Psychotherapy for Borderline Personality Disorder

Workshop on Mentalisation Based Treatment

Anthony Bateman & Peter Fonagy
Introduction to Mentalization
Mentalizing:
A new word for an ancient concept

Implicitly and explicitly interpreting
the actions of oneself and other as
meaningful on the basis of
intentional mental states

(e.g., desires, needs, feelings, beliefs, & reasons)
Introduction to theory of mentalisation

- The normal ability to ascribe intentions and meaning to human behaviour
- Ideas that shape interpersonal behaviour
- Make reference to emotions, feelings, thoughts, intentions, desires
- Shapes our understanding of others and ourselves
- Central to human communication and relationships
- Underpins clinical understanding, the therapeutic relationship and therapeutic change
Characteristics of mentalising

- Central concept is that internal states (emotions, thoughts, etc) are opaque
- We make inferences about them
- But inferences are prone to error
- Overarching principal is to take the “inquisitive stance”

= Interpersonal behaviour characterised by an expectation that one’s mind may be influenced, surprised, changed and enlightened by learning about another’s mind
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

surprised

joking

sure about something

happy
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

friendly

sad

surprised

worried
Being misunderstood

- Although skill in reading minds is important, recognising the limits of one’s skill is essential.
- First, acting on false assumptions causes confusion.
- Second, being misunderstood is highly aversive.
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection.
Related/Linked concepts

- empathy
- insight
- psychological mindedness
- observing ego
- potential space
- transitional space
- subjectivity
- mindfulness
- reflection
Mentalizing implicitly versus explicitly

- Implicit
  - nonconscious
  - nonverbal
  - procedural
  - unreflective
  - e.g., “mirroring”

- Explicit
  - conscious
  - verbal
  - deliberate
  - reflective
  - e.g., “interpreting”
Broad scope of mentalizing:

- **LEVELS**: implicit, explicit
- **TARGETS**: self, other persons, relationships
- **PROCESSES**: desires, feelings, beliefs, etc.
The concept of mentalizing as a fulcrum for contemporary theory and research

- evolutionary biology
- neurobiology
- attachment
- theory of mind
FAQs about Mentalization Based Treatment
FAQ’s about Mentalization Based Treatment: 1

- Is this a new therapy?
  - No! It is a focus for therapy in borderline personality disorder

- Do I have to be an expert therapist?
  - No! We have implemented MBT using generic mental health nurses. However someone well–trained in basic psychotherapy technique and familiar with mentalization needs to provide supervision
  - It is more important that therapists are confident in basic communication with patients and experienced in appraising risk e.g. suicide threats, potential violence, emergency admission
FAQ’s about Mentalization Based Treatment: 2

- Can I work alone using MBT?
  - Of course you can BUT for severe borderline patients we recommend that people work together as a team often using split roles but all having a focus of increasing mentalization as the core of the therapeutic interaction.

- What is the format of the treatment you are providing, i.e., individual and group, anything else for the patients?
  - Format is 1/7 individual (50mins) + 1/7 group (1.5hrs).
  - Nothing else provided except psychiatric out-patient as and when necessary for medication.

- What about format from the perspective of the therapists?
  - Format for therapists is team meetings and group supervisions.

- Do other personality disorders show reduced mentalizing?
  - Probably but not in the same way as BPD.
FAQ’s about Mentalization Based Treatment: 3

- I am a radical behaviourist. Isn’t mentalisation a cognitive/behavioural therapy?
  - No. MBT has an emphasis on affective states and ‘depth’ analysis, intentionality and motivation. It does not focus on behaviour alone. Anyway we are radical analysts!

- Isn’t mentalisation just supportive therapy
  - Yes/No. It is supportive but not JUST supportive therapy. Other active techniques are used.

- Is mentalisation an analytic therapy?
  - MBT fits best into the plurality of analytic therapy with its emphasis on patient/therapist relationship, understanding of dynamic processes, and its move in treatment from conscious understanding to unconscious meaning.

- I’ve been told that transference isn’t used
  - Who told you that? Transference is used but in a titrated way. The use of transference differs from TFP.
FAQ’s about Mentalization Based Treatment: 4

- Mentalisation theory blames the mother
  - Most certainly not! We consider a complex gene-environment interaction as the most likely cause of the reduction on mentalizing capacity in BPD

- Mentalization doesn’t seem specific to this therapy. All therapies promote mentalizing so what is so special about this?
  - Perfectly true. The only specific aspect of MBT is placing the enhancement of mentalizing itself as the focus of treatment. All therapies probably increase it indirectly but they are not aware that that is what they are doing!
FAQ’s about Mentalization Based Treatment:5

- Do I have to do years of training, loads of supervised videos, be rated by experts overseas and be certified?
  - A very brief training is probably adequate to ensure that you modify your current technique to include a focus on mentalizing
  - Videos may be helpful for learning and discussion but this may be something that you already do
  - No certification is necessary, especially from ‘experts’ from overseas!

- Does it matter if a patient has mixed therapies? e.g. cognitive interventions, dynamic therapy, and expressive therapy?
  - No! As long as the therapists all meet to integrate their knowledge and understanding from a mentalizing perspective and this provides a coherent focus between all therapies.
Some basic theory
The Role of Early Attachments

- Attachment confers a selective advantage to humans by the opportunity it affords for the development of neurocognitive social capacities

- Evolution has charged attachment relationships to ensure the full development of the social brain
The Theory: Three Assumptions Related to Self Development

- that the agentive, mentalizing, psychological sense of *self* is *rooted in the attribution of mental states*

- that this capacity emerges through interaction with the caregiver, in the context of an attachment relationship, via a *process of contingent mirroring*

- that this capacity *may be inhibited* (decoupled) temporarily or more extensively in response to relational (interpersonal) conflicts, acute stress or trauma in vulnerable individuals ➔ reemergence of non-mentalizing forms of cognition
Theory: Birth of the Agentive Self

Attachment figure “discovers” infant’s mind (subjectivity)

Infant internalizes caregiver’s representation to form psychological self
Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality ➔ mentalization
Incongruent/unmarked contingent mirroring

Non-secure base

Enfeebled Affect Representation and Attention Control Systems
Theory: Revision of Attachment Theory

Developmental Functions of Attachment

- Affect Representation
- Attentional Mechanisms
- Mentalizing Capacities

2nd Order Representations
Effortful Control
Reflective Function

The Interpersonal Interpretive Function (IIF)
Psychological Self: 2nd Order Representations

Physical Self: Primary Representations

Representation of self-state: Internalization of object’s image

symbolic binding of internal state

Constitutional self in state of arousal

Expression

Reflection

Resonance

contingent display

expression of metabolized affect

signal

non-verbal expression

Infant

CAREGIVER

Fonagy, Gergely, Jurist & Target (2002)

