

Introduction to Mentalisation

A Training Workshop

Clinical Question?

- Patient with BPD sends an e-mail to you stating her current feelings. At the end of the e-mail she says – ‘that is how I am’. Don’t bother to reply. I will see you tomorrow.’
- What do you do as therapist and why?

Exercise – mentalization or mentalizing?

- What is mentalization or mentalizing?
 - Give 3 key aspects of the psychological processes that the concept tries to encapsulate
 - Should we use mentalization or mentalizing?

Mindblindness

- Imagine what your world would be like if you were aware of physical things but were blind to the existence of mental things. I mean of course blind to things like thoughts, beliefs, knowledge, desires, and intentions, which for most of us self-evidently underlie behaviour

Baron-Cohen S (1995) Mindblindness

The Artful use of Science

- To do anything well you must have the humility to bumble around a bit, to follow your nose, to get lost, to goof. Have the courage to try an undertaking and possibly do it poorly. Unremarkable lives are marked by the fear of not looking capable when trying something new.

Epictetus, *Manual*

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

Mentalizing: further definitions and scope

- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Past, present, and future
- Introspection for subjective self-construction – know yourself as others know you but also know your subjective self

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”

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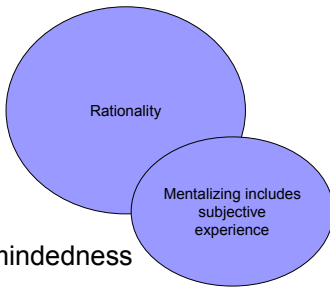
Interpersonal behaviour characterised by an expectation that one's mind may be influenced, surprised, changed and enlightened by learning about another's mind

Why mentalize?

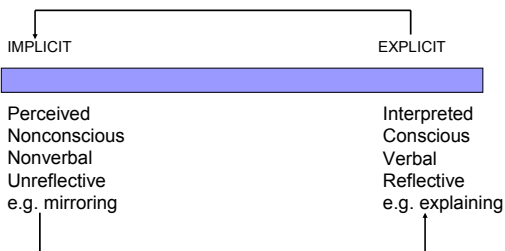
- Instrumental value
 - We are all folk psychologists
 - We predict and influence the interpersonal and intrapersonal world operating subjectively
 - To obtain desired goal
- Intrinsic value
 - Meeting of minds
 - Sense of connection and shared attention

Mentalizing and rationality

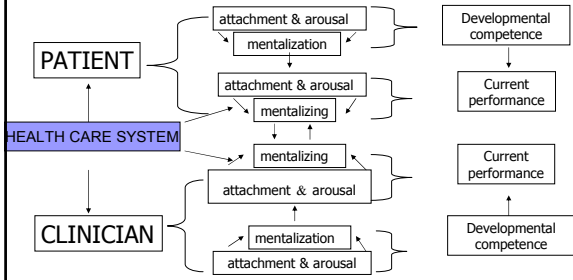
- Rationality
- Thinking
- Deliberating
- Reflecting
- Anticipating
- Reasoning
- Psychological mindedness



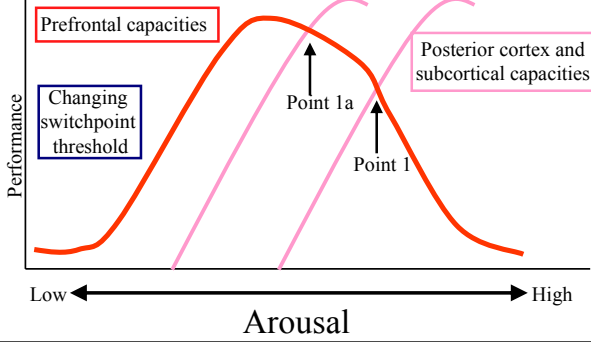
Mentalizing: Implicit 'v' Explicit



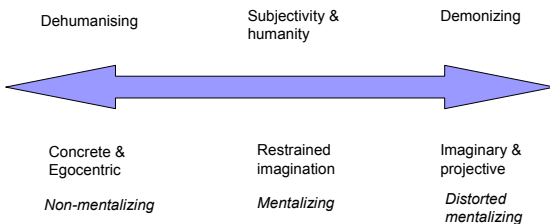
Parallel contributions to mentalizing: Meeting of minds



Mayes' (2001) Adaptation of Arnsten's Dual Arousal Systems Model: Implication of the Hyper-activation of Attachment



Failures of imagination in mindblindness



Mentalizing interactively and emotionally

- Mentalizing interactively
 - Each person has the other person's mind in mind (as well as their own)
 - Self-awareness + other awareness
- Mentalizing emotionally
 - Mentalizing in midst of emotional states
 - Feeling and thinking about feeling (mentalized affectivity)
 - Feeling felt

Example of mentalizing interactively and emotionally

The appetite which we call LUST is a sensual pleasure, but not only that; there is in it also a delight of the mind: for it consisteth of two appetites together, to please, and to be pleased; and the delight (we) take in delighting, is not sensual, but a pleasure of joy of the mind, consisting in the imagination of the power (we) have so much to please.

Thomas Hobbes, quoted in Simon Blackburn (2004) Lust

Mentalizing and psychopathy: Compartment-mentalizing

- Psychopathy entails elements of intact mentalizing
- Partial mindblindness:
 - Failure of imaginative empathy
 - Failure to identify with victim's distress
 - Mind uninfluenced and unchanged easily – control and protection of self from shame/humiliation paramount
 - Distorted mentalizing – paranoid demonizing e.g. interpreting the child's frustrating behaviour as intended to torment the parent

Mentalizing objects and others

- Our relations with other people do not have the same structure as our relations with inanimate objects, plants or machines. We do not deal with our family members, friends, colleagues or fellow citizens, as we do with volcanoes, fields of wheat or kitchen mixers, namely, by trying to figure out the nature and layout of their innards so that we can predict and perhaps control them.

What we hope of another with whom we interact is not that he or she will go through some gyrations which we have already planned in detail, but that he or she will make some contributions to moving forward the joint and co-operative enterprise in which we are both, more or less explicitly, engaged

Heal, J. (2003) *Mind, Reason and Imagination: Selected Essays in Philosophy of Mind and Language* CUP, Cambridge.

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

Some boring theory

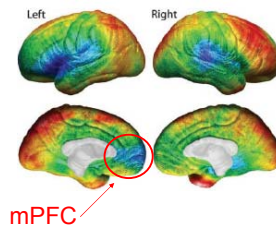
Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

- unstable relationships**
- affective dysregulation**
- impulsivity**
- aggression**

The social brain

1. Medial prefrontal cortex

- Mentalising proper
 - Implicit ability to infer mental states such as beliefs, feelings and desires

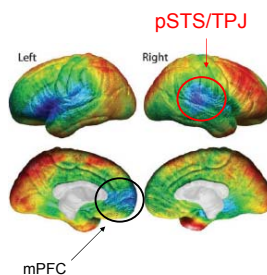


Fletcher et al., 1995; Gallagher et al., 2000;
Gilbert et al., 2006 (meta-analysis)

The social brain

2. pSTS/TPJ

- Prediction
 - Biological motion, eye gaze
- Perspective-taking
 - Different physical points of view

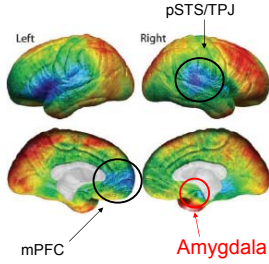


Pelphrey et al., 2004a,b; Kawawaki et al., 2006 (review);
Mitchell 2007

The social brain

3. Amygdala

- Attaching reward values to stimuli
 - 'Approach' vs. 'avoid'
- Facial expressions

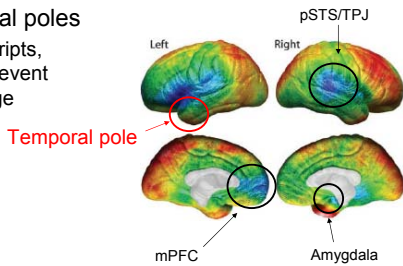


Dolan 2002; LeDoux 2000;
Winston et al., 2002; Phelps et al., 2000, 2003

The social brain

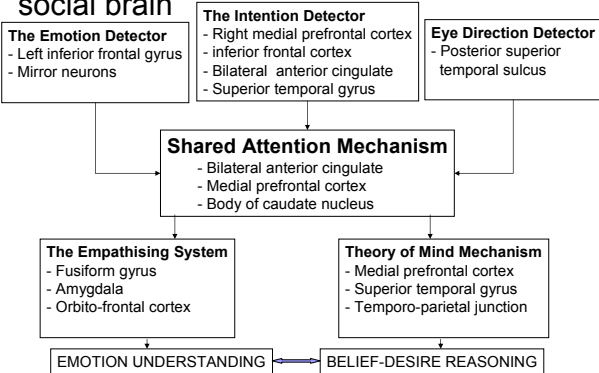
4. Temporal poles

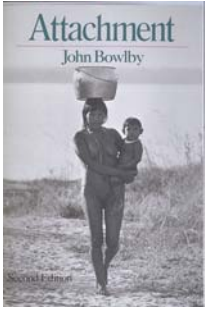
- Social scripts, complex event knowledge



Funnell, 2001; Damasio et al., 2004;
Moll et al., 2001, 2002, 2005 (review)

Baron-Cohen's (2005) model of the social brain



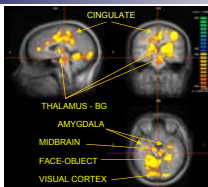


The Nature of Attachment

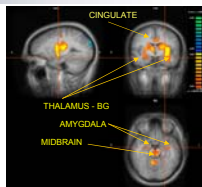
Attachment as an Addiction

- MacLean (1990) speculated that substance abuse and drug addiction were attempts to replace opiates or endogenous factors normally provided by social attachments
- Panksepp (1998) a common neurobiology to
 - mother–infant,
 - infant–mother, and
 - male–female attachment
- Insel (2003) “Social attachment is an addictive disorder?”

