# A Competency-Based Developmental Progression Pathway for MBT Clinicians (version 1.2)

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## Description

Mentalization Based Treatment (MBT) is a specialised model of clinical intervention that is used to treat a range of complex psychopathological presentations. The model can be adopted as a primary treatment or alternatively used as an underpinning stance to support a variety of other psychological interventions. MBT sessions are structured in a specific fashion (*Mentalizing Sessional Structure*). Within this structure, clinicians are required to adopt a specific stance (*Not-Knowing Stance*), demonstrate explicit attempts at engaging a *Mentalizing Process*, and attend to a range of interactional phenomena (*Nonmentalizing Modes, Mentalizing Affects,* and *Relational Mentalizing*). In addition, MBT clinicians are asked to develop explicit *Formulations* with their patients to focus treatment. Finally, prospective MBT supervisors must demonstrate the ability to explicitly integrate *MBT Theory* when supervising the clinical practice of others. Each of these eight competencies can be demonstrated with varying sophistication. As such, this document details a competency-based developmental progression pathway for MBT clinicians. Each level of development is explained and linked to training requirements and a series of competencies that clinicians must demonstrate in order to progress to a subsequent developmental level. Competency, and the process by which this is determined, is also elaborated.

In sum individuals seeking competency in MBT must:

- Demonstrate an appropriate knowledge about mentalizing and MBT
- Acquire and maintain the skills and competencies of MBT
- [For supervisors] Confidently evaluate others' adherence to MBT principles and support this developmental process in a mentalizing fashion

## Rationale

This document has been created to ensure that the MBT developmental progression is transparent, navigable, and standardised. Organisations implementing MBT as a treatment model need to regularly monitor fidelity to the model, since this protects treatment outcomes and helps to identify areas of strength and weakness in clinical implementation. This is particularly important when MBT is being delivered as a primary intervention (i.e., as a specialised and therefore more costly treatment than standard clinical management).

## Monitoring Adherence and Competency

In MBT, supervisors are encouraged to regularly rate the adherence of clinicians whom they are supervising. This necessarily occurs as a collaborative process and in the context of reviewing video footage of clinical practice. This process helps clinicians to identify their MBT strengths and weaknesses, the latter of which can be improved via targeted supervision and continuing professional development.

**Eight MBT Competencies**

1) Formulation: MBT is fundamentally a goal-directed treatment approach. A collaborative formulation is developed with every patient and at the level of the patient's mentalizing ability. As such, it is ideal that the focus of each session and the clinician's intervention decisions both be ostensively related to the formulation.
2) Mentalizing Sessional Structure: Clinicians demonstrate (i) warmth and engagement; (ii) the ability to identify priorities, channel these into a specific focus for a session, and bring sessions to an appropriate close; and (iii) the ability to go around and identify individual problems in group sessions and channel these into a synthesised session focus.
3) Not-Knowing Stance: An attitude of curiosity and openness to the one's own and others' mental states is central in MBT. Clinicians are asked to mark whose mental state is being discussed, respond contingently, and try to understand self and other without foreclosing on mental states.
4) Mentalizing Process: In order to engage in a mentalizing process with patients, clinicians are asked to actively manage the form of the session, demonstrate their understanding using high level empathic validations and use contrary moves to engage and shift flexibly between inter-related mentalizing systems. In groups, active management can require skill at sensitively parking and shifting foci.
5) Non-Mentalizing Modes: When mentalizing is impaired, pre-mentalizing modes are employed to understand mental states (Psychic Equivalence, Pretend Mode, Teleological Function). Clinicians are asked to consciously utilise particular indicated interventions at such times in order to minimise the risk of iatrogenesis.
6) Mentalizing Affects: Focal emphasis is placed on affect in MBT. As such, clinicians must help patients to recognise, identify, clarify, and sequence affect, particularly that which is interpersonally significant. As this skill develops, clinicians use an affect focus to address implicit subtext in the therapeutic relationship. It is through this process that alternative interpersonal perspectives derive meaning.
7) Relational Mentalizing: The goal of MBT is to assist patients to recover and maintain mentalizing in difficult interpersonal settings. As such, explicit attempts are made to mentalize the clinician-patient relationship, the relationships between group members, and the counter-relationship experiences of the clinician.
8) MBT Theory: Knowledge of MBT theory supports the adherent implementation of MBT treatment. In addition, prospective supervisors need the ability to communicate MBT theory, link MBT theory with clinical practice, and (with more experienced clinical teams) compare/contrast MBT with alternative treatments.

**Competency Achievement**

In this document, competencies can be met to three levels of sophistication. At a basic level, clinicians can demonstrate attempts at meeting competencies. With development, clinicians can demonstrate ability at meeting each competency. At the highest level, clinicians can demonstrate skill at meeting each competency. These specifiers are deliberately non-numeric, since this encourages supervisors to monitor the overall qualitative improvement in clinician skills over time.