Theory: Intersubjective Space and the Symbolization of Emotion

Theory: Maternal Brain Responses to Infant Facial Cues: Exploring the Neurobiology of Attachment

1 - 2: AFFECTIVE CONTRAST
Crying – Smiling
In the affective contrast between the unexpected delivery of crying vs. smiling faces, the control women showed activation of the medial prefrontal cortex (mPFC) and cingulate cortex, areas involved in emotion recognition and processing. However, with the teen mothers, activation was limited to the caudate/ventral striatum.
**Theory:** Conditions for Robust Establishment of Representations of Internal States (Gergely & Watson, 1996)

- **Contingency of Mirroring**
  - The caregiver accurately matches the infant’s mental state

- **Markedness of Mirroring**
  - The caregiver mirrors while indicating that she is not expressing her own feelings

- **Incongruent mirroring** → representation of internal state corresponds to nothing real → pretend mode

- **Un-marked mirroring** → caregiver’s expression seen as externalisation of experience → psychic equivalent mode
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Non-secure base

Disorganized Attachment and Self

Enfeebled Affect Representation and Attention Control Systems

Establishes

The Alien Self
**Theory:** Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

**Attachment Figure**

- Absence of a representation of the infant’s mental state

**Child**

The nascent self representational structure

Internalisation of a non-contingent mental state as part of the self

The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Non-secure base

Disorganized Attachment and Self

Controlling IWM in Middle childhood

Enfeebled Affect Representation and Attention Control Systems

Establishes

The Alien Self
Creating a Coherent Self-representation by Controlling and Manipulation – Hyper-activation of Attachment

Through coercive, controlling behavior the individual with disorganized attachment history achieves a measure of coherence within the self representation and a controlling and hyperactivity of the connection to the attachment figure.
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized/Controlling Attachment System

Hyper-activation of attachment

Non-secure base

Lack of playfulness

Trauma: early or late

Enfeebled Affect Representation and Attention Control Systems

Failure of Mentalization

The Alien Self

Establishes
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

surprised

sure about something

joking

happy
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

friendly  sad

surprised  worried
Performance on Eyes Test and Physical Abuse

(Fonagy & Stein, 2001)

Pearson $r = .43$, $p < .005$
Performance on eyes test and sexual abuse

Pearson $r=.46$, $p<.005$
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized/Controlling Attachment System

Hyper-activation of the attachment system

Non-secure base

Lack of playfulness

Trauma: early or late

Failure of Mentalization

The Alien Self

Establishes

Enfeebled Affect Representation and Attention Control Systems
The Neural System Underpinning Attachment: From Rodents and Humans (Insel, 2003)

- **Mesocorticolimbic dopamine**
  - an important candidate in addiction,
  - also critical for maternal behavior in rats
  - and pair bonding in voles

- A circuit linking the anterior hypothalamus (MPOA) to the VTA and the nucleus accumbens shell may be especially important for mediating the rewarding properties of social interaction

- The neuropeptides OT and AVP are released by sociosexual experience in rodents and humans

- Can activate this reward circuit change attachment behaviour (at least in voles)

- fMRI studies indicate activation of same pathways in relation stimuli relating to own infant and partner
Common regions of deactivation with maternal and romantic love (Bartels & Zeki, 2004)
Attachment and the deactivation of mentalizing

Both maternal and romantic love elicit an overlapping set of deactivations

- temporal poles, parietotemporal junction and mesial prefrontal cortex

  - social trustworthiness, moral judgements, ‘theory of mind’ tasks, solely negative emotions, attention to own emotions

  • underpin capacity for determining other people’s emotions and intentions
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Disorganized Attachment and Self

Hyper-activation of attachment

Enfeebled Affect Representation and Attention Control Systems

Failure of Mentalization

Trauma: early or late

The Alien Self

Establishes

Colonizes

Failure of Mentalization

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Non-secure base

Lack of playfulness

Disorganized Attachment and Self

Hyper-activation of attachment

Incongruent/unmarked contingent mirroring
Self-destructiveness, Attachment and Externalisation Following Trauma in Vulnerable Individuals

Coercive, controlling behavior is used to reduce the experience of unbearably painful emotional state of attack from within – hyperactivation of the attachment system and externalisation becomes a matter of life and death.
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Non-secure base

Disorganized Attachment and Self

Enfeebled Affect Representation and Attention Control Systems

Hyper-activation of attachment

Failure of Mentalization

Lack of playfulness

Trauma: early or late

Arousal ‘Switch’

Establishes

The Alien Self

Colonizes

Prefrontal capacities

Posterior cortex and subcortical capacities

Changing switchpoint threshold

Point 1a

Point 1

Low → High

Arousal

Performance
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized Attachment and Self

Hyper-activation of attachment

Non-secure base

Enfeeled Affect Representation and Attention Control Systems

Lack of playfulness

Trauma: early or late

Arousal ‘Switch’

Failure of Mentalization

Psychic Equivalence

The Alien Self

Establishes

Colonizes
**Theory:** The Modes of Psychic Reality That Antedate Mentalisation and Characterize Trauma

- **Psychic equivalence:**
  - Mind-world isomorphism; mental reality = outer reality; internal has power of external
  - Associated with insufficiently marked mirroring
  - Experience of mind can be terrifying (flashbacks)
  - Intolerance of alternative perspectives (“if I think you had your door shut because you want to reject me, then you want to reject me”)
  - Self-related negative cognitions are TOO REAL!
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized Attachment and Self

Hyper-activation of attachment

Failure of Mentalization

Enfeebled Affect Representation and Attention Control Systems

Non-secure base

Lack of playfulness

Trauma: early or late

Arousal ‘Switch’

Psychic Equivalence

Pretend mode

Establishes

The Alien Self

Colonizes
Theory: The Modes of Psychic Reality That Antedate Mentalisation and Characterize Trauma

- **Pretend mode:**
  - Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
  - Associated with non-contingent mirroring
  - Linked with emptiness, meaninglessness and dissociation in the wake of trauma
  - In therapy endless inconsequential talk of thoughts and feelings
    - Simultaneously held contradictory beliefs
    - Affects that do not accompany thoughts
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized Attachment and Self

Hyper-activation of attachment

Teleological stance

Non-secure base

Enfeebled Affect Representation and Attention Control Systems

Trauma: early or late

Lack of playfulness

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Colonizes
Theory: The Modes of Psychic Reality That Antedate Mentalisation and Can Characterize Trauma

Teleological stance:

- Expectations concerning the agency of the other are present but these are formulated in terms restricted to the physical world
- A focus on understanding actions in terms of their physical as opposed to mental outcomes
- Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
  - The therapist’s benign disposition, her motivation to be helpful, has to be demonstrated by increasingly heroic acts,
  - Availability on the telephone ➔ extra sessions at weekends ➔ physical touching ➔ holding ➔ serious violations of therapeutic boundaries.
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized Attachment and Self

Hyper-activation of attachment

Teleological stance

Non-secure base

Lack of playfulness

Trauma: early or late

Arousal 'Switch'

Pretend mode

Psychic Equivalence

Failure of Mentalization

The Alien Self

Establishes

Colonizes

Reveals

Reveals
A Model of Borderline Pathology

Incongruent/unmarked contingent mirroring

Disorganized Attachment and Self

Controlling IWM

Teleological stance

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Enfeebled Affect Representation and Attention Control Systems

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Psychic Equivalence

Reveals

The Alien Self

Reveals

Establishes

Colonizes
Clinical Applications of Mentalization
Using Mentalizing in treating patients

- Mentalizing is using “folk psychology” or commonsense understanding to interact and to make sense of the patient and yourself in the therapeutic interaction.

