Advanced MBT: Applications and Delivery

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced MBT: Applications and Delivery

Adaptations, groups and running an MBT programme

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Advanced MBT: Applications and Delivery course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 9 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This advanced course is designed for experienced practitioners seeking to extend the scope of Mentalisation-Based Treatment (MBT) beyond the individual dyad into complex group settings and systemic programmes. You will explore nuanced adaptations for challenging presentations, including antisocial behaviour, severe eating disorders, and the specific dynamics of adolescent and family work. The curriculum emphasises the delicate balance required to adapt core MBT principles to these contexts without compromising the integrity of the therapeutic frame, specifically examining the Social GGRRAAACCEEESSS model as a tool for understanding relational dynamics in these populations. The second module provides a comprehensive guide to the practicalities of running MBT groups and establishing a full-scale MBT programme within a service. You will develop the skills necessary to foster a robust team culture that supports mentalising, ensuring high standards of supervision and fidelity to the model. Furthermore, the training addresses the critical importance of outcome measurement, equipping you with the knowledge to utilise standardised tools such as the PHQ-9 and GAD-7 to monitor progress and refine clinical practice. This module is essential for service leads and senior clinicians dedicated to advancing their professional development and enhancing service delivery.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Deliver MBT with severe and comorbid personality difficulty over full treatment arcs
- Run MBT groups: mentalizing the group process itself, not just members serially
- Apply MBT adaptations, including for antisocial presentations and adolescents, at awareness level
- Supervise for mentalizing: spotting and repairing therapist non-mentalizing
- Maintain the model under service pressure, and know what fidelity requires
- Weigh the MBT evidence base and its comparative standing honestly

PART 1

Adapting MBT for Complex Clinical Presentations

This module explores specialized MBT adaptations for trauma, eating disorders, psychosis, groups, and family work.

CHAPTER 1

Adapting MBT

Adaptation is the crucible in which a therapeutic model demonstrates the coherence of its principles, and Mentalization-Based Treatment (MBT) offers a particularly instructive case because its adaptations are driven not by clinical fashion but by the specific mentalising profile each population presents. The question that guides every faithful adaptation, as articulated by Bateman and Fonagy and refined by Luyten and colleagues, is twofold: what must change for mentalising work to reach these minds, and what must remain inviolate if the work is to remain MBT? This lesson examines the three adaptations with the most developed evidence bases — MBT for antisocial personality disorder (MBT-ASPD), MBT for eating disorders (MBT-ED), and MBT for adolescents and families (MBT-A and MBT-F) — and extracts from them a disciplined framework for adaptation that can be applied to any new clinical terrain. The practitioner who masters this framework moves beyond technique borrowing into principled derivation, able to defend each modification to commissioners, governance panels, and the patients themselves.

MBT for antisocial personality disorder, developed initially for men whose difficulties manifest as violence, exploitation, and repeated collision with criminal justice institutions, begins by revising the population's caricature. The model's reading, grounded in Fonagy and Luyten's dimensional account of mentalising, is not that these men lack the capacity altogether but that their mentalising is systematically imbalanced: cognitive mentalising of others is often intact, sometimes strikingly sharp, while affective mentalising and self-directed mentalising are profoundly impoverished. Other minds are legible as instruments to be manipulated, while the individual's own internal states — shame above all — remain unmentalised and explosive, driving the teleological mode in which action substitutes for representation. The adaptation's signature moves follow directly from this profile. The work is group-first because peer challenge lands where clinician challenge triggers dominance dynamics, and because the group is the arena where status, respect, and threat — the population's core currencies — actually occur and can be slowed into mentalising moments. The affect focus is disciplined

