

# National curriculum for mentalisation based treatment

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## Introduction

MBT is an evidence-based treatment for emotionally unstable or so-called borderline personality disorder (EUPD/BPD) and is included in the NICE Guideline for the treatment of BPD and in the Cochrane Review of treatments for BPD. The content of this national curriculum is aligned to the knowledge and skills covered in the MBT specific section of the Roth and Pilling competence framework<sup>1</sup>. Recruitment for the courses will be aimed at clinicians who can already evidence core competences for work with individuals with personality disorder, general therapeutic competences and assessment and formulation competences specified in the Roth and Pilling framework. These clinicians may be drawn from qualified mental health professionals such as psychiatrists, practitioner psychologists, mental health nurses, allied health professionals, psychotherapists, counsellors as well as people with experience of mental health in other professional capacities including graduate entry mental health workers who can demonstrate professional and academic equivalence. The curriculum ensures trainees have ability to reach a level of competence that would enable them to obtain the outcomes reported in the NICE Guidelines.

Trainees will work in adult mental health services where individuals with EUPD/BPD commonly present for treatment including Community Mental Health Teams as well as specialist Personality Disorder services.

## Course Aims and Objectives

Courses will aim to provide trainees with the knowledge and conceptual understanding of mentalising, its relevance to clinical problems associated with EUPD/BPD and the clinical skills to deliver MBT to a defined standard of competency. Courses will aim to increase trainees' knowledge of the developmental understanding of mentalising, its relevance to understanding psychological functioning as a higher order social cognitive system, its clinical application to mental disorder as mentalisation based treatment (MBT), and its underlying research base. Ultimately, the training will equip trainees to become skilled and creative independent MBT practitioners in accordance with quality assurance guidelines for good practice as published by the Anna Freud National Centre for Children and Families (AFC), a Registered Incorporated UK Charity.

At the end of the course students will be able to:

1. Demonstrate a detailed understanding of the knowledge and research base of mentalising and the concepts and principles underpinning the mentalising approach (the mentalising frame of reference)
2. Understand the developmental and cognitive processes involved in generating effective mentalising
3. Demonstrate a critical understanding of the research evidence for mentalising and MBT
4. Recognise the range of applications of MBT techniques
5. Conceptualise clinical phenomena generally considered under the heading of personality disorder in the mentalising framework as limitations in effective mentalising
6. Follow the principles of MBT and their application in clinical practice

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<sup>1</sup> Psychological Interventions with People with Personality Disorder Competence Framework:  
<https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-12>

7. Practise MBT with clients presenting with problems associated with personality disorder skilfully and effecting good outcomes
8. Develop a detailed personalised conceptualisation/formulation of a client's presenting problems using a mentalising frame of reference
9. Develop in a collaborative manner with the client a systematic mentalising formulation to focus therapeutic intervention
10. Develop specific treatment plans, including initial aims, using the formulation and the MBT framework
11. Support people with personality disorder, particularly those with BPD, who are at high risk of self-destructive behaviours using the MBT mentalising functional analysis
12. Utilize understanding of mentalising to creatively manage complex issues arising in clinical practice
13. Demonstrate ability to use the therapeutic relationship to generate an alliance, form a relationship characterised by epistemic trust ensuring the generalisation of learning from therapy to the client's broader social world
14. Select and agree appropriate session monitoring measures and instruments to assess outcome and guide treatment process toward greater effectiveness.
15. Be an evidence-based practitioner recognising strengths and limitations of own clinical practice
16. Be reflective and use MBT skills to help manage interpersonal issues arising as part of clinical work and other stressors
17. Commit to maintaining and developing additional skills in MBT.

## **MBT Competences**

At the end of this training participants will be able to demonstrate knowledge and skills relating to the following competencies:

The general competencies outlined below are aligned to the Roth and Pilling MBT competency framework.

- Knowledge of the developmental model underpinning an understanding of BPD and other personality disorders
- Knowledge of the aims and focus of the intervention
- Knowledge of the intervention strategy
- Therapeutic stance
- Model-specific areas of assessment
- Engagement
- Formulation and planning
- General content of interventions
- Usual process of intervention
- Facilitating the client's capacity to mentalise
- Ability to re-establish mentalising
- Helping the client to mentalise the therapy relationship
- Working with prototypical impulsive behaviours of personality disorder
- Ending the intervention

Each component of the curriculum contains general and specific learning outcomes. It is anticipated that the general learning outcomes and competencies will already be achieved by participants. The assessment and formulation competences and specific competences for MBT

accumulate as students progress through the six MBT training components. Competences in this framework should be read in conjunction with the two published MBT treatment manuals (Bateman & Fonagy, 2006, 2016). For more information on the competencies please refer to:

Psychological Interventions with People with Personality Disorder Competence Framework:  
<https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-12>

### Course Structure

Courses will be organised to ensure trainees can meet practitioner requirements within 1 year, although some students may take longer to meet supervision and competency requirements due to personal and work circumstances.