HEALTHY MOTHERS OF FIRST INFANTS
N=13



own baby pictures minus other baby pictures



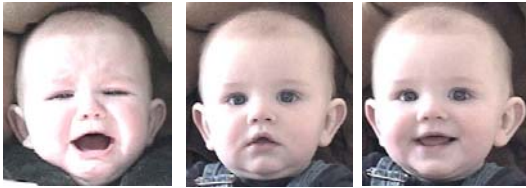
own baby pictures minus houses

Do Different Affective States Trigger the Attachment System Equally?

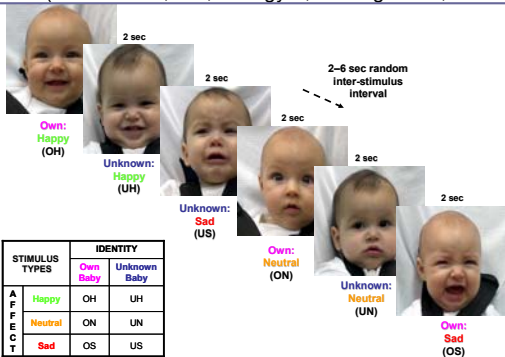
Crying

Neutral

Smiling

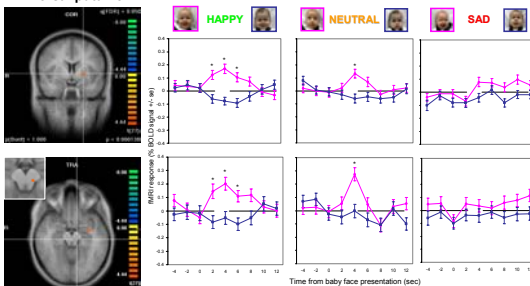


What's in a Smile? Maternal Brain Responses to Infant Facial Cues (Strathearn L, Li J, Fonagy P, Montague PR, submitted)



Brain response of mothers viewing their own baby's face

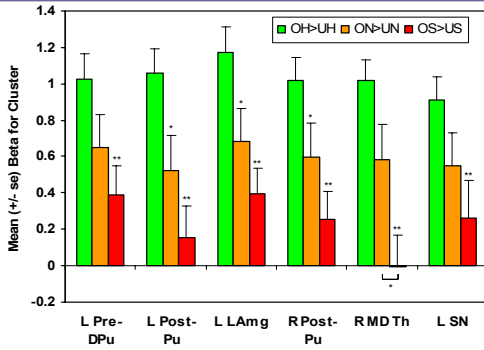
A. Dorsal putamen



B. Substantia nigra

Own baby face Unknown baby face

Progressive decrease in activation depending on infant affect

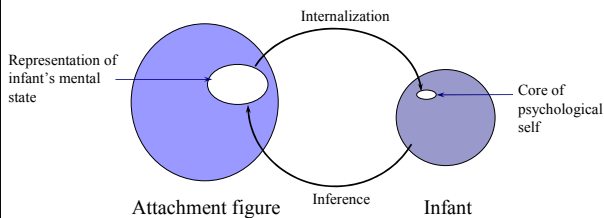


Intersubjectivity and Affect Regulation



Theory: Birth of the Agentive Self

Attachment figure "discovers" infant's mind (subjectivity)

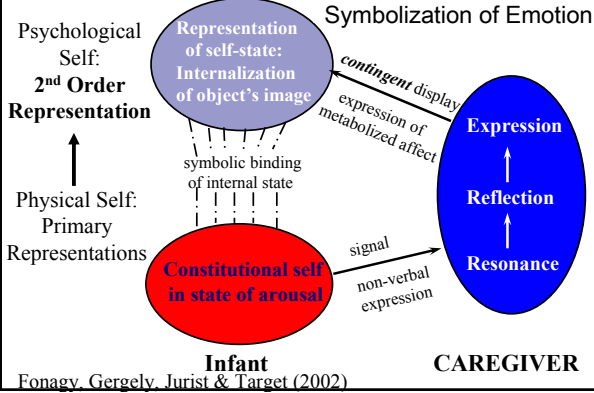


Infant internalizes caregiver's representation to form psychological self
 Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality → mentalization

The Development of Affect Regulation

- Closeness of the infant to another human being who via **contingent marked mirroring** actions facilitates the emergence of a symbolic representational system of affective states and assists in developing affect regulation (and selective attention) → secure attachment
- For normal development the child needs to experience a mind that has his mind in mind
 - Able to reflect on his intentions accurately
 - Does not overwhelm him
 - Not accessible to neglected children

The development of regulated affect



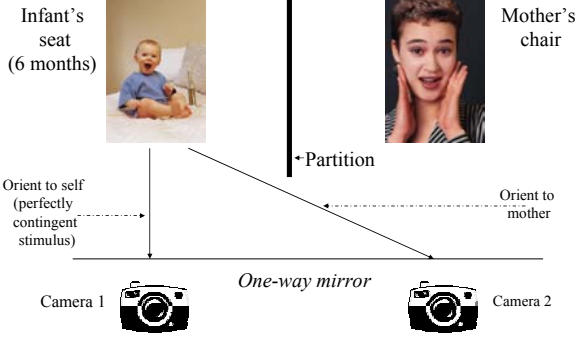
Mirroring sadness



Unmarked mirroring

Marked mirroring

Experimental Arrangements for the Contingency Performance Modified Still Face Study (Koos et al, 2000)



High congruent & marked mirroring

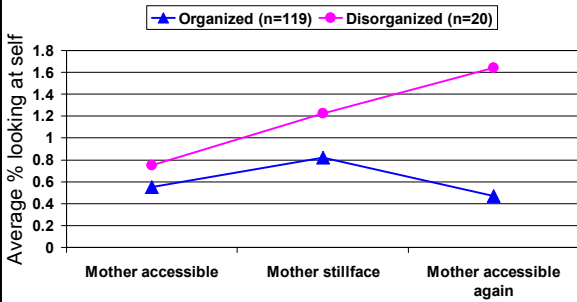


Low congruent & marked mirroring





Duration of Looking at Self During Three Phases of Modified Still Face Procedure

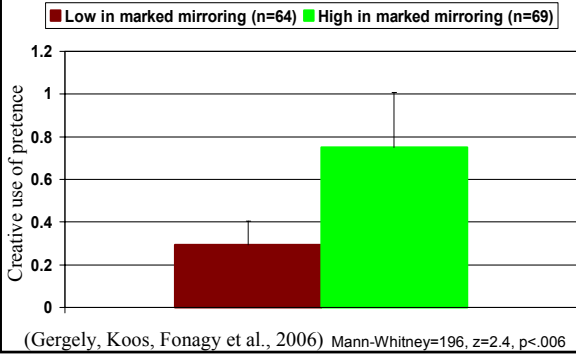


(Gergely, Fonagy, Koos, et al., 2004) $F(\text{interaction})=12.00, df=2,137, p<.0001$

Pretence task at 3 years



High and low marked mirroring by mothers in the MIS (6m) predicting the creative use of pretence (3 years)





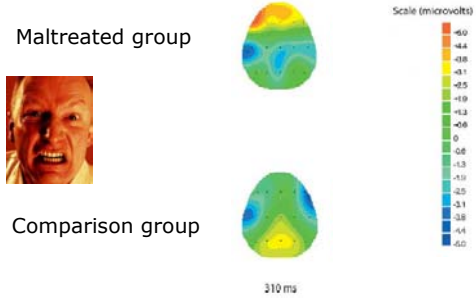
*Attachment
Trauma*

Child Abuse and Neglect

- In the United States, almost 3 million allegations of child abuse and neglect are received each year (1 million confirmed)
- Mortality: 2,000 deaths per year
- Morbidity: 18,000 permanently disabled children per year
 - Cognitive impairment
 - Behavioural and psychiatric morbidity
- 80% of patients with BPD have history of childhood trauma
 - In *some* individuals trauma disrupts the attachment system



EEG study of the responses of maltreated and non-maltreated children to viewing an angry face (Cicchetti & Curtis, 2005 *Dev. & Psychopath.*)



Attachment Disorganisation in Maltreatment

Exposure to maltreatment

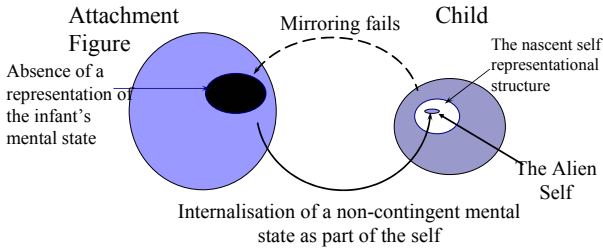
The 'hyperactivation' of the attachment system