- Scientific psychology creates professional knowledge and treatment manuals, but folk psychology is required for their implementation.
Advantages of mentalizing in therapeutic interactions

- Provides a buffer against overwhelming affect for patient and clinician
- Can be consciously targeted
- Can be done outside the heat of the kitchen - ‘Let’s think about that, now it is not so ‘raw’”
- Focus on present either within or without therapeutic process
- Develops a transference focus
- Mentalizing fosters mentalizing, through practice, identification, and results
- All therapists mentalize, irrespective of model
**MODEL**

**THERAPIST**

1. **Stimulate**
   - Activation of Attachment system

2. **Focus**
   - Enfeebled Mentalization

3. **Stabilise**
   - Unstable Self

4. **Contain**
   - Action Emotional Storm

**PATIENT**

**Stabilise**
The challenge of mentalizing interactively

- Mild to moderate arousal is conducive to optimal prefrontal functioning and the employment of flexible mental representations and response strategies.
- As task complexity increases, the optimal level of arousal decreases.
- Mentalizing interactively (e.g., holding an emotional conversation) is among the most complex cognitive and emotional tasks.
- Mentalizing interactively is therefore highly vulnerable to hyperarousal-- in our patients and ourselves.
Optimizing Mentalization for the patient

- Therapist requires
  - An attachment history that supports
development of the capacity (competence)
  - ability *in the interactive moment* that supports
use of the capacity to mentalize (performance)
Which requires:
  - Optimal level of arousal of attachment system
to enable pre-frontal cortex function
Parallel contributions to mentalizing: Meeting of minds
Mentalizing (processing) trauma requires containment

- Secure attachments
- MENTALIZING
- Trauma
- Thinking, feeling, & talking about it
- Treatment frame & alliance
- Self-regulation

Education
Processing trauma from the perspective of mentalizing

- Goal of processing is to mentalize trauma
- Mentalizing trauma entails being able to have the memory of trauma in mind as meaningful experience
- Goal is *not* to rid the mind of traumatic memories
- Mentalizing is key to the therapeutic process, regardless of technique (e.g., exposure, cognitive restructuring, EMDR, psychotherapy)
Mentalisation: a common theme of all therapies for BPD

- All psychotherapies develop an interactional matrix in which the mind becomes a focus
- Therapists consider the patient by representing them in their mind and communicating that representation to them
- Experience of patient is of another human having their mind in mind ➔ Process more important than content
Mentalisation: a common theme of all therapies for BPD

- Therapy activates an attachment system which is a pre-requisite for mentalisation
- Therapists reconstruct in their own mind the mind of the patient – label feelings, explain cognitions, identify implicit beliefs
- Therapy is a shared attentional process which strengthens interpersonal function and integrative mechanisms
- Content of interventions is mentalistic irrespective of model
- Dyadic nature of therapy fosters capacity to generate multiple perspectives
The nature of BPD therapies

- Many individuals with BPD ‘recover’ to a significant extent without extensive formal therapeutic intervention
- Many therapies are highly effective for BPD
- Many therapies appear to do harm to individuals with BPD or at least appear to be able to impede a natural process of recovery

The Fonagy & Bateman Principle:

- A therapeutic treatment will be effective to the extent that it is able to enhance the patient’s mentalising capacities without generating too many iatrogenic effects.
- Iatrogenic effects are reduced if intensity is carefully titrated to patient capacities and if treatment is coherent and flexible.
Mentalizing in the pause mode (Stop, Listen, Look)

- Awareness of distressed state as a problem
- Identifying feelings
- Feeling and thinking about feeling
- Establishing freedom of movement
- Enabling inquisitiveness
- Getting it out of the head and into the world to facilitate explicit mentalizing
  - Drawing
  - Writing
  - talking
On feelings

- One’s own thoughts are central to many therapies (e.g. CBT)
- In Mentalising therapy this is extended to and emphasises
  - the thoughts of others
  - The feelings of others and oneself
  - The process by which thoughts and feelings are communicated
  - The role played by misunderstanding thoughts and feelings
  - The role played by non-mentalising interactions
- In mentalising therapy, feelings are given top priority
- Central to change is recognising and empathising with the feelings of others: breaks inhibitory cycle
Interventions and Change

- **Key intervention**
  - To model the inquisitive stance – mentalizing stance
  - balance intensity of attachment relationship and complexity of mentalization

- **Change occurs**
  - when patient learns something new or is reminded of something forgotten about the inner experience of oneself or others
  - when understanding through mentalization is associated with optimally activated attachment system
Structure of Mentalization Based Treatment
**TRAJECTORY**

- Initial sessions
  - Engagement in treatment

- Middle sessions
  - Hard work
  - Maintain therapeutic alliance
  - Repair alliance ruptures
  - Manage countertransference

- Conclusions of acute treatment

**PROCESS**

- Assessment of Mentalization
- Diagnosis
- Psychoeducational discussion
- Hierarchy of therapeutic aims
- Stabilisation
- Crisis Pathway

- Interpersonal work
- Individual + Group therapy
- Specific Techniques
  - Interpretive mentalizing
  - Mentalizing the transference

- Separation responses
- Contingency planning

- Follow-up
  - How to maintain mentalizing?
  - Are rehabilitative changes stimulated?

- Prevention of relapse
Formulation: Content

Aims
- Organise thinking for therapist and patient – see different minds
- Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exampled)
- Modelling humility about nature of truth

Management of risk
- Analysis of components of risk in intentional terms
- Avoid overstimulation through formulation(?)

