THE MENTALIZING MODEL OF EMERGING BPD IN ADOLESCENCE: THE STATE OF THE ART AND THE SCIENCE

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Average Adult: Hears half; Understands half; Believes half; Remembers half
Mentalizing: Skills and attitudes deployed to understand (to grasp and to interpret) human behaviour – that of self and that of others – as based on intentional mental states
The mind is a scary place.
Lindsey, Age 16
Everything's about the same here.
"Are you a faggott?"

"I can find where you live."

Joe, age 14
A Clinical Moment (2)

“Infinite jest”
David Foster Wallace

“Purging is perfect”
“l hate mentalizing”
Lindsey, age 16
OBJECTIVES

- To review the capacity to mentalize, it’s components and development in an attachment context
- To discuss the mentalizing hypothesis of the development of emerging BPD in adolescence
- To understand the objectives and principles of mentalizing-based treatment for adolescents with emerging BPD
ATTACHMENT THEORY: FROM PROTECTION FROM PREDATORS TO THE REPRESENTATION OF EXPERIENCE

Down regulation of stress → Developmental Functions of attachment → Sensitivity to social stimuli

Affect Representation ← Effortful control of attention ← Mentalizing

Fonagy, 2003
Trauma and Genetics in BPD: A Diathesis – Stress Model Mediated by Mentalizing
A Test of Diathesis-Stress Theories of the Etiology of Borderline Personality Disorder in a Birth Cohort of 12 Year Old Children

- **Objective.** To test if children with a positive family history of psychiatric disorder were more vulnerable to developing borderline personality symptoms following exposure to physical maltreatment and maternal negative expressed emotion.

- **Design.** Prospective longitudinal cohort study of a nationally representative birth cohort in Great Britain.

- **Participants.** 1,116 families with twins were followed from birth to age 12 years (retention 96%).

- **Main Outcome Measure.** Dimensional borderline personality symptoms and dichotomous extreme borderline group membership (dimensional symptoms ≥95th percentile).

Interaction between family history of psychiatric illness and history of maltreatment on BPD symptoms

Figure 2. Diathesis-Stress Interaction Between Family History of Psychiatric Illness and Physical Maltreatment: The figure shows diathesis-stress interaction in analyses of the dimensional outcome of borderline personality related characteristics (Panel A) and the dichotomous outcome of extreme borderline group (Panel B). The convergence between these analyses indicates the interaction is not an artifact of measurement scale.

**Analysis of Extreme Borderline Group Membership**

<table>
<thead>
<tr>
<th>Extreme Borderline Group Prevalence</th>
<th>Positive Family History</th>
<th>No Family History</th>
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<tbody>
<tr>
<td>Maltreatment</td>
<td>42%</td>
<td>8%</td>
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<tr>
<td>No Maltreatment</td>
<td>7%</td>
<td>3%</td>
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</table>

**Extreme Group**

<table>
<thead>
<tr>
<th>Comparison Children</th>
<th>RR</th>
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<tbody>
<tr>
<td>++</td>
<td>20</td>
</tr>
<tr>
<td>+-</td>
<td>48</td>
</tr>
<tr>
<td>-+</td>
<td>3</td>
</tr>
<tr>
<td>--</td>
<td>44</td>
</tr>
</tbody>
</table>

Departure from Additivity = 9.73

95% CI (1.90, 15.73)

Antecedents and co-morbidities of BPD related characteristics in 12 year old children (Belsky et al., 2012)

**Figure 1. Psychiatric Antecedents and Comorbidities of Borderline Personality Related Characteristics in 12 Year Old Children**