onto the sequence around violence: the humiliation-to-rage pipeline is walked in rewind, the unbearable self-states that action discharges are given names before alternatives are offered. The stance retains its warmth but its not-knowing is edged with steadiness; no fear is performed, no moralising is indulged, and the clinician's own states, including intimidation, are owned in marked form where useful. The frame is explicit about limits and mandatory reporting from the outset, honesty being the only ground on which epistemic trust can even be attempted with men whose institutional experience has been one of surveillance. A concrete worked example illustrates this: in a probation-based MBT-ASPD group, a participant describes an assault as "just teaching him respect". The facilitator, rather than confronting the justification, marks the affective shift: "I notice as you say that, your voice drops and your fists tighten — there's a surge of something that feels like power, but underneath it, something else that's harder to stay with." The group is invited to wonder about that "something else", and the participant eventually names a flash of humiliation from an earlier encounter with a supervisor. The sequence — trigger, unmentalised affect, action — becomes visible, and the group practices staying with the affect without acting. Trials and service evaluations, including work in high-security and community probation settings, show reductions in aggression and improved engagement; evidence is younger than the borderline base but robust and replicable.

MBT for eating disorders reads the disorder in mentalising terms with uncomfortable precision. Drawing on the work of Robinson, Luyten, and Schmidt, the formulation positions the body as the arena in which unmentalised states are managed: psychic equivalence made flesh, where "I feel disgusting" becomes "I am disgusting" becomes "the body must be punished". The concrete certainties of weight, calories, and ritualised eating substitute, teleologically, for the intolerable ambiguity of minds — one's own and others'. Starvation itself then closes the loop, because malnourished brains mentalise worse, creating a self-reinforcing cycle that standard cognitive-behavioural approaches may interrupt behaviourally but leave relationally untouched. The adaptation's moves are therefore precise. Medical monitoring is integrated without letting the numbers colonise the therapeutic space; the model's attention is held on the states the numbers are carrying. An embodied focus is introduced: states are located and named in the body before the behaviour — "what was in you in the hour

before you stepped on the scales?" Explicit work targets the disorder's pretend-mode fluency, the articulate recovery talk that changes nothing, met with the present-tense affect pull that grounds mentalising in lived experience. Patience with epistemic mistrust is essential, this population having often been managed, refed, and lectured into deep vigilance about professional agendas. Where MBT-ED sits in the treatment landscape is as one credible specialist option, its distinctive claim being reach into the relational and identity machinery that symptom-focused approaches can leave unaddressed. Outcome studies, including randomised trials comparing MBT-ED with specialist supportive clinical management, demonstrate comparable weight restoration with superior gains in mentalising capacity and interpersonal functioning, suggesting the mechanism of change is indeed the restoration of mentalising under attachment stress.

MBT for adolescents and families, developed most fully around self-harm and emerging personality pathology, adapts to a mind still building the capacity rather than one that has lost it. Mentalising in adolescence is developmentally turbulent: hypermentalising is its characteristic excess, the elaborate, certain readings of peers' and parents' minds that feel like knowledge but are in fact defensive projections. The attachment field is current, not historical; the family is the live regulatory environment, not a backdrop. The adaptation's moves follow developmental logic. Shorter arcs and developmental framing replace the open-ended exploratory stance of adult MBT. Hypermentalising is met with the slow concrete rewind rather than more meaning-making: "You're sure she hates you — what did her face actually do when you walked in?" The family is brought into the room through MBT-F, its loops taught as core method. The family's collapses are mapped as a system: each member is helped to mentalise the others aloud, the parent's "my daughter is manipulating me" and the daughter's "they just want me gone" both walked back to the states beneath. The family practices on its own hardest material with the therapist as referee, learning to interrupt the teleological escalation that leads to self-harm. Trial evidence, notably the randomised controlled trial led by Rossouw and Fonagy, supports reduced self-harm and depression, and the family work exports well beyond diagnosis into conduct problems, anxiety, and the complex presentations seen in looked-after children. Assessment in this context routinely incorporates the PHQ-9 and GAD-7 alongside the Reflective Functioning Questionnaire and the Social GGRRAAACCEEESSS framework to capture the

intersection of identity, power, and developmental context.