Beliefs about the self
- Relationship of these to specific (varying) internal states
- Historical aspects placed into context

Central current concerns in relational terms
- Challenges that are entailed

Positive aspects
- When mentalisation worked and had effect of improving situation

Anticipation for the unfolding of treatment
- Impact of individual and group therapy
Early Issues

- Introducing the approach
- Treatment organisation
- Agreeing on a contract
- Beginning a mentalizing focus
- Containment of family, partners, friends
Treatment Organisation

- **Pathway to admission**
  - Provision of information
  - Clarification of key problems, as identified by the patient
  - Explanation of the underlying treatment approach and its relevance to the problems
  - Information about individual and group therapy and how it can lead to change
  - An outline of confidentiality

- **Clarification of some basic rules**
  - Violence
  - Drugs and alcohol
  - Sexual relationships

- **Stabilising social aspects of care**

- **Assuring the possibility of contact with the patient**
Provision of Information: Expert Role

Information – personalised

- Understanding of BPD
  - Genetics
  - Biological processes – arousal, hormonal pathways
  - Neurobiology – emotional circuitry
  - Developmental
  - Interpersonal inventory
  - Mentalisation – Pause Button/Stop and Search
Treatment Organisation: Agreed Goals

- Initial goals
  - Engagement in therapy
  - Reduction of self-damaging, threatening, or suicidal behaviour
  - Appropriate use of emergency services
  - Stabilising accommodation
  - Rationalisation of medication
  - Development of a psychodynamic formulation with the patient
Treatment Organisation: Agreed

Goals

- Long term goals
  - Identification of emotions and their appropriate expression with others
  - Personal integrity
  - Personal responsibility
  - Interpersonal function
Treatment Organisation Formation of working alliance

- Empathy and validation
- Reliability and readiness to listen
- Team morale
- Supervision
Transferable Features

Structure

- Patients and therapists are able to think about aspects of treatment from a shared base, the purpose of therapy and reasons for its components ➔
  - Information/education
  - Shared formulation
  - Therapist can deal with common clinical problems fairly and consistently
  - Structure is framework around therapy which is neither intrusive nor inattentive

- Frames inevitable regressive processes ➔ boundary violations
- Rejection of ‘communalism, ‘democracy’, ‘egalitarian principles’
- Rejection of ‘authoritarianism, ‘controlling attitudes’, mindless enforcement of rules
Transferable Features
Consistency, Constancy & Coherence

- Recognition that patients perceive and exploit inconsistency but the problem may also lie within the team itself
- Counteracts reactive, fragmented, unreliable TAU mirroring unstable self
- Treatment must minimise inter- and intra-professional disputes
- When inconsistency (splitting) occurs in treatment team or within clinician it must be recognised, understood and worked through
- The therapeutic frame must be protected, consistency of times, constancy of treaters, coherence of therapeutic message
Transferable Features

Relationship Focus

- BPD is characterised by problems of forming and maintaining constructive relationships.
- It is expected to disrupt treater – patient relationship and this therefore has to be the focus of treatment.
- To understand treater – patient relationship all other relationships must become focus of therapy.
- Developmentally elaborated dysfunctions (mentalization vs. unintegrated self-object representations) underpinning interpersonal problems are addressed.
- Behaviors are not understood in isolation of the mental processes that have led to the enactment (mentalising stance).
Transferable Features

Flexibility

- Instability of lifestyle is inevitably manifested in relation to therapeutic services (e.g. fluctuations of motivation for help, valuing of therapy) and is not be taken as either indication of success or unsuitability for treatment.
- Treatment must be flexible and there must be willingness to compromise (e.g. recognise therapy induces panic, temporarily focus on housing).
- The compromise must be recognised by patient and therapist.
- The recognition of ‘psychic equivalence’ in the face of patient’s insistence that therapist has a particular state of mind forces the therapist to be (sceptically) accepting of the ‘patient’s subjective reality’.
- Differences in perspective are be explored and not reduced.
Transferable Features

Intensity

- Understanding of the pathology indicate that most intensive possible (e.g. 5 times weekly) treatment is not the ideal treatment for trauma.
- Trapped by situations that require high levels of interaction.
- Comes to be fixed in ‘pretend mode’ of psychic reality.
- Treatment provides balance between need safety and dependency on one hand and autonomy, risk and self reliance on the other.
- Adequate time between sessions is provided for patients to reflect, to distract themselves, and not to overwhelm fragile reflective capacities.
Transferable Features
Integration of Medication

- Medication is an adjunct to psychotherapy
- Enhances the effectiveness of psychotherapy
- Improves symptoms
- Stabilises mood
- Help patients attend sessions
- Prescription needs to take into account transference and countertransference phenomena
- Integrate into the programme itself.
Transferable Features

Clinical Guidance on Medication

- Consider the primary symptom complex
  - affect dysregulation
  - Impulsivity
  - cognitive-perceptual disturbance
  - current transference
  - countertransference themes

- Discuss implementation of medication within the treatment team

- Educate the patient about reasons for medication, possible side-effects, expected positive effects
Transferable Features

Clinical Guidance on Medication

- Make a clear recommendation but allow the patient to take the decision and do not try to persuade the patient to take the medication.
- Agree a length of time for trial of medication (unless intolerable side-effects) and do not prescribe another drug during this time even if the patient stops the drug.
- Prescribe within safety limits, for example giving prescriptions weekly.
- See the patient at agreed intervals to discuss medication and its effects. Initially this may be every few days to encourage compliance, to monitor effects, and to titrate the dose.
- Do not be afraid to suggest stopping a drug if no benefit is observed and the patient experiences no improvement.
Treatment Organisation

Common problems

- Dropouts
  - Barriers to treatment
    - Geography
    - Appointment times

- In-patient care
  - Suicide/homicide risk
  - Comorbidity
  - Anxiety in countertransference
  - Respite for patient and carers
  - Contraindications
    - Emotional crisis
    - Hate in the countertransference
    - Panic
Assessment of Mentalization
Questions that can reveal quality of mentalisation

- why did your parents behave as they did during your childhood?
- do you think your childhood experiences have an influence on who you are today?
- any setbacks?
- did you ever feel rejected as a child?
- in relation to losses, abuse or other trauma, how did you feel at the time and how have your feelings changed over time?
- have there been changes in your relationship with your parents since childhood?
Indicators of very poor mentalizing during the assessment process

1. Anti-reflective
   - hostility
   - active evasion
   - non-verbal reactions

2. Bizarre responses

3. Failure of adequate elaboration
   - Complete lack of integration
   - Complete lack of explanation

4. Inappropriate
   - Complete non-sequiturs
   - Gross assumptions about the interviewer
   - Literal meaning of words
Assessment of mentalization

- Distinguish four main types of problem - not mutually exclusive; more than one may apply to the same person
  - Concrete understanding
    - Generalised lack of mentalising
  - Context-specific non-mentalising
    - Non-mentalising is variable and occurs in particular contexts
  - Pseudo-mentalising
    - Looks like mentalising but missing essential features
  - Misuse of mentalising
    - Others’ minds understood and thought about, but used to hurt, manipulate, control or undermine
Concrete understanding

- General failure to appreciate feelings of self or others as well as the relationships between thoughts, feelings and actions
- General lack of attention to the thoughts, feelings and wishes of others and an interpretation of behaviour (own or others) in terms of the influence of situational or physical constraints rather than feelings and thoughts
- May vary markedly in degree
Signs of concrete understanding (1)