**Correlations (Pearson's r) Between Child Characteristics and Borderline Personality Related Characteristics:**

<table>
<thead>
<tr>
<th>Child Characteristics 5</th>
<th>r</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Functioning (5 yrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IQ</td>
<td>-0.11***</td>
<td>(-0.16, -0.06)</td>
</tr>
<tr>
<td>Executive Function</td>
<td>-0.06*</td>
<td>(-1.11, -0.10)</td>
</tr>
<tr>
<td>Theory of Mind</td>
<td>-0.11***</td>
<td>(-0.16, -0.07)</td>
</tr>
<tr>
<td>Behavioral and Affective Probs (5 yrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviewer Rating of Temperament</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Control</td>
<td>0.10***</td>
<td>(0.04, 0.15)</td>
</tr>
<tr>
<td>Approach</td>
<td>0.01</td>
<td>(-0.04, 0.06)</td>
</tr>
<tr>
<td>Inhibition</td>
<td>-0.01</td>
<td>(-0.07, 0.04)</td>
</tr>
<tr>
<td>Mother &amp; Teacher Rating of Impulsivity, Behavioral &amp; Emotional Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Mother Rating)</td>
<td>0.34***</td>
<td>(0.29, 0.38)</td>
</tr>
<tr>
<td>(Teacher Rating)</td>
<td>0.22***</td>
<td>(0.16, 0.28)</td>
</tr>
<tr>
<td>Externalizing Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Mother Rating)</td>
<td>0.44***</td>
<td>(0.38, 0.49)</td>
</tr>
<tr>
<td>(Teacher Rating)</td>
<td>0.24***</td>
<td>(0.17, 0.30)</td>
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</table>

Characteristics of Children in the Extreme Borderline Group and Comparison Children:

Means and 95% Confidence Intervals(a)
BPD AND CHILDHOOD ADVERSITY

- High rates of childhood trauma (73% abuse of which 34% is sexual abuse; 82% neglect) (Ball & Links, 2007)

- 2.5 fold increase in BPD associated with abuse and neglect (neglect is a more potent predictor for both boys and girls, physical abuse only for boys. Sexual abuse did not increase the risk for neither boys nor girls (Widom, Czaja & Paris, 2009)

  - 14.9 of abused children met criteria for BPD as adults
  - Between 8 - 35% (Kingdon et al, 2010) of confirmed BPD have no history of abuse
Procedural pattern (affect, motricity, perception, physiology) genetically prepared to be activated by stimuli (internal and external) that have evolved to be encoded as signals of threat to the survival of the self.

These signals automatically trigger a fear/alarm response that activates the amygdala, locus coeruleus (norepinephrine), H-P-A Axis (Cortisol), Insula
ATTACHMENT cont.

- Alarm response automatically activates attachment, which has evolved as a signal seeking to evoke proximity, protection and regulation in caretakers.

- The attachment response of proximity, protection and regulation changes the internal (stress / fear response) and external conditions associated with threats to the survival of the self, down regulating the stress response in the baby’s brain.

- Safe Haven. J Bowlby
CONTINGENCY DETECTION – SEEKING MECHANISM

Specialized psychobiological disposition to detect and seek out the causal contingent relationship (the match between the infant’s specific responses, signals and procedural patterns and the environmental (social) outcome. (Contingent relation: “B” is contingent on “A” as detected by “B” following “A” preceding “B”).

Gergely & Watson
CONTINGENCY – DETECTION MECHANISM AND PSYCHIC EQUIVALENCE

- Psychobiological disposition to detect and seek out a matching, attuned, contingent response: Psychic equivalence “what I feel / experience, you feel / experience”

- Contingent (“causal”) relationship between infant’s distress signal and the social outcome of the signal ie: parent’s soothing response (“oh honey”) follows the baby’s crying and the soothing response is preceded by the baby's crying

- Contingent match activates reward system (Meso - Cortico – Limbic Dopaminergic System; Endorphins; Oxytocin
Psychic equivalence

- Seeks emotional resonance – a match between one’s mind (procedural experience) and other’s procedural experience
- “What I feel and experience, others feel and experience”
- Match is achieved and maintained through procedural means
- Conflates self-other experience
Evoking a contingent “match” as the basis of the procedural sense of self as agent

Evoking a contingent match as basis of internal working models of the self as effective and others as responsive, underlying secure attachment
THE PROTOTYPE OF TRAUMA

- Brain evolved a pre-wired encoding of survival of the self as predicated on another person’s contingent, procedural, matching response. Pre-wired (narcissistic) vulnerability triggered by absence of contingent response from others.
Lack of reciprocity (non-contingency) is a signal of threat to survival and evokes fight-freeze-flight.
Certainty about other minds and the way the world IS…
CONTINGENCY DETECTION, ATTUNEMENT AND MARKEDNESS
MENTALIZATION

Beginning of Mentalizing and Subjectivity

2: Order Representation of Internal State

States

Mentalizing
Resonance

Caretaker

Signal

Temperament & Innate Basic Emotions

Baby

Constitutional Self: Attachment-Seeking, Contingency-Detecting

Contingent, Attuned, Marked, Response

constitutional self: attachment-seeking, contingency-detecting

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CARETAKER’S RESPONSE PROMOTES DEVELOPMENT OF EXPLICIT/SYMBOLIC/PRETEND MODE OF SUBJECTIVITY