Training providers may adjust the training format for example in terms of blocks of teaching or weekly training days, to meet the following requirements of training:

1. A minimum equivalent to 3 days basic knowledge and clinical skills training for clinicians to start practising MBT clinical interventions
2. Supervision of clinical work in the workplace – either within the clinical team if an accredited MBT supervisor is available or from an appointed MBT supervisor through telephone, video conferencing. Supervision will be minimum of twice monthly for 1 hour with a minimum of 22 supervision sessions attended.
3. Weekly peer supervision with other clinicians developing MBT skills. Attendance at a minimum of 40 peer supervision sessions over the training year
4. Satisfactory demonstration of competencies through the treatment of 4 patients for at least 24 sessions each in individual MBT and co-clinician for 1 MBT group for minimum of 40 sessions
5. Work as a co-clinician with an MBT practitioner in a complete MBT-Introductory group
6. Satisfactory completion with an accredited supervisor of 4 hours of MBT supervision on each patient with no more than 3 other supervisees (from the same team when possible if enough clinicians working as a team are at the same stage of training).
7. Observation and discussion and review of video or audio tapes of the trainee's MBT individual sessions – 3x15 minute sections from different sessions over the whole treatment for each patient.
8. A minimum attendance equivalent to 2 days at a MBT higher skills workshop comprising clinical presentation of own clinical work with video/audio when possible, with adherence scale review, and clinical role plays.

Students will:

1. Attend the 3-day basic skills course and 2-day higher skills practitioner training course or equivalent according to course arrangements decided by the provider. 100% attendance required
2. Treat a minimum of 4 cases for a minimum of 24 sessions to embed basic and practitioner MBT skills
3. Run a full MBT-introductory group of 10-12 sessions
4. Act as joint therapist for an MBT group for minimum of 9 months
5. Regularly review video or audio sessions from MBT sessions with a course-approved supervisor. One video/audio MBT session to be rated using the MBT adherence scale (available

at <https://www.annafreud.org/training/mentalization-based-treatment-training/mbt-adherence-scale/>

6. Maintain a record of clinical practice and supervision
7. Provide a written reflective summary of an MBT case to be discussed with supervisor

### Trainer Qualifications

The lead trainer of the course should be an accredited MBT trainer as accredited by Anna Freud National Centre, MBT Scotland, MBT Netherlands, TMB Francophone or other AFC listed MBT organisation. Staff teaching on the course must be on the MBT practitioner list of the British Psychoanalytic Council with some being at MBT supervisor level as accredited by Anna Freud National Centre, MBT Scotland, MBT Netherlands, TMB Francophone or other AFC listed MBT organisation.

### Entry Requirements

Training providers must formally assess suitability of trainees in detail against the following requirements:

- Demonstrate evidence of all of the following as outlined in the Roth and Pilling Framework for Psychological Interventions for people with Personality disorder:
  1. Core competences for working with people diagnosed with a personality disorder.
  2. Generic therapeutic competences.
  3. Assessment and formulation competences.

This must be assessed formally before admission to the course through direct observation of psychological therapy practice (role play or recording) and a written case study demonstrating each competence.

Practitioners attending the course are expected to:

- Be given the required amount of time built into their job plan to undertake the training, required casework and associated supervision to become proficient in the approach.
- Be highly motivated to treat people with personality disorder and to undertake what can be demanding programmes of study.
- Have the required experience and competences for the training e.g. mental health professional, skilled in basic psychological interventions and competence in managing risk;
- Have the required job roles with identified capacity and at the required grade to implement MBT and manage patients at risk;
- Have time for the required specialist supervision during and beyond the training period;
- Spend a minimum of two days per week implementing the interventions they are being trained in. Any less would be considered a poor return on public investment in the training and is likely to lead to rapid skills decay post-training.

### Service Organisation

Training and service managers sending clinicians to MBT training are committed to sending enough clinical staff to develop a comprehensive MBT programme in clinical services comprising:

1. A minimum of 1 MBT supervisor for the clinical team
2. A minimum of 3 MBT clinicians working towards practitioner level (to meet the standard requirements of 3 or more practitioner level clinicians in the clinical team)
3. MBT-Introductory groups
4. A weekly MBT group lasting a minimum of 75 minutes
5. Provision of weekly MBT individual sessions for clients
6. MBT-FACTS families programme as required
7. Integration with crisis and other services open to the client

### Learning and Teaching Strategy

The specific learning and Teaching Strategy can be decided by the training provider but should incorporate the following:

1. MBT is principle driven and based on an evidence based developmental model of personality development. Training will establish critical understanding of the developmental model and establish a programme of learning that translates coherently the knowledge base into a clinical programme covering all modules of training.
2. Training will include didactic learning, personal study and a range of methods to generate skills acquisition, integrating learning and practice in the training course as an experiential space with clinical practice in the workplace. Didactic learning, academic study and skills acquisition will be used creatively in all modules.
3. Knowledge and up-to-date research acquisition will be acquired partly through recommended reading prior to the course and before each module, personal academic study and didactic teaching.
4. Web-based materials will be made available to participants for study, including lectures and clinical examples of techniques.
5. MBT is a self-reflective intervention with some knowledge being clinically derived through identifying a clinical problem, researching the literature in academic study, discussing the findings, and implementing a solution. This practice-based learning will be incorporated into training.
6. Skill acquisition in all modules will be at the programmatic level through experiential learning during the training course and at the point of clinical practice. The range of methods may include observation of expert intervention, role play of common clinical situations followed by review with experts and a clinical team, clinical practice in the workplace using video observation and/or active feedback in a session, and other methods as appropriate.
7. Trainings will provide continual opportunity for skills acquisition over time giving a robust foundation for the implementation of MBT as a co-ordinated and structured programme of treatment.
8. Self-reflective practice will be engendered through modelling from trainers, supervision of teamwork, clinical case discussion and personal supervision of personal clinical practice which will include video/audio observation. Supervision will be provided by course staff and also within the clinical team.
9. MBT is outcomes based at the level of individual and group sessions. Personalising patient level outcomes and facilitating case management, for example in module 2 on formulation, will be delivered through course work, team supervision, and clinical presentation of personal work and discussion.



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10. MBT is relationally transactional at the level of patient-clinician interaction. Training will use didactic, experiential and reflective process to incorporate this core aspect of MBT throughout the training and particularly in the advanced skills module through work-based supervision, peer discussion, and by facilitating clinician self-reflective process.

Training Providers will offer a programme that meets the following requirements:

1. Training Days 1-3
  - a. cover all aspects of the 6 components of the MBT curriculum
  - b. ensure that trainees receive the knowledge base underpinning MBT
  - c. generate MBT clinical skills to a competence level which allows trainees to start implementation of MBT in the workplace safely with supervision.
2. Provide expert supervision to trainees in the workplace after trainees have met requirements of Days 1-3. Supervision will:
  - a. Support further development of higher-level clinical skills from all components of MBT using appropriate methods to include clinical presentation and discussion, video/audio, role play
  - b. Initially focuses on generating skills of components 2,3 and 4. Once these are achieved, supervision will support learning of MBT skills to a higher level of competence of all 6 components of MBT but focus on components 5 and 6.
  - c. Prepare trainees for training days 4 and 5
  - d. Include focus on:
    - Support for MBT teams to develop a service integrated within the overall pathway of local mental health services to create an environment supporting the delivery of MBT
    - Skill development to structure MBT sessions and establish a coherent intervention process
    - Observation, practice, and illustration of specific MBT interventions
    - Understanding of the use of clinician mind states in relation to patient mind states as part of relational work in treatment of people with personality disorder
    - Team working to facilitate the delivery of MBT including the integration of individual and group MBT
    - Mentalising management of risk and comorbidity as an integrated aspect of MBT
    - Recognition of similarities and differences between MBT and other treatments for personality disorder
3. Training Days 4-5
  - a. embed clinical skills learned in Days 1-3 and subsequently developed further in supervision in the workplace, focusing on a higher level of competence of implementation
  - b. focus on higher level competences of more complex interventions in MBT of components 5 and 6.
  - c. Support learning for self-reflection and self-assessment of adherence to MBT model
4. Use the learning and teaching strategies flexibly in all aspects of training to meet the general and specific learning outcomes of each MBT component.
5. Establish an integrated programme of Days1-3 and Days 4-5 to deliver all components of MBT training as a coherent evidence-based intervention.

A 3-day (Day 1-3) or equivalent basic training covering all 6 components of the curriculum, for example delivered flexibly over a series of half-days, will:



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- a) Provide the knowledge and research framework and the principles underpinning MBT which are to be followed in delivering MBT
- b) Result in an understanding of service organisation for providing MBT as a team approach and the clinical processes required for adherent implementation of MBT
- c) Give opportunity to observe and practise in a safe training environment all the skills required to deliver MBT interventions to the level that the trainee can commence delivery of MBT in the workplace.
- d) Instil an ability to work with self-observation and self-reflection and to use these to improve clinician implementation of mentalising interventions in the clinical practice in the workplace.
- e) establish a mentalising attitude in clinical practice and an ability to distinguish characteristics of interventions that stimulate mentalising and interventions that undermine mentalising.
- f) Introduce the MBT group approach to skill the trainee-to-become.

