Mentalizing the Interpersonal

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Mentalizing: What is it?
Summary

- Depression disrupts mentalizing
- Mentalizing is necessary to change mood
- Mentalizing is vulnerable to collapse in people with personality disorder
- People with PD and Depression, a common comorbidity, have a double whammy on mentalizing process
- Mentalizing develops in attachment process
- Attachment process underpins interpersonal interaction
- IPT primary focus is on interpersonal work but interpersonal work can undermine mentalizing
- IPT clinicians use mentalizing techniques
  - Could IPT benefit from awareness of mentalizing?
A working definition of mentalization

Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of *intentional* mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
What is mentalizing?
Mentalizing: further definitions and scope for thinking about it

- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Being mind minded
- Being mindful (of minds)
- Past, present, and future
- Seeing oneself as agentive and intentional being
- Creating phenomenological coherence about self and others
Prementalizing Modes of Subjectivity

Psychic equivalence:
- Mind-world *isomorphism*; mental reality = outer reality; internal has power of external
- Intolerance of alternative perspectives → concrete understanding
- Reflects domination of self:affect state thinking with limited internal focus
- Managed by avoiding being drawn into non-mentalizing discourse

Pretend mode:
- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- “dissociation” of thought, hyper-mentalizing or pseudo-mentalizing
- Reflects explicit mentalizing being dominated by implicit, inadequate internal focus, poor belief-desire reasoning and vulnerability to fusion with others
- Managed in therapy by interrupting a non-mentalizing process

Teleological stance:
- A focus on understanding actions in terms of their physical as opposed to mental constraints
- Cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Extreme exterior focus, momentary loss of controlled mentalizing
- Misuse of mentalization for teleological ends (harming others) becomes possible because of lack of implicit as well as explicit mentalizing
Mentalizing, attachment and psychopathology
The two-dimensional space defined by attachment anxiety and avoidance, showing Bartholomew’s 4 categories:

- **High avoidance**
  - -ve view of other
  - Fearful avoidant

- **Low avoidance**
  - +ve view of other
  - Dismissing avoidant

- **Low anxiety**
  - +ve view of self
  - Secure

- **High anxiety**
  - -ve view of self
  - Preoccupied
Attachment as Moderator of Treatment Outcome in Major Depression: Interpersonal Psychotherapy Versus Cognitive Behavior Therapy.

Regression lines for posttreatment (A) Ham-D6 and (B) Beck Depression Inventory-II scores as a function of Treatment Condition x Avoidant Attachment.
Imbalance of mentalization generates problems

**Implicit-Automatic-Non-conscious-Immediate.**

- Impulsive, quick assumptions about others' thoughts and feelings not reflected on or tested, cruelty
- Mental interior cue focused
- Lack of conviction about own ideas, seeking external reassurance
- Overwhelming emptiness, seeking intense experiences

**Explicit-Controlled-Conscious Reflective**

- Does not genuinely appreciate others' perspective. Pseudo-mentalizing, interpersonal conflict ‘cos hard to consider/reflect on impact of self on others
- Mental exterior cue focused
- Hyper-vigilant, judging by appearance.
- Evidence for attitudes and other internal states hasto come from outside

**Cognitive agent: attitude propositions**

- Unnatural certainty about ideas, anything that is thought is REAL
- Intolerance of alternative ways of seeing things.

**Affective self:affect state propositions**

- Overwhelming dysregulated emotions, not balanced by cognition come to dominate behavior. Lack of contextualizing of feelings leads to catastrophizing
- Unnatural certainty about ideas
- Anything that is thought is REAL

**Imitative frontoparietal mirror neurone System -Other**

- Hypersensitive to others’ moods, what others say. Fears ‘disappearing’

**Belief-desire MPFC/ACC inhibitory System -Self**

- Rigid assertion of self, controlling others’ thoughts and feelings.
Inhibition of social and self/other understanding associated with depression

Inaccurate judgements of own affects, hypermentalizing/hypomentalizing cycles
Delayed cognitive understanding
Failure to understand the situational determinants of emotions
BPD, Depression and Non-mentalizing modes

- Psychic equivalence
  - Self harm arises in context of disorganised self-structure of BPD
  - Self critical thoughts real
  - Fear of abandonment and loss a fact