- Mismatch (2/3 of the time) → effort to find the “right” contingent, attuned match

- Attunement (1/3 of the time) is conveyed by displaying the procedural aspects and qualities of the infant’s internal state (the “architecture” of the internal state, D. Stern) re: affect quality, arousal level, tempo. This display, however, is expressed in a different behavioral mode (no imitation)

- Attuned display is marked by communicative cues such as eye contact (Farroni, et. Al., 2002); “Motherese” (Fernald, 1992; Cooper and Aslin, 1990); High contingent-reactivity (Movellan and Watson, 2002); Empathic affect-mirroring (Bigelow, 1999; Gergely, 2004, 2007) that promote attention and learning in the infant; the pedagogical mechanism
Contingent and marked mirroring

Contingency of Mirroring
The caregiver offers a response that has a “fit” with the infant’s current intentional mental state, at the time it is expressed

Markedness of Mirroring
The caregiver mirrors while indicating that she is not expressing her own feelings (caricaturing)
Transformed version of the caregivers display of their own affective state

Exaggerated, slowed down, partial and accompanied by communicative cues (direct eye contact, eye brow raising, motherese)

Cue to decouple affective display from the caregiver her/himself

Prompt infant’s receptivity to learn and identify the infant’s affective state as the referent of the caregiver’s mirroring response and the source of the infant’s contingent control over the caregiver’s response
CARETAKER’S RESPONSE PROMOTES DEVELOPMENT OF EXPLICIT/SYMBOLIC/PRETEND MODE OF SUBJECTIVITY

- Coming “on line” of control of attention and awareness of different perspectives and joint attention (9 months)
- Coming “on line” of medial prefrontal cortex and anterior cingulate “puts the breaks” on automatic matching
- Separation of the representational (a perspective or a mental model) from the concrete and procedural: pretend vs “for real” encoded as explicit memories
EXPLICIT/SYMBOLIC MENTALIZATION (Controlled)

* Declarative/Episodic/Semantic
* Representational/Autobiographical Narrative
* Conscious/Preconscious/Unconscious “Pretend Mode”

*Gallagher & Frith
Trends in Cognitive Sciences 7: 77-83, 2003
Contingent, attuned and marked attachment is the epigenetic signal to “pay attention and learn”…signal that it is safe to inhibit automatic defensive response and psychic equivalence (one perspective) and shift to multiple perspectives (play, effortful control of attention) and representation of experience (categorical, symbolic, accessible to introspection / reflective, can be put into words / symbols, seeks narrative coherence ie: autobiographical narrative)
Mentalizing, *Learning*, and the hard-to-reach
“Pedagogical stance” and “Epistemic Trust”

An *evolved mechanism*
For communicating culturally-specific “knowledge-about-living”

Csibra and Gergely
EPISTEMIC TRUST cont.

Marked (ostensive communication) signals, in a contingent and attuned attachment context, induce epistemic trust in the infant that:

- Ensure very fast and efficient intergenerational transmission of cultural knowledge (language, do’s and don'ts, morality, gender roles)
- Activate innate disposition in the infant to effortfully control attention, orient self to language and symbolic communication, represent experience, play and explore
Trust, pay attention and learn from this person

“what you are learning is crucial for your survival and is universally shared”
The “Pedagogical Stance”: Mentalizing and Learning

“I see my mind in your mind, more or less accurately represented…”

“Now I’m interested to learn from you about this situation, & I will apply this learning elsewhere, with others…”

Another’s (re-) presentation of MY SPECIFIC dilemma

Recognition of this “Pedagogical Stance” triggers Epistemic Trust (Opens the Door):
EPISTEMIC TRUST cont.