The 2 day (Day 4 and 5) or equivalent practitioner course will follow adequate practice in the clinical workplace and embed skills to a higher level of competence during/after supervised practice in the workplace. Whilst embedding the skills learned earlier and re-visiting those developed through supervision, the focus of Days 4 and 5 will be on higher level competences particularly of components 5 (Group MBT) and 6 (Relational Mentalising). Training methods will be flexible but will include video of MBT sessions and a focus on developing higher skills. Whilst these and other core MBT skills will have been outlined in earlier training, their implementation requires careful application in clinical practice to achieve higher level skills.

Days 4-5 higher level competence practitioner course will:

- a) Embed core skills of MBT in both individual and group context following practice in the workplace
- b) Increase understanding of the flexibility inherent in MBT to engage in patient centred treatment
- c) Establish peer group supervisory practice of specific MBT interventions and clinical management of sessions.
- d) Ensure higher skills are developed for the core interventions of MBT, in particular the higher skills associated with working clinically with relational mentalising
- e) Generate discussion in teams to develop a pathway towards becoming a self-sustaining MBT service over time.
- f) Establish confidence in skill to deliver all aspects of relational mentalising
- g) Establish understanding and clinical use of the MBT adherence scale to support self-reflective practice.

### Assessment

Formal assessment must be incorporated into training and will include:

- Direct observation of MBT individual or group session
- Formative video/audio recording of MBT and review
- Summative video/audio recording showing competence and fidelity to model assessed using MBT adherence scale
- Clinical case report outlining mentalising formulation and intervention and outcomes discussed with MBT team and colleagues.

- MCQ questions on basics of mentalising and MBT with 75% pass mark

Logbook of specific experience requirements and learning  
(may include):

- Observation of role plays of clinician managing clinical session problem
- Written material including literature review, research assessment

### Equality and Cultural competence

Course objectives to acquire cultural competence align with statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between people of shared protected characteristics and those who do not. Achieving cultural competence is a lifelong learning process and students will be expected to participate in mandatory training on this issue within their NHS organisation.

Courses will consider a culturally normative view of mentalising and recognize that the foregrounding mentalising may on the surface represent a particular Western orientation that may seem alien to those brought up with social influences where individual subjectivity was apparently less valorised. The teaching must communicate the recognition that mentalising is a developmental phenomenon and always acquired within specific social context and, as language, will evince the priorities of its human ecology. But taking a different perspective the training should show that mentalising is perhaps the only genuinely valid approach to appreciating cultural differences and the genuine appreciation of alternative perspectives. Thus the programme should communicate that the focus of MBT on subjectivity is far from being culture bound but rather represents signposting the therapist and patient to the core of human nature biologically embedded in the intimately related constructs of community, trust, culture and cooperation. So far from mentalising being bound in any one culture, it serves to bind groups together to form culture and understand cultural differences.

### Experts by Experience (EbE) and Families

Courses will recognise the value of experts by experience in training and in MBT service development and provision. MBT also has expert by experience involvement in engagement of clients and in treatment groups. MBT learns from experts in a reciprocal manner.

Family involvement in treatment of people with BPD is essential. Courses will take this into account in training.

## **Implementation**

Training providers will:

1. Integrate the formal training with the clinical services to ensure clinicians have an appropriate context and job plan for clinical implementation.
2. Assess regularly if the MBT service is working towards meeting the requirements of a comprehensive MBT programme
3. Support course participants in obtaining their clinical experience
4. Ensure routine outcome monitoring of treatment is in place
5. Engage experts by experience in co-design and delivery of the training programme where possible.
6. Organise training provision to deliver the competences defined in the MBT components

## MBT Components

### Component 1: Theories and Principles of MBT

MBT is governed by principles rooted in an empirically based understanding of mentalising, its role in development and effects on personality functioning. Training will enable students to conceptualise personality disorder as reflecting ineffective mentalising using the core theories of mentalising and its developmental roots, and to use this to organise treatment intervention specific to the mentalising difficulties of the individual, recognising that MBT takes an idiopathic approach to treatment.

#### Learning Outcomes

- Knowledge of the developmental model underpinning an understanding of BPD
- Knowledge of the aims and focus of the intervention
- Knowledge of the intervention strategy related to the mentalising model of PD

#### General learning outcomes

This component of training will allow students to critically appraise the knowledge base underpinning MBT and generate understanding of how to translate this into clinical skills.