The hyperactivation of attachment in BPD

- We assume that **the attachment system in BPD is "hypersensitive"** (triggered too readily)
- Indications of attachment hyperactivity in **core symptoms** of BPD
 - Frantic efforts to avoid abandonment
 - Pattern of unstable and intense interpersonal relationships
 - Rapidly **escalating tempo** moving from acquaintance to great intimacy

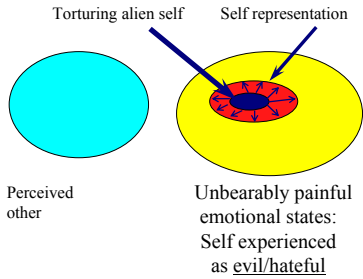
Theory: Birth of the "Alien" Self in Disorganized Attachment

The caregiver's perception is inaccurate or unmarked or both



The child, unable to "find" himself as an intentional being, internalizes a representation of the other into the self with distorted agentic characteristics

Theory: Self-destructiveness and Externalisation Following Trauma



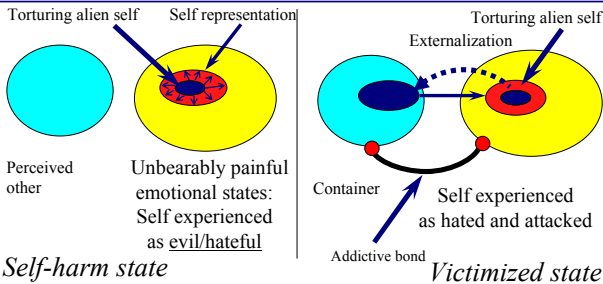
Perceived other

Unbearably painful emotional states:
Self experienced as evil/hateful

Self-harm state

Attack from within is turned against body and/or mind.

Theory: Self-destructiveness and Externalisation Following Trauma



Perceived other

Unbearably painful emotional states:
Self experienced as evil/hateful

Container

Externalization

Self experienced as hated and attacked

Addictive bond

Victimized state

Self-harm state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops



Attachment and Social Cognition

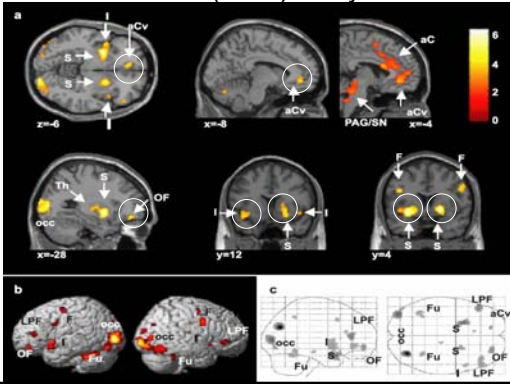
Environmental Influences on the Development of Social Cognition

- **Maternal disciplinary style** (Ruffman, Perner, & Parkin, 1999; Vinden, 2001)
- **Other features of the emotional climate within the family** (e.g., Cassidy et al., 1992; Denham, Zoller, & Couchoud, 1994)
- **The inclination of mothers to take the psychological perspective of their child, including *maternal mind-mindedness* and *reflective function* in interacting with or describing their infants** (Fonagy, Steele, Steele & Holder, 1996; Fonagy & Target, 1997; Meins et al., 2003; Meins, Fernyhough, Wainwright, Das Gupta, Fradley, et al., 2002; Peterson & Slaughter, 2003; Slade, 2005; Sharp, Fonagy; & Goodyer, 2006)

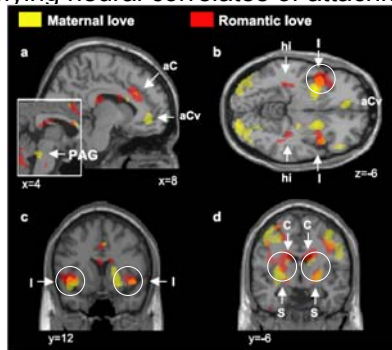
Range of Environmental Influences on the Development of Social Cognition

- **The quality of children's primary attachment relationship *facilitates theory of mind development*** leading to passing standard theory of mind tasks somewhat earlier (e.g., de Rosnay & Harris, 2002; Fonagy & Target, 1997; Fonagy, Redfern, & Charman, 1997; Harris, 1999; Meins, Fernyhough, Russell, & Clark-Carter, 1998; Raikes & Thompson, 2006; Steele, Steele, Croft, & Fonagy, 1999; Symons, 2004; Thompson, 2000; Ontai & Thompson, 2002)
 - Not all studies find this relationship and it is more likely to be observed for emotion understanding than ToM

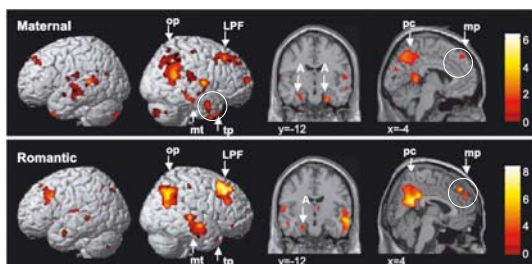
The Bartels & Zeki (2004) study: Maternal Love



The Bartels & Zeki (2004) study of overlap implying neural correlates of attachment



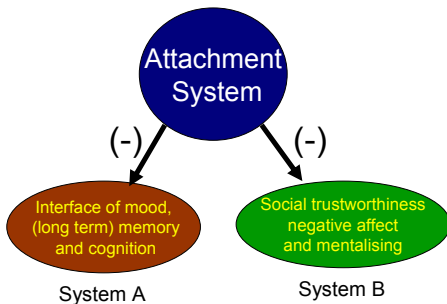
Common regions of deactivation with maternal and romantic love (Bartels & Zeki, 2004)



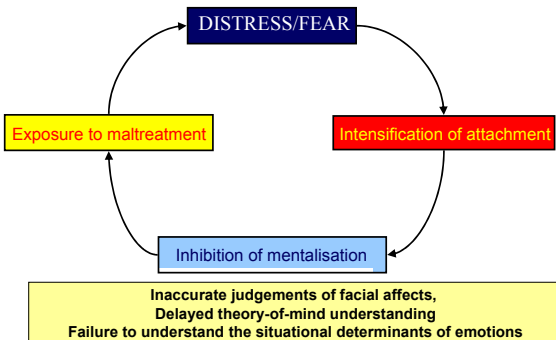
Both maternal and romantic love elicit an overlapping set of deactivations

- middle prefrontal, inferior parietal and middle temporal cortices mainly in the right hemisphere, as well as the posterior cingulate cortex →
 - attention, long-term memory, variable involvement in both positive but mainly negative emotions →
 - underpin interface of mood related memory & cognition
- temporal poles, parietotemporal junction and mesial prefrontal cortex →
 - social trustworthiness, moral judgements, 'theory of mind' tasks, solely negative emotions, attention to own emotions
 - underpin determining other people's emotions and intentions

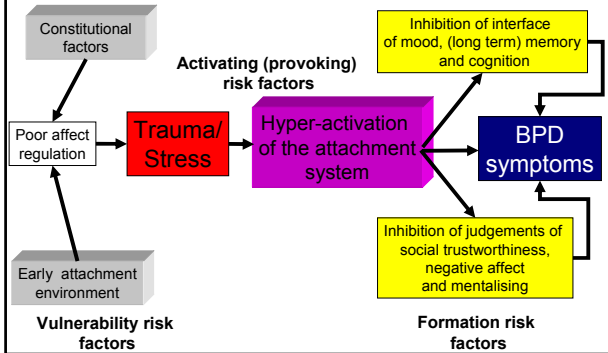
Schematic Representation of Attachment Related Brain Activation



Inhibition of social understanding associated with maltreatment can lead to exposure to further abuse



Schematic Model of BPD



The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Psychic equivalence:

- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Experience of mind can be terrifying (flashbacks)
- Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise”)
- Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Pretend mode:

- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- Linked with emptiness, meaninglessness and dissociation in the wake of trauma
- Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
- In therapy endless inconsequential talk of thoughts and feelings
 - The constitutional self is absent → feelings do not accompany thoughts

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ 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.
- Only action that has physical impact is felt to be able to alter mental state in both self and other
 - Manipulative physical acts (self-harm)
 - Demand for acts of demonstration (of affection) by others

Understanding suicide and self-harm in terms of the temporary loss of mentalization

■ Loss →

➢ *Increase attachment needs → triggering of attachment system →*

■ Failure of mentalization →

➢ *Psychic equivalence → intensification of unbearable experience →*

➢ *Pretend mode → hypermentalization meaninglessness, dissociation →*

➢ *Teleological solutions to crisis of agentive self → manipulative suicide attempts, self-cutting*



*Testing the
mentalisation
model of
BPD*

Social Cognition in Personality Disorder

- Fonagy, Stein, Allen and Vrouva (submitted)
 - 100 young adults recruited from mid-West town
- Mixture of community sample and patients matched for age, gender and IQ
 - BPD n=25
 - Cluster A/C n=25
 - Axis-I n=24
 - non-Psychiatric Controls n=25
- Mentalizing deficit associated with BPD in young adults

