can we talk a bit more about that? Sadness is a feeling that most people experience. It is a natural reaction to losing something.”

Examples of interventions relevant for expressing emotions include:

“What would be a suitable way for you to express these feelings, do you think? . . . I am thinking in relation to X in particular. How much do you think he/she can stand?”

“How strong do you believe your emotional message need to be, in order for you not to be misunderstood?”

Examples of interventions that are relevant for the group as a whole include:

“Is it a bit slow here today?”

“Any thoughts about the mood in the group today?”

“It seems to me that there is some irritation in the air. Is that so?”

“How come there is still some tension between you two, Linda and Peter?”

“What’s it like to talk about this here?”

“Yes, I’m smiling. . . . No, it isn’t because I’m laughing at you. Quite the contrary, I think it’s nice to listen to you when you talk about things the way you are doing now.”

Of particular importance in this process is working in detail. Therapists should not accept generalizations about emotions but try to explore the feelings in detail in relation to the movement in an interpersonal interaction described by patients. It is not enough, for example, to accept that the patient felt hurt during an interaction with his/her boyfriend. It is necessary for therapists to explore exactly what it was that led the patient to have the feeling he/she describes—it is something about *how* the boyfriend said it, *what* he was saying, or was it

something *about* what he was saying, for example. The therapist can then move the patient forward “frame by frame,” as it were, so that important features are not missed. Clearly this should be done sensitively and the therapist should desist if the patient is finding it difficult; for example, many patients with BPD find it hard to identify emotions, but the principle of exploring mental detail in relation to the interpersonal event should not be lost.

Examples of interventions that are relevant for emotions and interpersonal transactions include:

“You seem a bit on edge today, I’m wondering how you are doing . . . So you’re quite irritated then? . . . When did it start? . . . So it was the encounter in the hallway with patient Y from the group that you reacted to. . . . What happened between the two of you? . . . You felt that she ignored you, is that what you felt? . . . What was it that she did or didn’t do that made you feel that way? . . . How did you react then? . . . Do you have any thoughts about why she behaved the way she did?”

“We should look at the incident that happened yesterday morning in a bit more detail. Tell me from the start, what happened exactly? . . . You were talking on the telephone. . . . So it was when your mother said “That’s obvious dear” that you reacted. . . . As far as I can understand, it made you feel discouraged, disappointed, and irritated . . . A range of different affects. Previously these feelings have made you withdraw from the conversation, but this time you tried to deal with what she said. How was that?”

Since patients with PDs often carry a history of emotional abuse, many will be quite confused as to what counts as “normal” emotional responses. In groups, it might transpire that emotions are clarified as well as the intersubjective transactions and the context, while the protagonist still questions whether he/she had a “right” to such emotions. It concerns the right to own certain feelings or if one is prohibited from having certain feelings, or if it’s only a waste of time to feel X or Y, or if one has the right to express feelings X and Y, or if somebody might be hurt by one’s feelings, and so on.

Such questions, which often become voiced near the end of a sequence, are good “thought food” for the group. There is seldom any need for the therapists to introduce any scale of “normality” with respect to emotions. Fellow group members usually have lots of opinions about such matters. The therapists can restrict themselves to the job of modifying grossly unwarranted opinions if they seem to influence the discourse. One should be careful not to confuse the not-knowing stance with not-knowing in questions of normality, normal range, and morality. The answer to the question of if one has the right to feel damaged, in despair, or mad at being sexually abused, is a clear and simple: “Yes.” It belongs to a “marked” response that therapists acknowledge that patient’s reactions are comprehensible, that the therapists take them seriously as valid reactions, and

that they often are shared by others under similar circumstances, that is, that they are “normal” in that sense.

Interventions that concern the issue of “normality” might include:

“You ask me about my opinion, if you have the right to feel this way. Let’s first go through it in detail once more and let’s involve others here in the group, and then we can return to your question.”

“What do you think? Did Tom have any good reason to react?”

“Yes, I believe we might label this as jealousy. . . . Sounds like it’s a feeling you have found hard to accept. I can understand it might be unpleasant. On the other hand it’s part of being human.”

“Yes, I too believe you react somewhat more strongly than most people.”

“You wonder if you react too strongly or not enough. Any thoughts about this in the group?”

“So, you didn’t feel anything after having kicked her down. Too me that sounds strange. What are your thoughts about this now?”

“Yes, it seems to me that you have good reasons to react to this.”

“I think most people would become angry in a situation like that.”

Other relevant interventions include:

“Yes, I smile, but’s not because I’m laughing at you. On the contrary, I find it nice and amusing when you talk the way you do now.”

“I’m not quite sure, but I got the impression that something happened between us some moments ago, and I wonder if you reacted to something that I said.”

“You, Robert, didn’t turn up last session. . . . Something affecting you from the session before? . . . OK, so you felt ignored and misunderstood. Let’s go back and discuss what happened.”

“You say that you don’t feel welcomed in the group. Can we find out where that’s located?”

Examples of interventions with low competence include:

“I don’t think you should control those feelings. Tell him straight out what you feel!”

“Yes, I hear and see that you are sad, but what you are actually feeling is a rage because you were dumped, but you just don’t want to admit it.”

“You are asking whether you were right in feeling ignored in this situation. That is not easy to answer. It was a rather complex situation and your perspective is just one of many possibilities. Besides there is a group dynamic going on here . . .”

Guidelines for rating of quality

Low (1–3): The therapists do not focus on emotions in the group. To the extent that patients talk about or show emotions in the here and now, it is not noticed or commented upon. The therapists focus on emotions, but only in a cursory way. The therapists misunderstand the patients’ emotions or misunderstand the

kind of problems patients have with particular emotions. The therapists encourage patients to reveal dysfunctional affects. The therapists identify with emotional states rather than mark and explore them, or they display exaggerated worry about emotional display in the group.

Adequate (4): The interventions focus primarily on emotions—more than on behavior. The attention is particularly directed at emotions as they are expressed in the here and now in the group, and particularly in terms of the relationship between patients and between patients and therapists.

High (5–7): The therapists' interventions are to a large extent directed at the patients' emotions and they cover many aspects of emotional processing: emotional awareness, tolerance, comprehension, expressivity, and intersubjective transformation. The therapists are able to explore different emotions in multiple contexts, pertaining to the self, to others, to the here and now, to the group, and the relationships between patients in the group as well as between patients and therapists.

Item 18: Stop and rewind

“Stop and rewind” has been alluded to in several previous examples. It often concerns getting more control over the group and the process and it presupposes a modicum of authority. It is a technique that is particularly relevant when “things are going too fast,” for example, when patients race through a story, often in an emotionally aroused state of mind, “jump to conclusions,” or when transactions in the here and now are fast and turbulent. Therapists should try to slow down the pace of the discourse, both for their own sake and for the sake of the patients. It is important to try to understand the details in situations that have taken an unpleasant or destructive course. Therapists should invite patients to engage in a detailed review of the events. This is particularly important when the therapists observe a decline in mentalization in one or more patients or in the group as a whole. It might be conflicts, quarrels, or withdrawal from a former protagonist, or that the group as a whole has adopted a fight-flight mode, or a decline into pretend mode. The therapists invite the members to pause, to regain their ability to reflect, and to find out where, when, and how the discourse deflected.

This item may sound simple, rather banal, and not so significant, but it is very important and many group therapists would do better if they adopted it more frequently.

For an example of good performance, see the vignette with Åse in “Introduction: The mentalizing stance” at the start of this chapter. Åse held that the therapists had made her sound like a racist. The therapists rewound and mobilized the group in a conjoint exploration.

Guidelines for rating of occurrence

Among the interventions that count for this item are the following:

“Please let us stop for a second, this is going a bit too fast for me. Something happened between you, Tom and Clara. What was it?”

“I’m getting a bit breathless and my mind is racing. Can we just go back to . . . ?”

“I’m sorry, but I’m not able to keep up with you now. Everyone is talking at once. Could we sort this out in a more orderly fashion?”

“I think I lost you. Can we go back to X? Or where was it the entire thing started? Can we go a bit more slowly now, step by step? So it started when you began scrolling through his mobile telephone, is that right? Or did it start earlier?”

“I see. Now I think I’m beginning to understand a bit more. You had been looking forward to showing her this video recording that you made on Sunday with the music that you had composed. What happened then? She simply didn’t want to look at it? . . . Not at all? Did you hesitate to ask her then? . . . So that was what you meant when you said that she should have taken the initiative? . . . How did you know that she didn’t want to look at it?”

Guidelines for rating of quality

Low (1–3): There is at least one incident in which patients react in a maladaptive way to an interpersonal event without the therapists stopping, trying to slow down the pace, or trying to recruit the group to look closer into the incident. The competence is rated somewhat higher if the therapists at least stop and make an attempt, but then give up too soon.

Adequate (4): The therapists identify at least one incident in which patients describe interpersonal events in a noncoherent and affected way, try to slow down the pace, and find out about the event step by step. In a similar way, the therapists halt events in the group that tend to be destructive and take the initiative to explore the sequence together with the patients.

High (5–7): As above, but in a more convincing and empathetic manner, the therapist shows a great deal of understanding for the various elements in the sequences and explores them extensively, taking a lead in keeping the patient focused.

Item 19: Focus on the relationship between therapists and patients

In MBT-G, patients are explicitly asked to attach themselves to the group and its members. This adds to the automatic processes that are set in motion within a helper–helpseeker relationship. The relationship to the therapists becomes important and laded with emotions. However, in MBT-G, there is this general focus on interpersonal transactions, and the relations to fellow group members

are exploited for all their worth. The relation to the therapists is therefore not as paramount as it is in individual psychotherapy. One might say that the “transference becomes diluted.” The practical arrangement adds to this “dilution.” In individual psychotherapy, there are two people who are in a constant intersubjective transaction throughout three-quarters of an hour. In group psychotherapy, the individual members oscillate between participant and spectator roles. For some patients, relatively few words will be shared with the therapists during a group session. However, the therapists are under constant surveillance as to what they do and what they don’t do.

The relationship which each patient develops towards the therapists is characterized by a combination of rational, collaborative elements, and irrational elements that are remnants of earlier problematic object relations. Patients are therefore disposed towards experiencing and interpreting the therapists in distorting ways. The latter is what is usually labelled *transference*. In groups, it is even more difficult than in individual therapy to determine what counts as transference in the strong sense, and what are rather plausible reactions in a complex and ambiguous (group) situation. This adds to the arguments for being cautious with transference interpretations which aim at generating insight and connecting the past with the present. Transference interpretations in groups carry the risk of invalidating the significance of the here and now. What the patients risk hearing is:

“Attacking me in this way has nothing to do with me or my behavior, it’s because you are mad at your father.”

Typical transference interpretations in groups for borderline patients may exert iatrogenic harm. They often sound speculative and risk deactivating the patients’ competence.

We therefore coined the phrase “mentalizing the transference” which could equally be termed “mentalizing the relationship.” Mentalizing the transference is a shorthand term for encouraging patients to think about the relationship they are in at the current moment (in this case, the therapist relationship) with the aim of focusing their attention on another mind, the mind of a therapist, and helping patients to contrast their own perception of themselves with the way they are perceived by others, by the therapists or indeed by members of the group.

In short, this means that transference phenomena are not interpreted in light of the past as in the following example:

“You have difficulties accepting anything good from me because I remind you too much of your father to whom you are in constant opposition.”

Transference phenomena should be dealt with as current phenomena that are difficult to understand by themselves:

“Several times recently I have noticed that you have rejected what I have suggested. You seem to have good arguments, but it seems also as if you have become more critical of me. Is this an accurate perception? . . . Is it possible to find out more about that? . . . Can you tell me more about what is irritating you? . . . Is it something about the way I am expressing myself? . . . If I understand you correctly, you have got the impression that I am somewhat authoritarian and that I care about you as though you were a child which you don’t like. Let’s look at the authoritarian aspect first. What is it about me that you find authoritarian? . . . I understand what you mean, but is it possible to look at this from a different perspective?”

As evident from the above-mentioned example, transference phenomena are dealt with the same way as unwarranted beliefs are dealt with (item 12). They are highlighted in an attempt to establish them as objects of joint attention, and then explored using MBT approaches.

We have set out a series of steps to be followed although not all of them need to be present in order to rate this item on a satisfactory level. However, therapists need to demonstrate an ability to explore the patient–therapist relationship, linking some of the following steps:

Our first step is the validation of transference feelings through exploration. The danger of the generic approach to transference is that it might implicitly invalidate the patient’s experience. MBT therapists spend considerable time within the not-knowing stance, verifying how patients are experiencing whatever they say they are experiencing.

This exploration leads to the next step. As the events which generated the transference feelings are identified and the behaviors that the thoughts or feelings are tied to are made explicit, sometimes in painful detail, the contribution of the therapists to these feelings and thoughts will become apparent. Therapists should acknowledge the ways in which they may have contributed to the patient’s experience.

Most of the patient’s experiences in the transference are likely to have some basis in reality, even if they only have a partial connection to it. We refer to previous discussions of the theme “enactment.” It often turns out that therapists have been drawn into the transference and acted in some way consistent with the patient’s perception of them. It may be easy to attribute this to the patient but this would be completely unhelpful. On the contrary, the therapists should initially explicitly acknowledge even partial enactments of the transference as inexplicable voluntary actions that need to be explored and for which they accept agency rather than identifying them as a distortion of the patient.

Authenticity is required to do this well. If the therapists really cannot identify some aspects of themselves or their actions that might have been involved in creating the patient's experience, then they should suggest that they hold alternative perspectives and that the question remains open for future exploration. Drawing attention to therapists' contributions may be particularly significant in modeling to patients that one can accept agency for involuntary acts, and that such acts do not invalidate the general attitude which the therapist tries to convey. Only then can distortions be explored.

The final step is collaboration in arriving at an alternative perspective. Mentalizing alternative perspectives about the patient–therapist relationship presuppose the general mentalizing stance which permeates MBT. The metaphor we use in training is that the therapists should imagine themselves sitting beside the patients rather than opposite them. Sitting side by side, looking at the patient's thoughts and feelings, all parties should try to cooperate by the mentalizing stance.