- Typically concrete understanding characterised by emphasis on
  - Mental or physical illness(es)
  - Preoccupation with grievances and taking revenge for slights
  - Lack of forgiveness – ‘He did that so he deserves all he gets’ ‘I will never forget what he said to me’
  - Excessive detail to the exclusion of motivations, feelings or thoughts
  - External social factors, such as the housing, the council, the neighbours etc.
Signs of concrete understanding 2

- Psychologically implausible accounts, such as a person’s intrinsic malevolence (e.g. “he’s just spiteful”), star signs, genetic defects (born like that, just like his father)
- Preoccupation with good Behavior versus bad Behavior
- Undimensional views with fixed characteristics such as clever versus stupid
- A tendency to deny their own involvement in the problem
- Blaming or fault-finding?
- Speaking in absolute terms, suggesting that their feelings or the feelings of others cannot change and will always be like this
Context Specific - Relational

- Dramatic temporary failures of mentalisation
  - “You’re trying to drive me crazy”
  - “You hate me”
  - ‘She does my head in. I can’t think once she starts on me’
Pseudo-Mentalization

There is apparent thoughtfulness about mental states, but some essential features of mentalization are missing

- A tendency to express certainty about others’ experiences
- Highly selective or self-serving recognition of mental states
- Inaccurate attribution of improbable states of mind to self or others
Pseudo-mentalising subtypes

- Intrusive mentalising
  - Opaqueness of mental states not respected
  - Thoughts and feelings talked about, may be relatively plausible and roughly accurate, but assumed without qualification

- Overactive-inaccurate mentalising
  - Lots of effort made, preoccupation with mental states
  - Off-the-mark and un-inquisitive

- Bizarre mentalising
  - Highly inaccurate, highly psychologically implausible mental states inferred
Forms of Pseudo-Mentalization:
Intrusive sub-type

- The separateness/opaqueness of minds is not respected
  - someone thinks they *know* what another person thinks/feels.
  - other person’s thoughts/feelings overly similar to person’s own thoughts/feelings

- Elements of the image of the other’s mind might be correct but lack subtlety that comes through discourse
  - E.g. subtle differences between what a parent expresses and what the child is likely to feel reveal that they are not in touch with the thoughts and feelings of a child.

- Lack of awareness that telling others what they think and feel can inhibit their capacity to have their own mind
Forms of Pseudo-Mentalization: Overactive-Inaccurate sub-type

- Individual invests excessive energy in thinking or talking about how they or others think or feel (pre-occupied)
- This has little or no relationship to the other person’s reality: An idealization of ‘insight’ for its own sake.
- Links with pretend mode and analysis ‘interminable’
Forms of Pseudo-Mentalization: Inaccurate/Bizarre subtype

- At extreme: bizarre attributions
  - “you are trying to drive me crazy”
- Denials of objective realities
  - “you wanted to fall down the stairs, I hardly touched you”
- Denial of the other’s feelings
  - “you don’t care about whether your girlfriend is here or not”, “you don’t care about me”
  - “you would be glad if I was dead”
- Traumatized by misperception ➔ seeks to inhibit capacity to mentalize e.g. may walk out
- Shades into misuse of mentalisation if understanding distorted to serve goal of other – identification with the aggressor
Misuse of Mentalizing (1)

- Understanding of the mental state of the individual is not directly impaired yet the way in which it is used is detrimental
  - May be unconscious but is assumed to be motivated
  - Self-serving distortion of the other’s feelings
  - Self-serving empathic understanding
  - A person’s feelings are exaggerated or distorted in the service of someone else’s agenda
Misuse of Mentalizing(2)

- Coercion against or induction of the thoughts of others
  - Deliberate undermining of a person’s capacity to think by humiliation
  - Extreme form is sadistic or psychopathic use of knowledge of other’s feelings or wishes
  - Milder form is manipulation for personal gain
    - inducing guilt
    - engendering unwarranted loyalty
    - power games
    - Understanding used as ammunition in a battle
Exercise to identify non-mentalising

- Interviewer asks questions from role player that DEMAND mentalising
- Role-players answers for 3 minutes as
  - Reflective psychologically minded person
  - As concrete, non-mentalising person
  - As pseudo mentalising person
  - As person who misuses mentalising
- Observers write down non-mentalising script
Assessment of interpersonal/representational world
Interpersonal/Relational Representations
Normal

- Balanced – selective
- Flexible – reversible
- Stable – consistent over time
- Developmental – change over time
Interpersonal/Relational Representations

BPD

- Centralised
  - Unstable
  - Self focused
  - Inflexible

- Distributed
  - Stable
  - Distancing
  - Inflexible
The hierarchy of relationship involvement - Normal

Intended relationships:
- Most involved
- Least involved

Relationships:
- Best friend
- Partner
- Mother
- Teacher
- Colleague
- Daughter

Self

Intensity of emotional investment
The hierarchy of relationship involvement - BPD

Centralised - Unstable

Self

Most involved

Least involved

Intensity of emotional investment

Best friend
Partner
Daughter
Teacher
Colleague
Mother
The hierarchy of relationship involvement - BPD

- Best friend
- Partner
- Colleague
- Daughter
- Mother
- Teacher

Intensity of emotional investment:
- Most involved
- Least involved

Distributed – Relatively stable
The titration of relationships and interventions

Intensive of emotional investment

- Most involved
- Least involved

Distributed – Relatively stable
Assessment: specific aspects
Interpersonal World

- Identify all important current and past relationships but with emphasis on present
  - Characterise each relationship according to
    - form,
    - process
    - change
    - behaviour

- Explore how relationships relate to problems e.g. suicide attempts, self-harm, drug misuse

- Link past to current relationships (BUT eschew causality) where similarities exist – ‘that sounds just like you felt with your present partner’

- Identify priorities/hierarchy for intervention
Assessment: Interpersonal World

- Elicit a detailed account of some important current interpersonal interactions in which attachment relationship has been activated e.g. argument with partner
  - Identify common communication difficulties
  - Explore any open conflict with affect storm - outcome
  - Characterize ambiguous, indirect non-verbal communication
  - Delineate incorrect assumptions i.e. that one has communicated or that one has understood
  - unnecessary, indirect verbal communication

- Identify silent closing off communication and repetitive statements – ‘I know that I am no good’

- Identify faulty communication by listening for the assumptions that the patient makes about other's thoughts or feelings including in therapy dialogue
Assessment: Interpersonal World

Common questions

- Looking back, can you think a bit about what made her behave like that?
- How do you explain his action?
- Is that something that has happened before?
- Is there any other explanation?
- What do other people think about it?