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

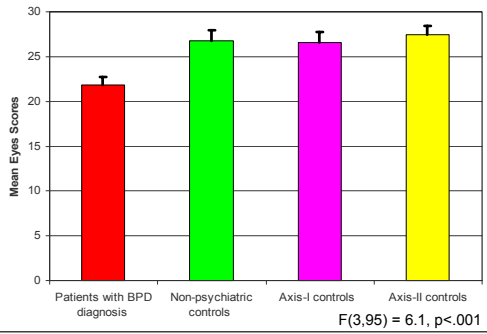
sad



surprised

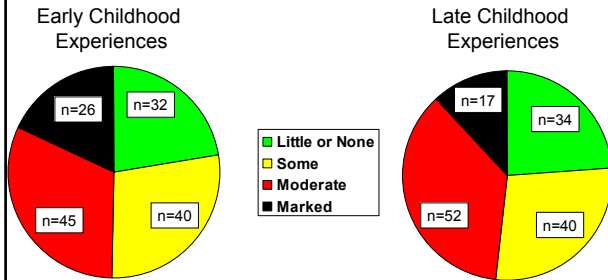
worried

Mean Eyes Scores of BPD (n=25) Cluster A/B (n=25), Axis-I (n=24) and non-Psychiatric Controls (n=25)



(Fonagy, Stein, Allen & Vrouva, submitted)

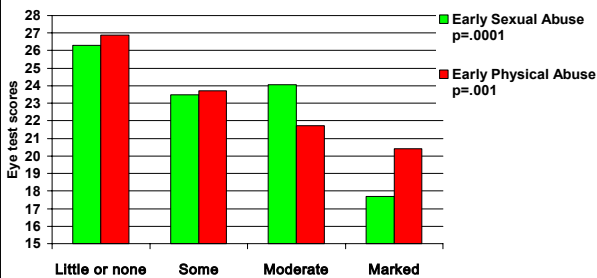
Participant's (N=143) Childhood Experiences of Care and Abuse



Agreement with contemporary records:
Kendal's tau-b = .47, t = 5.81, p = .00001

(Fonagy, Stein, Allen & Vrouva, submitted)

Performance on Eyes Test and Early Physical, Sexual and Psychological Abuse



R² (all CECA subscales) = .35, p < .005

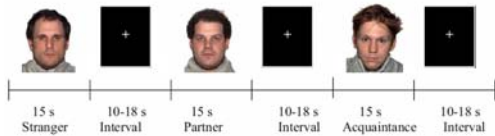
(Fonagy, Stein, Allen & Vrouva, submitted)

The Neural Correlates of Attachment and Mentalizing in BPD (H-17313)

- **Co-investigators:** Carla Sharp, Brooks King-Casas & Peter Fonagy
- **Mentalization deficit in attachment context in BPD**
 - Previous work suggests inhibition of mentalization associated with activation of attachment circuit
- **Aim:**
 - To examine activation of mentalizing when thinking about partner vs acquaintance
 - To examine activation of mentalizing circuits in BPD patients
- **Participants for whom data analyzed**
 - BPD n=13
 - Normal (age and gender match) n=13

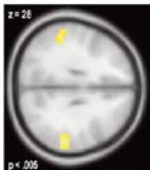
Task

Pictures (romantic partner, stranger, acquaintance) were shown for 15 seconds in 9 random permutations of the 3 types.

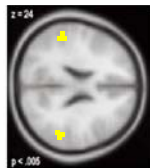


Age and gender matched controls

Acquaintance vs Stranger



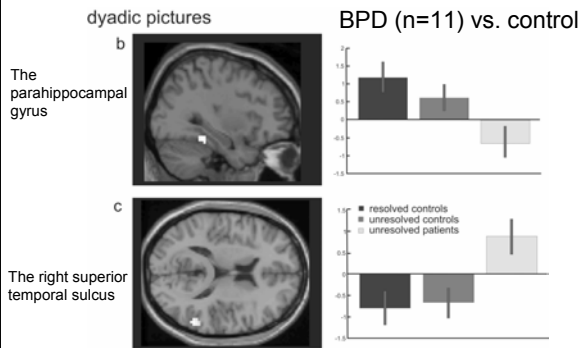
Partner vs Stranger



Summary

- Relative to Borderline patients, controls showed greater activation in the bilateral temporal parietal junction in response to photos of acquaintances & partner vs. strangers
- Normal control subjects show a brain response in areas associated with mentalizing when looking at acquaintances or partners, such interest in the mental states of others are absent in Borderline patients
- No evidence yet of predicted increase in areas associated with activation of attachment system

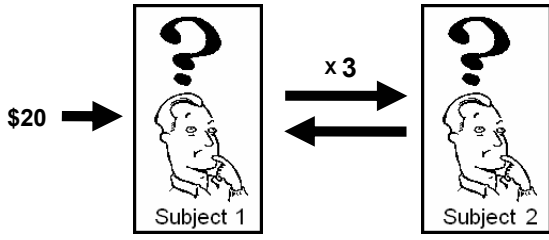
Neural correlates of attachment dysregulation in BPD (Buchheim et al, 2006)



Trust in Borderline Personality Disorder (H-17348)

- **PI:** P. Read Montague Jr.
- **Co-Investigators:** Carla Sharp, Brooks King-Casas, Peter Fonagy, Laura Lomax-Bream
- **Aim:** To identify reliable neural signature for BPD
- **Total patients screened → assessed → scanned:**
 - BPD: 1,060 → 224 → 62
 - Mood control: 622 → 235 → 22
 - Normal control: 877 → 398 → 116
- So far analysed data from 42 BPD and 26 control

A dynamic version of the Trust game (10 rounds)
 BPD: The absence of Basic Trust



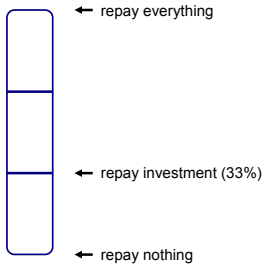
Investor

Trustee

Camerer & Weigelt, (*Econometrica*, 1988)
 Berg, Dickhaut & McCabe (*Games and Economic Behavior*, 1995)

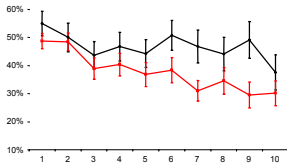
King-Casas, Sharp, Fonagy, Lomax and Montague (in preparation)

Average Repayment:

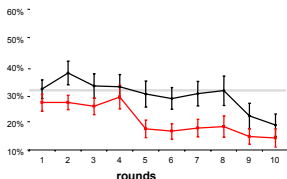


*King-Casas et al, in preparation

Investor Sent
 MU sent / MU available
 36 non-psychiatric investors
 42 non-psychiatric investors

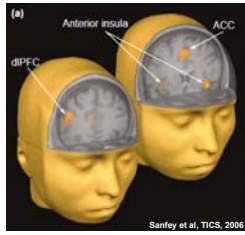
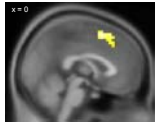
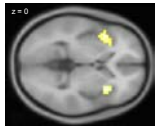


Trustee Repaid
 MU sent / MU available
 36 non-psychiatric trustees
 42 BPD trustees



*King-Casas et al, in preparation

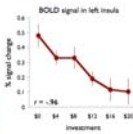
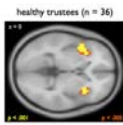
Reaction to Small Investments



response to "unfair" offers in an Ultimatum Game (take it or leave it)

$|t| < .25$ minus $|t| > .5$; $p < .004$, uncorrected, $n = 36$ trustees

A Neural Signature of 'Borderlineness' in Trust Task



Clinical Implications

Dysregulation of attentional capacities

- With individuals whose attachment relationships have been disorganized we may anticipate quite severe problems in affect regulation and attentional control along with profound dysfunctions of attachment relationships
- Exploratory psychotherapy techniques are likely to dysregulate the patient's affect
- It is wise to anticipate difficulties in effortful control

Disorganisation of self

- The therapist should be alert to subjective experiences indicating discontinuities in self structure (e.g. a sense of having a wish/belief/feeling which does not 'feel like their own'.)
- It is inappropriate to see these states of minds as if they were manifestations of a dynamic unconscious and as indications of the 'true' but 'disguised' or 'repressed' wish/belief/feeling of the patient
- The discontinuity in the self will have an aversive aspect to most patients leading to a sense of discontinuity in identity (identity diffusion)

Projection of alien self

- Patients will try to deal with discontinuous aspects of their experience by externalisation (generating the feeling within the therapist)
- The tendency to do this had been established early in childhood
- It is not going to be reversed simply by bringing conscious attention to the process – therefore interpretation of it is mostly futile

Projective identification

- Disowned mental states may include the internalisation of a frankly malevolent state of mind.
- Patient should be given some limited opportunity to create relationships where they involve the other in enactments
- Their experience is of a hostile/ persecutory state that must be got rid of to stop the experience of attack by the self from within
- The degree to which patients engage in externalisation must be carefully controlled
- Too many regressive enactments will undermine opportunity for using the relationship to enhance mentalisation

The Alien Self

A clinical description

If someone was causing you pain or simply tormenting you, perhaps not everyday for the whole day, parts of a day, or for days and weeks on end,

You could if you were brave or desperate enough, defend yourself, by perhaps attacking (and eliminating) your persecutor.