Clinicians can demonstrate competencies in individual, group, and/or family therapy contexts. Similarly, clinicians may demonstrate competency in their work with particular cohorts of patients (e.g., infant/child/adolescent mental health; working with specific disorders, and so on). Whilst we do not stipulate the extent to which clinicians ought to apply MBT skills across contexts, we do expect clinical supervisors to aid their supervisees to consider the contexts in which they may need to gain additional experience.

**Developmental Level A: MBT Interest/Skills**

At this level, clinicians have undertaken an accredited Basic Training Course in the MBT model, which provides an overview of the theory and practice of MBT. Clinicians are then encouraged to deliver treatment as usual, but with explicit attempts to incorporate aspects of MBT in small but deliberate ways. Note that at this level, it is recommended that clinicians engage in supervision to develop and embed MBT competencies in their clinical practice.

**Prerequisites**:

- ❏ Confidence in the use of basic counselling microskills
- ❏ Complete an accredited 3-day MBT Basic Training Course
- ❏ Some prior counselling experience

**Knowledge to achieve at this level**:

- ❏ Knowledge of what mentalizing is and its developmental origins
- ❏ Knowledge of the defining features of non-mentalizing modes

**Competencies to achieve for progression**:

- ❏ C1: Attempts to develop a collaborative formulation to guide treatment with each patient
- ❏ C2: Attempts to establish a focus across treatment and in each session
- ❏ C3: Demonstrates ability to adopt the not-knowing stance and recover it when lost
- ❏ C4: Attempts to differentiate mentalizing from non-mentalizing (in self and other)
- ❏ C4: Demonstrates ability to use empathic validation
- ❏ C4: Attempts to use contrary moves to emphasise under-active mental processes
- ❏ C5: Attempts to identify and differentiate non-mentalizing modes and respond using indicated interventions
- ❏ C6: Attempts to identify and focus on affect in sessions
- ❏ C7: Attempts to monitor changes in mentalizing during session interactions and make such changes explicit

**Developmental Level B: MBT Practitioner Trainee**

Clinicians are explicitly attempting to incorporate all elements of MBT into clinical practice. In addition, clinicians attend to here-and-now mentalizing processes during clinical interactions. At this level, it is understood that clinicians are working to become accredited MBT Practitioners and that achieving this requires endorsement by a clinical supervisor.

**Prerequisites**:

- ❏ Meets all of the competency requirements of Level A
- ❏ Complete an accredited 2-day MBT Practitioner Training Course

**Knowledge to achieve at this level**:

- ❏ MBT Manual has been read
- ❏ Working knowledge of psychological disorders and particularly of personality disorder and/or problems characterising the developmental period within which a clinician works (e.g., infant/child/adolescent)

**Practice to achieve at this level**:

- ❏ Current use of MBT as a primary intervention in clinical practice (with at least some patients)
- ❏ MBT supervision received in relation to a minimum of four patients or two groups (MBT as primary intervention)
- ❏ Presents video footage for consideration in supervision

Note: Based on supervisory experience, it is recommended that clinicians at this level receive weekly supervision for at least a short period to embed MBT practices.

**Competencies to achieve for progression**:

- ❏ C1: Demonstrates ability to develop a collaborative formulation to guide treatment with each patient
- ❏ C2: Demonstrates ability to establish a focus across treatment and in each session
- ❏ C3: Demonstrates skill at maintaining the not-knowing stance and recovering it when lost
- ❏ C4: Demonstrates ability at differentiating mentalizing from non-mentalizing (in self and other)
- ❏ C4: Demonstrates skill at high level empathic validation (acknowledgement of affect and effect)
- ❏ C4: Demonstrates ability to use contrary moves to emphasise under-active mental processes
- ❏ C5: Demonstrates ability to identify and differentiate non-mentalizing modes and respond using indicated interventions
- ❏ C6: Demonstrates ability to identify and focus on affect in sessions
- ❏ C6: Attempts to identify shared affective dilemmas and address these using an affect focus
- ❏ C7: Demonstrates ability to monitor changes in mentalizing during session interactions and make such changes explicit
- ❏ C7: Attempts to mentalize aspects of the self-other relationship and counter-relationship (including alternative perspectives in group)
- ❏ C8: Attempts to link theory to clinical practice during supervision
- ❏ C8: Attempts to monitor adherence of self and others to the MBT model

**Developmental Level C: MBT Practitioner**

The MBT model continues to evolve alongside the research underpinning it. As such, MBT Practitioners take responsibility for the upkeep and development of their MBT knowledge and skills. At this level, clinicians are competent at monitoring their own adherence to the MBT model. MBT Practitioners can continue to develop their competence if they wish to be endorsed as an accredited MBT supervisor.