Exploring the patient–therapist relationship is a demanding task. It is intimate and sensitive. It presupposes a well-established alliance. In MBT-G, the therapists are initially supportive, pedagogical, and containing. Mentalizing the transference is something that can be gradually addressed when the therapy is well underway and the patient is reasonably stable. In the therapy's early stages, however, therapists can still comment on what are called “transference traces,” which is a term that refers to attitudes relating to earlier therapists, health services in general, the treatment program as such, and so forth (Bateman & Fonagy, 2006). Examples of this type of comment include the following:

“You told me that in previous therapies everything used to start out fine, but then it was as if the therapist would lose interest in you for some reason. You would then become disappointed and would stop talking about what was most important to you. Then you would quit. We should be aware of that kind of development, so we can possibly avoid it this time.”

“You told me that you have often been misunderstood by people in the health services. It is important that you tell me if you feel the same thing is happening here with me.”

The relationship between patients and therapists includes *countertransference*, that is, the therapists' emotional reactions towards their patients. The technical use of countertransference in MBT borrows heavily on the work of Racker (1957), who distinguished between complementary and concordant countertransference.

Complementary countertransferences are emotions that arise out of the patient's treatment of the therapist as an object of one of his earlier relationships, and are closely linked to the notion of projective identification. This leads to countertransference experience of the therapist being considered as part of

the patient's internal state and technically leads many therapists to place the experience they themselves are having back with the patient. This is avoided in MBT. Why? Countertransference experiences are most commonly associated with turbulence in the patient's mental state; asking the patient to consider their feelings in the context of a theoretical projection of emotion onto the therapist will overwhelm their precarious state of mentalizing just at the time when they need mental support, as in the following examples:

"I am noticing an increasing frustration over our relationship. I think it may be because you unconsciously want to undermine the therapy and that you therefore are behaving in a way aimed at provoking me to say that therapy is getting nowhere and that we'd better end it now. Then you could leave as a victim, a role that you seem to be quite comfortable with."

The therapist, experiencing himself as becoming confused and then bored, states to the patient:

"It strikes me that you have been feeling confused and are now rather bored. In this way you escape remaining feeling so confused."

In contrast, concordant countertransferences are empathic concordant responses, based on the therapist's resonances with his patient. Concordant countertransferences therefore link with affective attunement, empathy, mirroring, and a sense that certain aspects of all relationships are based on emotional identifications that are not solely projections. Stern's (1985) "affective attunement" between mother and baby, and, by extension, between patient and therapist, is a different way of explaining such interactions, involving as it does the ability of the mother (therapist) to "read" the patient's behavior and respond in a complementary manner, which is in turn "read" by the child (patient). Technically, in MBT, countertransference experience is used with this understanding in mind.

Countertransference is stated as the therapist's experience, that is, it is "marked." It is not considered initially as a result of projective identification and the therapist must identify the experience clearly as theirs. The simplest way to do this is to state "I" at the beginning of an intervention. Intriguingly this seems to be hard for therapists who understandably worry about violating boundaries of therapy. Yet we are not suggesting that therapists start expressing their personal problems or start talking about any feeling that they might have in a session whether relevant to the process or not. Rather we maintain that the therapists' current experience of the process of therapy has to be shared openly to ensure that the complexity of the interactional process can be considered. Patients need to be aware that their mental processes have an effect on others' mental states and that those, in turn, will influence the direction of the interaction.

There are a number of common countertransference experiences for therapists when treating patients with BPD which are associated with particular modes of psychological functioning. Gradually therapists need to become comfortable with managing these states of mind and be able to express them constructively in the service of extending the patient–therapist collaboration. Many non-mentalizing states of mind are indicated by the actual behavior of the therapist who for a considerable period of time may be unaware that their actions are changing. Therapists who only grunt as the patient talks and clearly lose concentration are often being affected by pretend mode functioning in the patient; therapists who start to give suggestions about how to solve problems or who tell the patient what to do without exploration are likely to be involved in teleological process; the confused therapist who nods wisely is more often than not struggling with understanding what is being said and is trying too hard to understand psychic equivalent modes of thought. In all circumstances the therapist, once alerted by a change in their behavior, should focus more carefully on their feelings and identify them.

To reiterate, the expression of the underlying feeling of the therapist is a useful tool in therapy if done openly and carefully marked. It is “owned” by the therapist to ensure that the patient is not overburdened with emotional responsibility. Implicitly telling the patient that they have created the feelings in the therapist *increases* the mental work required from the patient just at the time when their mentalizing is in danger of being lost, thereby inadvertently increasing the likelihood of this outcome.

When it comes to countertransference, it is important to find a form through which this can be expressed without humiliating the patient. This applies particularly to negative countertransference. There is no point in uttering: “I get exhausted listening to you.” Instead, it should be something more like: “I am beginning to notice that I have lost interest in what you’ve been talking about the past few minutes. I think we need to stop for a second to find out why.”

The use of countertransference can be an extremely powerful tool. Just as with transference, it is a tool that the therapist should be careful in using in early stages in therapy. It will become more appropriate as the course of the therapy develops.

Managing one’s countertransference is fundamentally important for maintaining one’s own mentalizing ability. In group supervision, when asking why therapists did not intervene in certain situations, one often hears that they felt paralyzed and totally occupied with handling their countertransference internally: “I was so perplexed,” “I was just out of my mind,” “I really didn’t know what to do,” “I got so enraged that I just had to shut up,” “I tried, but everything sounded weird in my mind and eventually I didn’t even manage to think.” We

know that it is demanding, and particularly since there is no tradition for this, but we recommend that therapists in situations like this reveal their states of mind. We believe such a policy has large modeling potentials. In such situations, one may lean on the co-therapist for support and use him/her as a means to regain one's mentalizing ability.

The relationship to the therapists is mentioned in several previous examples. As for poor performance, we refer to the vignette about Brita ("Item 5: Identifying and mentalizing events in the group") who pours out a stream of complaints, making the therapists defensive and compliant instead of exploring what happens in the here and now. See also the vignette about Lise ("Item 6: Caring for the group and each member"). Lise's transference towards the male therapist became too strong and "realistic." The alliance fragmented and the treatment had to be terminated. As for good performance, see the vignette about Kari ("Item 5: Identifying and mentalizing events in the group").

In the following example the therapist acknowledges his own part of a piece of muddled communication and thereby stimulates the interest of fellow patients:

The group talks about a hot issue, immigrants and terrorism. Helena is the only member in the group who has an immigrant background. She is also a quite new member and her history is poorly known. One of her problems is a tendency to dissociate when interpersonal tensions arise. The therapist addresses her and asks in an overly complex way if the current theme in the group is more sensitive for her than for the others. She listens and replies that she doesn't quite get what the therapist is wondering about. The therapist repeats himself, again rather clumsily. Helena repeats that she doesn't understand, but that it might be because she is not attentive enough, since "she often switches off" when people talk. The therapist responds that it might be possible, but this time he believes that part of the problem resided in him. When talking about it, he realizes that actually he knew very little about her background and that he might have been vague because he didn't want to hurt her by revealing his ignorance. This comment triggers interest among the other patients. What is her country of origin? Is she a first- or second-generation immigrant? What about her parents? Does she experience herself as "equally Norwegian" compared to the other members in the group? Through this sequence, Helena becomes better integrated in the group.

Guidelines for rating of occurrence

The following types of interventions can be included in this item:

"And now, I get a feeling that I'm pushing you." "Yes, you are!"

"How are you in the group?"

"Does the same apply here in the group also, in relation to the therapists? . . . No? . . . What is the difference do you think?"

"At the end of the last group session, things went a bit fast and I got the impression that you didn't like how I terminated the group since feelings were still quite

heated. . . . I'm not sure if I'm right. . . . How do you feel about it now? . . . So you contemplated not coming to the group. . . . I'm glad you came. . . . What exactly was the worst part of this?"

"You mentioned a second ago that you think I am disappointed with you. How did you come to that conclusion?"

"That was nice to hear."

"If I am disappointed in you? Hmm, . . . no, I don't think so. I do feel a bit frustrated, though. I'm frustrated that we weren't able to find out more together during the last session. But maybe we both see things a bit more clearly now?"

"This was a tough story. I'm touched by it. What feelings does it stir up in other people here?"

"I must admit that I'm a bit confused here. What about you, co-therapist?"

Examples of low competence interventions include:

"No, I have a professional attitude about this kind of thing. The fact that people hurt themselves doesn't affect me anymore."

"Maybe it is you who feels bored and that is why I have begun to be bored by the session."

"When you were growing up you were used to getting things the way you wanted by expressing strong emotions. You are now doing the same thing here, but you probably have noticed that it won't work."

Guidelines for rating of quality

Low (1–3): The therapists do not comment on how patients relate to the therapists during the session, even though it would have been relevant. The therapists ignore obvious transference phenomena, seriously misunderstand transference phenomena, or interpret transference in a rigid manner as simple repetitions of the past. The therapists display obvious indications of being emotionally aroused, or they are exposed to situations where most people would do so, but don't comment on their own reactions. On a somewhat higher level, the therapists may comment on the relationship, but in a rather superficial way.

Adequate (4): The therapists comment on and attempt to explore—together with the patients—how the patients relate to the therapist during the session and stimulate reflections on alternative perspectives whenever appropriate. The therapists speak about their own feelings and thoughts, related to the patients, and in this way they try to engage all parties in mutual exploration.

High (5–7): In addition to level 4, the therapists comment on and explore several aspects of the therapist–patient relationship and link this to themes that are highly relevant for the patients and the group and this performance is a significant part of the group process.

Transcript of a mentalization-based group therapy session

Introduction

In the following chapter, we present a complete transcript of an entire group session in order to give the reader a better feeling of what MBT-G looks like and how the rating scale works. All interventions by the therapists (T1 and T2) are rated for adherence. At the end of each intervention there are one or more notations that indicate the appropriate item: A-1, A-2, etc., means “adherence item 1,” “adherence item 2,” etc. Some interventions do not receive a rating because either they are too short (e.g., “Hmm”), or they do not comply with any item (e.g., counseling).

A summary for each item follows the transcript, including ratings of quality, and finally a rating profile.

The group belonged to a MBT program, implying that the patients also had received 12 sessions of psychoeducational MBT-G, as well as weekly individual MBT in the first year. The individual therapy was less frequent in the second and third years. Mean treatment time in this group was around 2 years.

The group had eight members. Three members were absent from this particular group session; two of them had sent messages to say they'd be absent. Before the video camera was turned on, the group was told about the absences and the members signed a declaration of consent for publication. All patients were female and their fictive initials are: A, C, K, M, and Å. They had been members in the group for various lengths of time, from 6 to 24 months.

There is a prehistory which the reader should know in order to understand the content. This session was the second session after the summer break of 2011. At the first session, the group used half of the time to discuss the terrorist attack in Utøya, Norway, on July 22, 2011, when 69 young Norwegian political activists were massacred. At this meeting, patient Å said that she found the mass media reports of the event so terrible that she had to turn off her TV and could not read any newspapers. She also reported strong fantasies about Utøya, for example, what she might have done if she were present. T1 was worried

about patient Å's reality testing and asked her if these fantasies almost were confused with reality. Patient Å felt misunderstood during this exchange and it is referred to during a sequence in this group session.

The transcript

T2: Last time we spoke about the disaster of 22 July and other things as well. There have presumably been some thoughts and feelings in the aftermath? I suppose it also has been discussed in the individual sessions. (A-2, A-11)

A: I have many feelings around it, not only 22 July, but from the last group session.

T2: So you have something you would like to discuss around this issue? (A-2, A-3)

T2: Someone else? K, there were some you knew . . . (A-2)

K: They are doing fine now.

T2: What about you, Å? (A-2)

C: I had some thoughts when we left, but they have not disturbed me much. We are different, emotionally.

Å: I am embarrassed by who I am, that I'm not like others, it is as if I'm an actor, I pretend, pretend that I am like other people.

T1: Mm, are you referring to what happened last session? (A-11)

Å: It concerns feelings in general, I dismiss them. I know I do. I let them come when I am alone. I never show them to other people, even if I'm in deep trouble, so other people will not know.

T1: That's a theme which is fine to explore here. (A-7)

T2: Then we have two themes here, and you should get some space. (A-2, A-3)

Å: And I'm hospitalized again, he, he.

C: Here?

Å: No, at another place.

C: You should talk about it. Why, what has happened?

Å: Nothing has happened.

T1: Yes, we are curious. (A-11)

C: And I wonder why.

T2: Have you two something else which you want to talk about today? (A-2, A-3)

K: I could talk about anger.

T1: Mm, yes, that's a good theme. (A-7)

T2: Now I've become curious. (A-19)

C: I have some small stuff around flipping out and mentalizing poorly, something from yesterday, relating to my boyfriend. It's ok now, through with it in a way, although I feel . . . It was bad mentalizing, I went from zero to ten within a second.

[Group laughter]

C: Could have tried to stop at five.

T2: What happened? (A-11)

- T1: Shall we take that later? (A-2, A-7, A-9)
- T2: Yes, I realized it could be misunderstood. I wanted to say it could be a theme for you. (A-3, A-9)
- C: It's about a deep relation. I'll wait, until after "anger."
- T2: It's an advantage being in a small group. Everybody will get their time. So, who will start? (A-2, A-3, A-7)
- K: You, A, were the first . . .
- A: It's possibly a bit about anger, I don't know. It was last session . . . there are so many feelings on top of each other . . . well . . . I reacted when the two of you said something to me, I don't quite remember, "You have to understand" or something.
- T1: The two of you, who?
- C: It was not aimed at you, it concerned understanding . . .
- T1: Just to clarify this, the two . . . was it K and . . . ?
- A: Å.
- T1: OK, what did they say? (A-11)
- A: I don't remember what they said, it was the manner.
- Å: Yes, but . . .
[Patient M comes in]
- T1: Hello [greeted patient M]. (A-1, A-6)
- A: I don't want to speak about what, that's insignificant. The point is that both of you looked at me and said something, "but can't you understand," or something like that. When someone talks to me in that manner, especially if there's more than one, I get lost, and that's the point, not what they said. I only got that feeling, and then the group was about to end, and then you, T1, said "OK, well . . ." and was about to explain something, and I just sat there, ah awful . . . [hides her face in her hands], and then it was over. I reacted strongly, but it was not recognized.
- T1: Ok, so you . . . it was right at the end of the group, and I did not recognize your feelings, is that what you mean? (A-11, A-17, A-19)
- A: Yes, I felt it a bit like that.
- T2: Yes.
- A: Even if . . . perhaps it was not like that.
- T1: Yes, but I think you are right that I overlooked it. (A-14, A-19)
- Å: I have actually thought about it and I feel bad about it.
- A: You should not, since this happens in everyday life, with all kinds of people who might be irritated at me, or at someone else, and who talk to me in a strained manner, and then I react. So it is nothing to do with you. You did no wrong. I must learn to cope with that in a way.
- T1: Let's clarify, you say that when C and Å talk to you in a certain manner, something happens with you, which expression are you using? It's like . . . you used an expression . . . (A-5, A-11)
- A: I don't know.
- C: Against you in a way.
- A: I felt attacked.