- Knowledge of the developmental model underpinning an understanding of BPD including the following:
  - a) a mentalisation based approach is grounded in neurobiology and attachment theory;
  - b) the MBT model formulates the vulnerabilities associated with BPD as arising from the loss of a capacity for mentalisation in the context of attachment relationships
  - c) developmental factors and experiences typically associated with a vulnerability to a loss of mentalisation (e.g. a history of neglect, abusive relationships, or attachment trauma)
  - d) vulnerability to a loss of a capacity for mentalisation makes it likely that the client's internal reality will rest on modes of experiencing associated with early phases of development, and that this will undermine the coherence of self-experience
- Knowledge of the aims and focus of the intervention:
  - a) MBT aims to increase the client's capacity to mentalise at points where this would otherwise be lost
  - b) indicators that signal 'effective' and 'ineffective' mentalising and where support is needed
  - c) intervention techniques are designed to support the recovery and maintenance of mentalisation (and not the acquisition of insight into unconscious dynamics)
  - d) intervention systematically focuses on the client's state of mind (not their behaviour) and how to manage the client's affects in the here-and-now of the session or recent past (not on the interpretation of distal or unconscious events)
- Knowledge of the intervention strategy
  - a) Knowledge of the three main phases of treatment and their aims:

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- i) an initial engagement phase (which is also used to assess the client's capacity to mentalise, to make a collaborative formulation, develop a crisis plan, and set reviewable short- and long-term aims)
- ii) a middle phase, which focuses on helping the client to develop a capacity for mentalising and to retain it amidst emotional states
- iii) a final phase which focuses on preparation for ending the treatment
- b) Knowledge that the intervention makes active use of the client-therapist relationship to explore failures of mentalisation and their consequences
- c) Knowledge that the trajectory of sessions usually follows a stepwise process (moving from initial support to affective and interpersonal exploration)
- d) Knowledge of the indicators for the different MBT interventions especially those focused on affect and challenges
- e) Knowledge of the need to maintain client arousal at an optimal level in order to facilitate their capacity for mentalising.

## **Component 2: Clinical application of MBT**

This component enables participants to translate the principles learned in Component 1 into an organised MBT service. MBT requires 3 or more practitioners to work together as a clinical team to implement the model within their own setting. Implementation requires agreement about referral criteria, ability to assess people for personality disorder, skills to set up the framework of treatment individually and in an MBT introductory group, agreement of how to monitor progress in treatment and how to assess overall outcomes of treatment.

The curriculum will comprise the following:

- Development of skills in conceptualising clinical presentations within an MBT framework
- Working jointly with clients to agree this framework
- Identifying the immediate foci for treatment and organising those within longer term goals
- Identifying with the client ineffective mentalising modes to name, note and explore them to establish more stable mentalising
- Agreement on measures to monitor the foci of treatment

### Learning Outcomes

This component covers all the skills required to structure treatment and collaboratively agree a pathway for effective engagement and treatment through formulation and planning and introduction of the framework. Students will develop skills and understanding of the following:

### General Learning Outcomes

- Ability to share a written formulation with the client that uses examples drawn from the assessment to set out relevant issues relating to their vulnerability to a loss of mentalising and its adverse consequences, balancing this with examples of the benefits when mentalising has been maintained.
- Ability to work collaboratively with the client to agree short term and long term aims, and to identify what the client can do for themselves in a crisis and how they will access help if necessary
- Ability to monitor and validate the client's reactions to the formulation and to re-visit and revise the formulation accordingly
- Ability to identify the client's main subjective concerns and problem areas and link those in the formulation to a pathway for change
- Skills to deliver information about mentalising, personality disorder, attachment and other aspects of the framework for treatment

## **Component 3: Core components of MBT interventions**

This component introduces the therapeutic stance and the basic therapeutic interventions that facilitate and stabilise mentalising. MBT specifically targets the clients mental processing. Facilitating mentalising process in group and individual treatment requires empathic validation, recognition of ineffective mentalising modes and the contribution to these from imbalances in the dimensions of mentalising, reciprocity and balance in the therapeutic interaction, exploration of poorly mentalized experiences for learning about oneself and others and consideration of attachment processes and social and interpersonal interaction to effect more constructive social interaction and understanding of personal biases.

### **Learning Outcomes**

This component will allow students an opportunity to develop and practise skills in the following:

#### **General Learning Outcomes**

- Ability to establish and maintain a supportive, reassuring and empathically validating relationship and therapeutic stance with the client
- Ability to adopt an authentic stance of 'not knowing' in order to communicate that a genuine attempt is being made to find out about the client's mental experience
- Ability to sustain a non-judgmental, mentalising stance, prioritising joint exploration of the connection between the client's mental states and behaviours and interpersonal processes
- Ability to sustain a positive supportive stance while maintaining boundaries and without undermining the client's autonomy
- Ability to judge when and how self-disclosure is appropriate as a way of fostering mentalising (e.g. by communicating their own way of thinking about the client's experiences, or reflecting on their own non-mentalising errors)
- Ability to make interventions characterised by:
  - (a) a focus on the client's thoughts and wider mental states rather than their behaviour
  - (b) a focus on affect, primarily in relation to the here-and-now of the session
  - (c) a focus on current events and on conscious or near-conscious content
  - (d) the use of simple, short and unambiguous statements
  - (e) the use of qualified and tentative statements that model the management of uncertainty in relation to the mental states of others
- Ability to restate the assumptions accurately and succinctly behind the client's thoughts and feelings, in a manner that neither oversimplifies nor overcomplicates their experience
- Ability to tailor interventions to the mentalising capacity of the client
  - (a) recognises the level of anxiety determines the type of intervention
  - (b) the clinician does not meet non-mentalising in the client with his own high level of mentalising)
  - (c) the clinician does not take over the client's mentalising – performing the mentalising for the client does not exercise the client's mentalising necessary for improvement.
- Usual process of intervention
  - a) Ability to respond to the client's requests for clarification in a direct and clear manner that models a self-reflective stance that is open to correction