Whatever the population, the practitioner adapting MBT should work through the same sequence of derivation questions. First, what does the mentalising profile of this group actually look like, established from systematic assessment rather than stereotype: which dimensions — self versus other, cognitive versus affective, implicit versus explicit — are unbalanced, in which direction, and under what conditions of arousal? Second, which elements of standard MBT already meet that profile, and which would miss it? The ASPD adaptation exists precisely because standard affect-focused work in a homogeneous borderline group misses the externalising, other-blaming profile that requires peer confrontation and a focus on the shame-rage sequence. Third, what must change in the frame rather than the technique: session length and frequency for adolescents, mandatory family involvement for young people and eating disorders, the group-first emphasis for ASPD where peer challenge lands differently from clinician challenge, the integration of medical monitoring for eating disorders without surrendering the therapeutic frame to the medical model. Fourth, what in the clinician's own stance will be tested: contempt and fear with antisocial patients, rescue and frustration with chronically restricting patients, over-identification or parental alignment with adolescents. Fifth, what outcome the adaptation is actually aiming at, since symptom endpoints differ — offending behaviour, weight restoration alongside relational change, family communication and reduced self-harm — even while the mechanism, restored mentalising under attachment stress, stays constant. Adaptation is thus a disciplined derivation from the model's theory, not a loosening of it, and the practitioner who can articulate the derivation can defend the adaptation to any panel that funds or governs it.

Faithful adaptation, the lesson's yield, then has statable principles that can be held up against any proposed modification. What never changes: the capacity as target — mentalising itself, not merely symptoms; the stance — not-knowing, marked, self-owning; the arousal law — intervene where the window of tolerance permits, regulate before exploring; the modes as the working map — psychic equivalence, pretend mode, teleological mode; the structures that hold heat — group where possible, team always. What legitimately changes: the arena the work enters through — violence, the body, the family system; the balance of strands — more cognitive structuring for adolescents, more embodied focus for eating disorders, more peer-mediated

challenge for ASPD; the tempo and the arc — shorter, more directive, more psychoeducational where developmental stage demands it; the vocabulary — translated to the population's registers, from street language to adolescent slang to the somatic lexicon of the eating disorder; the interfaces — probation, medicine, schools, social care. And the test for any proposed adaptation, this pathway's recurring discipline: is this the model's principles applied to a new terrain, or its demands quietly dropped where the terrain is hardest? Close by running that test in writing: choose the population nearest your own work, draft its adaptation card — three signature features of the population in mentalising terms, two changes you would make, two things you would refuse to change, and the sentence defending each refusal. The next lesson goes deeper into the two settings all these adaptations lean on: the group, and the family.

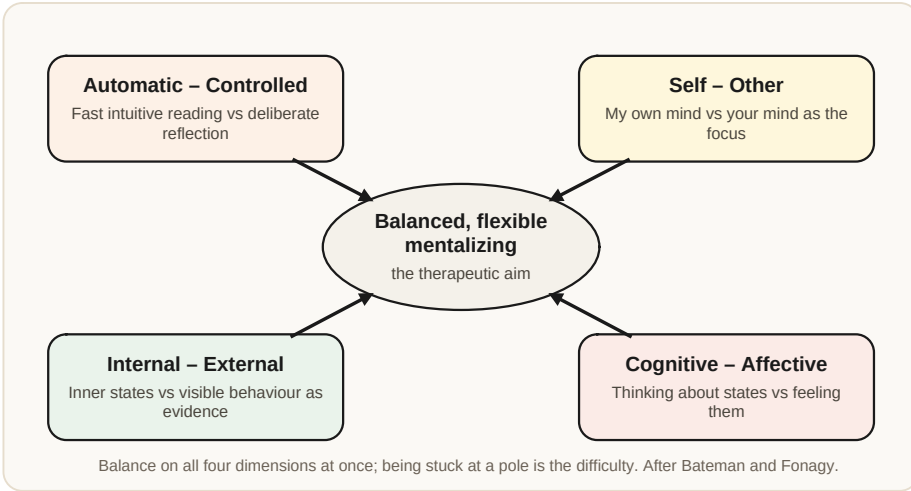


FIGURE 1.1 The four dimensions of mentalizing

Mentalizing runs on four balancing dimensions. Effective mentalizing moves flexibly along each; characteristic problems arise when someone is stuck at a pole, for example certainty about others' minds with no curiosity, or affect so hot that reflection collapses.