- Pretend Mode
  - Hypomentalizing followed by rebound hypermentalizing
  - Self-fulfilling logic of failure and futility
  - Suicide as part of hypermentalizing process

- Teleological
  - Insistent demand for attachment figures
  - Requirement for extra sessions
  - Potential boundary violations
<table>
<thead>
<tr>
<th>Number</th>
<th>Exptl N=71</th>
<th>Control n=63</th>
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<tbody>
<tr>
<td>Suicide past 6 months</td>
<td>53</td>
<td>42</td>
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<tr>
<td>Number of serious self-harm episodes past 6 months</td>
<td>4.1</td>
<td>3.8</td>
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<tr>
<td>Days of hospitalization past 6 months</td>
<td>5.5</td>
<td>6</td>
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<td>Hospitalized past 6 months</td>
<td>23</td>
<td>19</td>
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<tr>
<td>Major depressive disorder</td>
<td>41</td>
<td>34</td>
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<tr>
<td>Depressive disorders - inc dysthymia</td>
<td>56</td>
<td>47</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Number of Axis 1 diagnoses</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Drug misuse (&gt;4x per week)</td>
<td>29</td>
<td>26</td>
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</table>

**Percentages:**
- Suicide past 6 months: 75.0% (Exptl), 67.0% (Control)
- Number of serious self-harm episodes past 6 months: 78.9% (Exptl), 74.6% (Control)
- Days of hospitalization past 6 months: 32.0% (Exptl), 30.0% (Control)
- Major depressive disorder: 57.7% (Exptl), 54.0% (Control)
- Depressive disorders - inc dysthymia: 40.8% (Exptl), 41.3% (Control)
**Random-effects meta-analysis: Overall Outcome**

<table>
<thead>
<tr>
<th>Study or subcategory</th>
<th>Personality disorder</th>
<th>No personality disorder</th>
<th>log (OR) (s.e.)</th>
<th>Odds ratio (random) 95% CI</th>
<th>Weight %</th>
<th>Odds ratio (random) 95% CI</th>
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<tbody>
<tr>
<td>Total (95% CI)</td>
<td>2047</td>
<td>2104</td>
<td></td>
<td></td>
<td>100.00</td>
<td>2.18 (1.70–2.80)</td>
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<td>Test for heterogeneity: $\chi^2 = 82.92$, d.f. = 33 ($P &lt; 0.00001$), $I^2 = 60.2%$</td>
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<tr>
<td>Test for overall effect: $Z = 6.09$ ($P &lt; 0.00001$)</td>
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<td></td>
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Random-effects meta-analysis stratified by treatment modality:

Psychotherapy

<table>
<thead>
<tr>
<th>Study or subcategory</th>
<th>Personality disorder n</th>
<th>No personality disorder n</th>
<th>log (OR) (s.e.)</th>
<th>Odds ratio (random) 95% CI</th>
<th>Weight %</th>
<th>Odds ratio (random) 95% CI</th>
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</thead>
<tbody>
<tr>
<td>Black (1988)</td>
<td>27</td>
<td>28</td>
<td>0.67 (0.56)</td>
<td>2.52</td>
<td>1.95</td>
<td>(0.65–5.86)</td>
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<tr>
<td>Casey (2004)</td>
<td>54</td>
<td>249</td>
<td>0.71 (0.36)</td>
<td>3.74</td>
<td>2.03</td>
<td>(1.00–4.12)</td>
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<tr>
<td>Diguer (1993)</td>
<td>12</td>
<td>13</td>
<td>1.55 (0.92)</td>
<td>1.29</td>
<td>4.71</td>
<td>(0.78–28.59)</td>
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<tr>
<td>Hardy (1995)</td>
<td>27</td>
<td>85</td>
<td>0.58 (0.45)</td>
<td>3.13</td>
<td>1.79</td>
<td>(0.74–4.31)</td>
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<td>Leibbrand (1999)</td>
<td>39</td>
<td>18</td>
<td>-0.18 (0.54)</td>
<td>2.62</td>
<td>0.84</td>
<td>(0.29–2.41)</td>
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<tr>
<td>Pfohl (1984)</td>
<td>8</td>
<td>3</td>
<td>1.79 (1.39)</td>
<td>5.99</td>
<td>1.23</td>
<td>(0.39–91.32)</td>
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<td>Shea (1990)</td>
<td>86</td>
<td>34</td>
<td>0.21 (0.36)</td>
<td>3.74</td>
<td>1.23</td>
<td>(0.61–2.50)</td>
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<td>Stuart (1992)</td>
<td>14</td>
<td>39</td>
<td>0.36 (0.63)</td>
<td>2.19</td>
<td>1.43</td>
<td>(0.42–4.93)</td>
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<tr>
<td>Thompson (1988)</td>
<td>25</td>
<td>50</td>
<td>1.31 (0.53)</td>
<td>2.67</td>
<td>3.71</td>
<td>(1.31–10.47)</td>
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<tr>
<td>Tyrer (1990)</td>
<td>13</td>
<td>9</td>
<td>-0.05 (1.04)</td>
<td>1.07</td>
<td>0.95</td>
<td>(0.12–7.30)</td>
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<tr>
<td>Subtotal (95% CI)</td>
<td>305</td>
<td>528</td>
<td></td>
<td>23.62</td>
<td>1.74</td>
<td>(1.25–2.42)</td>
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Test for heterogeneity: $\chi^2 = 7.42$, d.f. = 9 ($P = 0.59$), $I^2 = 0$
Test for overall effect: $Z = 3.31$ ($P = 0.0009$)

Ten-Year Course of Borderline Personality Disorder: Psychopathology and Function From the Collaborative Longitudinal Personality Disorders Study

IPT and mentalizing the interpersonal – a core strategy for comorbidity
Review of the 6th edition of the APA’s Textbook of Psychiatry

Psychosocial treatments have been streamlined in this edition to provide clinicians with a broader understanding of the concepts that all psychosocial treatments share at a deeper level and to allow busy clinicians the opportunity to review the individual psychosocial treatments in an efficient manner. An example of concepts shared by many of the psychosocial treatments is mentalization, and a section on mentalization has been added to this version of the textbook. It discusses definitions and concepts related to the term mentalization. In addition, how mentalization relates to attachment is described as is how it relates to psychopathology. Finally, the authors highlight how mentalization relates to multiple types of psychotherapies.
IPT Core Strategies

- Focal areas: Grief and loss, Role transitions, Interpersonal disputes, Interpersonal sensitivity
- Emphasise the current interpersonal relations
- De-emphasise current predicament as manifestation of an internal conflict
- Explore symptoms in terms of interpersonal relations
- Use transference only when obvious or in deficit states
- Link symptom change to the way the patient thinks, feels and acts in problematic interpersonal relationships
- Don’t uncover distorted thoughts systematically by giving homework
- Draw attention to distorted thinking in relation to significant others
Selection, training and supervision in the NIMH trial

- Selection of therapists
  - 2-27 years experience, average 11.4 years, prior experience of treating at least 10 depressed clients
  - All candidates screened for competence using CV, interview and video of treatment sessions

- Training
  - IPT training (from Weissman) - 5 days
  - CBT training (from Beck) - 1-2 weeks
  - Monthly, plus call-back if red-line
Ratings of competence

- Therapist Strategy Rating Form & Process Rating Form – evaluates:
  - therapist accuracy in identifying problem areas
  - strategies for bringing about change
  - quality of application of IPT techniques

- Includes ratings of generic therapeutic skills e.g.
  - Alliance
  - Maintaining session focus
Competence and Outcome – IPT with 3 year maintenance

- Therapists stratified into high and low competence (median split)
- Median survival time to relapse
  - ‘high’ competence therapists - 2 years
  - ‘low’ competence therapists - 5 months
Assessment of interpersonal/representational world:

Taking the inventory
Interpersonal Inventory

- Significant contemporary relationships – recent changes, losses, and gains
- History of current problems and effect on relationships and vice versa
- Communication styles & patterns of interaction
- Level of social support
- Relationship expectations
- Facilitates planning of treatment interventions
- Evolves and changes during treatment and may re-orientate therapy
Interpersonal/Relational Processes: Normal