- T1: You felt attacked, yes. (A-17).
- A: And I know I am not . . . mentally. I am fully aware of what happens in the situation, but I cannot control my feelings, and therefore I often get very angry. When this happens I can say “but don’t get so angry at me,” but actually I did not believe that you were angry at me. In this way I can start quarrels.
- T1: Yes.
- T2: I think you describe it very well. I too remember that episode. It seems that you have been able to reflect upon it afterwards. You others here, do you feel you understand what it’s all about? (A-4, A-14)
- Å: I reacted because I felt that people misunderstood me, and it was tough, because I felt that I was considered a total idiot. I never speak loud, but then I actually cracked, because I felt . . . OK . . . listen, I felt that I had tried to say something, but I was not understood. I never raise my voice, but just then I did.
- A: I believe it was why I reacted, because you never act like this. And then you did, and I felt . . . I actually got very sorry.
- Å: I’m always in control, but . . .
- A: You did not frighten me, but I get sorry when people get angry at me.
- T1: Mm, hmm.
- A: And then I felt misunderstood, because I did not think it was stupid, I only did not understand. I tried to pose some questions since I did not quite understand you. I felt the same as you C, that it was strange that you could think like that, because I disagree, because I value you a lot, I cannot understand how you can think like that.
- Å: Yes . . . there is something inside me in a way, it’s like . . . I believe I also have another problem, I believe when people say things like that, that they don’t understand, that they say it only to be nice in a way, and that might irritate me, when people says nice things to me, because I don’t believe it, and I get like: Ah, stop this bullshit.
- T2: So you were somewhat irritated last session? Because you [looking at A] felt that people were angry at you. However, it was not quite so, could it be . . . (A-11, A-17)
- A: That was not my point. I understood that Å was irritated or angry there and then, but essentially it does not concern me if people are angry at me or not, the problem is that I perceive it like they hate me, but I want to be able to endure and cope with people even if they are irritated with me.
- T1: Yes, it is convenient to be able to handle such things. Everyday life becomes much easier. If I had said “Pull yourself together, A,” that would have been . . . (A-7, A-11, A-17)
- A: Yes, if you say it like that.
[Group laughter]
- T1: [Laughs] Yes, and I would not . . . but you seem very sensitive to criticism and anger towards yourself. (A-17)
- A: After some drinking I often get angry and mad, not violent, but radiating violence maybe. Well, I want to be violent, and I have been it too, and I may . . . well I don’t know, yes I get very angry if someone does something that . . .

- T1: How should we help A with these problems? (A-4)
- M: Are you talking about the things at Utøya [from July 22]?
- T2: Yes, you were a bit late. Can somebody clarify for M what we are talking about? (A-6)
- M: Something from the last session?
- C: Yes, from the last session, right at the end.
- M: When we talked about those Utøya things.
- C: Mm.
- M: OK.
- C: We are talking about feelings, about reacting when there is disagreement and feelings when the atmosphere is somewhat . . .
- M: OK, I did not perceive at all that somebody was irritated.
- C: I did. I was a bit irritated myself. There was a lot that I did not understand.
- M: Well, that I can see . . . Anyway . . . I'm with you.
- T2: Interesting . . . perhaps we are different with respect to sensitivity for irritation. T1 also said that he did not perceive that A reacted emotionally towards the end, and you did not either. Maybe we are different as to how sensitive we are towards each other in the group. (A-9, A-17, A-19)
- M: I can express myself in a rather aggressive manner even though I am not aggressive, so perhaps I'm not very good at picking up the nuances in other's speech, I'm not quite sure how well I remember it.
- Å: I recognize myself . . . like the way you felt it, since it was that which made me, ugh . . . just . . . yes, then I felt that everybody just hated me.
- T1: Here in the group?
- Å: Yes.
- T1: OK . . . well . . . you have announced this as a theme in itself, but let me just clarify this, I did not hate you. (A-2, A-16, A-17, A-19)
- A: Not me either.
- C: It is so easy to say, that since you feel that people disagree with you, that they hate you.
- Å: Yes, but . . . it is this . . . that I have trouble with displaying feelings, that I laugh when things get tough. I'm so ashamed by it, actually, but it's hard to change it, because I don't like to display that side of myself. I prefer to hide at home, but when people don't understand that I actually have feelings, then I feel like evil, in a way . . . I feel somehow that I have the feelings inside me, I feel sad and the like, but . . .
- T1: Yes . . . but, should we stick a bit longer with A's experiences? You are expressing yourself quite clearly, A. So, the question for us now is, how can we help you with it? You state quite clearly that you wished you were somewhat more robust, that you could endure more, isn't that so? (A-3, A-7, A-11, A-17)
- A: Yes, but I do not quite understand why I react with such an insane explosive rage if anybody, let's say my boyfriend, gets a bit irritated at me. I can get so angry that I want to crush him, and then I start a quarrel and respond in an aggressive voice.

T1: So you blow it up . . . if anybody gets irritated or aggressive towards you, you expand on it? So it will spiral upwards instead of you trying to level it out? (A-11, A-17)

C: Yes, it seems like attack on attack, isn't it?

A: Yes, that's in a way the strategy.

T1: So that's the strategy.

C: Yes.

A: Hit back twice as hard, to crush the enemy.

T2: Yes.

T1: Mm.

C: Instead, perhaps, to halt and take a time-out and try to listen to what he actually is saying.

A: Yes . . . yeah . . . "Let's sort this out."

T1: There you are! (A-14)

T1: [Laughs] It seems to be there, but it's hard to do it. (A-14)

A: It's like a reflex.

C: There is a pattern here, a track which you are used to, emotionally.

M: There is something here, I have also trouble with accepting critical remarks, because I often accept it too much in a way, because I am so self-critical, and can think that yes, he is right. But I hesitate to accept it, that that's the case. With me too, attack can be the best defense, instead of just saying, yes, I agree, see your point, sorry, or something.

A: But how can one change such reactions, emotionally?

C: Difficult, very difficult.

A: Yes it is, I'm there 80% of the time.

M: Well, I've noticed that it is easier to stop it and avoid that impulsive blow out if things are more orderly around me, in a way, if things are . . . simple things like it is orderly and clean and if I feel I have control in other areas of life. If everything is chaotic, I feel that the trigger is more easily pushed.

C: But, does he use your faults against you? Can he say "I feel" when you are self-absorbed and push your buttons?

A: I don't know.

C: Because communication is different things, how one decides to use . . .

A: I don't know, but I try to use that technique myself, that I feel such and such, but perhaps I say it . . . it can work against one's intention also.

C: Yes.

A: When it comes to him, it's like we're fighting, as if it is a question of being the winner. I had such a childish episode recently this summer. We were in the park, barbecuing, and then we needed something from the shop, and nobody would go and get it, and it turned into a kind of competition where nobody could go because then the other would lose, and it was embarrassing, in front of other people, it's like being 4 years old.

A: Instead of saying, OK, I'll do it . . . it turns to a feeling that the other will be the winner.

- T1: Well, the way we think about these matters . . . There are several ways of self-development, for example, being able to tolerate more. One way is simply to practice, through exposure, and that's what you are doing now. In a group like this you will be exposed to critical remarks, that's unavoidable, and you can learn to handle it better in this group. (A-7, A-17)
- A: I know that, but tell me how I shall cope with it.
- T1: Like you are coping with it now, for example, point one, by taking the initiative to talk about it in this way. (A-14)
- C: That you are curious about it.
- T1: And by addressing this theme from the end of the last group session, right at the start of this group, you invited others into it to explore it, that's a good start. (A-14)
- A: Well . . .
- T1: You don't seem . . . (A-11, A-17)
- A: No, I am not satisfied with that. I have spoken to other people too, but it doesn't help as long as . . . It's the very situation I do not handle. I can think and speak about it afterwards, but when my feelings get intense . . . then, I can't use any techniques.
- C: But you and your boyfriend can make a sort of deal, if you notice that you two are going in a clinch, make a deal on some kind of time-out.
- A: No . . . he bangs his head against the wall, real hard, and he turns almost crazy.
- C: That's him, not you.
- A: But, no . . .
- T1: I'm not sure if I got it. (A-11)
- C: Hmm.
- T1: You said something about him hitting his head against the wall? (A-11)
- C: He gets angry.
- T1: Does he? (A-11, A-17)
- A: I'm afraid his head will burst or something, it's so . . .
- T2: Oh. (A-6)
- T1: Surely that must be awful? (A-6, A-17)
- T1: I'm still not sure if I've got it. Is it when he gets angry that he hits his head against the wall? (A-11, A-17)
- A: Yes, a kind of self-injury.
- T2: Does it make you afraid of him getting angry? Or, what do you others think? (A-4, A-11, A-17)
- A: I'm not afraid that . . . well, yes . . . no . . . I don't know. I arrange my day so that he will not get angry, I do.
- C: So when he gets angry, he does it? Every time?
- A: It makes me anxious . . . I don't know. We don't have to talk about it here.
- C: If I had a boyfriend like that, I would also avoid situations that made him angry. That's natural.
- T1: It created, what shall I say . . . a sort of dramatic new direction here, when you said about him banging his head. It seems like you are . . . crushed in a way . . . is that right? (A-5, A-11, A-17)

A: This morning, when he woke up . . . you know, tonight I've planned to have a friend of mine sleep on the sofa in the dining room, but this scares my boyfriend. He'd been worrying about it the whole night through, because he has some social anxiety, and then he woke me up this morning, standing there, trembling like hell, and he panicked and says "You must not not leave that guy here alone, you must not, you must not," and then he banged his head against the wall, really hard, he is like crazy . . . And I don't know what to do. I haven't seen my friend for a long time, he lives far away, and suddenly I have this problem that I might have to tell him that he cannot stay with us, that my boyfriend can't stand having him here, and a lot of things.

T2: Really difficult. (A-6)

A: And then I get angry, because I find him malevolent, acting it out in this way so that a visit from a friend turns into a very unpleasant thing . . . I don't know. But I've now spoken for a long time . . .

C: It seems like you are the one that have to carry his feelings, his anxiety.

A: Yes, I have to protect him.

T1: How did you others react to A's story? (A-4)

C: It's a very difficult emotional situation to be in, isn't it?

A: Yes.

C: Is it healthy for you?

A: What did you say?

C: Is it a healthy relationship?

Å: In my former relationship, I was also very considerate, but it was self-destructive, to keep that going, that's my view now.

M: It sounds difficult to be two people with problems in a relationship, since one must perhaps delete themselves in order to protect the other.

A: That's the way I do it, but perhaps it is not necessary.

M: Well, listening to this story, I notice that I got really irritated. I don't know, but if it had been me, well: "Hello, pull yourself together my friend, go for a walk," but I don't know if that would help.

Å: I get really sad since I recognize myself so thoroughly, and I know how destructive it was, to be in a relationship with a lot of problems, even if it was really good at times. I was very much in love, but I destroyed a lot, lost all my friends and the like.

M: Shouldn't he, for his own's sake and for yours, seek help, it can't be your responsibility to save him.

A: I have asked for help.

T1: Yes, you said last session that he has contacted an addiction unit.

A: I have.

T1: So you were the one that contacted the unit?

A: Yes.

T1: And how are things going?

A: He is like a little child. He is waiting for an appointment which I have asked for. If I'm like a mother for him, it works in a way. The addiction clinic has to call me, and then I'll inform him, and then supposedly he will turn up.

T1: Mm.

A: He will do it for my sake, but he does not take responsibility in his own right.

M: Sounds immature.

A: I believe he is frightened to quit.

C: Quit?

A: Quit smoking hashish.

T1: Because what happened this morning, that he came in to you, woke you up, and he was terrified? (A-11, A-17)

A: Yes, he is frightened. Because my friend who is visiting us has been “saved” by Narcotics Anonymous. He is “happy-sober.”

T1: Happy-sober? (A-11)

[Laughter in the group]

C: Yes, that’s a phrase.

T1: OK.

A: Instead of having found Jesus, he’s a strong believer in Narcotics Anonymous. My boyfriend is an addict, and, I think, terrified at looking at himself in the mirror. Meeting this “saved” sober guy may be too much; he’s possibly mulled over this the whole night, trembling with anxiety. He’s not malevolent towards me, he just does not know how to cope with it. However, he copes badly, and it frightens me.

C: So his feelings become your feelings then?

A: I have trouble with my boundaries.

M: Is it possible to get out of the situation? I know it’s a tough option, but could you possibly just go?

A: Well, I have tried somewhat.

M: Just saying: “Sorry, I cannot cope with this.”

A: Yes, he he.

C: It’s difficult to set limits for such kind of things.

M: Of course, but he has to learn . . . sounds almost like a little child in a shop who hasn’t got his chocolate, having a tantrum and screaming when you say no.

C: No, it’s not like that . . . I hear someone with a lot of anxiety and problems and who simply needs help.

A: Yes, that’s what I hear too . . . but it’s me who has to do it, even if I don’t want that responsibility.

M: But if you just leave, what would happen?

A: I sometimes say that I can’t relate to this, but I could not this morning. He came into my room, there was no space to pass by, and I was so sleepy.

M: But what happens when you go?

A: He follows me.

M: Follows you?

A: Yes, and he makes use of it in a way . . . no . . . I don’t know . . . I have talked too long here.