But what if this thing you hate, was inhabiting your head?

You can't exactly say please leave my body, you can't do anything to get it to just pack up and leave because technically, physically that isn't possible.

You can say fuck you. I hate you. You can self-harm with the hugest force your body can withstand, with all you can muster.

You can do that. You can be very very angry and show them who's boss, you won't stand for it, you won't take it lying down. You want to be heard, you want to say right, you think you can hurt me? I'll show you, I'll show you how much I can hurt you!

But you and this thing, you are inhabiting one body. You attack this thing you attack yourself. You don't have a choice though. That's a sacrifice you make over and over.

Eventually, you realise the only way to get rid of this thing, once and for all is getting rid of yourself. What choice do you really have?

No doctor can specify the problem. No medication can fix the problem that can't be specified.

You fail to understand yourself. You can't explain to your family and docs, they can't help you because you do not talk.

You doubt yourself "do I even have a problem?"

People in real life often treat you like you don't have a real problem. They talk to you stupidly, you complain that they don't understand, you look a fool. Perhaps that is why you don't talk to them anymore.

Maybe you don't have a problem anyway.

You are a child, quite possibly you are just making this up for some attention, finding an excuse for why you can't stay in college or get a job. Maybe you don't have an excuse, you are just a stubborn little child.

From what everyone tells you perhaps that is true.

You have doubt. You are willing to listen to someone else.

For now that is the only reason why you are not, at this moment trying to do it.

Core morbidities

- The interrelated deficits associated with BPD include
 - Impulsiveness
 - Emotion regulation
 - Relationship problems
 - Identity formation
- Problems in mentalization may relate to any or all of these deficits
- Typical problems associated with BPD may be direct consequences of not perceiving the mental states of other with sufficient accuracy OR the re-emergence of non-mentalising modes of social cognition OR both

Context specificity

- The quality of mentalisation varies widely in BPD, largely as a function of the patient's interpersonal context
- The clinician should monitor several parameters in relation to the quality of mentalisation
 - Level of emotional arousal
 - Intensity of attachment
 - Need to avoid perceived threat from hostile other
- Mentalisation is at least in part a function of the prefrontal cortex and any activity that leads to an inhibition of this part of the brain is likely to lead to the loss of mentalisation
 - Hyperactivation of the attachment system
 - High levels of arousal
- Mentalisation may be defensively inhibited in specific (traumatogenic) relational contexts

Psychic equivalence

- Characterised by conviction of being right that makes entering into Socratic debates mostly unhelpful
- Patients commonly assume that they know what the therapist is thinking - claiming primacy for introspection (i.e. saying that one knows one's own mind better than the patient) will lead to fruitless debate
- The rigid character of the patient's thoughts are made more aversive by hostile presuppositions of the patient
- Therapist may make ill advised attempt to 'defend' position
- Grandiosity and idealization are also expectable consequences of an unquestioning mind

Psychic equivalence

- It is not the action itself that carries most meaning in this mode but deviation from action that is contingent with the patient's wishes
- Self-harm, suicide attempts and other dramatic actions tend to bring about contingent change in the behaviour of most people - patient experiences a sense of being cared about
- Misuse of mentalisation may be linked to such pseudo-manipulativeness and involve realistic risk of harm to the patient or interactive partner

Pseudomentalizing

- Challenging pseudo-mentalisation in the pretend mode can provoke extreme reactions because of the vacuum it reveals
- Pretend mode pseudo-mentalisation denies the therapist's own sense of reality and the therapist can be left feeling excluded and trying harder to connect to the patient's discourse
- The patient's experience of lack of meaningful connection to reality can be the prompt and drive behind the search for connection but the connections found are often random, complex, untestable and confusing – exploration is unproductive

Self-harm

- It is difficult to remember that it is not the action itself that carries most meaning in this mode but the deviation from routine actions that is contingent with the patient's wishes
- Self-harm, suicide attempts and other dramatic actions tend to bring about contingent change in the behaviour of most people which may be the only route to the patient experiencing a sense of being cared about
- Misuse of mentalisation may be linked to such pseudo-manipulativeness and involve realistic risk of harm to the patient or interactive partner

iatrogenesis

- Therapeutic interventions run the risk of exacerbating rather than reducing the reasons for temporary failures of mentalising
- Non-mentalising interventions tend to place the therapist in the expert role declaring what is on the patients' mind which can be dealt with only by denial or uncritical acceptance
- To enhance mentalising the therapist should state clearly how he has arrived at a conclusion about what the patient is thinking or feeling
- Exploring the antecedents of mentalisation failure is sometimes but by no means invariably helpful in restoring the patient's ability to think

FAQs about Mentalization Based Treatment

Overall Aims

- The aims
 - To promote mentalizing about oneself
 - To promote mentalizing about others
 - To promote mentalizing of relationships
- Via
 - Structure
 - Therapeutic Alliance
 - Focus on interpersonal and social domain
 - Exploration of patient-therapist relationship

Standard MBT Modes

- Individual psychotherapy
- Group Psychotherapy
- Crisis Planning
- Team Supervision
- Integrated psychiatric care

FAQ's about Mentalization Based Treatment

- 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

- 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?
 - Partial hospital
 - 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

- Isn't mentalisation a cognitive/behavioural therapy?
 - No.
 - Any psychological therapy utilises the cognitive system but MBT has an emphasis on affective states and 'depth' analysis, intentionality and motivation. It does not focus on behaviour and cognition only
- 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

FAQ's about Mentalization Based Treatment

- Isn't mentalisation a cognitive/behavioural therapy?
 - Different models of human behaviour
 - CBT origins in social learning theory and MBT in attachment/dynamic theory
 - MBT therapists asked to think about unconscious thoughts, feelings, wishes, desires
 - MBT therapists do not delineate cognitive distortions outside the patient-therapist relationship or focus on behaviour
 - MBT therapists do not identify schemas
 - BUT
 - MBT also discourages therapists from focusing on unconscious determinants in their interventions
 - Some CBT strategies are inherently mentalizing – motivational interviewing

FAQ's about Mentalization Based Treatment

- 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

- **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
- **Are mentalizing problems specific to BPD?**
 - No. All personality disordered patients probably show different problems with mentalizing e.g. ASPD show misuse of mentalizing. Mentalizing deficits have been shown in other psychiatric disorders. But it is BPD that is uniquely vulnerable to mentalizing problems within interpersonal contexts

FAQ's about Mentalization Based Treatment

- **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.

FAQ's about Mentalization Based Treatment

- **Do you use validation?**
 - Yes
 - observing and reflection - two aspects of validation are common to every therapy and are an essential aspect to MBT.
 - Direct validation
 - DBT - used to confirm the patient's experience and contingent response as being understandable in a specific context.
 - MBT follows the same principles but the focus is on exploration and on elaborating a multi-faceted representation based on current experience particularly with the therapist.

FAQ's about Mentalization Based Treatment

■ Do you use fantasy development about the analyst?

➤ No

- Stimulating fantasy about the therapist is likely to be experienced as fact
- Confirms the patients distorted beliefs or assumptions
- Borderline patient does not retain an 'as if' quality or 'observing ego' when operating in psychic equivalence

FAQ's about Mentalization Based Treatment

■ Do you ask patients to report dreams?

- No. Sometimes patients do report dreams. We do not then use free association to elaborate the latent content of the dream
- Take the dream as a depiction of metacognition i.e. the patients experience of their own mind

FAQ's about Mentalization Based Treatment

Aren't all therapies mentalizing?

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**

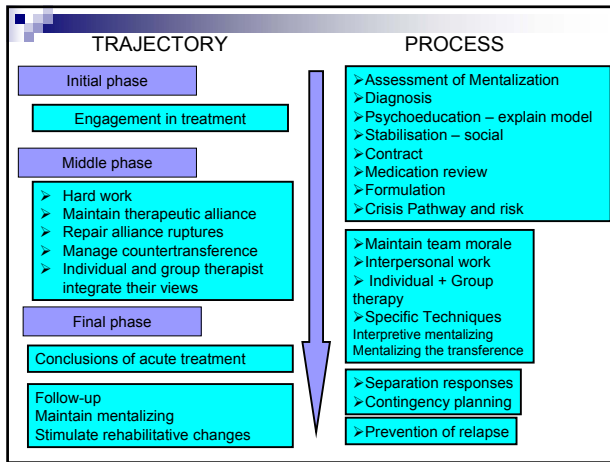
Mentalisation: a common theme of all therapies for BPD

- 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.*

Structure of Mentalization Based Treatment



Formulation: Content

- Aims
 - > Organise thinking for therapist and patient – each sees different minds
 - > Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exemplified)
 - > Modelling humility about nature of truth
- Management of risk
 - > Analysis of components of risk in intentional terms
 - > Avoid over-stimulation 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

Large group exercise

- A patient in emotional crisis telephones you to say that she feels useless and nothing can be done. Even her boyfriend doesn't answer the phone and she feels something awful is going to happen.

➤ Talk to her on the phone.

