Case vignette

Sarah is a 15-year-old adolescent who was admitted to an inpatient unit after she made a serious threat to kill herself. Sarah’s parents got divorced when she was four years old and she has been spending alternate weekends with her father. On the day she was admitted to hospital, Sarah’s father brought her to the meeting point (a park) where he was going to drop off Sarah to be picked up by her mother. When he began to leave, Sarah clung to him and started to cry. Sarah has had a tendency in the past to engage in dramatic displays to stop her parents or good friends from leaving her. This time, Sarah told her father that living with her mother had become unbearable and that if he did not stay with her she would kill herself. During the past two years, Sarah has often threatened to kill herself. Her father tried to calm her down but she shouted that he was not hearing her and she pulled up her skirt to reveal significant cuts and burns on her thighs. Her father was shocked; since childhood, Sarah had always been highly emotional and reactive. Recently, her father had become concerned about Sarah’s alcohol intake and the fact that she was caught shoplifting a few times, but her father had not been aware of any self-harm. Sarah disclosed that she has been cutting and burning herself for at least two years. By this time Sarah was sobbing angrily and accusing her father of never being there for her and choosing a life with his new family instead of her. When her father tried to hold her to comfort her, she punched him in the face and started running away. When a car nearly ran her over she collapsed and her father was able to catch up with her to take her to the hospital. On admission, Sarah appeared completely calm and said that she felt separated from her body—a feeling which she said she often has when she becomes stressed. She kept scratching herself. She did not want her mother to come to the hospital.

Sharp & Fonagy (2015) JCPP

What do you think?

Would you diagnose a personality disorder?

0 10
What do you think?

Would you assess for personality pathology?

0 10

Westen et al. (2003)

- Randomly select one of your adolescent patients, e.g. “the last patient you saw last week”.
- 296 patients.
- Clinicians:
  - Highly experienced (years post training 13.4)
  - 34.8% psychodynamic; 11.6 CBT; 42% eclectic
  - Most worked in multiple settings
  - Knew the patients well – more than 20 sessions
- Clinicians were given assessment tools that contained questions about PD.
- They were also asked to diagnose the adolescent.
- Only 28.4% received PD diagnosis (most common BPD).
Laurensen et al. (2013)

- 596 psychologists in the Netherlands.
- 75% female; mean age 40; average 12 years in clinical practice.
- 27% primary care; 58% in secondary care; 14% in psychiatric hospitals.
- 57.8% agreed that PDs can be diagnosed in adolescents.
- However, only 8.7% reported that they diagnose PDs and only 6.5% offered specialized treatment:
  - 25% MBT
  - 17.7% ERT
  - 12.5% SFT
  - 12.5% DBT
- Laurenssen et al. (2013)

Griffiths et al. (2011)

- Annual general meeting: 2009 child psychiatry conference.
- 52 child and adolescent psychiatrists.
- 82% accepted overall validity of BPD for adult populations vs. 17% for adolescent BPD; 2% accepted validity for children <12.
- 23% used the diagnosis in regular clinical practice; and of those only 60% feedback the diagnosis to young people and families.
- Qualitative feedback:
  - "The diagnosis can help families and young people understand their experiences and difficulties." It may also help young people access appropriate interventions such as dialectical behaviour therapy (DBT).
  - "The label may have stigmatizing, marginalizing and objectifying effects on young people".
  - "Making the diagnosis can lead to a worsening of the difficulties".
  - "The diagnosis leads to therapeutic pessimism and a belief that change is impossible.".
  - "The diagnosis is conceptually problematic, as it omits crucial developmental factors and makes assumptions about the enduring nature of certain personality variables, which is considered developmentally naive in adolescent populations".
- Concludes: "conceptually problematic, empirically insufficiently supported, lacking in clinical utility".

What do you think?