- Balanced – selective
- Flexible – reversible
- Stable – consistent over time
- Developmental – change over time and context dependent
Interpersonal/Relational Processes: Attachment patterns

- Centralised
  - Unstable
  - Self focused
  - Inflexible

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

- Most involved
  - Best friend
  - Partner

- Intensity of emotional investment
  - Colleague
  - Daughter
  - Teacher
  - Mother

- Least involved
  - Self
The hierarchy of relationship involvement

Intensity of emotional investment

Most involved

Least involved

Integrity of emotional investment

Centralised - Unstable
The hierarchy of relationship involvement

- Self
- Best friend
- Partner
- Colleague
- Daughter
- Teacher

Intensity of emotional investment:
- Most involved
- Least involved

Distributed – Relatively stable
The two-dimensional space defined by attachment anxiety and avoidance, showing Bartholomew’s 4 categories.

- **Low anxiety**
  - +ve view of self
  - Secure

- **High anxiety**
  - -ve view of self
  - Preoccupied

- **High avoidance**
  - -ve view of other
  - Fearful avoidant

- **Low avoidance**
  - +ve view of other
  - Dismissing avoidant
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, mood

- Link patterns in current relationships 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 OR DEACTIVATED 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?
Interpersonal Formulation

**Biological Factors**
- Recurrent depression in family
- Hormonal change

**Social Factors**
- Distant relationship with family
- Separated from husband
- Good social support at work

**Psychological Factors**
- Insecure attachment styles
- Paranoid defences
- Irritable temperament

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Interpersonal Crises: Separation
Interpersonal Disputes: family and friends
Role transitions: Married to separated

Interpersonal Distress
- Poor work performance

Depression
IPT: 
Mentalizing the affect
Use of Affect in IPT

<table>
<thead>
<tr>
<th>Content</th>
<th>Present</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>As I talk about my former partner it makes me think of all the things we wanted to do together until he became selfish</td>
<td>I mostly remember feeling disbelief that he hadn’t involved me in his arrangements</td>
<td></td>
</tr>
<tr>
<td>Affect</td>
<td>Sadness</td>
<td>Numbness</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
<td></td>
</tr>
</tbody>
</table>
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) c.f. basic and social emotions
- Reflect on what it must be like to feel like that in that situation –’ if that was me I would feel X’
- 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?
Affect Focus: Making implicit mentalizing explicit

- Not the affect associated with the story or event
- Patient may have different affect related to story
- Affect focus is current affect as experienced in the telling of the story
- Make explicit if important in interpersonal terms in patient/clinician relationship
- Naturally moves towards mentalizing the relationship
Current affective interpersonal experience = affect focus

- Define the current affective state shared between patient and therapist
- Do this tentatively from your own perspective
- Do not attribute it to the patient’s experience
- Link the current affective state to therapeutic work within the session itself
- IPAF of Dynamic Interpersonal Therapy
IPT:
Mentalizing
interpersonal role
disputes
INTERPERSONAL ROLE DISPUTES
Overall Goals

- Help the patient identify the dispute
- Determine the form of the dispute
- Make choices about a plan of action
- Modify maladaptive communication patterns or reassess expectations
- Identify pathway of rapidly escalating disputes and emotional arousal
Interpersonal Role Disputes

- Evidence of current overt and covert conflicts with a significant other
  - Dismissive or over-idealised descriptions of current or recent relationships
    - ‘He betrayed me and so I refuse to talk to him’. ‘Don’t mention him again’

- Inconsistent description of relationship within the same narrative
  - ‘I am frightened of him but I love him because he really looks after me’
Common Interpersonal Disputes

- Overt hostility – domestic violence, abuse
- Betrayals – infidelity
- Psychological dominance – control, sadistic
- Covert hostility – withdrawal, denial of intimacy
- Integration of self-harm in disputes
Misuse of relationship

- 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 relationship

- 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
Interpersonal Role Disputes

Tasks 1

- Develop a treatment plan: the therapist first determines the stage of the role dispute
  - Renegotiating
  - Impasse
  - Dissolution
  - Excitement
  - Hurt and abandonment
  - Anger, bitterness,

- Identify how non-reciprocal role expectations relate to the dispute
  - ‘what would be have to do or be like to make you feel better?’