Probes

- I can see that you must have wanted to end the relationship but somehow you stuck it out. Tell me what made you carry on.
- You must have been so excited when the relationship started and felt so let down when he was unreliable. How did you manage those feelings?
Therapist stance
Therapist Stance

- **Not-Knowing**
  - Neither therapist nor patient experiences interactions other than impressionistically
  - Identify difference – ‘I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you’.
  - Acceptance of different perspectives
  - Active questioning

- **Monitor you own mistakes**
  - Model honesty and courage via acknowledgement of your own mistakes
    - Current
    - Future
  - Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings
Therapist Stance

- **Reflective enactment**
  - Therapist’s occasional enactment is acceptable concomitant of therapeutic alliance
  - Own up to enactment to rewind and explore
  - Check-out understanding
  - Joint responsibility to understand over-determined enactments
Therapist Stance
Implicit Mentalization

- The therapist is continually constructing and reconstructing an image of the patient, to help the patient to apprehend what he feels.
- Mentalizing in psychotherapy is a process of joint attention in which the patient’s mental states are the object of attention.
- Neither therapist nor patient experiences these interactions other than impressionistically.
Therapist Stance
Explicit Mentalization

- Not directly concerned with content but with helping the patient
  - to generate **multiple perspectives** on the fly
  - to free himself up from being stuck in the “reality” of one view (primary representations and psychic equivalence)
  - to experience an array of mental states (secondary representations) and
  - to recognize them as such (**meta-representation**).

- Explication draws attention back to implicit representations—feelings for example
  - use language to bolster engagement on the implicit level of mentalization
  - highlight the experience of “feeling felt” (mentalized affectivity)
Therapist Stance
Mentalization

- Therapist continually questions his and patient’s internal mental state:
  - What is happening now?
  - Why is the patient saying this now?
  - Why is the patient behaving like this?
  - Why am I feeling as I do now?
  - What has happened recently in the therapy that may justify the current state?
Therapist Stance
Mentalization

- Using questioning comments to promote exploration
  - What do you make of what has happened?
  - Why do you think that he said that?
  - I wonder if that was related to the group yesterday?
  - Perhaps you felt that I was judging you?
  - What do you make of her suicidal feeling (in the group)?
  - Why do you think that he behaved towards you as he did?
Therapist Stance

Highlighting alternative perspectives

- I saw it as a way to control yourself rather than to attack me (patient explanation), can you think about that for a moment?
- You seem to think that I don’t like you and yet I am not sure what makes you think that.
- Just as you distrusted everyone around you because you couldn’t predict how they would respond, you now are suspicious of me.
- You have to see me as critical so that you can feel vindicated in your dismissal of what I say.
Therapist Stance

Affective experience and its representation

- Focus the patient’s attention on therapist experience when it offers an opportunity to clarify misunderstandings and to develop prototypical representations
  - Highlight patient’s experience of therapist
  - Use transference to emphasise different experience and perspective
  - Negotiate negative reactions and ruptures in therapeutic alliance by identifying patient and therapist roles in the problem
Therapist Stance
The Group Therapist and Affect

Group affects are

- Identified and agreed by the group
- Explored and understood by the group
- Where appropriate related to group transference to the therapists
- Recognised as being the responsibility of the group
Techniques of Treatment

Therapist Stance

- The group therapist ensures that affects are:
  - Identified within the group and by the group
  - Verbalized and explored in relation to others within the group
  - Recognised as having influenced others in the group
  - Recognised as having been induced in oneself by beliefs about others’ reactions and motivations
  - Retained in the group and feelings, however intense, do not spill over from the group to other settings in the treatment
Workshop Exercise – stimulation of mentalization

- Patient – describes an incident in his life

- Therapist
  - Focus on the incident
  - Intervene to move non-mentalizing to mentalizing
  - Explore the incident
The mentalizing focus
Beginning a mentalizing focus

- Goal is to learn how to find out more about how a person is thinking or feeling
- Therapist task is NOT to become perfect at guessing
- Listen for statements suggesting mentalizing strengths
- Highlight competencies
- Identify context of affects
Clinical Pathway for interventions

1. Identify the Affect not simply the behaviour
2. Explore the emotional context
3. Define the current Interpersonal context outside
4. Examine the broad interpersonal theme in treatment
5. Explore the specific (transference) context
Interventions: principles

- Simple sound-bite
- Affect focused (love, desire, hurt, catastrophe, excitement)
- Focus on patients mind (not on behaviour)
- Relate to current event or activity – mental reality (evidence based or in working memory)
- De-emphasise unconscious concerns in favour of near-conscious or conscious content
Interventions: Spectrum

- Supportive & empathic
- Clarification & elaboration
- Basic Mentalising
- Interpretive Mentalising
- Mentalising the transference
- Non-mentalising interpretations – to use with care
Interventions: Spectrum (1)

- Supportive & empathic
  - “I can see that you are feeling hurt”

- Clarification & elaboration
  - “I can see that you are feeling hurt, I wonder how come?”

- Basic Mentalising
  - “I can see that you are feeling hurt and that must make it hard for you to come and see me/be with me today” (depending on amount affect arousal that you want to allow)

- Interpretive Mentalising
  - Transference tracers: “I can see that you are feeling hurt and that reminds me of how you often react when you feel someone does not do exactly what you want them to do”
Interventions: Spectrum

- Supportive/empathic
- Clarification and elaboration
- Basic mentalizing
- Interpretive mentalizing
- Mentalizing the transference
Interventions: Spectrum (2)

- **Mentalising the transference**
  - “I can see how you can end up feeling hurt by what is happening here” (empathy), “and then you are not sure if you want to be here or not” (outcome of feeling - experience near), “In the end I think that the only way you feel you deserve my attention is if you can feel that you are the hurt victim who has a right to treatment (motivation)”

- **Non-mentalising interpretations – to use with care**
  - Dyadic transference interpretation (Kernberg): “You need to create a relationship in which you feel the victim of someone who is cruel and hurtful to you”
  - Triadic transference (Strachey): “You felt victimised as a child and now with me and with other people you feel compelled to recreate relationships where you are the person who is hurt by those who do not care for you enough”
  - Historical (past blaming, trauma focused): “Your feeling of hurt at the moment is because you have been reminded of how you felt rejected by your mother”
Titration of intervention to involvement

Most
- Supportive & empathic
- Clarification & elaboration
- Basic Mentalising
- Interpretive Mentalising (Transference tracers)
- Interpretive Mentalising (Mentalising the transference)

Least
Interventions: Supportive & empathic

- Respectful of their narrative and expression
- Positive/hopeful but questioning
- Unknowing stance – you cannot know their position
- Demonstrate a desire to know and to understand
- Constantly check-back your understanding – ‘as I have understood what you have been saying is…
- Spell out emotional impact of narrative based on common sense psychology and personal experience
- For the patient but not acting for them – retains patient responsibility
Interventions: Supportive & empathic