Large Group Exercise

- A patient calls you to say that he has had enough. He feels that no one cares about him. He doesn't know what to do.

➤ Talk to him on the phone

Initial phase



Establishing a diagnosis

- How would you describe yourself as a person?
- What makes you an individual?
- How would someone else describe you?
- What sort of person are you in close relationships?
- What are your best features as a person?

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

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

Goals of final phase

- Increase patient responsibility and independent functioning
- Facilitate patient negotiation about future eg with outside organisations
- Consolidate and enhance social stability
- Collaboratively develop a follow-up treatment plan
- Enhance patient understanding of meaning of ending treatment
- Focus on affective states associated with loss

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 to 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 to 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

Transferable Features

Clinical Guidance on Medication

- 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

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ **Psychic equivalence:**

- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Experience of mind can be terrifying (flashbacks)
- Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise”)
- Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ **Pretend mode:**

- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- Linked with emptiness, meaninglessness and dissociation in the wake of trauma
- Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
- In therapy endless inconsequential talk of thoughts and feelings
 - The constitutional self is absent → feelings do not accompany thoughts

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ **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.
- Only action that has physical impact is felt to be able to alter mental state in both self and other
 - Manipulative physical acts (self-harm)
 - Demand for acts of demonstration (of affection) by others

Understanding suicide and self-harm in terms of the temporary loss of mentalization

■ Loss →

➢ Increase attachment needs → triggering of attachment system →

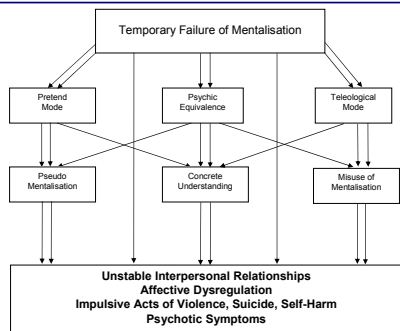
■ Failure of mentalization →

➢ Psychic equivalence → intensification of unbearable experience →

➢ Pretend mode → hypermentalization
meaninglessness, dissociation →

➢ Teleological solutions to crisis of agentive self →
manipulative suicide attempts, self-cutting

Understanding suicide and self-harm in terms of the temporary loss of mentalisation



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?*

Elaboration of interpersonal event

- Thoughts and feelings in relation to the event
- Ideas about the other person's mental state at turning points in narrative
 - Elaborate on actual experience
 - Reflecting on reconstructed past
- Understanding own actions (actual past and reflection on past)
- Counter-factual follow-up questions

Interpersonal interaction

- Last night Rachel and I had an argument about whether I was doing enough around the house. She thought I didn't do as much as her and I should do more. I said I did as much as my work obligations allow. Rachel got angry and we stopped talking to each other. In the end I agreed to do the shopping from now on. But I ended up feeling furious with her

What does non-mentalizing look like?

- Excessive detail to the exclusion of motivations, feelings or thoughts
- Focus on external social factors, such as the school, the council, the neighbours
- Focus on physical or structural labels (tired, lazy, clever, self-destructive, depressed, short-fuse)

What does non-mentalizing look like?

- Preoccupation with rules, responsibilities, 'shoulds' and 'should nots'
- Denial of involvement in problem
- Blaming or fault-finding
- Expressions of certainty about thoughts or feelings of others

What does good mentalizing look like?

- In relation to other peoples thoughts and feelings
 - Acknowledgement of opaqueness
 - Absence of paranoia
 - Contemplation and reflection
 - Perspective taking
 - Genuine interest
 - Openness to discovery
 - Forgiveness
 - predictability

What does good mentalizing look like?

- Perception of own mental functioning
 - Appreciation of changeability
 - Developmental perspective
 - Realistic scepticism
 - Acknowledgement of pre-conscious function
 - Awareness of impact of affect
- Self-presentation e.g. autobiographical continuity
- General values and attitudes e.g. tentativeness and moderation

What does extremely poor mentalizing look like?

- Anti-reflective
 - hostility
 - active evasion
 - non-verbal reactions
- Failure of adequate elaboration
 - Complete lack of integration
 - Complete lack of explanation
- 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

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-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
- Destructively inaccurate
 - Denial of objective reality, highly psychologically implausible mental states inferred

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

Video coding


Assessing mentalizing

Small Group Exercise

- Patient talk about an emotional event within a relationship
- Therapist
 - Explore the events
 - Try to intervene when non-mentalising occurs
 - Counter-factual
 - Praise mentalizing
- Observers
 - Rate mentalising and therapist skill




Assessment of interpersonal/representational world



Interpersonal/Relational Representations Normal

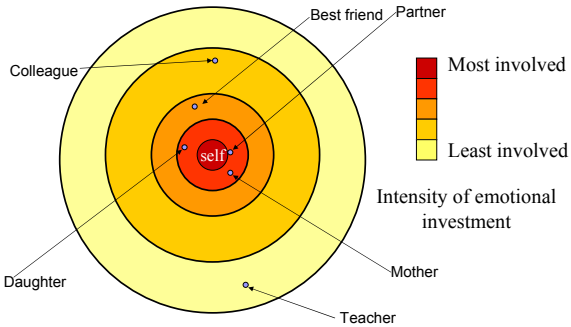
- Balanced – selective
- Flexible – reversible
- Stable – consistent over time
- Developmental – change over time



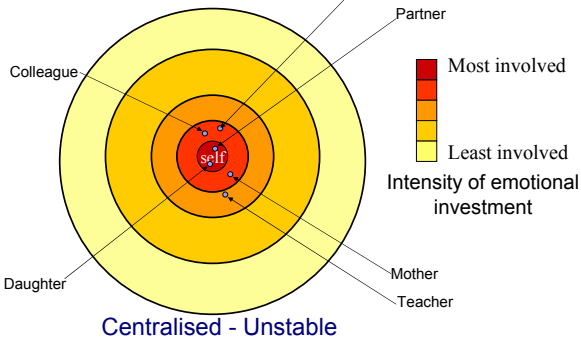
Interpersonal/Relational Representations BPD

- Centralised
 - Unstable
 - Self focused
 - Inflexible
- Distributed
 - Stable
 - Distancing
 - Inflexible

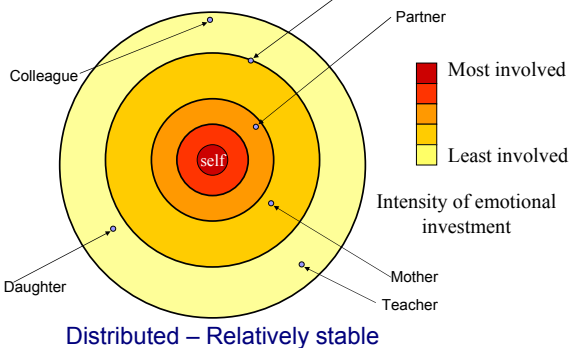
The hierarchy of relationship involvement - Normal



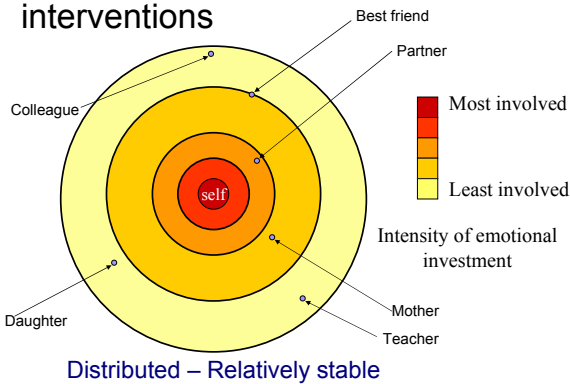
The hierarchy of relationship involvement - BPD



The hierarchy of relationship involvement - BPD



The titration of relationships and interventions



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

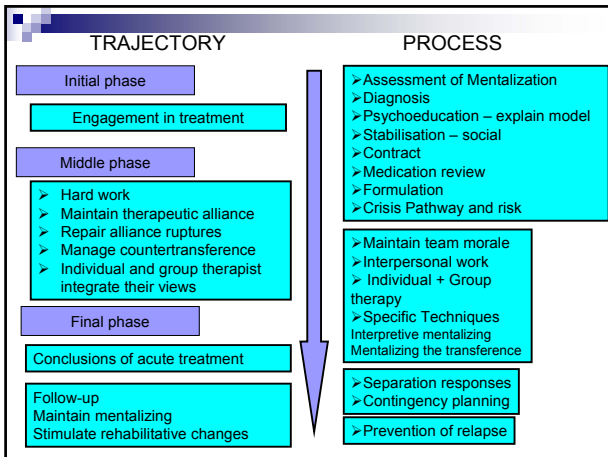
Common questions

- 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?