Points worth keeping

- MBT for antisocial presentations
- MBT for eating disorders
- MBT with adolescents and families
- Faithful adaptation

PRACTICE TASK

Choose one adaptation and note its key modification.

CHAPTER 2

Groups and family work

If the dyad is where mentalising is modelled, the group and the family are where it is built under load, minds practising on minds with the therapist as architect rather than counterpart, and advanced MBT lives or dies on facilitation craft. This lesson teaches that craft in its two arenas: the MBT group run to standard, and the family work where mentalising is grown between the people who trigger one another most.

Group facilitation begins with a role clarified against both neighbouring failures: the MBT group facilitator is neither the teacher delivering content to a class nor the analyst interpreting the group's unconscious from the corner; they are an active, transparent manager of the group's mentalising, in the model's phrase, and their authority is spent on process, relentlessly. The core crafts, named and trainable. Traffic control: the room slowed, exchanges taken one at a time, the facilitator unembarrassed to interrupt, hold on, this matters, let us take it slowly, because simultaneous heat in eight minds mentalises nothing. The public rewind: the group's own signature move, something just happened between you two, can we walk it back, the break replayed at group speed with both parties' states gathered. Distribution: the watchers recruited, what did others see happen there, Ana, what do you imagine Marcus felt when the room laughed, the group taught, question by question, that its job is wondering about one another, and the quiet members given low-heat entry points before the hot seat ever finds them. Marked facilitation: the facilitator's own mind used aloud exactly as in the dyad, I noticed I tensed when the topic turned, and their fallibility displayed, the misread owned publicly, because the group learns repair by watching its architect repair. And frame protection as clinical act: starts, ends, membership, absences pursued, the group's reliability being the floor under everything, and every frame event, the new member, the departure, the missed fortnight, treated as mentalizable material rather than administration.

Managing group arousal extends the practitioner course's thermostat to a system with hot spots and draughts. The escalating pair are slowed and separated in time, each mind gathered singly before the exchange resumes;

the scapegoating drift, the group's oldest reflex, is caught early, named warmly, and converted, what is the group handing to Dev right now that might belong to more of us; the deadening, whole sessions in collective pretend mode, is met with the affect pull applied to the room itself, we are being very sensible today, and I wonder what we are all avoiding feeling; and the contagion crisis, one member's disclosure detonating others, is met with the facilitator's steadiness, the room grounded as a room, and the model's quiet confidence that a group that survives heat together is doing exactly the treatment.

Family work shifts the object: here the unit of treatment is the family's mentalising, the loops between members rather than any one mind, and the facilitator's map is the systemic collapse. Families arrive in interlocking modes: the parent in teleological reading of the adolescent, only actions count, the self-harm is manipulation; the adolescent in equivalence about the parent, they want me gone, fact, closed; each side's certainty feeding the other's collapse, the loop the treatment must slow. The crafts translate with adjustments. The loop walked: one recent incident, the Tuesday kitchen scene, reconstructed step by step with each member's states gathered at each step, what happened in you when she said that, and what did you imagine was happening in her, the family's first experience, often, of the same event existing in several minds at once. Mentalising the other prompted directly and scaffolded: parents asked to voice the adolescent's possible inside, adolescents the parent's, wrong answers welcomed as material, the practice being the point. The facilitator as fair witness: alliances refused, each mind marked as real, the room's power gradients, age, articulacy, volume, actively counterweighted. Parental mentalising given its own care, because the parent flooded by fear cannot mentalise anyone, and a validated parent recovers capacity that the whole system then breathes. And the family's repairs rehearsed: the rupture-and-repair cycle, run live in session, sent home as the family's new possession, the argument survivable because its walking-back has been practised.

Building a mentalising culture is the arena-level goal both settings share, and its markers are worth teaching as outcomes: the group that starts its own rewinds, members saying wait, what just happened, without the facilitator; the family whose kitchen acquires the phrase what is going on for you right now, used unironically; the curiosity reflex installed where the verdict reflex lived. Culture is built the only way it ever is, by repetition under warmth, and

its emergence is the advanced practitioner's quiet metric, the system beginning to run the treatment on itself.