- **Identifying and exploring positive mentalizing**
  - judicious praise – ‘you have really managed to understand what went on between you’
  - Examine how it feels to others when such mentalizing occurs – ‘how do you think they felt about it when you explained it to them’
  - Explore how it feels to self when an emotional situation is mentalized – ‘how did working that out make you feel’

- **Identifying non-mentalizing fillers**
  - Fillers: typical non-mentalizing thinking or speaking, trite explanations
  - Highlight these and explore lack of practical success associated with them
Interventions:
Supportive & empathic

- **Provoke curiosity about motivations**
  - Highlight own interest in ‘why’
  - Qualify own understanding and inferences – ‘I can’t be sure but’; ‘may be you’; ‘I guess that you’
  - Guide others’ focus towards experience and away from “fillers”
  - Demonstrate how such information could help to make sense of things
Intervention:
Clarification & Affect elaboration

- Clarification is the ‘tidying up’ of behaviour which has resulted from a failure of mentalization.
- Establish important ‘facts’ from patient perspective.
- Re-construct the events.
- Make behaviour explicit—extensive detail of actions.
- Avoid mentalizing the behaviours at this point.
- Trace action to feeling.
- Seek indicators of lack of reading of minds.
Intervention: Clarification & Affect elaboration

- **Labelling feelings**
  - During non-mentalizing interaction therapist firmly tries to elicit feelings states
  - Therapist recognises mixed emotions—probe for other feelings than first, particularly if first emotion is unlikely to provoke sympathy in others or lead to rejection (e.g. frustration, or anger)
  - Reflect on what it must be like to feel like that in that situation
  - Try to learn from individual what would need to happen to allow them to feel differently
  - How would you need others to *think about you*, to feel differently?
Intervention: Confrontation and Challenge

- **Stop and Stand**
  - Persist and decline to be deflected from exploration - ‘Bear with me, I think we need to continue trying to understand what is going on’
  - Steady resolve - ‘I can understand that you want me to support what you are doing but I don’t think that would be right because…
  - Convert deceit into frank truth - ‘although you feel he has so much that he wouldn’t miss it, the fact is that having stolen it you are a thief’
  - Identify affect attached to action – ‘I can see that although you tried not to ‘con’ them, the pleasure and delight of doing it seems to have been stronger
  - Ensure ‘here and now’ aspects are included in the challenge
Intervention: Confrontation and Challenge

Stop and Stand

- Clarify your boundary (should be a repetition of boundary agreed when therapy began) whilst giving your understanding of patients position in relation to it – ‘I think that you continue to attend simply so that you can force me to watch you deteriorate but I can’t continue to do that. We need to tackle this.

- When all avenues explored state impasse – ‘As far as I can tell we are going round in circles. When I say something you simply dismiss it as rubbish and whilst I am willing to accept that it sometime is, I cannot accept that it always is.

- Recruit group members to recognise impasses and shift from ‘dialogue of the deaf’ to a mentalizing discussion

- State own position – ‘If we can’t get around this I may have to say that treatment has failed and should finish

- Monitor countertransference to ensure no acting out by therapist
Workshop – Stop and Stand

- Patient – describe something in your life and in doing so make some gross assumptions either about the therapist or about someone in your story

- Therapist
  - Stop and stand
  - Re-introduce mentalization about the issue
Interventions: Basic Mentalizing

‘Stop, Listen, Look’
- During a typical non-mentalizing interaction in a group
  - stop and investigate
  - Let the interaction slowly unfold – control it
  - highlight who feels what
  - Identify how each aspect is understood from multiple perspectives
  - Challenge reactive “fillers”
  - Identify how messages feel and are understood, what reactions occur
- What do you think it feels like for X?
- Can you explain why he did that?
- Can you think of other ways you might be able to help her really understand what you feel like?
- How do you explain her distress/overdose
- If someone else was in that position what would you tell them to do

Recruiting
- Gemma is obviously angry. Can anyone help her with this because I wonder if beneath it she is beginning to feel ignored
Interventions:
Basic Mentalizing

- **Stop, Re-wind, Explore**
  - Lets go back and see what happened just then. At first you seemed to understand what was going on but then...
  - Lets try to trace exactly how that came about
  - Hang-on, before we move off lets just re-wind and see if we can understand something in all this.

- **Labeling with qualification** (“I wonder if…” statements)
  - Explore manifest feeling but identify consequential experience – ‘Although you are obviously dismissive of them I wonder if that leaves you feeling a bit left out?’
  - ‘I wonder if there are some resentments that make it hard for you to allow yourself to listen to rules. Lets think about why the rules are there?’
  - ‘I wonder if you are not sure if it’s OK to show your feelings to other people?’
Workshop Exercise to use Basic Mentalizing

- Patient – Discuss an important relationship and allow the story to unfold when prompted

- Therapists: Use empathic statements and basic mentalizing
  - Stop, Look, and Listen and explore important content
  - Stop, rewind, and explore
  - Stop and stand if patient uses non-mentalizing and gross assumptions about you or others
Interventions: Interpretive Mentalizing

- **Transference tracers – always current**
  - Linking statements and generalization
    - ‘That seems to be the same as before and it may be that’
    - ‘So often when something like this happens you begin to feel desperate and that they don’t like you’
  - Identifying patterns
    - It seems that whenever you feel hurt you hit out or shout at people and that gets you into trouble. May be we need to consider what happens otherwise.
  - Making transference hints
    - I can see that it might happen here if you feel that something I say is hurtful
  - Indicating relevance to therapy
    - That might interfere with us working together
Interventions: Mentalizing the Transference

- Transference Interpretation
  - Emphasis on current
  - Demonstrate alternative perspectives
  - Contrast patient’s perception of the therapist to self-perception or perception of others in the group
  - Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
  - Highlight underlying motivation as evidenced in therapy
Interventions: Mentalizing the Transference

- **Dangers of mentalizing the transference**
  - Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient feel that whatever is happening in therapy is unreal.
  - Thrown into a pretend mode.
  - Elaborates a fantasy of understanding with therapist.
  - Little experiential contact with reality.
  - No generalization.
How do I....?
How do I deal with? (1)

- **Function**
  - What is the function of this behaviour – it is commonly to restabilise instability (not primarily aggressive)

- **Context**
  - What is the context of the problem and how does it relate to interpersonal interaction

- **Affect**
  - What is the overt feeling and covert feeling ‘It is obvious that you were angry but it sounds like you were really hurt’

- **Motivation**
  - What conscious motivation does the patient report?
How do I deal with? (2)

- **Mentalise (basic/interpretive)**
  - the conscious motivation, the feeling, and the context - ‘you say that you cut yourself so that you can feel alive because when your partner leaves the house you begin to feel dead’. ‘When someone is not there you get frightened that you don’t exist’.