<table>
<thead>
<tr>
<th>DSM criteria</th>
<th>Sarah</th>
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<tbody>
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<tr>
<td>Abandonment fears?</td>
<td>Accuses father of not being there for him; clings to him; threatens suicide.</td>
</tr>
<tr>
<td>Affective instability and reactivity?</td>
<td>Highly emotional since childhood</td>
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<td>Impulsive?</td>
<td>Ran in front of car; alcohol problems; shop lifting</td>
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<tr>
<td>Angry behavior?</td>
<td>Punch father in face; sobs angrily</td>
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<tr>
<td>Dissociation?</td>
<td>Feels separated from her body</td>
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<tr>
<td>Relationship problems?</td>
<td>Refuses mother’s presence; Dramatic display.</td>
</tr>
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<td>Identity disturbance?</td>
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Westen et al: Only 28.4% received PD diagnosis (most common BPD) although 75.3% of patients met criteria based on clinician’s report of PD symptoms.

**Biases (myths)**

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5. Because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatizing to label an adolescent with BPD.
Agenda

9.30-10.30: Beliefs (myths?)
11.00-12.15: Assessment of BPD in adolescents
12.15-13.00: Developmental theories
14.00-15.30: MBT-A: The basics
16.00-17.30: Putting MBT to work

Learning objectives

• Understand the barriers (myths) regarding early detection and intervention of BPD in adolescents.
• Appreciate the evidence in support of the borderline diagnosis in youth.
• Know the key developmental theories on the development of BPD.
• Understand the focus on mentalization as malleable treatment target in BPD.
• Be able to assess borderline features and mentalization in youth.
• Understand the basic components of Mentalization-based Treatment (MBT) for BPD in youth and how to apply them.
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Legitimization in psychiatric nomenclature

- DSM-5 (allowed since DSM-III).
- ICD-11.
- National treatment guidelines:
  - National Institute for Health and Care Excellent (NICE): UK.
  - Australian National Health and Medical Research Council (NHMRC).

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DSM 5 Section II PDs

- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Avoidant
- Dependent
- Obsessive-compulsive
- Personality change due to another medical condition
- Other specified PD and/or Unspecified PD
A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following:

1) Frantic efforts to avoid real or imagined abandonment
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3) Identity disturbance markedly and persistently unstable self-image or sense of self
4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6) Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7) Chronic feelings of emptiness
8) Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9) Transient, stress-related paranoid ideation or severe dissociative symptoms

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DSM 5 Section II BPD criteria

- Criteria are the same for adults and youth.
- But: criteria have to be met for 1 year instead of 2 years.
- Caution: “those relatively unusual instances in which the individual’s particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder” (p.647).

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DSM 5 Section III BPD criteria

- No caution for diagnosing PD in adolescents.
- “relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood” (p. 761).
- Criterion A: severity of problems in identity, self-direction, empathy, and intimacy (Levels of Personality Functioning Scale).
- Criterion B: presence of 4+ of 7 pathological personality traits: Emotional lability, anxiety, separation insecurity, depression, impulsivity, risk taking, and hostility, of which at least one must be impulsivity, risk taking, or hostility (PID5).
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Anger

All the time. I don't know. I just get mad or angry for no reason. How often? Once a week. What kind of things make you mad? A teacher got me mad because he was being mean to the class for no reason and it got me mad. What did you do in that situation? I stayed quiet and listened to music. And so? It didn't happen a lot. More typical to keep it in. Why? I don't think other people can tell. (why not?) I didn't show my emotions. I just held it in like everything is ok. Now often do you hold it in like every week, but everyday? I try not to. But what? I try not to. That's hard to control. (How do you deal with your anger?) Put my head down. (normally do?) Yeah. (yell?) No. (hit someone?) No. Only time when I scream is when they bug me. (what did you do?) Put my head down. (family situations?) Just anyone. (when was the last time you felt you needed to scream?) Not sure. (hasn't happened a lot?) More typical to keep it inside. (why not?) I don't show my emotions. I just hold it in like everything is ok. Now often do you hold it in like every week, but everyday? (too much?) I try not to. But what do you do if you can't control it? I put my head down. (physically fight?) No. (moving people?) No.