T1: OK, should we . . . ? (A-3)

T2: I am curious about you, K, you too have a difficult relationship. What are your thoughts when listening to A? (A-4, A-11)

- k: Well, yes . . . I have a relationship with someone with mental problems, she is immensely troubled, but I'm the one that breaks the door with my own head, see? So I don't know.
- T2: So you recognize yourself in . . . (A-4, A-11)
- k: Yes, but not like him. The one I live with gets stuck and maintains that only her views represent the truth and she is very difficult to . . . and after heavy psychic pressure, I just explode . . . a tremendous rage.
- T1: Yes, that was the theme you announced, and it's on the agenda, but is there any preliminary conclusion here, A, on the issues you have talked about, or is it OK? Have this been useful for you? (A-3)
- Å: Can I say something?
- T1: Sure.
- Å: I'm becoming rather worried, because I recognize myself, and I believe you have a high estimate of him, but I pose the question of what this is doing to you, and him too. Will it destroy you instead of helping you?
- A: I think I understand what you are saying, but it isn't . . . him.
- Å: Yes, he is surely very kind and everything, but I have been seriously disturbed and in a relationship, and no matter what they felt for me, by the end they were all exhausted by this project of helping me.
- A: I understand what you mean, but I believe it's a bit different, because I have not imposed my stuff on him.
- Å: But you take responsibility for him when you have enough to do with caring for yourself.
- C: I believe it's important to try to separate a bit emotionally, so you don't become a carrier of his feelings.
- T1: Seems like it is difficult to come to a closure. (A-3, A-5)
- C: Yes, it does, because it is not . . .
- T1: Perhaps it's because there are . . .
- A: There are many layers here.
- T1: Yes, there are many layers. (A-14)
- A: And it is such that . . .
- Å: But we, or I, engage in it just because I have been there.
- M: I believe everybody here has experienced the same, and it is very difficult to provide simple answers to what should be done. But I believe he must grasp that you can't take all of the responsibility, he has to take some of it himself, for his own development and get some help, because it will be too hard for you alone. He needs support from other people as well.
- A: I believe it will come, but anyhow, the conclusion I believe is that I have to work more on my own emotions, something . . . but I'm actually finished.
- T2: There seems to be lots of care here, from the others. Yes, many people care for you and you care for yourself too by bringing it in here, and our starting point was how you should relate to anger here in the group, so part of the job can be done here, by working with . . . (A-5, A-17)

- A: Yes, but it's a bit unclear. Let's say it happens here, what should I do then in the group, should I say . . .
- T2: Yes.
- A: Should I say: Stop, I feel it's like . . .
[Laughter in the group]
- T2: Yes.
- A: Well . . . Hmm [laughs, and moves in the chair].
- T2: Yes, I was thinking about you the last session, A. I wondered if I should have stopped, and said "Is something happening now which is difficult?" but if you had done it yourself I believe it would have been good too. (A-19)
- A: I believe I also have a need for being seen, that someone see me.
- T2: So it would have been OK for you if I had stopped then? (A-11, A-19)
- A: Yes, I believe so.
- M: Possibly a wrong theme, but I have real difficulties with recognizing how other people feel. I'm blind at such things. But concerning your guy, I believe boundaries are important, that you manage to set limits when you feel that it's enough.
- T1: There seem to be some problems with boundaries here too, don't there? It seems difficult to come to a closure. (A-3, A-5, A-7)
[Group laughter]
- T1: And to get ahead with the other themes that are announced, it keeps going and going . . . (A-3)
- A: Thanks for the conversation.
[Group laughter]
- T2: Who is next? (A-3)
[Members look at each other]
- T1: You, K, haven't you already started? (A-3)
- A: [To K] I would like to hear more.
- T1: You were talking about your relationship, and . . . is it a pattern that you started to describe? (A-11)
- K: A pattern . . . yes . . . it is.
- T1: And this makes you increasingly . . . irritated? (A-11, A-17)
- A: Yes . . . she blurs things . . . and it becomes so narrow . . . it's almost too difficult to describe how she is . . . I have told you previously that she has tied me up with friends and the like, she is very dominating and controlling, if I have not cleaned the floor at the right time, she loses her temper, and . . .
- T2: Do you have any example, which we can explore and possibly learn from? (A-3)
- K: No . . . don't know . . . it's like that the whole time, every day . . . Any examples? I don't know if I can manage that, but she is very sensitive to criticism . . . If I don't answer the mobile immediately she believes I am ignoring her.
[K's mobile phone starts to ring]
- T1: Is it her calling now? (A-5)
- K: Yes, and if I don't answer, then . . .

- c: She knows that you are here.
- k: Yes, perhaps she has forgotten it, I don't know.
- T1: So what is happening right now is actually a typical example, that she is trying to reach you on your mobile? (A-5, A-11)
- k: And she gets furious.
- c: When she can't get in touch with you?
- k: I'll give you an example, when I flipped out. I went to Greece, I should have been there for 3 weeks, but she allowed me to stay for only 1 week. Well, having been there for 1 week, the night before the flight back home . . . I sent her a message saying blah blah blah.
- T1: You sent a message?
- k: A mobile text message, about what I'd done that day, and then I wrote "Just to let you know, I think I'm catching an upper respiratory infection." I had got some fever and felt it coming. Well, she became furious because she thought it was some excuse for not being intimate when coming home, for not touching her. I called her and tried to explain, but she was simply plain awful, it's hard to explain how, but she didn't believe me, and that made me break down.
- T2: So you were in Greece and sent her a text message.
- k: Yes.
- T2: Telling her that you were ill.
- k: Yes, that I was ill and that I would travel back home that night, and she said: No, no, it's better for you to stay in Greece.
- c: You should have done!
- k: Yes, it's very difficult, but I didn't want any trouble, so it ended with me giving in. I'm flattening out. Otherwise I flip out. Last time she did hit me. However, then I hit her back.
- T1: When you met after Greece?
- k: No, a couple of days ago
- T1: A couple of days ago?
- k: We quarrel a lot.
- T1: You quarrel a lot, and now you have started hitting each other? (A-11, A-17)
- k: Yes, and when she punched me, I flipped.
- T1: How did she punch you?
- k: She . . . she . . . hit me hard in the chest, and then I hit her arm. I am an aggressive person too, but I really try to hold it back, but she got so close and I could hardly recognize her, completely weird, her eyes get so dark, she doesn't see that what she does is not OK, not OK at all, and then I can become really self-destructive and bang my head against the wall.
- T1: OK . . . [Looks around the group] What . . .
- c: Oh . . .
- T1: You say Oh, what do the rest of you think about what we have heard so far? (A-4)
- m: I do recognize, I'm afraid, myself a little, in her role, when I was feeling incredibly low, so I feel that she can't possibly be in a good way.

- K: Yes, she's quite unwell I would think.
- A: Does she get any help?
- K: She's been to a mental health center and a referral has been sent somewhere. Yes, she needs treatment because I'm not able to carry her on my own. I'm carrying both myself and her, and . . . She doesn't manage to comfort me in any way, isn't able to say sorry . . . She seems to have been like this in previous relationships too; if she feel somewhat threatened or things like that she becomes horrible to that person, she does her best to break him or her down.
- C: She has no reflection ability?
- K: Well, she gets glimpses once a month. She breaks down and understands what she is doing and shows remorse. I have said to her that my wish is . . . I am meeting her wishes all the time, but that I have a wish to go to couples counseling, which is family therapy free of charge, because we need a third party to see us both, as she always sees me as the bad one, you know, and I am in need of someone to observe the two of us and be able to talk through and finish a normal conversation without it turning into hell.
- T1: What I am wondering, I don't know if the rest of you do too, is that she is saying and doing things that are hard to live with . . . (A-4, A-11)
- K: Hard demands.
- T1: But you are living together, the two of you have chosen this, so there has to be some positive sides. (A-11)
- K: Yes, I love her, that's why I am so . . .
- T1: What is it that you love? (A-11)
- K: She has got it all, apart from what happens in arguments, though, then everything turns different.
- T1: Mm.
- K: She is a wonderful person too, and I understand her, why she is so . . . why she feels the way she does . . . I understand very well why she reacts . . . no, not why she reacts, that is wrong, but how she handles things, and I think and hope that it can work out and be OK, that it can be resolved if she gets help. It got like this after we moved in together 2 months ago.
- T1: So then it got worse? (A-11)
- K: Got much, much, much worse.
- T1: When you moved in together?
- K: Yes.
- T1: Why do you think that is so? (A-11)
- K: She probably thought that now we are living together, that it is a lot more responsibility, which it also is, to an extent, but . . . if she says one day, what are we going to do today? Are you going to see a friend? Then it is OK, but if I make that suggestion, it all goes wrong.
- T2: Is there something we, the group, can do to help you relate to her? (A-4)
- K: No, for her there is nothing to do, but I'd like some help for my anger, because I have had this anger since childhood. Then I used to hold my breath if the juice I got was the wrong color.

[Group laughter]

- K: Yes, already as a baby I used to bang my head in the cot.
- T2: So you were born with a strong temper? (A-17)
- K: Yes, my brothers too . . . But the anger only comes in close relationships, not otherwise.
- T2: But what you describe is that you held your anger back, until you exploded, or . . . (A-17)
- K: Yes.
- T2: So it is not the anger in itself that is the problem, but that you hold it back and that . . . (A-11, A-17)
- K: Have had it under control I guess, but it has been too much between me and X.
- C: She does trigger you.
- K: Yes.
- C: She triggers you until you explode.
- K: She is challenging me, to put it that way.
- Å: Such things get very difficult, if you get pushed and pushed and pushed . . . I understand that you in the end . . . [waves arms]. It is the same with me, that if I get pushed until a point . . . I understand it well.
- C: I used to have it like that with my ex, but then I could give him a warning and say . . . that now you are triggering me so much that I am on the edge of exploding, I could give him three warnings, but if he kept on going then . . . I would explode.
- K: Mm.
- T2: You recognize . . . (A-4)
- C: Yes, yes . . . when you feel that now it is starting to come, now . . .
- K: Yes, I do feel that, and am trying to give some warnings.
- C: Then you can choose to tell her, that you . . . now I feel my anger coming to get me, kind of, do you remember last time how it turned out . . . I mean, starting to use words . . . that maybe that could dampen it down, a bit.
- K: Mm, yes.
- C: Sometimes . . . I . . . not always, but . . .
- K: I am the one who is trying to find solutions when we are arguing. Yes, when we begin to get a little wound up, we can go our different ways and think it over, but we keep winding each other up all the time . . . or we could say sorry, in a way.
- M: I really identify with that, both in what you say [to C] and in X, and I don't think it will get better unless she gets some help.
- K: Yes . . . no . . . because, even though I say that now we should part and think through things on our own, she doesn't manage to.
- M: It is too . . . she . . . takes you to your limits and it's . . . I remember that the only thing I wanted in a situation like that was to be comforted, embraced, and hear "I love you so much" and that he shouldn't have a life at all, kind of, for himself, and every time he was going to do anything, I turned . . . completely crazy.
- K: Yes, she needs help, and I need to have something to do. So I'm looking forward to starting school and . . .

- T1: Yes, to get out from home a bit.
 K: Yes, I'll probably feel a little freer then, not so locked up.
 T1: When do you start?
 K: Next week.
 T1: Such that . . .
 A: Is it completely filled up?
 K: Yes, full.
 A: People drop out in the beginning, so it might be . . .
 Å: [Laughing]
 T1: [To Å] Are you thinking about yourself? (A-11)
 Å: Yes, but I've found two other exams [laughs], each time when school stuff comes up I think, yes, think I have to improve [laughs], yes, should . . .
 T1: Yes, but to round off . . . yes? [A wishes to say something]. . . Sorry. (A-3)
 A: Yes, I have started to force myself to do other things, to get a distance from arguments like that. To spend time on other things; get out and away from it, then it is so much nicer to meet again.
 M: Doesn't she have any friends?
 K: Yes, one best friend, but . . . she used to have my friends, but she managed to ruin that because she doesn't like . . . doesn't like people all that much, so now she doesn't like any of my friends, so they don't want to be her friends, so she doesn't really have any friends . . . no. There are some people that she knows, but she isn't with them, so it's only me.
 C: So she is at home sleeping during the day?
 K: No, she is working, is there until quarter to five and we go to bed at ten.
 T1: What kind of work does she do?
 K: Works at a book warehouse.
 C: So that is functioning, so she is working . . . and doing all right in her job?
 K: Yes, she is very dutiful and . . . has a real pride in her work.
 T1: Is she Danish?
 K: Yes, she is Danish.
 T1: Maybe we should hear a bit more about . . . How old is she?
 K: Twenty-one. Moved to Norway in February.
 T1: So she has got her network in Denmark, then?
 K: Moved here with a Danish friend and stayed with her until we moved in together, but it changed when we all started hanging out together and her friend started having a beer after work, she didn't like that.
 T2: It is obvious that you have a tough time at home these days. It's good that you are telling us about it so we can hear more about it. (A-6, A-17)
 C: What happens when you leave the group, do you call and tell her that you've been here, does she understand that, or what?
 K: Yes, yes, of course.
 Å: I feel really mean because I am so split between two opinions, because I understand, if you love each other and things can be really good . . . but I have, from my experience, I have a very strong opinion, and it weighs on my conscience

because I have this strong opinion . . . but I have this theory that two mentally ill people who are struggling a bit with, well . . . if you are beginning to recover and can talk about ways, have received therapy, maybe together, I think perhaps that . . . but I don't believe at all that two people who are struggling that much together . . .

K: Most people have, you too [looks at A], wondered whether it is a good idea to go on with the relationship, and . . .

Å: In a way, I am trying to follow a rule for myself that no matter if I fall for someone with mental problems, I will pull back . . .

M: It gets so intense by living together, one doesn't get the space in a way, that escape route which you need in order to withdraw a little.

K: I am independent now and have been independent before . . .

M: How old are you?

K: Twenty-two . . . I was perhaps a little bit like my girlfriend previously, with my former partner, from 18 to 20. I was just sitting at home, waiting for her.

M: Has she had any time by herself?

K: Yes, in Denmark, actually. But relationships make her ill! She is independent, strong, social, and makes friends too, a completely different person when she is single, I knew her as a totally different person . . .

T1: Closeness and living together is difficult, very difficult. (A-17)

Å: I am getting really engaged in this, I relate to both so incredibly much, like when I was together with Z, difficult, but I had some time off every night, was on Skype, had some distance so I could work with myself, yes it's like that in my life, when there are two struggling, notice that I get so engaged . . .

C: I used to be a bit like that too, when I was single and on a break from A, I used to be so independent, extrovert, in control, but after a few weeks of living together I handed all responsibility over to him, then he could control it all, and I got self-effacing and devoid of initiative.

T2: I'm thinking that we should start rounding off, is that ok for you? When you, Å, get so engaged, it seems like you're identifying strongly with what has been said? (A-3, A-11)

Å: Yes, I either shut it all out, or . . . it can become quite perilous, I noticed lately, I want to help everyone, if people are just talking about something, are moving, for instance, I don't even have to know the person, I am going to help out and help out. I am a therapist for many . . .

C: But first you have to help yourself.