- **Mentalise (transference) (later)**
  - ‘You will feel like cutting yourself after the session because not being here is likely to bring out that dead feeling. Perhaps you believe that I will forget about you between sessions and out of sight for you is out of mind and out of mind means you become terrified that you are dead’.
Interventions: Spectrum

- Supportive/empathic
- Clarification and elaboration
- Basic mentalizing
- Interpretive mentalizing
- Mentalizing the transference
How do I deal with?
Self-harm

**Function**

- To maintain the self-structure
- Explore reasons for destabilisation of self-structure
  - Tell me when you first began to feel anxious that you might do something?’
- Make a systematic attempt to place responsibility for actions back with the patient to re-establish self-control
  - ‘I can’t stop you harming yourself or even killing yourself but I might be able to help you understand what makes you do it and to find other ways of managing things’.
How do I deal with? Self-harm

**Context**

- Investigate external and internal interpersonal context
  - Seek obvious external interpersonal precipitants
  - Explore repetitive relational fantasy, often of rejection or abandonment
  - Consider recent treatment history within individual and group therapy
How do I deal with?
Self-harm

- **Affect**
  - Feeling of badness = I am bad (psychic equivalence) = Self-harm
  - Explore rejection, loss, hurt, abandonment, and panic
  - Emptiness and experience of a void or ‘black hole’
  - Link to context
How do I deal with? Self-harm

**Motivation**
- Re-stabilise
  - Predictable, mentalisable schematic relationships
  - Rigid understandable motivations – ‘He didn’t turn up because he wanted me to suffer’.
  - Formulaic explanations – ‘He deserves to suffer because he is bad’. ‘I won’t come because they don’t want me there’.
- Reduce panic
- Establish existence
  - Support for body existence through seeing blood
  - When mental existence is in doubt reinforce existence through your body
  - Emptiness becomes partially filled
- Rarely to control/attack other
How do I deal with?

Self-harm

- Intervention
  - Empathy and support
    - You must not have known what to do?
    - Oh dear! That must be disappointing after all this time.

  - Define interpersonal context
    - Detailed account of days or hours leading up to self-harm with emphasis on feeling states
    - Moment to moment exploration of actual episode
    - Explore communication problems
    - Identify misunderstandings or over-sensitivity

  - Identify affect
    - Explore the affective changes since the previous individual session linking them with events within treatment
    - Review any acts thoroughly in a number of contexts including individual and group therapy.
How do I deal with? Self-harm

➤ Explore conscious motive
  o How do you understand what happened?
  o Who was there at the time or who were you thinking about?
  o What did you make of what they said?

➤ Challenge the perspective that the patient presents

➤ DO NOT
  o mentalize the transference in the immediacy of a suicide attempt or self-harm
  o Interpret the patient’s actions in terms of their personal history, the putative unconscious motivations or their current possible manipulative intent in the ‘heat’ of the moment. It will alienate the patient.
Clinical Example
Self-Harm (1)

- Example: Teacher throws herself down stairs and spends time in hospital where she is highly critical of staff. She can’t understand how hospital staff can treat people as they do. She would never treat her pupils so badly.
  - Projected Self-hatred
  - Filling the vacuum by creating
    - Predictable (mentalisable - schematic) relationships
    - Support for body existence (mental existence is in doubt regress reinforcing your existence through your body)
Clinical Example
Self-Harm (2)

- Explication of patient understanding of motives of nurses
  - ‘how do you explain their attitudes to you’
- Identify other contexts in which these feelings have occurred
- Link to earlier feelings before the self-harm episode
- Interpretive mentalizing
  - ‘you seem to have to experience them as wicked and seeing you as horrible so that you yourself don’t have to consider how horrible it is that you keep trying to harm yourself in this way.'
How do I deal with?

Suicide attempt

Example:

Patient e-mails to state that she is going to kill herself by taking an overdose: ‘I know that you have tried but there is nothing more to do. So I am writing to say goodbye. Don’t blame yourself because I know that you have tried’.
How do I deal with?
Suicide attempt (1)

**Function**
- Re-stabilise herself by destabilising the therapist. She was frightened and now has you frightened so she may be more stable but how long that lasts will be dependent partly on your reaction.
- Note the positive aspect of her letting you know about her intention

**Context - What is the context of the problem and how does it relate to interpersonal interaction**
- Therapist thinks about recent events in patients life and in treatment. He is aware that patient feels that she never manages to complete tasks and is currently struggling with a sense of inadequacy.
- Therapist e-mails back asking if anything has happened that might have made her feel so bad about herself and suggests a time that he is available to talk to her on the phone – Stop.
How do I deal with? Suicide attempt (2)

- **Affect** What is the overt feeling and covert feeling?
  - Elicit patients sense of futility and talk about the context of the feelings. Elicit that the patient felt quite pleased with some work that she was doing and went to photocopy some of it. When she got home she realised that she had left the work and the photocopies in the library. This led her to feel that her mind was disintegrating and the only way to manage this is to recreate her mind by disintegrating the mind of the therapist.

- **Motivation** - What conscious motivation does the patient report?
  - Wants to relieve therapist of seeing such a useless patient and to protect him from her badness – ‘All that you have done and I can’t even manage to photocopy anything without losing it.
  - Continue to explore with her all thoughts and feelings that she has had around it – Rewind and Explore
How do I deal with? Affect Storm

Example:

- Patient walks into the consulting room and starts shouting whilst marching around the room. She then takes off her sweater revealing her bra and becomes increasingly angry and insulting about everybody including the therapist.
How do I deal with?
Affect storm (1)

Function
- Once again it should be in the realm of trying to re-stabilise herself. If she gets through the affect storm Uncertain and cannot be understood within the immediate context. However it will restabilise

Context - What is the context of the problem and how does it relate to interpersonal interaction
- There is no clear context initially and so the therapist has to rely on his current understanding of the patient.
- Therapist attempts to establish a context – ‘keep talking’.
- Maintain calm, verbal, contact with patient.
- Point out your puzzlement about what is going on – ‘Can we just sit down and find out what is going on?’
How do I deal with?

Affect storm (2)

- **Affect** What is the overt feeling and covert feeling?
  - Stop, Rewind, Explore
  - The patient’s mother had telephoned the previous evening and asked the patient to come and help her with a party the following weekend and the patient had initially agreed but then felt bullied into it.

- **Motivation** - What conscious motivation does the patient report?
  - Affect storm moves her away from the complex feelings about her mother and everyone becomes distracted from disentangling the feelings about the mother. The removal of the bra is a further distraction and should not be directly interpreted as an act of sexual provocation.
  - Continue to explore with her all thoughts and feelings that she has about her mother.
Workshop Exercise – Self-Harm

- Patient – recently self-harmed. Be unclear or unreasonably clear about why you self-harmed.

- Therapist – Identify and explore
  - Function of behaviour
  - Context
  - Affects
  - Motivation – conscious followed by inquisitive of unconscious motives