Structure of Mentalization Based Treatment

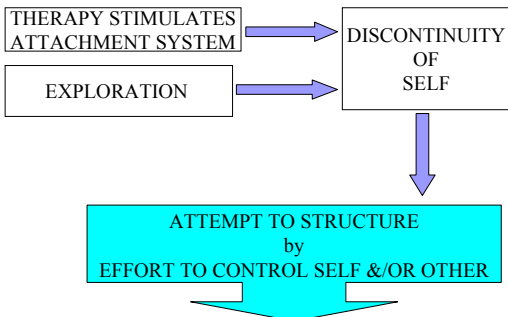


Formulation: Content

- Aims
 - > Organise thinking for therapist and patient – each sees different minds
 - > Modelling a mentalising approach in formal way – do not assume that patient can do this (explicit, concrete, clear and exemplified)
 - > Modelling humility about nature of truth
- Management of risk
 - > Analysis of components of risk in intentional terms
 - > Avoid over-stimulation 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

Therapist stance

Therapist/Patient Problem



Therapist/Patient Problem

ATTEMPT TO STRUCTURE
by
EFFORT TO CONTROL SELF &/OR OTHER

RIGID SCHEMATIC REPRESENTATION
NON-MENTALIZING
CONCRETE MENTALIZING (PSYCHIC EQUIVALENCE)
PSEUDO MENTALIZING (PRETEND)
MISUSE OF MENTALIZING

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 your 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

- Empathic is about how they are thinking and feeling, getting them to describe important
- Cannot explore before empathy
- Use not knowing what to say as clue that something does not make sense and there is something to be curious about
- Curiosity about experience, probing about patients experience serves to validate the experience
- Normalizing is component of moving to transference work – stating feelings in first person: "I would feel X, so surprised you appear not to..."

Essential to the Stance

- Keep it current – what the patient feels right now
- Start by empathising – finding a way of stating that you genuinely understand distress
- Explore in the relational realm not just the intrapsychic
- Lower arousal by bringing it to the person of the therapist
 - What have I done?
- Stick to mentalizing aim in somewhat dogged manner
- Quickly step back if patient seems to lose control

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

Clinical summary of intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- Explore current emotional context in session by identifying the momentary affective state between patient and therapist
- Identify your contribution to the break in mentalizing
- Seek to mentalize the transference

Workshop Exercise

- Patient to talk about incidents in his/her life
- Therapist
 - Inquisitive stance
 - Therapist to focus patient attention on current situation
 - Stimulate alternative perspectives
 - Demonstrate humility - not knowing
 - Make an error
 - Accepting your own misunderstanding
 - Focus on the incident
 - Intervene to move non-mentalizing to mentalizing
 - Explore the incident

Video

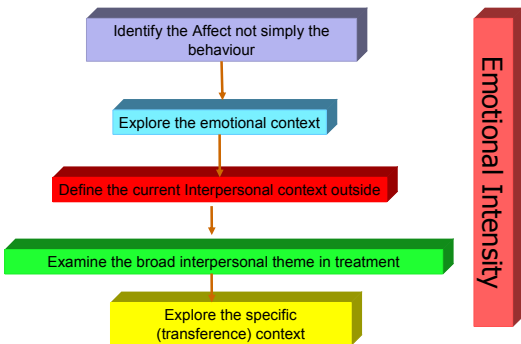
Therapist Stance (0-5 & 6.40-7.30)

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

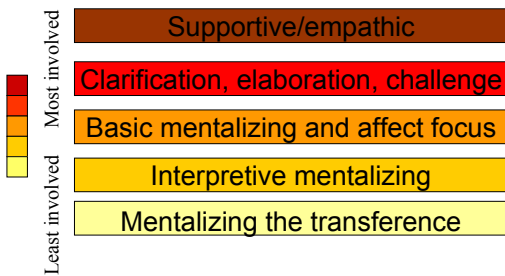


Interventions: principles

- Simple
- Affect focused but remember most reactions are about survival
- 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

- <http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>

Interventions: Spectrum



Interventions: Spectrum

- Supportive & empathic
- Clarification, Challenge, & elaboration
- Basic Mentalising
- Interpretive Mentalising
- Mentalising the transference
- Non-mentalising interpretations – to use with care

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

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

- Patient does not feel that you understand and think that it would be better to have another therapist.
- Therapist
 - Clarification
 - Elaboration and affect focus
 - Stop and stand if necessary
 - Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.

Workshop Exercise

- Patient has been shouting at staff. Therapist has to process what has been happening.
- Therapist
 - Clarification
 - Elaboration and affect focus
 - Stop and stand if necessary
 - Work within the relationship if the patient allows it and if not see if you can create circumstances so the patient can focus and consider the relationship.

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
 - Use techniques learned so far
 - Stop and stand

Video

Challenge assumptions

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. Maybe 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

■ Working in the transference

- 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

Components of mentalizing the transference

- 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 perspective
- Monitor the patient's reaction
- Explore the patient's reaction to the new understanding

Interventions: Mentalizing the Transference

■ Dangers of using 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

Video

Challenge assumptions

Components of mentalizing the countertransference

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.

Typical Countertransferences

- Pretend mode
 - Boredom, temptation to say something trivial
 - Sounding like being on autopilot, tempting to go along
 - Lack of appropriate affect modulation (feeling flat, rigid, no contact,)
- Teleological
 - Anxiety
 - Wish to DO something (lists, coping strategies)
- Psychic equivalence
 - Puzzlement, confused, unclear, excessive nodding
 - Not sure what to say, just going
 - Anger with the patient

Workshop Exercise

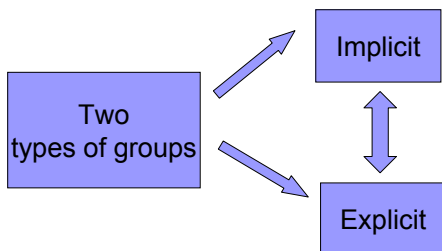
- Patient states that when you are going on holiday next week they will kill themselves. It will be your fault..
- Therapist
 - Clarification
 - Elaboration
 - Work within the relationship
 - Mentalize the transference

Workshop Exercise to use Basic Mentalizing and mentalizing transference

- Patient – Discuss an important relationship and allow the story to unfold when prompted
- Therapists: Basic mentalizing
 - Stop, Look, and Listen and explore important content
 - Stop, rewind, and explore
 - Stop and stand if patient uses non-mentalizing
- Therapist: transference tracers and mentalizing the transference

Mentalizing and Group Psychotherapy

Mentalizing and Groups



Implicit mentalizing group

The aims of the implicit mentalizing group are

- To promote mentalizing about oneself
- To promote mentalizing about others
- To promote mentalizing of relationships

Implicit mentalizing group

- The therapist will at times need to take control of the group while still remaining a participant, not an observer
- Anxiety levels of both group and individuals must be monitored to ensure they become neither too high nor too low
- Interventions aiming to increase mentalizing within the group in the immediacy of the moment are key to the group's constructive development

Implicit mentalizing group: ways to explore understanding of each other

- Focus on what a patient is saying asking him to clarify and expand
- Ask other patients for their understanding of what is being said during moments of uncertainty
- Generalize the problem – 'Has anyone else experienced this?'
- Return to a topic sensitively or if necessary Stop and Stand if the group dismisses something of manifest importance

Implicit mentalizing group: ways to explore understanding of each other

- Generate a group culture of enquiry about motivations
- Insist that patients consider others' perspectives and work to understand someone else's point of view
- Challenge inappropriate certainty and rigid representation
- Therapist should directly express own feelings about something that he believes is interfering with group progress

MBT Lite

An introduction to mentalising

Explicit Mentalizing Group

■ Exercises

- are arranged in a sequence progressing from emotionally 'distant' scenarios to some which are more personalized.
- Are related to personal experience only when the group have developed a cohesive atmosphere and some trust has been established between participants.
- are developed to ensure that there is a focus on 'self' or 'other' and on the perceptions and experiences of others about self or self about others.
- Move between explicit and implicit mentalizing

MBT Lite Introductory Week 1

What is mentalising?

- Discussion of what is in our mind
- What does it involve
- Being aware of thoughts and feelings
- Is it the same as empathy
- Includes oneself as well as others
- Mentalising and emotion - Disrupts mentalising

MBT Lite Introductory Week 1

- Clinical examples given
 - Making assumptions – my boss does not say hello to me. This means he does not like me.
 - I later rant at someone unnecessarily
 - Becoming ruminative
 - Certainty
- Exercise to take home – Notice moments of non-mentalising in self and others

MBT Lite Introductory Week 2

What is personality?

- Each group starts with open feedback for 15 mins
- Developmental perspective
- How do we experience personality
- What is likely to disturb sense of identity
- What happens when identity disturbed or threatened
- What if we protect ourselves via destructive acts to self or others

MBT Lite Introductory Week 3
What happens to thoughts and feelings?

- How would I describe myself?
- What do I think others think of me?
- How does what I feel affect my thoughts
- What effect do my thoughts and feelings have on my motivations.
- What effect do my thoughts and feelings have on my relationships.

MBT Lite Introductory Week 3/4
What can thoughts and feelings do?

- Depression
 - Negative thoughts
 - Perceptions of self and others
 - Withdrawal and why bother to mentalise?
- Anxiety
 - Fight flight mode

MBT Lite Introductory Week 3/4
What can thoughts and feelings do?