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- b) Ability to follow changes in the client's understanding of their own and others' thoughts and feelings
- c) Ability to identify and respond sensitively to failures of mentalisation in the client, and to make use of the here-and-now relationship to help the client notice and explore the consequences of these failures
- d) Ability to titrate the timing and the type of interventions in relation to the client's current emotional state, and so maintain an optimal level of arousal that supports (and does not disrupt) mentalising

## **Component 4: Ineffective mentalising modes**

This component builds on earlier components to enable students to develop skills in managing ineffective/non-mentalising modes. MBT describes 3 modes of ineffective mentalising – psychic equivalence, teleological function, and pretend mode. Each mode is formed from an imbalance or rigidity of the dimensions of mentalising and each mode has recommended interventions to support the return of mentalising.

The curriculum will comprise skills in the following:

- Recognition of a client’s vulnerabilities to lose mentalising
- Ability to explore the cascade of mental change occurring in a client when mental processing changes from mentalising modes to ineffective mentalising modes
- Conducting interventions to re-instate mentalising when lost and to stabilise mentalising sensitive to anxieties

### **Learning Outcomes**

Ability and skills to

- distinguish mentalisation from:
  - a) hypermentalising (e.g. appearing to mentalise but in a way that is not linked to appropriate affect, or where discussion of thoughts and feelings leads to rapid and unreflective attribution of motives of others and oneself that are not rooted in any reality) and other forms of pretend mode;
  - b) concrete thinking/psychic equivalence (where reality is equated with mental states, and the sense of representation of mental states is absent)
  - c) a teleological understanding of motives (where internal states are assumed from what happens in the external world)
  - d) misuse of mentalisation (e.g. using an understanding of another’s mental state to exert power over them, rather than to communicate and foster understanding)
- use clarification and elaboration to explore feelings and mentalising associated with a specific behavioural sequence – a mentalising functional analysis
- identify collaboratively and name and note ineffective mentalising states
- restate and elaborate the client’s description of thoughts, feelings, beliefs and other mental states in a way that opens up further discussion
- use sensitive diversion from content of low mentalising to rekindle mentalising process in related content
- help the client develop curiosity about their motivations and underlying mental states, and make links between their actions and feelings and mentalising or loss of mentalising
- help the client identify instances where they have failed to ‘read minds’ (their own or others), and the consequences of this failure
- shift the client’s focus to their felt experience, motivations and current state of mind, and to point out non-mentalising ‘fillers’ (such as rationalisations, or dismissive statements)
- maintain the balance and flexibility of the main dimensions of mentalising within the client’s mental processes and in the interpersonal process of the client-clinician relationship

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- identify failures in mentalising (by the client, therapist or both) and to redirect the focus on understanding the rupture or impasse
- challenge the client's perspective while exploring their underlying emotional state
- communicate the affective processes that inhibit the capacity to mentalise
- sensitively yet firmly persist with a focus on exploring the client's state of mind in the face of difficulty re-establishing mentalising.

## **Component 5: Clinical Skills in Group MBT**

This component builds on skills learned in all earlier components. MBT is delivered in individual and group formats and clinicians need to be skilled in delivering mentalising skills in both contexts. Group work is organised as a psychoeducational programme and also as a group process programme. Students will receive more detailed instruction about implementation of MBT in group contexts and learn about the content of the psychoeducational group.

Aspects of this component of MBT training will be delivered within compulsory supervision. Some audio or video material of students' clinical work will be submitted for review to the supervisor and discussed according to the MBT model and MBT adherence. Supervisors should have successfully completed the requirements to be an MBT supervisor and be on the list of recognised MBT supervisors:

<https://www.annafreud.org/training/mentalization-based-treatment-training/mbt-supervisors/>

The curriculum will comprise the following:

- Skills in delivering the detailed content of MBT psychoeducation to patients
- Support for students to develop their own materials, tailored to their service needs e.g. leaflets and group exercises
- Understanding group process and how an MBT group differs from other forms of group intervention
- Skills in implementing group MBT and maintaining the structure and format
- Skills in restoring group mentalising when this appears to be lost
- Skills in managing specific commonly occurring groups problems that endanger group process.
- Supervision of application of clinical skills within the workplace overseen by a supervisor who reviews video or audio tapes of the group work