- Explore resolution of disputes and role negotiations
  - ‘Does it ever get better’ ‘Are there times when you make up (beware use of self-harm)’.
Interpersonal Role Disputes

Tasks 2

- Investigate parallels in previous relationships
  - ‘Have your relationships been like this before’.

- What does the patient gain by the behaviour
  - ‘I suppose that sometimes you find all this quite exciting – there is never a dull moment’.

- What are the central unspoken assumptions that lie behind it
  - ‘It seems that you are always trying to find out if he loves you’.
Non-reciprocal Roles

- Clarify expectations of other
- Identify times when roles are fulfilled and times when unfulfilled
- Explore underlying assumptions of role
  - ‘He should look after me – that is what men are supposed to do’
- Consider any compromise on roles
  - If I am like that then perhaps he will be a bit nicer to me’
Interpersonal Disputes - summary

Clarification

Expression of affect

Communication analysis

Non-reciprocal role expectations

Relationship appraisal

Role playing

Ending of relationship

Acceptance of relationship limitations

Resolution
Mentalizing the interpersonal: More about how than what.
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
- Eschew your need to understand – do not feel under obligation to understand the non-understandable.

**Monitor you own misunderstandings**
- Model honesty and courage to accept mentalizing errors via acknowledgement of your own misunderstanding
  - Current
  - Future
- Suggest that misunderstandings offer opportunities to re-visit to learn more about contexts, experiences, and feelings
Mentalizing Process - trajectory

Narrative of event

Experience at time

Reflection on events

Alternative perspective

Experience talking about it in therapy

Current feeling about events
Mentalizing process

- Not directly concerned with content/narrative but with helping the patient 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).
Components of mentalizing the therapeutic relationship

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist’s own distortions)
- Collaboration in arriving at an understanding
- Present an alternative/additional perspective
- Monitor the patient’s reaction
- Explore the patient’s reaction to the new understanding
Therapist Affect (Mentalizing the Relationship)

- 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 alternative perspectives to emphasise different experience which needs exploring
  - Negotiate negative reactions and ruptures in therapeutic alliance by identifying patient and therapist roles in the problem – accept your contribution
Components of mentalizing the counter-relationship

- Anticipation of response/reaction of patient
- Mark your statement
- Do not attribute what you experience to the patient
- Keep in mind your aim
  - Re-instate your own mentalizing
  - Identify important emotional interaction that affects therapy relationship
  - Emphasise that minds influence minds
Therapeutic relationship

- Patient-therapist relationship is not the primary focus of treatment.

- Use Transference interpretations sparingly.

- Relate patterns in the patient’s relationships to the immediate interpersonal problem.

- Give attention to the here-and-now relationship if patient thinks about or acts towards therapist in a way that interferes with the process of therapy.
Negative Therapeutic Relationship

- Encourage patient at the onset of treatment to express to the therapist complaints, apprehensions and/or other negative feelings that arise.

- State that the therapy itself is a relationship and so is likely to have problems because the patient is tackling interpersonal difficulties.

- Explore alternative ways of handling negative reactions both in and out of therapy when they occur.
Explore disruptive attitudes and behaviours by moving from matter-of-fact mention of the behaviour towards attempting to understand its meaning and interpersonal function.

Disruptive behaviour can be understood as indirect and inefficient communication of negative feelings.

If you are responsible for the rupture of alliance - APOLOGISE
Thank you for mentalizing!

For further information
anthony.bateman@ucl.ac.uk

Slides available at:
http://www.ucl.ac.uk/psychoanalysis/people/bateman
Ten-Year Course of Borderline Personality Disorder: Psychopathology and Function From the Collaborative Longitudinal Personality Disorders Study
Intermediate sessions
Specific techniques

- Limit setting for highly impulsive individuals whose behaviour is destructive
- Directive techniques (educating, advising, modelling)
- Role playing to facilitate behaviour change
- Decision analysis whenever the patient has an interpersonal problem to be solved - "What alternatives do you feel you have now?" or "Why don't we try to consider all the choices you have?".
Theory
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 mirroring.
- that this capacity may be inhibited (decoupled) in response to trauma in vulnerable individuals.
Focal Area for BPD – The Self