Å: It's so strange, I know what I should do. I can talk about it, but am not doing it, but others who might need help with just about anything, I am on it.

T2: You had a theme related to this. (A-3)

Å: The only way I can help is to help others.

A: That's how I feel too, I call it the Mother Theresa syndrome; my identity used to be in being self-effacing and only helping others.

Å: Yes, I notice that.

T2: Do you notice when you are entering the role? (A-11)

- Å: Well, in a way it has become better too, while at the same time it hasn't, there is so much going on at once, I got that understanding at the ward. I was hospitalized because of suicidal thoughts.
- T2: Yes, there are several things, you were hospitalized, and why? And the other thing is that you push things away and later have a bad conscience about it, and what happens here is that you are engaging strongly with what is being said. So what do you wish to change? (A-11, A-17)
- Å: The two things bothering me the most are that I cannot give myself the space to be. In addition, I get angry with myself, can't accept it, alright, I don't show emotions to others, but I go home with those emotions, and that people . . . but I have nothing to be ashamed of, I'm not a bad person . . .
- T2: Could we now go back to the previous group session, you told us that you then were left with a feeling of being a bad person and that we hated you, was that it? (A-17, A-18, A-19)
- Å: Yes, well . . . usually I hit rock bottom, it weighs me down very much that . . . because I meant that I didn't want the status of a hero you know, and when I felt that someone thought so, I felt they perceived me as a very bad person, but to make it completely clear, this is the situation, but anyway I am clearly hitting bottom and think I am the worst person in the world.
- T2: Do the rest of you follow? My understanding is that you received comments on having fantasies about being a hero, or . . . (A-4, A-11)
- Å: Yes, but that's not how I feel, it is that I engage so much in others and I feel that my life should be that of being there for everyone else, being strong for others, it's not that I crave recognition. Should I receive recognition, it should be for performing well, or being slender and pretty, but . . .
- T2: Should we stop here, you say that your life should be a kind of "being there for others." What do the rest of you think? (A-4, A-18)
- A: I don't think . . . I said different things, but I don't think that you [Å] are looking for recognition in that way.
- Å: No, that's not it.
- C: You were talking about how you had fantasies about going to Utøya [referring to the July 22 terrorist attack] and that you could die in the place of someone else who wished to live.
- Å: Yes, but that is about a lot of things, that that person's life is more important, not that . . . I'm thinking a lot about changing a situation where someone is trying to kill me and that if I get away from it, I will take that as a sign that I should live, and I have a fantasy in my head that I am not afraid of meeting it because then I will have a confirmation of whether I should live or not . . .
- T1: I commented on this last session by saying something about whether your ideas were rather close to reality, whether it was nearly like you had actually been there, almost doing it, instead of kinds of fantasies which are coming and going, like thoughts do, that's what I tried to say something about, and you reacted, A . . . (A-16, A-19)
- A: Yes, but I reacted because I was maybe a little jealous of Å, he he . . .

[Group laughter]

T2: Yes, I noticed that it was difficult for you, what happened, and then I brought that up with T1 later, and he hadn't noticed, so I can understand that, tell us more. (A-9, A-17, A-19)

A: Oh, I am ashamed. Å . . . I get jealous, maybe because I am struggling with the same thing, and then I feel that T1 gives a lot of attention to Å because she feels like this, but you don't see that I am sitting there feeling much of the same.

T1: Oh! It is very good that you are saying this, because we discussed this in the post-session meeting and you, T2, told me that maybe A was jealous, then I said, I remember, that yes, that is theoretically possible, but that on my part I hadn't noticed that she did or said anything to imply that she actually was jealous, but you had a good hunch there. (A-5, A-9, A-14, A-17, A-19)

T2: Yes, I can understand that there might have been some uncertainty around what Å's problem was, what she wished to work on, so I thought it wasn't necessarily that bad, but then the main issue seemed to be that you felt it the same way, yes as you say that you were a bit jealous about the attention, so what you are saying now . . . (A-17, A-19)

A: It's so embarrassing . . . It's embarrassing to be here now . . .

C: That is an OK thing, surely. Those feelings are obviously strong, here in the group.

A: Yes, but why? . . . I think it is embarrassing.

T1: Yes, I can understand that, but there is something about being able to own one's emotions. Emotions are emotions. (A-17)

M: I think it is very good you opened up, it is very brave.

A: Yes, he he.

T1: Did something happen here now too, when we were talking about Å? (A-5)

A: Yes, it came as a little wave, but I see myself so much in Å. I am often used to having your role, Å, used to have it, the one being the most confused and saying a lot of the things you are saying, becoming one of those who people wish to take care of. I have always had that role . . .

Å: It's strange, because outside I am like . . . well, a bit like you, that I hope someone will see it, but no one is seeing it because I am not saying anything . . .

A: Yes, but I used to be like that, especially around adults, or therapists or in care settings, then I would be the one being taken care of, and I feel that you become that one in the group here, but that outside you are the one trying to take care of others . . . yes I used to be like that.

T2: Do you have a sister?

A: An older sister.

T2: Do you feel like, do you have the impression that you have become an older sister to Å? (A-11)

A: The moment Å entered here, I felt I should take care of Å.

[Group laughter]

Å: I get a bad conscience because a lot of what I say is hard for you to hear, I tell myself that I should shut up.

- A: Well, because I feel I have been there before, that's why I know, or don't know but feel, feel that I know what you need, so I can look after you, it is totally silly, I don't know where it comes from.
- T2: Could it be that there is room for both, care for both older sister and younger sister, how is that here? (A-6)
[Group laughter]
- T1: You laugh. (A-17)
- C: I think it is sweet, but my impression is that you actually do get as much care as Å from T1, but that is what I see.
- A: Yes, I too think that my siblings have the same amount of care and that I am seen as much as them, by dad, for instance, so I don't know where that is coming from . . . but now it is turning towards me again . . .
- T1: But what is happening now, is it especially Å? (A-5)
- A: Yes.
- T1: That you react to? How about the others? (A-5)
[Group laughter]
- A: Are you thinking about the others here?
[Group laughter]
- T1: Does it mean that I am less concerned with the rest? (A-12, A-19)
- A: No, don't know, it's the way you do it maybe, I think you are especially interested in Å, but I am sure you are not, but I feel it like that and don't know why, think I want you to be like that, but also be there for me.
- T1: Yes I am interested in Å. . . (A-19)
- Å: You were irritated with me, oh, he he . . .
- T1: Was I irritated with you? (A-17, A-19)
- Å: No, but . . . "You should calm down now" . . . [imitating]
- T1: But I don't know if I am more interested in Å than in the rest of you. Maybe in a different way. (A-19)
- M: I don't notice any difference at all. I think you are the same to all.
- C: You might be more interested in Å, but . . . no, I don't think so . . . Well, maybe.
- T2: It's interesting that there are different opinions around this and different experiences of it. Do you all get a feeling of an extra care for Å, as a younger sister, or . . . ? (A-11, A-17)
- M: No, I have trouble getting to understand you [to Å].
- Å: I feel that T1 becomes like . . .
- K: Yes, maybe he is trying to get something off the ground in you that the rest of us have to try to understand, he is a therapist after all.
- Å: Yes I am pretty hard to understand, I am so different.
- M: Do the rest of you follow? [To T1:] I could do with some extra explanation.
- T2: Do you [Å] believe that T1 has difficulties in understanding you? (A-19)
- Å: He asks me a lot, but it can be because I am often quite confused.
- T2: Do you recognize yourself in that, T1? (A-9, A-19)
- T1: Yes . . . or rather that you can be a bit confusing. It is often . . . like, have I understood you now, or what? Was it like this or was it like that, because you are rather

contradictory. Before long, you can be like this, and then you can be like that. Then you have these emotions and later you have those emotions, and you go so in detail into things. (A-17, A-19)

Å: Yes, things can go very fast.

T1: And then it can be hard to follow the twists and turns. (A-19)

Å: Things are going so quickly, in my head.

T1: But it is going fast here as well, I see that we don't have many minutes left, should we simply move on a little here, you had something too [directed at C]? (A-2, A-3)

C: It is nothing dramatic, but . . .

T1: Just to say, I think it was quite useful, this last sequence, about the feelings between us in this room that you brought up. It has something to do with being able to be aware of one's feelings, take them seriously, own them, and thus they might become less catastrophic. (A-7, A-14, A-17, A-19)

SEVERAL: Mm, mm.

T1: But it is your turn [to C]. (A-3)

C: I have been in a relationship for a while and now we have moved in together.

M: [Applauds]

T1: Well now, I have to admit . . . have we been updated? (A-19)

C: It was the summer vacation, but when I said about getting a partner, you were not here, it was this other therapist [stepping in for T1].

T1: Aha.

T2: Possibly I didn't catch that either.

M: No, I wasn't here either.

C: I actually met him last summer, but then I wasn't ready to have a relationship. I was emotionally low, didn't know who I was, didn't have a sense of self, didn't have values, didn't have anything. When the relationship got intense I chose to break it off and focus on therapy and focus on myself and not be in any intimate relation.

M: He was from The Netherlands, right?

C: Yes.

C: However, we met again in January and then I was much stronger, had filled in my own void and I was safe and stable, and then it was so much easier to go into a relationship, because I know what I stand for, I know my limits. Then it was so much easier to be with a person who loves you a lot. That love I am getting from him now is kind of a bonus because I don't need a man to fill the emptiness from my belly up. I fill it myself and therefore it is going very well. But of course . . . eh . . . and now we have moved in together and I was very afraid, because I am too fond of my escape routes if things get tough emotionally.

T1: Did he move in with you?

C: Yes.

T1: Did he live in Nadderud, did you say?

C: No, he is from The Netherlands

T1: Oh, The Netherlands . . . yes . . .

GROUP LAUGHING: Nadderud—Netherlands!

T1: So he has moved in with you. From when?

C: Paying his rent from a few months ago.

T1: OK . . . What does he do?

C: He is working with buses and . . . fixing buses, working day and night.

T1: OK.

C: What is so nice is that when I now get into situations that are hard to handle emotionally, I haven't had this feeling of escape, that I ought to kick him out, or that I won't bother with this mess anymore because I can't handle it. I have worked a lot with it, but yesterday, I went [gesticulating] from zero to ten, felt it was rather good too, to be in that old role. That role is one I haven't been in for a while, being a real bastard, and childish and whiny and . . .

T1: What happened? (A-11)

C: He is standing there, you know, solid as a mountain.

T1: Yes, but what happened? (A-11)

C: Nothing, really.

T1: Yes, obviously, but tell us what happened? (A-12)

C: Yes, well, I am quite premenstrual, my mood can swing from feeling well to becoming incredibly irritated, and then all the time he's asking what it is, what is it . . . No, it is nothing! Right? And when it happens many times . . . what can I do for you, what is it . . . then I have said beforehand that when I have a day like this, it is ok to just leave me alone, because the more you ask me what it is, the worse the situation gets. And he did that yesterday, he took it personally. He felt it was something he had done, or that I didn't love him anymore or didn't want to be with him anymore. And then he gets sensitive, when I have maybe put up the somewhat strict mask, or, and then I burst.

T1: And when you burst, how . . . (A-11)

C: Got angry [raises arms], bloody hell can you stop nagging, nagging, nagging . . . and . . . I'm so sick of this, so sick of this . . . and then lots came out. But I didn't say that he should move out and I didn't say that it was over, so that is an improvement.

T1: Yes, that is good news. (A-14)

C: Yes, that is good news for me, because that has been a pattern for many years.

T1: Did you manage to fix it? (A-11)

C: Yes, yes [laughs]. . . This happened on our way to IKEA, we decide to . . . I am about to turn around, fuck it, I won't bother to go to IKEA, I won't bother to be out among people, I won't bother, won't bother . . . But he stands there: "What can I do? Sweetheart, can't we just sit down at a café and have a cup of coffee?" And then I begin to calm down and lower my shoulders. Oh no . . . and then we talk about it, that he mustn't take it personally . . .

M: Not to be rude or anything, but does he know what premenstrual means, with the hormones and all that?

C: Yes, yes, he is a well-informed man.

- M: Not everyone knows.
- T1: Now we have heard, and there are not so many minutes left, and we have to hear the reactions here now, what do the rest of you think and feel? (A-4)
- A: Yes I very often feel like you, but I'm impressed, that you . . . let's have a coffee . . . let's resolve . . . then I think, don't know, but then you use [points to head].
- C: That is what I have learned! That exact minute up there, it was so familiar, the emotions were so familiar, it is a pattern I have had for many years, it was almost good to be there again, it had been a long time since I was there, but still it is not the way I want it.
- A: No, no.
- C: We got to talk about it, went to IKEA and had some food, and had a nice time afterwards.
- M: I have to say that I recognize myself a hundred percent, I think I am close to where you are, the same place, really recognize myself, having someone at your side or with you who is so stable and at the same time having that safe feeling inside yourself, that is new to me and very enjoyable.
- T1: Are you thinking that the other person is receiving it in a way, without hurling it back, is that what you are thinking about? (A-4)
- M: Yes, stable.
- C: And not starting to plough on with the same pattern, or throw the same anger back, or [looks at K] getting this clash, anger against anger.
- M: Then it might be easier, perhaps, to control oneself.
- A: When I don't manage what you did, it is a bit about pride, for some reason, don't know . . .
- C: Earlier, yes earlier, that is what it was. But being able to back down . . . swallow your feelings . . . and say sorry, or that I am saying sorry on my own behalf too . . .
- M: And simply respect for the other, because I notice that I have never had respect for other people before, before the one I am with now.
- C: But I have to laugh, when I am standing in the middle of hell, he says: "You are incredibly beautiful, but now you are a difficult woman."
[Group laughter]
- T1: He says so?
- C: Yes
[Group laughter]
- C: "You are a beautiful woman, C, but now you are rather difficult." It kind of takes the edge off the mood [snaps fingers], it makes me come down again.
- T1: Well, that is quite right, a good characterization!
[Group laughter]
- C: I managed to come out of it, emotionally, very, very, heh, so I am proud of myself for that.
- T2: Yes, how wonderful. You have been in the group for about a year now, so you have worked a lot with . . . (A-14)

C: Oh yes I have. Earlier I would have broken up. With my ex . . . throw him out, or myself out, because those were the escape routes I used to have. I have to say that this is the first time that I am in a healthy, deep, natural and good relationship, really, I feel that I can be myself a hundred percent, for better or worse.

M: I am just sitting here nodding, I recognize it so well.