### **Learning Outcomes**

- The clinical implementation of MBT groups within a comprehensive MBT programme
- Generating a mentalising milieu in MBT group through example, psychoeducation, and therapeutic stance
- Modelling of the reciprocity of mentalising when interacting with co-clinician in group work
- Integrating the client's therapeutic work in the MBT group with MBT individual therapy to ensure continuity of focus and exploration
- Managing anxieties in a group that interfere with mentalising of the participants
- Focusing on the interactional/interpersonal relationships between group members - those that facilitate understanding of relationship patterns and those that lead to cycles of non-mentalising interaction
- Understanding the need for clinician authority in MBT-G and demonstrating skills to implement authority without being authoritarian

## **Component 6: Advanced skills in MBT**

This component embeds all the previous components of MBT in daily clinical practice with a focus on effective intervention for prototypical impulsive behaviours, and introduces more advanced skills in relational mentalising. The mentalising model of PD is based in attachment theory and other developmental processes; using the client/clinician relationship is essential to treatment. Building a therapeutic alliance begins this process early in treatment but gradually the client and clinician generate epistemic trust within their interaction. Once this is in place, MBT focuses on relationship processes in terms of how the client interacts with the treatment team, the clinicians, and others whom they work with, for example in the MBT Group.

Students learn the knowledge framework and basic skills in MBT in earlier components but are supported in this component through regular supervision to implement the model in a coherent, consistent, and comprehensive programme which is continuous over time. In keeping with module 5, aspects of this component of MBT training will be delivered within compulsory supervision. Some audio or video material of the student's clinical work will be submitted for review to their supervisor and discussed according to the MBT model and MBT adherence. Supervisors should have successfully completed the requirements to be an MBT supervisor and be on the list of recognised MBT supervisors.

The curriculum will comprise the following:

- Learning to flexibly implement mentalising interventions in the therapy interaction respecting the patient's anxieties and clinician responsiveness
- Working with prototypical impulsive behaviours of personality disorder
- Using relational mentalising as a vehicle for understanding client attachment strategies and how they function in their daily lives.
- Focusing on relational mentalising and its transactional nature by expressing counter-relational responsiveness to increase understanding of the reciprocity of all relationships
- Recognising the importance of counter-responsiveness and learning to discuss this constructively with the client and with other clinicians working with the client
- Identifying relationship factors that interfere with treatment response or create problems in therapeutic interaction

### **Learning Outcomes**

- Knowledge that mentalising the therapy relationship is only indicated when the client can reflect on their mental state in the context of heightened affect
- Ability (over the course of the intervention) to help the client progress from exploring emotional experience in the context of external relationships, to interpersonal themes as they emerge in relation to the treatment, and finally to exploration of the therapy relationship
- An ability to use clarification and elaboration to elicit a detailed picture of what transpires between client and therapist and develop a shared alternative perspective
- Ability to recognise any contributions the clinician may have made to interactions in the therapy relationship
- Ability to identify and work with implicit affective processes that might be interfering with mentalising in the therapy relationship.
- Ability for the therapist to monitor their own feelings and convey these openly, and to openly acknowledge their own enactments

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- Assessing threats of impulsive behaviour e.g. suicide and self-harm and violence for risk and safety intervention
- Identifying suicidal thoughts as escape phenomena to stabilise mentalising
- Exploring suicide attempts/self-harm/violence using a mentalising functional analysis in a systematic manner

## Appendix

### MBT Supervisor Training

MBT practitioners with extensive MBT clinical experience may undertake training as a supervisor. This may be applicable to those clinicians who already have MBT training and who are responsible for clinicians delivering an MBT service. It is anticipated that experienced MBT clinicians will attend the 3-day MBT basic knowledge and skills course for an up-date and their professional development and participate in the teaching and then take a supervisor pathway rather than the practitioner training pathway. Clinicians starting out in MBT training may also apply for supervisor training after becoming practitioners and who meet the following criteria when commencing the supervisor course:

Practitioners applying for Supervisor training

- Mental health professional registered with a professional organisation
- Meet criteria for MBT practitioner and evidence of continued status.
- Show evidence of continuing education in MBT through attendance at additional training/learning events annually.
- Completed at least 6 supervised MBT treatments dating from period after having acquired MBT practitioner therapist listing (supervision individually or in group supervision)
- Completed 2 x 18-month MBT groups as primary clinician following practitioner level with supervision individually or within group supervision.
- Supervision from a minimum of two recognised supervisors.
- Satisfactory report from two or more MBT supervisors

They should also meet the general competences for supervisors outlined in the Quality Assurance document for MBT which can be found at:

<https://www.annafreud.org/media/7863/quality-manual-2018.pdf>

Expertise and competences

At the end of the course the MBT supervisor will

- Show capacity to establish a framework for mentalising competence-based supervision
- Understand the theories about what supervision is, what are the different types of supervision, what is competency-based supervision, what is evidence-based supervision practice
- Be able to make a self-assessment of their own supervisor competences and set personal goals as supervisor
- Generate a supervision process in keeping with the mentalising model and develop personalised supervision trajectories for supervisees stimulating the integration of declarative, procedural and reflective knowledge about MBT clinical process
- Show competence in using the MBT Adherence scale in supervision and rate sessions to individualize goals for MBT supervisees
- Be able to use different ways of learning e.g. feedback, role-play, modelling, experiential learning



- Understand the importance of the supervisor-supervisee working alliance and the possible problems e.g. ruptures that may occur when using competence-based supervision practice
- Be able to manage the failing supervisee and implement a pathway for learning and improvement
- Generate their own expert clinical and supervision skills by using reflective practice and from direct observation and feedback of their clinical and supervision work from senior MBT supervisors
- Have the ability to use their teaching and supervision skills to support novice and expert practitioners learning MBT.

The course is expected to take place over a maximum of one year.

The course requires four days x six hours of direct learning – one day each for Component one and two; two days for Component three.

ten supervision sessions of supervision by an approved supervisor either live or through video recording.

### Component 1 – The Process of Supervision

This component will focus on the general aspects of supervision and how to establish a culture of learning psychotherapy considering supervisees previous experience and training.

The curriculum will comprise the following:

- The aims of supervision and the focus on supervision process, skills, and content
- Supervision methods for transfer of psychotherapy skills to trainees
- Didactical qualities that support learning
- Awareness of personal biases in psychotherapies
- Use of supervision as a parallel process, mirroring treatment process

### Learning outcomes

- Knowledge of the range of supervision methods and the psychotherapy literature on supervision
- Knowledge of the range of interventions used for the treatment of people with BPD and how supervision complements practice in specialist treatments
- Understanding about how to organise psychotherapy supervision in the clinical workplace and support learners to generate competence in generic psychotherapy process and MBT psychotherapy process
- Ability to consider how to transfer knowledge and clinical skills to both novice and expert trainees

## **Component 2 – Adherence and Competence in MBT**

This component focuses on how the supervisor uses supervision to ensure trainees learn the MBT model. Trainees need to learn all the different aspects of MBT and to integrate them into a coherent programme and therapeutic intervention. Supervisors will become familiar with the main domains of the adherence scale and how to deliver learning in each domain of the scale considering the items that make up the domains.

The curriculum will comprise the following:

- Principles underpinning the MBT adherence scale and the core domains
- Understanding of the items that form each domain
- Learning how to assess each domain through rating standardised audio/video recording of MBT sessions
- Ability to use the adherence scale in supervision of trainees
- Learning to rate adherence and competence of MBT sessions and benchmarking ratings with other supervisors.

### **Learning Outcomes**

- Recognition of the advantages and disadvantages of psychotherapy adherence and competence scales
- Understanding the development of the MBT adherence and competence scale
- Ability to assess adherence and competence to the MBT model
- Ability to use the scale to facilitate learning in supervision

## **Component 3 - Supervision in Clinical Practice**

This component includes meeting with other supervisors to present clinical supervision and to discuss the supervision critically. Each supervisor trainee will present video material of a minimum of two supervision sessions of their clinical supervision, one being supervision of novice trainees and the other being supervision of expert clinicians. These may be taken from the 10 supervision sessions discussed with their personal supervisor. Each supervision observation will be followed by review and discussion of the process. There will be a minimum 10 supervision sessions directly observed and discussed with outcomes of the review recorded.

The curriculum will include the following:

- Critical appraisal of the supervision process and benchmarking with other supervisors
- Demonstration of ability to teach MBT to new and expert clinicians
- Recognition of different MBT interventions and understanding on how to support trainees to deliver more skilful implementation

### **Learning Outcomes**

- Ability to explain the MBT model to new trainees who are treating a patient in MBT
- Capacity to ensure that supervisees implement the model with fidelity and to use a range of methods to assess this e.g. check of written formulation
- Ability to use video material of sessions to support learning of the range of MBT interventions.

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- Ability to recognise trainee problems and develop a plan to increase their skills in implementation
- Recognition of the common supervisee problems e.g. implementing effective interpersonal work and relational mentalising, and supporting learning to overcome them

## References

- Bateman, A., & Fonagy, P. (2006). *Mentalization based treatment: a practical guide*. Oxford: Oxford University Press.
- Bateman, A., & Fonagy, P. (2016). *Mentalisation based treatment for personality disorders: a practical guide*. Oxford: Oxford University Press.