- Self (a muddled concept)
  - Initiator of action
  - Experience of personal agency
  - Psychological structure
  - Superordinate structure (Kohut)
  - Defensive structure (False Self – Winnicott)
  - Autonomous strivings (Masterson)
Focal Area for BPD – The Self

A structure through which an individual acquires continuity, cohesion, and enduring organization

- Self-representations – how I portray myself to myself
- Self-identity – broad category
- Self-concepts – how I describe myself
- Self-image – how I see myself
- Self-esteem – affective evaluation of self
- Self-schema – mental model with prototypical interactions
Focal Area for BPD – The Self

- Explore view of self in multiple interpersonal contexts – relationships, social occasions, work, family
  - ‘How would you describe yourself when..’
  - ‘How do you see yourself as a person’
  - ‘How does she make you feel about yourself’
  - ‘Who can make you feel good about yourself’
  - ‘Who do you like to be with. How do you explain that?’
Standard IPT Structure – early sessions

- Review of symptoms
- Give disorder a name
- Explain the disorder
- Define and explore Interpersonal Inventory
- Giving the ‘sick role’
- Evaluation of need of medication
- Define interpersonal context
- Give the model – emphasise current
- Agree on treatment contract
Rationale for IPT for BPD

- BPD a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked instability
- Symptoms (affects) primarily provoked in interpersonal situations
- IPT targets affects within interpersonal contexts
- IPT emphasises therapeutic alliance
- BPD involved in interpersonal disputes and IPT specifically explores disputes and role expectations
Review of Borderline Symptoms

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships
- identity disturbance
- impulsivity in at least two areas that are potentially self-damaging
- recurrent suicidal behaviour
- affective instability due to a marked reactivity of mood
- chronic feelings or emptiness
- inappropriate, intense anger or difficulty controlling anger
- transient, stress-related paranoid ideation
Aims of early sessions – IPT for BPD

- Establish therapeutic relationship
- Identify affective states
- Define interpersonal inventory
- Link interpersonal context to behaviours and symptoms
- Explicate pathway to improvement
Modifications of IPT structure and content

- Conceptualisation of disorder
- Focus of therapy
- Length and frequency of intervention
- Integration of risk and pathway in crisis
- Termination
- Maintenance IPT
Length of Treatment

- No evidence that very brief treatments effective in BPD so IPT-BPD has two stages
  - IPT 16-24 sessions plus telephone contact and emergency pathway
  - Additional 16 sessions over 16 weeks if initial phase tolerated
  - ?IPT- M
Provision of Information: Expert Role

- Information – personalised - ?Leaflet
  - Understanding of BPD
    - Genetics
    - Biological processes – arousal, hormonal pathways
    - Neurobiology – emotional circuitry
    - Developmental
    - Interpersonal inventory
Focus on Affect

- Experience near
- Identify common affects of BPD – anger, anxiety, abandonment, emptiness
- Explore interpersonal context of emotion
- Identify patterns of affect storms
- Chart fluctuations – BPD is a relapsing and remitting disorder
The Patient and Affect

The patient must be helped to:

- Consider who engendered the feeling and how

- Ask ‘what feeling may I have engendered in someone else that may have made him do that to me’?

- Explore whether the feelings have occurred or are connected to events either in the immediate or longer term past but IPT works predominantly in the present

- Assess the appropriateness of the feeling to any given situation in terms of others’ understanding of them

- Establish the appropriate locus of these feelings within current relationships
Use of Affect in IPT

- Distinguish between process or present affect i.e. expressed in session and content or past affect i.e. as reported
- Explore incongruities between them
- Help patient become aware of underlying affects e.g. depression covers anger, anger covers hurt
# Use of Affect in IPT

<table>
<thead>
<tr>
<th>Content</th>
<th>Present</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>As I talk about my former partner it makes me think of all the things we wanted to do together until he became selfish</td>
<td>I mostly remember feeling disbelief that he hadn’t involved me in his arrangements</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Affect</th>
<th>Present</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Numbness</td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td></td>
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</tbody>
</table>