- Necessary to risk not knowing long enough to generate new understanding and knowledge

- The active ingredient of psychosocial interventions?
Model of the social brain - Baron-Cohen (2005)

**Emotion Detector**
- Left inferior frontal gyrus
- Mirror neurons

**Intention Detector**
- Right medial prefrontal cortex
- Inferior frontal cortex
- Bilateral anterior cingulate
- Superior temporal gyrus

**Eye Direction Detector**
- Posterior superior temporal sulcus

**Shared Attention Mechanism**

- Quick Fix – Teleology
  - Seeing Mum’s Eyes follow my gaze

**Empathizing System**
- Inside-out - Psychic Equiv
  - Seeing my feelings
  - Re-presented in Mum’s eyes

**Theory of Mind Mechanism**
- MAKE-BELIEVE – Pretend
  - (Imagining) Mum imagining why I cried out

**EMOTION UNDERSTANDING**

**BELIEF-DESIRE REASONING**

- EMOTION UNDERSTANDING

- BELIEF-DESIRE REASONING

- by 3 months

- by 12 months

- by 3 – 4 yrs
Mentalizing Implicitly & Explicitly

**Implicit/Automatic**
- Perceived/Felt/Acted
- Emotional Resonance
- Empathy (Match)
- Non conscious
- Procedural
- Non verbal
- Non Reflective

**Explicit/Controlled**
- Interpreted
- Explained
- Perspective
- Conscious (or potentially conscious)
- Can be verbalized
- Reflective (coherence)

- Functional integration at age 4
- Dissociation under \( \uparrow \) arousal (flight – or – flight)
Mentalizing
= Holding the Right Balance

Just enough Teleology so that things get done

Just enough Psychic Equivalence so that true feeling is communicated

Just enough Pretend, so that new ideas arise about other minds.
BRAIN DEVELOPMENT IN HEALTHY CHILDREN & ADOLESCENTS

Longitudinal and Cross-Sectional Data
(243 Scans from 145 Subjects)

Frontal Gray Matter

![Graph showing volume of frontal gray matter over age. The volume peaks around 12 years old and then decreases.]
Number of brain connections (synaptogenesis), which is followed by synaptic pruning on the “use if or lose it” principle prominent in the PFC and Orbito–Frontal cortex and – more protracted – in the Superior Temporal Cortex and STS

Axonal Myelination (Blakemore, 2010)

Sexual hormones increase density and reactivity in oxytocin receptors with associated sensitivity and reactivity to shared – emotions and attachment cues
Development of the SIPN
Social Information Processing Network
(Nelson et al, 2005, Psychological Medicine, 35, 163-174)
Adolescents are biased more by functionally mature limbic regions during adolescence (imbalance of limbic relative to prefrontal control), compared to children, in whom these systems are both still developing, and adults, in whom they fully mature.
CLUSTER B: DRAMATIC PERSONALITY DISORDERS

- ANTISOCIAL
- NARCISSISTIC
- HISTRIONIC
- BORDERLINE
- “PRETEND” DISPLAY vs REAL PAIN
- SENSITIVITY vs DISREGARD FOR OTHER PEOPLE’S FEELINGS
DIAGNOSTIC CRITERIA OF BPD
(5 out of 9)

1. A pattern of unstable intense relationships
2. Inappropriate intense anger
3. Frantic efforts to avoid abandonment
4. Affect instability
5. Impulsive actions
6. Recurrent self-harm and suicidality
7. Chronic feelings of emptiness or boredom
8. Transient, stress-related paranoid thoughts
9. Identity disturbance and severe dissociative symptoms
230 ways to be borderline
BORDERLINE PERSONALITY DISORDER

- 6% Lifetime prevalence (Grant et al, 2008)
- Co-morbidity
  - 70% Mood Disorders (Sjastad, Grawe & Egeland, 2012)
  - 50-60% Anxiety Disorders (Friborg et al, 2013)
  - 15% Bipolar Disorders (Perugi et al, 2013)
  - 50% Personality Disorder (Narcissistic, Histrionic, Antisocial, Schizotypal) (Tomko et al, 2013)
  - 30% Eating Disorders (Skaderud, 2007)
  - 40-50% Substance Abuse (Weig et al, 2013)
ARE P.D. STABLE AND PERSISTENT?

- Collaborative Longitudinal Study of Personality Disorders – 12 Years Prospective Follow Up, Skodol et al, 2005
- Children in the Community. Cohen et al, 2005
- Longitudinal Study of Personality Disorders, Lenzenweger et al 2004
- Dramatic, context-dependent fluctuations in symptoms and functioning
- Significant longitudinal changes in symptoms and functioning (decline)
CORE FEATURES OF BPD (Dimensions of Behavioral Phenotype and Subjective Experience)

- **Emotional Dysregulation**
  - Dramatic, context-dependent, intensely reactive, rapidly reversible shifts in mood states
  - Intense, prolonged rage and reduced inhibition of negative emotional states