**Prerequisites**:

- ❏ A satisfactory supervisor report indicates that the clinician has met all of the competency requirements of Level B

**Knowledge to achieve at this level**:

- ❏ If possible, attend at least one MBT training, seminar, or workshop per year
- ❏ Regular appraisal of current research related to the practice of MBT

**Practice to achieve at this level**:

- ❏ Maintenance of an MBT clinical caseload (minimum two cases per year encouraged)
- ❏ Ongoing MBT supervision (monthly encouraged)

**Competencies to achieve for progression**:

- ❏ C1: Demonstrates skill at developing a collaborative formulation to guide treatment with each patient
- ❏ C2: Demonstrates skill at establishing a focus across treatment and in each session
- ❏ C3: Demonstrates skill at maintaining the not-knowing stance and recovering it when lost
- ❏ C4: Demonstrates skill at differentiating mentalizing from non-mentalizing (in self and other)
- ❏ C4: Demonstrates skill at high level empathic validation (acknowledgement of affect and effect)
- ❏ C4: Demonstrates skill at using contrary moves to emphasise under-active mental processes
- ❏ C5: Demonstrates skill at identifying and differentiating non-mentalizing modes and responding using indicated interventions
- ❏ C6: Demonstrates skill at identifying and focusing on affect in sessions
- ❏ C6: Demonstrates ability to identify shared affective dilemmas and address these using an affect focus
- ❏ C7: Demonstrates skill at monitoring changes in mentalizing during session interactions and making such changes explicit
- ❏ C7: Demonstrates ability to mentalize aspects of the self-other relationship and counter-relationship (including alternative perspectives in group)
- ❏ C8: Demonstrates ability to link theory to clinical practice during supervision
- ❏ C8: Demonstrates ability to monitor adherence of self and others to the MBT model

**Developmental Level D: MBT Supervisor**

MBT supervisors must be experienced practitioners of MBT and who have demonstrated a solid grasp of MBT theory. Didactic teaching skills are ideal, as is past experience in clinical supervision. At this level we distinguish between Prospective and Accredited MBT Supervisors. The former is attempting to demonstrate the competencies at this level for the first time, whilst the latter has accomplished this and now seeks to maintain competencies at this level. Importantly, prospective MBT supervisors initially have video-footage of their supervision supervised by a more experienced MBT colleague. The focus of this is to ensure that one's supervisory practices remain adherent to the principles of MBT.

**Prerequisites**:

- ❏ Prospective MBT Supervisor: A satisfactory supervisor report indicates that the clinician has consistently met all of the competency requirements of Level C for a significant period of time
- ❏ Accredited MBT Supervisor: A satisfactory supervisor report indicates that the supervisor has consistently met all of the competency requirements of Level D for a significant period of time

**Knowledge to achieve at this level**:

- ❏ Attend at least one MBT training, seminar, or workshop per year
- ❏ Commitment to regular appraisal of current research related to the theory and practice of MBT

**Practice to achieve at this level**:

- ❏ Maintenance of an MBT clinical caseload (minimum two cases per year encouraged)
- ❏ Prospective MBT Supervisors: Direct supervision of supervisory skills by an experienced MBT supervisor (for the treatment duration of at least two clinical cases)
- ❏ Accredited MBT Supervisors: Exchange and discussion of video footage showing supervision at least once per year

**Competencies to achieve for progression**:

Note that at this level, the below competencies must be demonstrated both in one's clinical and supervisory practice.

- ❏ C1: Demonstrates skill at developing a collaborative formulation to guide treatment with each patient (and the collaborative generation of goals to guide supervision)
- ❏ C2: Demonstrates skill at establishing a focus across treatment/supervision and in each session
- ❏ C3: Demonstrates skill at maintaining the not-knowing stance and recovering it when lost (and supporting this maintenance/recovery in other clinicians)
- ❏ C4: Demonstrates skill at differentiating mentalizing from non-mentalizing (in self and other)
- ❏ C4: Demonstrates skill at high level empathic validation (acknowledgement of affect and effect)
- ❏ C4: Demonstrates skill at using contrary moves to emphasise under-active mental processes
- ❏ C5: Demonstrates skill at identifying and differentiating non-mentalizing modes and responding using indicated interventions
- ❏ C6: Demonstrates skill at identifying and focusing on affect in sessions
- ❏ C6: Demonstrates ability to identify shared affective dilemmas and address these using an affect focus. In supervision, such dilemmas are then linked back to the clinician-patient relationship with reference to parallel process.
- ❏ C7: Demonstrates skill at monitoring changes in mentalizing during session interactions and making such changes explicit
- ❏ C7: Demonstrates ability to mentalize aspects of the self-other relationship and counter-relationship (including alternative perspectives in group)
- ❏ C8: Demonstrates skill in relation to knowledge of the theory underpinning MBT

- ❏ C8: Demonstrates skill at explaining the links between MBT theory and clinical practice during supervision
- ❏ C8: Demonstrates skill at monitoring adherence of self and others to the MBT model