C: Even though there are challenges for me emotionally, it is the first time that I have lived with someone, actually, at my age of 39.

T2: It is wonderful and great that you still bring in episodes where you still wish to work with things. There is space for that too, not just the more serious things. (A-14)

T2: How has this time in the group been? We are in our last minute. I think it has been a good meeting, but what do you think? (A-2, A-5, A-14)

M: I was a little late, but I had something to say too. I have been thinking about it during the group, I have been completely at rock bottom.

T1: How bad (A-6)

M: It has gotten better. I could easily take your whole story [to C] and call it mine. I have moved and I'm incredibly stressed, and after last time I was here I have gone straight down to rock bottom and been to bed for a week and just staring out of the window and cried and haven't showered and only eaten junk food and chain-smoked and had my birthday last week and just cried and thought the world hated me and planned to kill me, and was about to go down and buy some booze and take a lot of pills and felt that my partner forgot about my birthday, and, la, la, la . . . and then I finally got everything in place in the house and money into the account again and now it is beginning to calm down, but it has been bloody horrible. And the conclusion, which is so dreary, is that my partner handled it very badly, he just let me lie there in bed and be in a bad place, he didn't relate to it, he hasn't supported me in it the way that I had thought, I have felt completely alone and we have nearly broken up and . . .

T1: Mm. It is a pity, but we won't be able to comment fully. (A-6)

M: I know that, but to have said it now makes it a lot better.

T1: But you have a session with your individual therapist on Thursday, and we will hear more about this next time. (A-6)

M: But the crisis is over, I just had to get it out.

C: It's good that you are here.

T1: OK. Thanks for the session. (A-1)

Notes on the ratings

In this session, the therapists performed approximately 180 interventions. Of these, 70 interventions (39%) could not be rated according to MBT-G-AQS. Some of these interventions were too short, a few were incomprehensible due to

the poor sound quality of the recording, and some were outside the realm of MBT (e.g., when T1 asks about facts which do not concern mental states, such as “What’s her job?” and “When do you start school?”)

The 110 interventions that complied with the manual received from one to five ratings each. In total, these 110 interventions received 186 ratings. An example of a single rating is “OK, what did they say?” (A-11, exploration). An example of a complex rating is “Oh! It is very good that you are saying this, because we discussed this in the post-session meeting and you, T2, told me that maybe A was jealous, then I said, I remember, that yes, that is theoretically possible, but that on my part I hadn’t noticed that she did or said anything to imply that she actually was jealous, but you had a good hunch there.” This intervention received five ratings: A-5 (identifying and mentalizing events in the group), A-14 (acknowledging good mentalization), A-17 (focus on emotions), A-19 (focus on patient–therapist relationship), and A-9 (cooperation between co-therapists).

Figure 5.1 displays the adherence profile. The columns indicate the number of interventions for each item. The most frequently used interventions are “exploration, curiosity, and not-knowing stance” and “focus on emotions.”

Figure 5.2 displays the quality ratings. All items are rated equal to or higher than 4 (“good enough”). There were no interventions on item 8 (“stimulating discussions about group norms”) and nothing to be qualified.

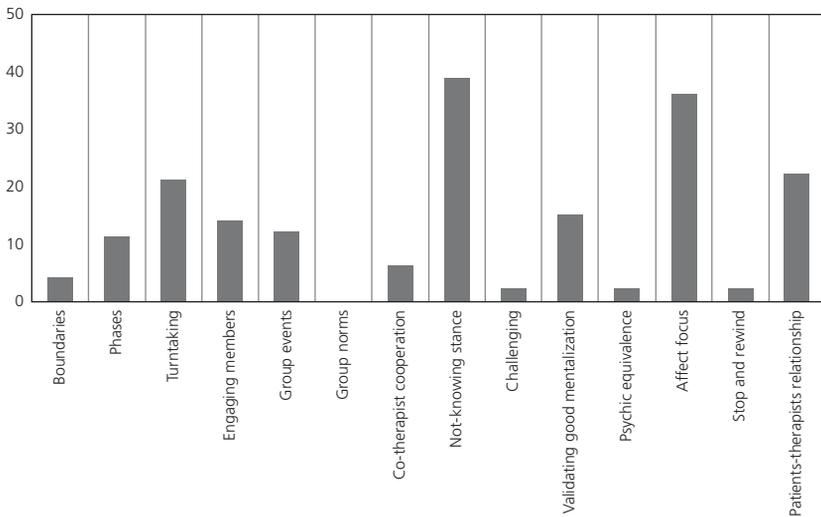


Fig. 5.1 MBT-G adherence of transcribed session.

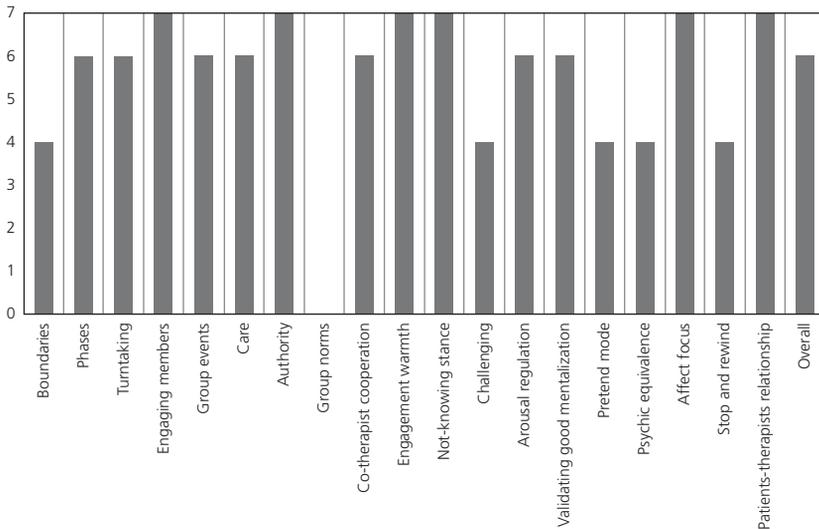


Fig. 5.2 MBT-G quality of transcribed session.

Ratings of each item

Item 1: Managing group boundaries

Before the video is turned on, the therapists make some comments about absent group members and the video recording. T1 marks and greets when patient M arrives. T1 terminates the group on time. There are no other boundary violations that need to be addressed.

Adherence rating: 4. Quality rating: 4.

Item 2: Regulating group phases

The therapists make several interventions in the opening phase and address all group members. T1 comments on T2 who invites exploration of a theme and this intervention helps to keep the discourse on an organizing level. The phase is short and focused and the group “gets to work” rather quickly. Later on, the therapists comment on time boundaries and provide space for all participants that have signaled their own themes in the opening phase. The therapists also comment on the termination, ask for opinions about the meeting, and build some kind of bridge to the next meeting. The session is very well organized without being rigid. On the negative side, the interventions that should “build bridges” to the previous meeting were sparse, particularly since the content of the previous meeting was so dramatic.

Adherence rating: 11. Quality rating: 6.

Item 3: Initiating and fulfilling turntaking

The therapists take several initiatives and several interventions serve to clarify the mentalizing stance on the themes that are presented. Interventions that clarify the context are not rated, unless they clearly try to get the protagonist “on track” and point toward a mental state.

Fulfilling turntaking does also concern the protagonist’s “ownership” of the sequence. The other group members will naturally associate round the main theme and talk about their own experiences. This provides the group with liveliness, diversity, and spontaneous emotions. However, if this goes too far, the therapists should intervene in order to re-establish the protagonist. T1 intervened in this way when he said: “Yes . . . but, should we stick a bit longer with A’s experiences?”

Fulfilling turntaking also involves terminating the sequence. The therapists make several interventions that concern termination, including difficulties with terminating. In this session, there are four well-delineated sequences and many of the interventions comply with item 3. On the negative side, was the sequence with patient K optimal? Was there any progress?

Adherence rating: 21. Quality rating: 6.

Item 4: Engaging group members in mentalizing external events

This is a lively group with engaged patients and the engagement mainly concerns thoughts about mental states and feelings and relations between people, outside and inside the group. We observe several comments on how to cope with difficult issues. This will always occur in such groups and the take is understandable since many of the participants have large coping problems. However, due to the therapists’ interventions, the group never declines into a counseling group. The therapists have several item 4 interventions. For example, T2: “I think you describe it very well. I too remember that episode. It seems that you have been able to reflect upon it afterwards. You others here, do you feel you understand what it’s all about? (A-4, A-14).”

Adherence rating: 14. Quality rating: 7.

Item 5: Identifying and mentalizing events in the group

The therapists identify several events in the group and explicitly invite the members for collective reflection. One instance is when T1 says: “It created, what shall I say . . . a sort of dramatic new direction here, when you said about him banging his head. It seems like you are . . . crushed in a way . . . is that right? (A-5, A-11, A-17)” This intervention reinforces the attention on A’s story and

the group oscillates between “there and then” and “here and now” (about the strong impact of listening to the story).

Adherence rating: 12. Quality rating: 6.

Item 6: Caring for the group and each member

Caring is not rated for occurrence. For pedagogical reasons we have nevertheless noted A-6 on some interventions that indicate care. For example, when T1 greets patient M (“Hello”) when she arrives (late) in order to mark that she has been noticed and that she is welcomed. Another example is when the therapists comments when patient A talks about her boyfriend:

A: I’m afraid his head will burst or something, it’s so . . .

T2: Oh. (A-6)

T1: Surely that must be awful? (A-6, A-17)

The group as a whole and each member are well taken care of in this session. Nobody is overruled or mistreated by someone else.

Rating of quality: 6.

Item 7: Managing authority

This item is not rated for occurrence, but here, as well as for item 6, we have noted some interventions that comply with the manual. For example, T1: “That’s a theme which is fine to explore here.” And T1: “There seem to be some problems with boundaries here too, don’t there? It seems difficult to come to a closure. (A-3, A-5, A-7)” The therapist refers implicitly through these interventions to the purpose of the group and to working methods, that is, that some issues are better than others (anger is good!) and that sequences have to be terminated. It is done in ways that signal these norms, but does not proclaim them in an authoritarian way. The therapists seem confident in their roles and the interpersonal drama of the group can be played out in a controlled manner, safeguarded by the frames created by the therapists.

Rating of quality: 7.

Item 8: Stimulating discussions about group norms

The norms in this group seem well established. No discussion occurs, and there does not seem to be any urgent need for it either, about how to handle typical group interaction problems. For example, “Is it allowed to be angry here?” or “Is it okay to be frank and straightforward here?” The group members seem to agree that emotions are the primary target of the group, but they find it hard to practice (of course!).

Rating of occurrence: 0. Rating of quality: 0.

Item 9: Cooperation between co-therapists

By and large, the co-therapists seem to work towards the same goals and they adjust to each other. Six interventions do explicitly concern their cooperation. In the opening phase, T2 asks patient C: “What happened?” while T1 says “Shall we take that later?” The implicit message from T1 is that T2 invites an exploration (which should come later). More important are the comments where T1 and T2 refer to what they had discussed at the post-session meeting. T2 had wondered if patient A was sort of jealous, while T1 had no such thoughts. These interventions are important for several reasons. Firstly because the therapists are open about their exchange at the post-session meeting, and secondly because the content matter concerns the core of mentalizing theory, that is, that mental states are opaque and not always easy to interpret and that even therapists can overlook or misinterpret mental states.

Rating of occurrence: 6. Rating of quality: 6.

Item 10: Engagement, interest, and warmth

As previously noted, this is an engaged and vital group. It oscillates between serious explorations, strong emotions, humor, and laughter. The therapists contribute to this with their own engagement. They are active, empathic, open, and authentic. When patient A says that she reacted at the end of last session because T1 overlooked her, T1 answers: “Yes, but I think you are right that I overlooked it. (A-14, A-19)” The therapists make several humorous comments that evoke laughter. This does not distract the group or call for just jokes and fun. It seems rather to have a liberating effect by indicating that it is also possible to play with serious matters (“reality”).

Rating of quality: 7.

Item 11: Exploration, curiosity, and not-knowing stance

This item is the most frequently used. The therapists maintain an exploratory and not-knowing stance through the entire meeting. It starts immediately, when T2 asks: “Last time we spoke about the disaster of 22 July, and other things as well. There have presumably been some thoughts and feelings in the aftermath?” Thereafter follows typical interventions, like: T1: “Mm, are you referring to what happened last session? (A-11)” And T1: “OK, so you . . . it was right at the end of the group, and I did not recognize your feelings, is that what you mean? (A-11, A-17, A-19)”

Rating of occurrence: 39. Rating of quality: 7.

Item 12: Challenging unwarranted beliefs

Unwarranted beliefs were uttered several times, and most frequently by patient Å. However, most of these were challenged by fellow group patients, or they did not have any dynamic significance, or they were subordinated to other major themes. Two interventions were classified as item 12. For example (during the discussion about if T1 favors patient Å): T1: “Does it mean that I am less concerned with the rest? (A-12, A-19)” The rater does not get the impression that there are a lot of unwarranted beliefs that pass under the radar.

Rating of occurrence: 2. Rating of quality: 4.

Item 13: Regulating emotional arousal

The emotional temperature in this group is optimal for psychotherapeutic work. As noted previously, there is vitality there and an oscillation between eagerness, interest, care, sadness, anger, and laughter. The group is neither flat nor boring, and not too emotional at the expense of RF. The therapists regulate arousal not so much through specific interventions as through their general therapeutic style.

Rating of quality: 6.

Item 14: Acknowledging good mentalization

There are several (15) interventions of this type. It starts with T2: “I think you describe it very well. I too remember that episode. It seems that you have been able to reflect upon it afterwards. You others here, do you feel you understand what it’s all about? (A-4, A-14)” In order to receive the highest quality rating, the therapists should have explored such phenomena more in detail.

Rating of occurrence: 15. Rating of quality: 6.

Item 15: Handling pretend mode

This item is not rated for occurrence. There were clearly some instances of pseudomentalization, for example, as part of the discussion about if it is wise that people with mental health problems live together. Patients Å and M are the major contributors to pretend mode. However, any lengthy discourse on emotions and relations will be credited with some degree of pseudomentalization. It is part of everyday discourse. Here it is up to the rater to decide if any clinically significant pretend mode sequences occurred where the patients were caught in a kind of aloof dialogue where the therapists should have intervened. According to this rater, no such lengthy sequence occurred, which signifies that the therapists handled the pseudomentalizing tendencies in an adequate manner.