- **Impulsivity**
  - Difficulties tolerating distress
  - Lack of inhibition to pursue long-term goals
  - Self-harm and suicidality
Social Dysfunction

- Lack of trust, reciprocity and difficulties solving social problems
- Hyperactivation and disorganization of attachment
- Social hypersensitivity
- Intolerance of aloneness, rejection and lack of response
- Anxious expectation of rejection and hostility which are intensely perceived, evoked and responded
Dissociation: in response to stress, rejection, loss, lack of response, hostility from detachment and “pretend” and “as-if”, to emptiness, “automatic behavior and disorientation

Disturbed sense of identity

- Reduced sense of continuity and coherence of the self
- Decreased sense of agency and intentionality

Intense, unbearable, indescribable inner pain
A PROPOSED DEVELOPMENTAL TRAJECTORY: HYPERBOLIC TEMPERAMENT

- Affective dysregulation
  - Highly polarized, environmentally (relationally) responsive, rapidly reversible shifts in affect (differences with mood disorders present in 10-15% of adult BPD)

- Impulse Dyscontrol
  - A lower threshold for activation of impulsive motoric responses, value short-term reward over long-term harm (impulsive choices) a heightened disposition to explode with rage, and a proneness to self-harm, recklessness and addictive patterns (promiscuity, drug abuse, eating disordered behavior, self-mutilation)
A PROPOSED DEVELOPMENTAL TRAJECTORY

- Supersensitive babies (Kagan)
  - Physiological and affective hyper-reactivity to changes, separations and mismatches predictor of social phobia and shyness

- Exceptional sensitivity to matching or mismatching and lack of reciprocity?

- Hyper-reactive, “hyperbolic” infants more difficult to match
A PROPOSED DEVELOPMENTAL TRAJECTORY cont’

- Mismatch of infant’s temperament and caregiver’s with similar temperament and/or traumatic histories

- Caregivers respond to their hypersensitive children’s signal of distress and hyperarousal with fight-or-flight
ADULT ATTACHMENT PREDICTS MATERNAL BRAIN AND OXYTOCIN RESPONSE TO INFANT CUES

**Study Timeline**

<table>
<thead>
<tr>
<th>3rd trimester visit: Pregnancy</th>
<th>7 month visit: Videotaping</th>
<th>10 month visit: Scanning</th>
<th>Visit 4: Follow-Up</th>
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<tbody>
<tr>
<td><strong>3rd trimester</strong></td>
<td><strong>7 mths</strong></td>
<td><strong>10 mths</strong></td>
<td><strong>14 mths</strong></td>
</tr>
<tr>
<td>BIRTH</td>
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**Data Collected**

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<tr>
<th>3rd trimester</th>
<th>7 mths</th>
<th>10 mths</th>
<th>14 mths</th>
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<tr>
<td><strong>Mother-infant separation 1</strong></td>
<td><strong>“Free play” interaction</strong></td>
<td><strong>Mirror-based interaction</strong></td>
<td><strong>Mother-infant separation 2</strong></td>
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<tr>
<td>Blood draws</td>
<td>• PANAS (1)</td>
<td>• PANAS (2)</td>
<td>• WTAR</td>
</tr>
<tr>
<td>• Oxytocin change</td>
<td>• IBQ</td>
<td>• Breastfeeding duration</td>
<td>• Bayley Scales of Infant Development</td>
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<tr>
<td>• Cortisol</td>
<td>• PSI</td>
<td>• Hours separated per week</td>
<td></td>
</tr>
<tr>
<td>• Adrenaline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Noradrenaline</td>
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**Adult Attachment Interview (AAI)**

*Type B: (Secure):* values attachment, coherent balanced account of experiences

*Type A: (Insecure):* deny experiences (can’t remember), devalue (denigrate)

<table>
<thead>
<tr>
<th>STIMULUS TYPES</th>
<th>IDENTITY</th>
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<tbody>
<tr>
<td></td>
<td>Own Infant</td>
</tr>
<tr>
<td>AFFECT</td>
<td>Happy</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>Sad</td>
</tr>
</tbody>
</table>
Maternal security and hemodynamic change

A

mPFC

y=11

x=-6

Anterior Insula

y=6

y=16

B

VS

R Ventral Striatum

R mPFC

% signal change

Type B (Secure)  
Type A (Insecure)

R Ventral Striatum

R Insula
Maternal brain response to own baby’s sad face, comparing attachment groups.
DISORGANIZED ATTACHMENT