Affective instability

I could be excited to do something, or get out with my friends, and then my mom will say no and that will trigger me and then I'll be upset. Does this happen for the right or the wrong reasons? Sometimes I get excited. If I go out with my friends, they do things they aren't supposed to do, but I still have the capacity to go back to the planned activity. (book changes?) I think gradually. I mean, I think it's a gradual thing when I read. If I read, it must be a gradual thing. When you think about the thing, it must be a gradual thing. I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read, I don't really think that I read. (read the thing by the book?) I don't think too much. I'd like to read a lot more and read the book that I read, but I can't read the book that I read. (read the thing) I read a lot more. I don't read very well. (read the thing) Yes, I can read a lot more. I don't read very well. (read the thing) Yes, I can read a lot more. I don't read very well.
Suicidal behaviors

Fifth grade I cut myself, sixth grade I cut myself, seventh grade is now, I haven't cut myself, but I did once, and that's right there [points to arm] see that scar right here. That was like once that was like two weeks ago. Not last week, but the week before, so like two weeks ago. Every time I cut myself I usually cut probably about ten times. Like all this [looks to arm] would be filled up, like right here, filled up last year in fifth grade, a little bit right here, right here, and over right here [points to arm] I went to - I was hospitalized twice - one in fifth grade, one in sixth grade, and then finally to a psych ward. I went in there because I need to work on my coping skills, my depression, my emotionalness.

(hurt yourself without meaning to kill yourself?) Uhm like I don't know how you mean about that just to see if it hurts? [reworded?] Yeah I've punched things. When I was like really mad [like what?] Like the usually stuff like walls things like that, I cut myself? Yeah by accident once but it didn't really hurt you know and usually does. [accident?] I was cutting something. I forget cutting stuff for my nephew I have to do everything for him and I cut myself right here and it didn't like [doesn't sound like self-mutilation?] No. [threaten to kill yourself.] No I don't think I would on purpose I don't think I would be brave enough to do. [tell someone kill yourself?] I probably wouldn't tell someone that I would kill myself but probably just tell them like I was in pain.

Emptiness

(empty?) Interesting question, um I would say...maybe no, definitely no. (no feelings?) I've always had feelings...yeah, I've always. (like void?) No I've never been void of. (nothing inside?) I don't know...what does that mean? (just like empty?) No I haven't ever felt that.

Identity disturbance

Yeah, (what's that like?) Well [incoherent] everyone different but um how like I don't know, what you grew up with, like your friends, they have taught you this and that and your parents taught you this and that. I don't know, I don't know which road to take should like be more like my friends, should I do more things for my parents? (idea) That's how I feel. (is it that more in the area of going to college and deciding on a career and things like that?) No I know what career. (okay so you know that?) I know I'm following that path but I mean that was over two years it took me until now to college to find out what direction I'm heading to and what person I'm going to be in.

I feel a little bit like I have no identity sometimes, yeah. I feel like I often, when I like first meet people, I only act like a chunk of who I am. Like I don't know to like, I don't know how to do it, and like, it becomes really confusing, enough to really know which me is really me. (Why is it confusing?) Because I feel sometimes like a blank canvas a little bit, but sometimes I feel like, a lot of times I find myself doing like, with my actions or with my words, kind of making so that it's not maybe what would be the best for me, but more like what would be the most dramatic.
Impulsivity

- Some anger, but not intense.
- Some alcohol but not frequently.
- Low sexual promiscuity.
- No drugs except occasional marijuana.
- No fistfights – if present <2 in the last two years.
- Few instances of breaking the law.
- Multiple and intense anger outbursts that may include fistfights.
- Sexual promiscuity.
- Drug and alcohol abuse.
- Shoplifting, driving under the influence.
- Trouble controlling eating (bulimia).
- Trouble holding on to money.