Rating of quality: 4.

Item 16: Handling psychic equivalence

The session is characterized by a notable willingness to explore and reflect. Although psychic equivalence themes are often referred to (in fact that is what preoccupies the group members the most), they are seldom enacted in the group as rigid and reality-distorting claims. Psychic equivalence phenomena are made a target from the very beginning through patient A who wants to discuss her experiences from the previous session, such as in the following clarifying sequence:

- T1: Let's clarify, you say that when C and A talk to you in a certain manner, something happens with you, which expression are you using? It's like . . . you used an expression . . . (A-5, A-11)
- A: I don't know.
- C: Against you in a way.
- A: I felt attacked.
- T1: You felt attacked, yes. (A-17)
- A: And I know I am not . . . mentally. I am fully aware of what happens in the situation, but I cannot control my feelings, and therefore I often get very angry. When this happens I can say "but don't get so angry at me," but actually I did not believe that you were angry at me. In this way I can start quarrels.

During the course of the group, fellow patients do most of the work by challenging each other and presenting different perspectives. A discrete intervention is the following from T1:

- "I commented on this last session by saying something about whether your ideas were rather close to reality, whether it was nearly like you had actually been there, almost doing it, instead of kind of fantasies which are coming and going, like thoughts do, that's what I tried to say something about, and you reacted, A . . . (A-16, A-19)"

Rating of occurrence: 2. Rating of quality: 4.

Item 17: Focus on emotions

As commented on several times, the session is loaded with a variety of emotions, in stories from there and then and in the current experiential flow of the group. The therapists make many interventions that address most aspects of emotions: consciousness of emotions, emotion tolerance, expression of emotions, ownership of emotions, intersubjective emotional transactions, and so on.

Rating of occurrence: 36. Rating of quality: 7.

Item 18: Stop and rewind

Two interventions are classified as belonging to item 18. Example: T2: "Could we now go back to the previous group session, you told us that you then were

left with a feeling of being a bad person and that we hated you, was that it? (A-17, A-18, A-19)”

Rating of occurrence: 2. Rating of quality: 4.

Item 19: Focus on the relationship between therapists and patients

Quite a lot of interventions have this target. The group provided ample opportunities for this focus since patient A started with an event from the previous session that involved one of the therapists. It starts when T1 says: “OK, so you . . . it was right at the end of the group, and I did not recognize your feelings, is that what you mean?” (A-11, A-17, A-19). Later there comes a lengthy sequence when patient A reveals her jealousy and T1 invites for an exploration of the theme in the group: “Does it mean that I am less concerned with the rest? (A-12, A-19)” Through the therapists’ interventions, the relationship between therapists and patients gains a clear and marked position as a favored theme for the group and it is explored to a significant degree.

Rating of occurrence: 22. Rating of quality: 7.

Overall rating

Altogether, 110 (out of 180) interventions were rated for occurrence and these 110 interventions received 186 ratings. Exploration was rated most frequently (39 times), followed by focus on emotions (36) and focus on the relationship between therapists and patients (22). Compared to other group sessions (data to be published), these are very high occurrences. It is also significant that the therapists cover almost all items (except for item 8). This is clearly a kind of group where the raters have no problems with recognizing the therapeutic style (as MBT) and what the therapists’ intentions are.

Overall rating of occurrence: 7.

As for quality, the mean score for all items is 5.8. This is not the way we decide on overall rating, but it hints at the level we are talking about. The most important question is the following: Do the therapists practice a mentalizing stance throughout the session? Yes, it covers most of their verbal and behavioral actions. All interventions are definitely not of Nobel prize quality (and should not be either). However, there are no long sequences where the therapists clearly deviate from what is recommended in the manual. As previously mentioned, the quality is reduced somewhat by a less than optimal closure of the sequence with patient K. However, this is a minor drawback. The overall impression is of a very good performance: “The therapists clearly demonstrated skill and expertise in handling the item content.”

Overall rating of quality: 6.

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Appendix 1

Rating scale for mentalization-based group therapy

Table A1.1 Rating scale for mentalization-based group therapy

Rater: _____ Rating date: _____ Therapists: _____

Group: _____ Session date: _____

Overall rating of MBT occurrence: _____ MBT quality: _____

Item name	Occurrence	Quality
1. Managing group boundaries		
2. Regulating group phases		
3. Initiating and fulfilling turntaking		
4. Engaging group members in mentalizing external events		
5. Identifying and mentalizing events in the group		
6. Caring for the group and each member	No rating	
7. Managing authority	No rating	
8. Stimulating discussions about group norms		
9. Cooperation between co-therapists		
10. Engagement, interest, and warmth	No rating	
11. Exploration, curiosity, and not-knowing stance		
12. Challenging unwarranted beliefs		
13. Regulating emotional arousal	No rating	
14. Acknowledging good mentalization		
15. Handling pretend mode	No rating	
16. Handling psychic equivalence		
17. Focus on emotions		
18. Stop and rewind		
19. Focus on the relationship between therapists and patients		

Appendix 2

Rating scale for mentalization-based group therapy quality

Table A2.1 is used for rating therapists' interventions during group therapy. The table describes the quality level 4 ("good enough"). For more detailed descriptions, please refer to the manual.

Table A2.1 Rating scale for mentalization-based group therapy quality

Item name	Quality level 4 ("good enough")
1. Managing group boundaries	The group is functioning smoothly with respect to boundary issues. The therapists identify boundary-relevant events and comment and deal with them in ways which seem appropriate and clarifying for the group as a whole
2. Regulating group phases	At least two phases are addressed in a way that engages members to reflect upon the possibilities and choices they have
3. Initiating and fulfilling turntaking	The therapists themselves take the initiative and they also follow up patients' initiatives for turntaking. They contribute to the unfolding of the story and identification of relevant scenes, intervene in ways that facilitate a comprehensive narrative, and keep a focus on emotions, mental states, and interpersonal interactions
4. Engaging group members in mentalizing external events	The therapists invite the other group members, implicitly or explicitly, to clarify relevant events and engage members to participate in a collective exploration of the mental states involved therein
5. Identifying and mentalizing events in the group	The therapists identify some important events in the group and engage group members in a collective exploration which seems meaningful and clarifying
6. Caring for the group and each member	At this level, the group process is on an even keel when it comes to care. The therapists seem to have an awareness regarding negative comments between group members and are quick to intervene in such situations
7. Managing authority	The therapists seem calm and confident as MBT-G therapists. In theory and practice they stand up for the group's basic values

(continued)

Table A2.1 (continued) Rating scale for mentalization-based group therapy quality

Item name	Quality level 4 ("good enough")
8. Stimulating discussions about group norms	The therapists take the initiative to norm discussions, engage in an interested way in spontaneous discussions, and try to modify restrictive group solutions which are being made, if these are not challenged by other group members
9. Cooperation between co-therapists	There seems to be a confident relationship between the therapists, their interventions are complementary, and they communicate with each other with open, reflective comments
10. Engagement, interest, and warmth	The therapists appear genuinely warm and interested in each member and the group as a whole. The rater gets the impression that the therapists care in a positive way. Several interventions and their stance indicate this
11. Exploration, curiosity, and not-knowing stance	The therapists pose appropriate questions designed to promote exploration of the patients' and other's mental states, motives, and emotions and communicate a genuine interest in finding out more about them
12. Challenging unwarranted beliefs	The therapists confront and challenge unwarranted opinions about oneself or others in an appropriate manner
13. Regulating emotional arousal	The therapists play an active role in terms of maintaining emotional arousal at an optimal level (not too high so that patients lose their ability to mentalize and not too low so that the session becomes meaningless emotionally)
14. Acknowledging good mentalization	The therapists identify and explore good mentalization and this is accompanied by approving words or judicious praise
15. Handling pretend mode	The therapists identify pretend mode sequences and intervene to improve mentalizing capacity
16. Handling psychic equivalence	The therapists identify psychic equivalence functioning and intervene to improve mentalizing capacity
17. Focus on emotions	The interventions focus primarily on emotions, more than on behavior. The attention is particularly directed at emotions as they are expressed in the here and now in the group, and particularly in terms of the relationship between patients and between patients and therapists
18. Stop and rewind	The therapists identify at least one incident in which patients describe interpersonal events in a noncoherent and affected way, try to slow down the pace, and find out about the event step by step. In a similar way, the therapists halt events in the group that tend to be destructive and take the initiative to explore the sequence together with the patients
19. Focus on the relationship between therapists and patients	The therapists comment on and attempt to explore, together with the patients, how the patients relate to the therapist during the session and stimulate reflections on alternative perspectives whenever appropriate. The therapists speak about their own feelings and thoughts, related to the patients, and through this they try to engage all parties in mutual exploration

Index

Notes

The following abbreviations have been used:
BPD - borderline personality disorder
MBT-G - mentalization-based group therapy

A

AAIs (adult attachment interviews) 10
absenteeism from meetings 104
active listening 61–2
active therapists 129
ADHD (attention deficit hyperactivity disorder) 40
adherence and quality rating scales *see* mentalization-based group therapy
adherence and quality rating scale (MBT-G-AQS)
adherence profile, transcript example 198, 198f
adult attachment interviews (AAIs) 10
affective mentalizing, cognitive mentalizing *vs.* 13–14
Affect Regulation, Mentalization and the Development of the Self (Fonagy et al) 4
amnesia, infantile 6
anger monitoring 146
anxiety disorders, group therapy 41
anxious attachment, BPD 11
attachment 4–7, 136
 anxious 11
 BPD 10
 evolution of 27
 needs, dismissal of 10
attachment hyperactivating strategies 10
attachment theory 123
attendance to meetings 47
attention deficit hyperactivity disorder (ADHD) 40
authenticity of transference 170
authority management *see* MBT-G-AQS item 7: managing authority
autobiographical self (5 to 6 years of age) 6–7
automatic (implicit) mentalizing, explicit (controlled) mentalizing *vs.* 10–12

B

balanced friendliness, therapists 136
Bateman, Anthony 7, vii
behavioural indicators, group membership termination 73
behavioural studies, implicit/explicit mentalizing 10

Bion, Wilfred 3
bipolar II disorder, group therapy 40
borderline personality disorder (BPD) 2–3
 anxious attachment 11
 attachment 10
 borderline groups 2–3
 deactivating/hyperactivating strategies 11
 definition *v*
 family conditions 11
 group therapy *see below*
 internal mentalizing 12
 maltreatment 11
 negative emotions 24
 non-mentalizing 9
 transference problems 171–2
borderline personality disorder, group therapy 18–26, 37–41
 clinical literature 19
 efficacy of 19–20
 problems 18
Bowlby, John 4, 29
BrainMind 33–4

C

CARE 27
 dependency group 36
caring
 for group *see* MBT-G-AQS item 6: caring for the group and each member
 importance of 47
challenging unwanted beliefs *see* MBT-G-AQS item 12: challenging unwanted beliefs
cheating 29
clarification of events, MBT-G 48–9
closing comments, in turntaking 111
closure time, in turntaking 111
cognitive group therapy, MBT-G *vs.* 79–80
cognitive mentalizing, affective mentalizing *vs.* 13–14
cognitive theory 7
Cognitive Therapy in Groups (Free) 80
combined psychotherapy 20
communication
 networks 89
 types of 87–8
complementary countertransference 170–1
component balance, mentalizing 9–10
concordant countertransference 171–2
concreteness of thought 156
conflicts, MBT-G sequence closing 68
conjoint psychotherapy 20–1

continuous interactions 49
 controlled mentalizing *see* explicit (controlled) mentalizing
 controlled premature termination 73
 countertransference 75, 170–3
 complementary 170–1
 concordant 171–2
 reactions 152–3
 crisis plans 16–17
 curiosity *see* MBT-G-AQS item 11:
 exploration, curiosity and not-knowing stance

D

dependency group 36
 destructive group behaviour 124
 devaluation of group by patient 76–7
 developmental psychology 5–7
Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 2
 dialectical behavioural therapy (DBT) 25
 MBT-G vs. viii, 80–2
 distorted communication 87–8
 dynamic formulations 16–17
 dynamic group psychotherapy 26
 dynamic matrix 88

E

educational advantages, MBT-G 47–8
 ego ideal 34
 emotion(s)
 arousal management *see* MBT-G-AQS item 13: regulating emotional arousal
 detector mechanism 30
 dysregulation 161
 focus *see* MBT-G-AQS item 17: focus on emotions
 identification 162
 reactions 64, 65–7
 emotional abuse, PD 164
 emotional bonds 27
 empathy, system for 30
 engagement *see* MBT-G-AQS item 10:
 engagement, interest and warmth
 events in MBT-G 56–8
 clarification of 48–9, 58–60
 external events 65, 120
 see also MBT-G-AQS item 4: engaging group members in mentalizing external events
 graveness in sequence closing 68
 identification 64–7
 see also MBT-G-AQS item 5: identifying and mentalizing events in the group
 mentalizing of 121
 see also MBT-G-AQS item 5: identifying and mentalizing events in the group
 non-exploration of 125–7

 relevance in sequence closing 68
 within the session 120–1
 evolution of thinking, group dynamics 26
Experiences in Groups (Bion) 34–5
 explicit (controlled) mentalizing
 acquisition 32
 definition 10
 implicit (automatic) mentalizing vs. 10–12
 exploration *see* MBT-G-AQS item 11:
 exploration, curiosity and not-knowing stance
 external events 65, 120
 external mentalizing 12

F

facial expression reading 12
 family conditions, BPD 11
FEAR 27
 fight/flight group 36
 fight/flight group 35–6, 146
 RAGE 146
 5–6 years of age (autobiographical self) 6–7
 Fonagy, Peter 3–4, 7
 foundation matrix 88
 4 years of age
 developmental psychology 6
 explicit mentalization 32
 free association 44
 Free, Michael 80
 friendliness, therapists 136–7
 future events, MBT-G 57–8