- Personality Disorder
 - Paranoid – prudent and cautious
 - Dependent – need and demand - adaptive but may become excessive
 - Narcissistic – need for affirmation, validation but also may dismiss others
 - Borderline – ‘kick and cling’, roller coaster ride

MBT Lite Introductory Week 5

Components of mentalising

- Mentalising proper
 - Imagining and thinking about self and other
- Empathy and attunement
 - Feeling for other whilst thinking
- Reflective and flexible thinking
 - Thinking about thinking, representing
- Awareness of reacting
 - Self-monitoring reaction to others and context
- Acting and reacting
 - Rigid and stereotypical responses

MBT Lite Introductory Week 6

The interpersonal

- Members talk about a close relationship to the whole group and consider:
 - Reading minds
 - Keeping mind in mind
 - Motivations
 - Our moods and effect on how we think others think of us
 - Assumptions
 - Over-imagination
 - When in doubt check it out

MBT Lite Introductory Week 7

Testing out understanding

- Divide group into East and West
- Outline the task to both groups
 - Two friends have arranged to meet to go for a drink followed by seeing a film.
 - The East person is 30 mins late when he arrives at the meeting point.
 - The West person was on time and waited for 30 mins

MBT Lite Introductory Week 7 The East group/person

- How do you feel about arriving late?
- What do you think of yourself at this time?
- How are you likely to behave in this situation?
- What do you think your friend will be thinking and feeling?
- What might you say when you arrive?

MBT Lite Introductory Week 7 The West team/individual

- How do you feel about waiting?
- What do you think of yourself at this time?
- How are you likely to behave when your friend arrives?
- What do you think your friend will be thinking and feeling?
- What might you say when he arrives?

MBT Lite Introductory Week 8 Interpreting others in context

- Use a photograph from a magazine
 - Each participant writes down
 - What is the atmosphere communicated by the picture
 - What is the person feeling
 - What is he/she trying to communicate
- Discussion of responses in relation to components of mentalising

MBT Lite Introductory Week 9

Writing exercise

- Write down a time when you felt impulsive but did not act.
 - What made you impulsive at the time?
 - If you had acted what would have happened?
 - What stopped you acting?
 - How did this help?
 - What did you do instead?
 - What were the consequences of this and how did you feel about yourself

MBT Lite Introductory Week 10

Testing out understanding

- Divide group into East and West
- Outline the task to both groups
 - One person in a close relationship has withdrawn from their relative/partner/friend
 - The East group have withdrawn from the West group
 - The groups will discuss their own responses to this situation

MBT Lite Introductory Week 10

The East group

- What sorts of things makes you withdraw?
- How does withdrawing make you feel about yourself?
- What are your thoughts about your relative/partner/friend
- What are your thoughts about yourself?
- What response do you anticipate?

MBT Lite Introductory Week 10 The West group

- What sorts of things will make someone withdraw?
- How does the withdrawal make you feel about yourself?
- What are your thoughts about your relative/partner/friend
- What are your thoughts about yourself?
- What response do you anticipate you will make?

MBT Lite Introductory Week 11/12 Ending

- Discussion and questions prepared over the week by participants
 - Thinking about my mind is not the same as others mind
 - Not assuming I am at fault
 - Not taking the blame for abusive behaviour of others
 - How I feel impacts on how I think
 - Impulsive actions tend to make me feel worthless
 - Try to think in the moment of feeling

Explicit Mentalizing: Introductory session

- **Method**
 - The group leader begins with an introduction to the concept of mentalizing covering a number of areas
- **Discussion**
 - consider times when someone else has lost the capacity to mentalize (note that this is often easier for patients than being asked to describe a situation in which they have lost the ability).
 - ask how the person regained his capacity
 - Ask the group to comment on each others stories
 - Only personalize the discussion if you feel that the group have become cohesive and it is safe to make it more intimate.
- **Alternatives**
 - Ask someone who has been in the group for a number of sessions to define mentalizing and to expand on his definition.

Explicit Mentalizing: Understanding emotions

■ Method

- Ask each member of the group to describe the prevailing mood of someone they know well and with whom they have a relationship e.g. close friend, mother, father, partner.
- help them recognize that moods are complex by asking them to describe in detail what they mean by anger, happy, sad etc

■ Discussion

- How do they explain the individuals prevailing mood?
- Does it affect their relationship?
- Is the primary contribution to their mood from current or past experience?
- Have they noticed anything that can change the mood?
- Can the patient help the person change their mood?

■ Alternatives

- Ask the participants to identify their own prevailing mood. Suggest they verify it with other members of the group. Divergence should be explored. Discussion as above.

Explicit Mentalizing: What makes me 'me'

■ Method

- Ask participants to give one or two aspects of themselves which they think differentiates them from others in the group.
- Do not ask them initially to comment on unique features of others in the group.

■ Discussion

- Each member spends a few minutes describing what makes me 'me' and contrasts it with other members of the group.
- participants to suggest common factors between themselves and others in the group. If this seems too difficult ask for contrasts and similarities with family members.
- Ask other members to comment and whether they agree or disagree and if so why. How have my unique features developed over time and what have been the most significant contributing factors?

■ Alternatives

- This group can be difficult for participants. Consider asking them to write down what makes me 'me' instead of having to talk about it straightaway. Participants can then read out what they have written.

Explicit Mentalizing: Understanding self through other

■ Method

- Ask group members to pick someone else in the group and to describe how they think that person actually sees them.
- Consider basic aspects of how people see each other as well as more complex psychological elements e.g. smart, capable, caring.
- Ask the person whose mind is being described not to comment on the accuracy until the group has explored the portrayal.

■ Discussion

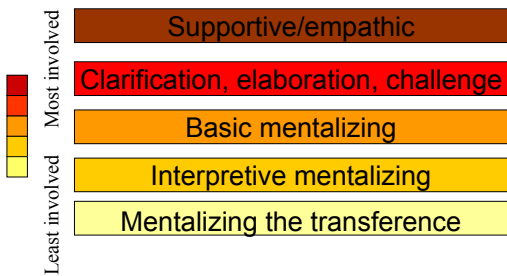
- Once the group have worked on the description ask the person to give his actual understanding of the person
- Discuss how difference in understanding might have developed.

■ Alternatives

- Ask participants to describe how they think someone who loves them or hates them sees them?
- How would that person describe them if he was in the group now?
- How has he come to that opinion?
- Has the patient contributed to development of the viewpoint?

Guidance on which intervention when

Interventions: Spectrum



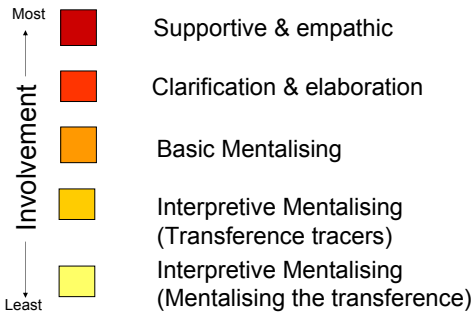
Which Intervention to use when?

- If in doubt start at the surface – support and empathy
- Move to ‘deeper’ levels only after you have performed the earlier steps
- If emotions are in danger of becoming overwhelming take a step towards the surface

Which Intervention to use when?

- Type of intervention is inversely related to emotional intensity
- Support and empathy given when the patient is overwhelmed with emotion; mentalizing transference when the patient can continue mentalizing whilst 'holding' the emotion
- Intervention must be in keeping with patients mentalizing capacity at the time at which it is given
- The danger is assuming that borderline patients have a greater capacity than they actually have when they are struggling with feelings.

Titration of intervention to involvement



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)

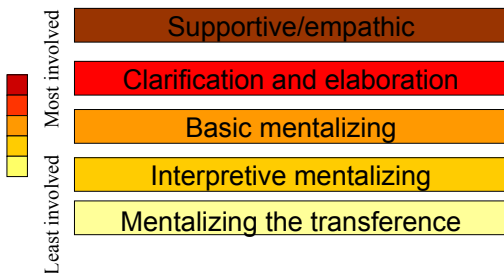
■ Mentalise (basic/interpretive)

- 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



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
 - How do you understand what happened?
 - Who was there at the time or who were you thinking about?
 - What did you make of what they said?
- Challenge the perspective that the patient presents
- DO NOT
 - mentalize the transference in the immediacy of a suicide attempt or self-harm
 - 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.

Workshop exercise

- Patient describes having cut himself and requiring sutures.
- Therapist
 - Identify feelings
 - Develop context
 - Integrate the relationship with you in the discussion
 - Aim to re-instate a continuity of self-structure by kick starting mentalizing
 - If unsuccessful work on what you and patient are to do

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.

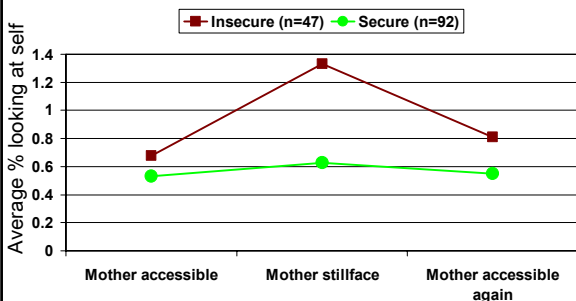
Workshop Exercise – Self-Harm

- 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

For further Information

- P.Fonagy@ucl.ac.uk
- anthony@abate.org.uk
- <http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>

Duration of Looking at Self During Three Phases of Modified Still Face Procedure



(Gergely, Fonagy, Koos, et al., 2004) $F_{(interaction)}=6.90, df=2,137, p<.0001$