Enfeebled Mentalizing
Disorganized Attachment

↑ Arousal
“Fight” - Freeze - or - Flight

Dissociation of
Implicit/Procedural
And Explicit/symbolic

Physical, Self
and the
Contingency
Detection
Mechanism

Procedural Experience
Of
Arousal/Distress

Baby

↑ Arousal/Distress

Fight – or - Flight

Resonance

Signal

No Response (Neglect)
Or Noncontingent,
Unattuned Response

Caretaker

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DISORGANIZED ATTACHMENT

- Attachment: ↓ Threshold for activation and ↑ intensity (hyperactivation of attachment)
- Mentalizing: ↓ Threshold for uncoupling of controlled and automatic mentalizing with hypervigilance of other’s emotional states and hyper-resonance with these states (hypermentalizing)
- Stress: ↓ Threshold for stress and ↑ activation of defensive reactions of fight – freeze - flight

- Controlled Mentalizing
- Automatic Mentalizing

Performance

Changing switchpoint threshold

Point 1

Point 1a

Low Arousal

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

*The caregiver’s perception is inaccurate or unmarked or both*

**Attachment Figure**
- Absence of a representation of the infant’s mental state

**Child**
- The nascent self representational structure
- The Alien Self

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

*The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics which disorganizes the self, creating splits within the self structure*
Creating a Coherent Self-representation by Controlling and Manipulation – Hyper-activation of Attachment

Through coercive, controlling behavior the individual with disorganized attachment history achieves a measure of coherence within the self representation
DISORGANIZED ATTACHMENT

- Activation of attachment → fight-or-flight → hyperactivation of attachment and fight-or-flight
- Non-mentalizing of states of vulnerability that activate attachment → psychic equivalence (coercion and control)
Coercion and control in both child and caretaker: fight-or-flight activated when attachment partner deviates from matching

Increased odds of maltreatment: physical, emotional, sexual abuse
A PROPOSED DEVELOPMENTAL TRAJECTORY cont.

- Increased affective instability, arousal and vulnerability (psycho-social mismatch) in adolescence + neurodevelopmental changes in social cognition; overwhelm mentalizing capacity in genetically and developmentally vulnerable adolescents.
A PROPOSED DEVELOPMENTAL TRAJECTORY cont’

Key adaptation in adolescence:

- Active inhibition of mentalizing and loss of epistemic trust in an attachment context

- Loss of self-coherence without contingent match: absence threatens coherence but presence activates attachment and fight-or-flight
Coexistence (side by side) Of Psychic Equivalence And Pretend Mode

- Can not inhibit or moderate “shared” state of mind (psychic equivalence): what is in my mind is “for real”; insistence (coercion, manipulation) on a procedural match

- Nothing feels “for real” (pretend mode): disconnection from one’s agency and intentionality (“my behavior happens to me”); disconnection from one’s subjectivity (numbness, emptiness) and other’s subjectivity (aloneness); pain and dread can not be described (feel damaged, rotten, helpless, hopeless, betrayed, overwhelmed)
Coping With Inhibited Controlled Mentalizing

- Teleological mode and the primacy of the physical and observable
- Physical, addictive patterns to create internal match (drugs, self harm, sex, eating disordered behavior)
- Coercive efforts to create contingent, procedural responses in others
Powerful emotion

Poor mentalising

Inability to understand or even pay attention to feelings of others

Others seem incomprehensible

Frightening, undermining, frustrating, distressing or coercive interactions

Try to control or change others or oneself

Person 1

Person 2

VICIOUS CYCLES OF MENTALIZING PROBLEMS WITHIN THE FAMILY
MENTALIZING ELEMENTS OF PSYCHOTHERAPY
(THE ACTIVE INGREDIENTS)

- **Slow down coercion**: To recruit family in an effort to exchange coercive interactions that foster defensiveness and non-mentalizing for mentalizing conversations.
Connection: to establish a relationship in which the patient’s subjective experience is recognized contingently, validated and represented (perspective, marking, modeling of mentalizing)

- Patient’s experience: “I see my mind reflected in your mind more – or – less accurately reflected, recognized and validated” “you miss about two times of every three but you keep trying to understand me and your keep trying to remain curious, open and interested and invite me to do the same”

- This contingent, marked, represented recognition generates epistemic trust: “now I am interested in putting my guard down and learning from you and with you – and generalize what I learn”
MENTALIZING ELEMENTS OF PSYCHOTHERAPY (THE ACTIVE INGREDIENTS) cont.