G

Gabbard's Treatment of Psychiatric Disorders (Gabbard) 22
 Gergly, György 4–5
 good mentalization *see* MBT-G-AQS item 14:
 acknowledging good mentalization
 group(s)
 boundary management *see* MBT-G-AQS item 1: managing group boundaries
 care for *see* MBT-G-AQS item 6: caring for the group and each member
 description of viii
 dynamics *see below*
 norm discussion *see* MBT-G-AQS item 8: stimulating discussions about group norms
 phase regulation *see* MBT-G-AQS item 2: regulating group phases
 purpose in MBT-G 45–6
 therapy *see below*
 group analytic (GA) psychotherapy, MBT-G vs. 82–3
 group dynamics 26–37
 contagious effect 34
 evolution of thinking 26
 group affiliation 26

group cohesion 29
 hierarchal structure 28
 male aggression 28
 primary emotion concerns 27
 primary emotion systems 26
 safety 28
 social behaviour modes 27
 Group Psychotherapy Intervention Rating Scale (GPIRS) 92–3
Group Psychotherapy: The Psychoanalytical Approach (Foulkes & Anthony) 87
 group therapy
 adverse effects 22–4
 cohesion 29
 destructive behaviour 124
 devaluation by patient 76–7
 dynamic psychotherapy 26
 individual therapy vs. 103
 inpatient 77–8
 insecure attachment patterns 39
 primitive defenses 38–9
 rating scales 91–3
 as stand-alone treatment 21
 see also specific types of therapy
H
 hierarchal structure, group dynamics 28
 historical background of MBT-G 1–41
 histrionic features 153
 hospital treatment, MBT-G 15
 hostility 130
 Hrdy, Sarah 27–8
I
 implicit (automatic) mentalizing
 definition 10
 explicit (controlled) mentalizing vs. 10–12
 importance of caring 47
 individual therapy, group therapy vs. 103
 infantile amnesia 6
 inpatient groups 77–8
 insecure attachment patterns, group therapy 39
 institutions 78
 intentionality, shared 31–2
 intention detector mechanism 30
Interaction Process Analysis (Bales) 92
 interactions, continuous 49
 interest *see* MBT-G-AQS item 10: engagement, interest and warmth
 internal mentalizing 12
 interpersonal group psychotherapy (IPT), MBT-G vs. 83–4
 interpersonal transactions 110
 MBT-G 50
 spontaneity 140
 IPT (interpersonal group psychotherapy), MBT-G vs. 83–4

K

Klein, Melanie 35
 Kohut, Heinz, v

L

language, evolution of 32
 Lineham, Marsha 25, 80–1
 listening, active 61–2
 loss of mentalizing 9
LUST 27

M

male aggression, group dynamics 28
 maltreatment, BPD 11
 management of authority *see* MBT-G-AQS item 7: managing authority
 managing emotional arousal *see* MBT-G-AQS item 13: regulating emotional arousal
 marked responses 162
 Marziali, Elsa 84
 member engagement in mentalizing, MBT-G 62–4
 mental health centers (MHCs) 78
 mentalization
 adjustment to level of 102
 definition 3, 5
 external events *see* MBT-G-AQS item 4: engaging group members in mentalizing external events
 good *see* MBT-G-AQS item 14: acknowledging good mentalization
 historical roots 3–4
 measured as reflective functioning 14
 mentalization-based group therapy (MBT-G)
 attendance 47
 continuous interactions 49
 control of 43–4
 course of treatment 72–4
 development of 25
 different contexts 77–9
 educational advantages 47–8
 events *see* events in MBTG
 external–internal mentalizing switch 49
 group phases 53–5
 see also specific phases below
 hospital treatment 15
 interpersonal transactions 50
 last session referencing 48
 matrix 87–90
 member engagement in mentalizing 62–4
 mentalizing training ground 44–50
 metacognition 50
 opening phase 53
 organization of group 48
 outpatient treatment 15–16
 phase termination 53, 55
 previous meeting summation 53–4, 106, 115

- mentalization-based group therapy (*continued*)
 - principles of 43–90
 - prior interviews 46–7
 - purpose of group 45–6
 - rating scale *see below*
 - sequence closing 68–9
 - sequence of event clarification 49
 - slow-open groups 70–1
 - starting groups 69–72
 - starting session 48
 - structure 25–6, 44
 - subject matter 99
 - successful 99
 - termination of group 72–4
 - themes of 99
 - therapist role 45
 - transcript of 175–205
 - turntaking 48, 55–6
 - see also* MBT-G-AQS item 3: initiating and fulfilling turntaking
 - unparticipatory members 59–60
 - working (middle) phase 53, 54–5, 106
 - see also* therapists
- mentalization-based group therapy adherence
 - and quality rating scale (MBT-G-AQS) 91–8, 217, 219–20
 - items 93–5, 99–174, 217
 - see also specific items below*
 - rater training and reliability 98
 - rating of occurrence 95–6, 205
- MBT-G-AQS item 1: managing group boundaries 104–6
 - rating of occurrence 105
 - rating of quality 105–6
 - transcript example 199
- MBT-G-AQS item 2: regulating group phases 106–9
 - fair example 107
 - poor example 107–8
 - rating of occurrence 108
 - rating of quality 109
 - transcript example 199
- MBT-G-AQS item 3: initiating and fulfilling turntaking 109–15
 - example of good practice 111–12
 - example of poor practice 112–13
 - rating of occurrence 113–14
 - rating of quality 114–15
 - transcript example 200
- MBT-G-AQS item 4: engaging group members in mentalizing external events 115–20
 - example of good practice 116–17
 - rating of occurrence 118
 - rating of quality 119–20
 - transcript example 200
- MBT-G-AQS item 5: identifying and mentalizing events in the group 120–3
 - rating of occurrence 122–3
 - rating of quality 123
 - transcript example 200–1
- MBT-G-AQS item 6: caring for the group and each member 123–8
 - example of good practice 124–5
 - example of poor practice 125–7
 - rating of occurrence 128
 - rating of quality 128
 - transcript example 201
- MBT-G-AQS item 7: managing authority 128–31
 - example of good practice 129
 - example of poor practice 129–30
 - rating of occurrence 131
 - rating of quality 131
 - transcript example 201
- MBT-G-AQS item 8: stimulating discussions
 - about group norms 130–3
 - rating of occurrence 133
 - rating of quality 133
 - transcript example 201
- MBT-G-AQS item 9: cooperation between co-therapists 133–6
 - example of good practice 134–5
 - rating of occurrence 135
 - rating of quality 135–6
 - transcript example 201
- MBT-G-AQS item 10: engagement, interest and warmth 136–8
 - rating of quality 137–8
 - transcript example 201
- MBT-G-AQS item 11: exploration, curiosity and not-knowing stance 138–42
 - rating of occurrence 140–1
 - rating of quality 141–2
 - transcript example 202
- MBT-G-AQS item 12: challenging unwanted beliefs 142–4
 - rating of occurrence 143
 - rating of quality 143–4
 - transcript example 203
- MBT-G-AQS item 13: regulating emotional arousal 144–9
 - example of poor practice 148
 - rating of occurrence 148
 - rating of quality 148–9
 - transcript example 203
- MBT-G-AQS item 14: acknowledging good mentalization 149–51
 - rating of occurrence 150
 - rating of quality 150–1
 - transcript example 203
- MBT-G-AQS item 15: handling pretend mode 151–6
 - rating of occurrence 155
 - rating of quality 155–6
 - transcript example 203

- MBT-G-AQS item 16: handling psychic equivalents 156–61
 example of good practice 157–9
 rating of occurrence 160–1
 rating of quality 161
 transcript example 204
- MBT-G-AQS item 17: focus on emotions 161–6
 rating of occurrence 162–5
 rating of quality 165–6
 transcript example 204
- MBT-G-AQS item 18: stop and rewind 166–7
 rate of quality 167
 rating of occurrence 167
 transcript example 204–5
- MBT-G-AQS item 19: therapist–patient relationship 167–74
 rating of occurrence 173–4
 rating of quality 174
 transcript example 205
- mentalization-oriented psychotherapy 14
- mentalizing
 affective vs. cognitive 13–14
 component balance 9–10
 controlled *see* explicit (controlled) mentalizing
 dimensions of 8–10
 explicit *see* explicit (controlled) mentalizing
 external 12
 failure identification 60–2
 implicit vs. explicit 10–12
 internal 12
 internal vs. external 12–13
 loss of 9
 member engagement in 62–4
 regaining 9
 rigidity 9
 self 13
 self vs. other 13
- mentalizing training ground, MBT-G 44–50
- mental state interpretations 102
- metacognition
 4 years of age 6
 MBT-G 50
- MHCs (mental health centers) 78
- “minding the group,” therapists 50–3
- mirror neurons 34
- multiround economic exchange game 12–13
- Munroe-Blum, Heather 84
- N**
- narratives, group membership termination 73–4
- neuroaffective theory 35–6
- neurobiological studies, implicit/explicit mentalizing 10
- neuroimaging studies, implicit/explicit mentalizing 10
- 9 months of age, developmental psychology 5
- normality issues 165
- not-knowing stance 139
see also MBT-G-AQS item 11: exploration, curiosity and not-knowing stance
- O**
- Oneself as Another* (Ricoeur) vi
- opening phase, MBT-G 53
- open questions 62
- other mentalizing, self mentalizing vs. 13
- outpatient treatment 78
 MBT-G 15–16
- P**
- pairing group 36
- panic attacks 127–8
- Panksepp, Jaak 35
- paranoid personality disorder (PPD) 8
- patient(s)
 group devaluation 76–7
 poor functioning 75–6
 relationship with therapists *see* MBT-G-AQS item 19: therapist–patient relationship
- personality assessments 16–17
- personality disorders (PDs) 7–8
 emotional abuse 164
- Pines, Malcolm v
- PLAY* 27
 pairing group 36
- poor functioning patients 75–6
- post-session meetings, therapists 51–3, 133
- prementalistic thinking 6
- pre-session meetings, therapists 51–3, 133
- pretend mode 151–2
 speech of 152
see also MBT-G-AQS item 15: handling pretend mode
- primary emotions, group dynamics 26, 27
- primate identification 28–9
- primitive defenses, group therapy 38–9
- prior interviews, MBT-G 46–7
- private practice 77, 79
- pseudomentalizing 39–40, 151
- pseudotherapy sequences 153–4
- psychic equivalence, concreteness of thought 156
- psychic equivalents *see* MBT-G-AQS item 16: handling psychic equivalents
- psychodynamic (PD) group psychotherapy, MBT-G vs. 82–3
- psychoeducational groups 69–70
- psychology, developmental *see* developmental psychology
- psychotherapy
 combined 20
 conjoint 20–1
 dynamic group 26
 mentalization-oriented 14

Q

quality of object relations (QOR) 21–2

R

RAGE 27

- fight/flight group 146
- rater training and reliability, MBT-G-AQS 98
- rating of occurrence, MBT-G-AQS 95–6
 - initiating and fulfilling turntaking 113–14
 - item 4: engaging group members in mentalizing external events 118
 - item 5: identifying and mentalizing events in the group 122–3
 - item 6: caring for the group and each member 128
 - item 7: managing authority 131
 - item 8: stimulating discussions about group norms 133
 - item 9: cooperation between co-therapists 135
 - item 11: exploration, curiosity and not-knowing stance 140–1
 - item 12: challenging unwanted beliefs 143
 - item 13: regulating emotional arousal 148
 - item 14: acknowledging good mentalization 150
 - item 15: handling pretend mode 155
 - item 16: handling psychic equivalents 160–1
 - item 17: focus on emotions 162–5
 - item 18: stop and rewind 167
 - item 19: therapist–patient relationship 173–4
 - managing group boundaries 105
 - regulating group phases 108
- rating of overall occurrence and quality, MBT-G-AQS 98
- rating of quality, MBT-G-AQS 96–7, 105–6, 128, 127–8
 - initiating and fulfilling turntaking 114–15
 - item 4: engaging group members in mentalizing external events 119–20
 - item 5: identifying and mentalizing events in the group 123
 - item 7: managing authority 131
 - item 8: stimulating discussions about group norms 133
 - item 9: cooperation between co-therapists 135–6
 - item 11: exploration, curiosity and not-knowing stance 141–2
 - item 13: regulating emotional arousal 148–9
 - item 14: acknowledging good mentalization 150–2
 - item 15: handling pretend mode 155–6
 - item 17: focus on emotions 165–6
 - item 18: stop and rewind 167
 - item 19: therapist–patient relationship 174

- regulating group phases 109
- tem 10: engagement, interest and warmth 137–8
- tem 12: challenging unwanted beliefs 143–4
- tem 16: handling psychic equivalents 160, 161
- transcript example 198, 199f
- reflective functioning (RF) 14, 101–2
- Ricoeur, Paul vi
- rigidity, mentalizing 9

S

- safety, group dynamics 28
- SEEKING* 27, 138
- self-awareness ability 30
- self-destructive act control, group membership termination 73
- self-development 4–7
- self-mentalizing, other mentalizing vs. 13
- self-report studies, attachment in BPD 10
- self-righteous attitudes 157
- separation distress 146
- SEPARATION DISTRESS* 27
 - dependency group 36
- sequence of event clarification, MBT-G 49
- SEX*, pairing group 36
- shared intentionality 31–2
- Skills Training Manual for Treating Borderline Personality Disorder* (Linehan) 81
- slow-open groups, MBT-G 70–1
- social behaviour modes, group dynamics 27
- speech, pretend mode 152
- starting session, MBT-G 48
- Stern, Adolf 3
- Structured Clinical Interview for DSM-IV Axis disorders (SCID-II) 2, 16–17
- subject matter, MBT-G 99
- system for empathy 30

T

- termination phase
 - controlled premature 73
 - MBT-G 53, 55
- therapists
 - active 129
 - activity monitoring 58
 - balanced friendliness 136
 - caring, importance of 47
 - co-operation between *see* MBT-G-AQS item 9: cooperation between co-therapists
 - errors 103
 - exploitation of 76
 - group organization 48
 - interventions 100
 - meeting coordination 74–7
 - “minding the group,” 50–3
 - post-session meetings 51–3, 133

pre-session meetings 51–3, 133
 relationship with patients *see* MBT-G-
 AQS item 19: therapist–patient
 relationship
 roles 45
 sophistication of 102
 talking during meetings 134
 turntaking control 110–11
 thought, concreteness of 156
 transactions, interpersonal *see* interpersonal
 transactions
 transference 168–70
 alternative perspectives 170
 authenticity of 170
 validation of 169
 turntaking
 MBT-G 48, 55–6
 therapists' role 110–11

see also MBT-G-AQS item 3: initiating and
 fulfilling turntaking
 2 years of age 5–6

U

unparticipatory members, MBT-G 59–60

V

validation of transference 169
 verbal language, evolution of 31

W

warmth *see* MBT-G-AQS item 10: engagement,
 interest and warmth
 working (middle) phase, MBT-G 53, 54–5, 106

Y

Yalom, Irvin 83