Group facilitation improves fastest when practitioners study their own recordings against a short checklist of the characteristic failures. Did the facilitators work as a pair, one tracking content while the other tracked the room's arousal, or did they collapse into a single interviewer with an audience? Was the group's attention distributed, or did one member's crisis annex the hour while six others rehearsed their resentments in silence? When one member read another's mind aloud, she only said that because she wants you gone, did a facilitator catch it as material, what did the rest of you see in that moment, or let it pass as conversation? Were concrete episodes mentalised in detail, or did the group drift into the pseudomentalising register of general psychological talk about patterns and journeys? Above all, did the facilitators protect the group as a mentalising space rather than a problem-solving one, resisting the gravitational pull towards advice, which is almost always the group's way of not feeling what has just been said? Family work rewards the same review discipline, with one addition: the facilitator watches for the family's habitual certainty about one another, decades of he always and she never, and treats each such formula as the family's shared symptom rather than any member's property.

Close with the two-scenario drill: script a group moment, an escalating pair, through traffic control, public rewind and distribution, six facilitator lines; and script a family loop-walk of one incident, the state-gathering questions for each of three members in sequence. The course's final module turns from rooms to institutions: the programme built, the fidelity held, the outcomes measured.

Going deeper: the facilitator's micro-economy.

Group craft decomposes into a micro-economy of attention, and advanced facilitation is largely the deliberate spending of it. Turn management is the base discipline: mentalising happens at working temperature, so the facilitator slows exchanges ('hold on, one at a time, this matters'), licenses interruptions of escalation, and protects airtime as a resource, because a group where two members transact and six spectate is running at a quarter of capacity. Distribution is the multiplier: the facilitator's characteristic move is not to answer but to route ('Priya, watching that, what do you imagine was happening for Sam?'), which turns every dyadic event into whole-group

practice and quietly teaches the group to do the routing itself, the true criterion of a maturing group. The silent member is approached as a mind, not a participation problem: silence has content ('you went quiet when the argument started; what was happening in you?'), and low-risk observer roles ('what did you see from the outside?') build a bridge in. The monopoliser is met with the same curiosity plus boundary-holding on the group's behalf, ideally by recruiting the group's own mentalising of the pattern rather than by chairmanly suppression.

Family work adds the dimension groups lack: the participants go home together, and the incidents are shared property with competing versions. The loop-walk this course scripts, one incident, each member's states gathered in sequence, no adjudication of facts, works because it replaces the family's habitual question ('who is right about what happened?') with the mentalising question ('what was happening in each of you?'), and the facilitator must police that substitution kindly but relentlessly, since families revert to the tribunal within sentences. Position work completes it: siblings, parents and identified patients hold structural positions that shape what each can see, and asking the family to speak from another's position ('say Tuesday as you imagine it felt from your daughter's chair') is the family-scale version of the perspective shifts the whole model trains. The culture goal in both arenas is identical: a room, or a household, where 'what is going on in you?' has become an ordinary question.

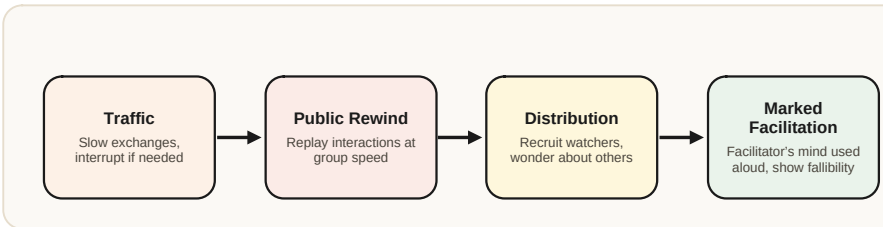


FIGURE 2.1 MBT Group Facilitation

This figure outlines the key steps in facilitating Mentalisation-Based Treatment (MBT) groups. It highlights the core crafts involved in managing the group's mentalising process.

Points worth keeping

- Facilitating MBT groups
- Mentalising between family members
- Managing group arousal
- Building a mentalising culture

PRACTICE TASK

Describe one technique for lifting mentalising in a group.