- **Calibration**: of the mentalizing demand and interpersonal distance to match the patient’s capacity to mentalize and represent in particular attachment contexts and degrees of stress
  - The spectrum of interventions
THE SPECTRUM OF INTERVENTIONS

+ Mentalizing the relationship in the “here – and - now”

Basic mentalizing: recovering and practicing mentalizing in the “there – and then”

The mentalizing challenge: challenging, inviting alternative perspectives and searching for hidden perspectives

Exploring, clarifying, expanding

Expanding, validating, supporting

- Stress

Mentalizing
MENTALIZING ELEMENTS OF PSYCHOTHERAPY (THE ACTIVE INGREDIENTS) cont.

Coherence and context

- Therapist offer a formulation of the problem and of the treatment process that provides a coherent model of the patient’s experience of self and others and of the approaches to address the problem.

- Therapists model a mentalizing stance of active engagement, interests, curiosity (and tolerance of not-knowing) and inquire about mental states behind behavior to promote sense of intentionality and choice (agency) → basis of realistic hope and put experience in context (multiple perspectives).

- Therapists support the patients mentalizing by:
  - Highlighting (marking) mentalizing when it happens
  - Interrupt non-mentalizing
Courage

- Therapists model honesty and courage by, monitoring and acknowledging their own mistakes, currently and in their future as opportunities to **rewind**, **reflect** and **repair**
- Therapists recognize the courage patients need to trust and “give up” defense non-mentalizing
- Therapists use peers to monitor and support their capacity to maintain mentalizing when present and restore it when it is lost (in self and in patient)
Practice “not knowing” and mentalizing, in particular moments of vulnerability, in individual, group, family sessions long enough to learn something new: opening the epistemic super highway
Engaging in treatment requires *courage*
Hypermentalizing is reduced with BPD symptoms during inpatient treatment (Sharp et al., 2012)

Tendency to hypermentalize is malleable through milieu-based inpatient treatment: interpersonal-psychodynamic, although cognitive-behavioral, family systems, and psychoeducational approaches are incorporated into the treatment approach.
### Sample characteristics of Self Harm And Mentalization Trial (Rossouw et al., 2012)

<table>
<thead>
<tr>
<th>Characteristics at Baseline</th>
<th>Routine Care</th>
<th>Mentalisation Based Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, n/N (%)</td>
<td>87.50%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>14.8 (1.2)</td>
<td>15.4 (1.3)</td>
</tr>
</tbody>
</table>

#### Chronicity of Self harming

- less than 3 months: 40% (Routine) 40% (Treatment)
- 3-5 months ago: 10% (Routine) 17.5% (Treatment)
- 6-11 months ago: 15% (Routine) 5% (Treatment)
- 1-2 years ago: 27.5% (Routine) 30% (Treatment)
- over 2 years ago: 7.5% (Routine) 7.5% (Treatment)
Self harm scores for TAU (n=40) and MBT (n=40) groups on the RSHI

Group differential rate of change: $\beta=-0.049$, 95% CI: $-0.09$, $-0.02$, $t(159)=-2.49$, $p<0.013$, $d=0.39$
Borderline personality features scores for TAU (n=40) and MBT (n=40) groups

Group differential rate of change: $\beta=-0.361$, 95% CI: -0.7, -0.03, p<0.034, d=0.34
Diagnosis of ‘possible’ BPD using Zanarini Adolescent Interview (cutpoint at 4 criteria)

Group differential rate of change: $\beta=-2.472$, 95% CI: -5.09, 0.14, $t(159)=-1.85$, $p<0.064$, $d=0.29$
Depression scores for TAU (n=40) and MBT (n=40) groups on the MFQ

Group differential rate of change: $\beta=-0.046$, 95% CI: $-0.09, -0.01$, $t(159)=-2.25$, $p<0.024$, $d=0.36$
Mentalizing scores on the HIFQ for treatment groups

Group differential rate of change: $\beta=1.49$, 95% CI: 0, 2.98, $t(159)=1.99$, $p<0.049$, $d=0.32$
Attachment avoidance scores from Experiences in Close Relationships Questionnaire for treatment groups

Group differential rate of change: $\beta=-0.696$, 95% CI: -1.48, 0.08, $t(159)=-1.75$, $p<0.081$, $d=0.28$