Abandonment fears

(Example?) Yes, well my friends well they do they go to different schools, so I try to tell myself like they went to different schools for a good reason. And that they didn’t abandon me and I’m not alone. Cause I can still keep in touch with them and I can still make new friends. (You described feeling that way without your friends being there?) Physically? No really (Ever physically clung to someone?) No. (What happens if you feel left out of something or that someone might leave you out?) Um I feel that all the time basically. Cause most of my friends are Hispanic and they always speak Spanish. And you don’t speak Spanish? No. (You can’t really even understand what they’re saying?) No. (They’re talking about you?) No. (Not like they’re talking about you?) No. (How do you feel about that?) So I feel left out during that. (What do you do?) Usually I just ignore it like I’m trying to learn Spanish right now, so yeah, I just I just ignore it. Cause I know that they’re not talking about me...

Unstable relationships

Yes, and it happens over a really small incident. And it goes from loving them to the completely calling them my enemy. (Most relationships are stormy?) Yeah. I’m not really good with relationships. That’s why I don’t really have any close friends.

No really. (What do you mean by that?) Like I like somebody but then like they do things, they give you a reason not to like them so just within you own control that you don’t like them? Yeah, yeah. (What kind of thing?) Like I like the person. They way they talk to you. And you want to like them then one day they decide like you know I found out like what type of person they are and you know they’re still doing the same thing but you know they’re still doing it and it’s like they just don’t care anymore. And they don’t really care about you. And it’s like they they don’t care about like their relationships or any relationships. And they just don’t care about like being in a relationship or anything. That’s why I don’t really have any close friends.
Paranoid ideation

My mom says I don’t have evidence but I always feel like it’s so crystal clear that it’s there and my therapist told me over and over again not to make judgments but I always feel like people are talking about me but there’s no real evidence.

Uhm no only the only example I can think of is this one girl who is well I am not gossiping but I know like around school she is known to always lie and things like that so I know I can’t completely trust her because she lies about everything. But I am not distrustful of people in general. I am like a trusting person. (taken advantage of you?) sometimes I feel like my parents blame me for things that are not my fault that are my sisters fault but not like always just like the older child and my mom was the oldest child and she said it’s like some people will only blame you. (right then, blame you?)

Just like that I feel like that’s not the right way to do things. If I were the one to turn it on the one to get the brunt of the lecture even if I were the one to do it then I would be the one to get the blame and I would be the one to get the brunt of the lecture. Even if I were the one to do the thing that I’m not sure if I can understand because I’m not like the older one more responsible. I am more like the younger one sometimes.

She occasionally would look away that would remember them but I would look away that stuff because it happened to her and not to me so I would look away that stuff because it happened to her and not to me so I don’t remember that stuff because it happened to her and not to me so I don’t remember that stuff because it happened to her and not to me so I don’t remember that stuff because it happened to her and not to me so

Dissociation

I’m too overwhelmed by my feelings, and too in the middle of them. But sometimes there are moments where I, I think I do it as kind of a coping mechanism where I kind of take myself out of my feelings, um. My psychiatrist says my dad had referred to it as dissociation, where I kind of did just a lot of the time I just like sit in one position, I don’t really move any muscles in my body, and I have a really strange but really good feeling throughout my whole body, and um, I don’t usually like to talk that much and if you know, really only move my eyes and sometimes my head when I do it, and it kind of just has a numbing effect but it’s also a really good feeling. Um, and I don’t really feel any of the crazy emotions that I usually feel when I’m not doing that.

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Rank-order stability for PD symptoms in the range of .40-.65 (Bornavola et al., 2013)

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<th>Outcomes</th>
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<tbody>
<tr>
<td>Chanen et al (2008)</td>
<td>RCT in HYPE</td>
<td>CAT</td>
<td>Both showed improvement; CAT faster</td>
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<tr>
<td>Jackson et al (2009)</td>
<td>41 CAT vs. 32 TAU</td>
<td>CBT</td>
<td>CBT groups reduced drinking, suicide attempts, hospitalization, ED visits</td>
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<td>Esposito-Smythers et al. (2011)</td>
<td>RCT 19 CBT vs. 17 TAU</td>
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<td>Cooney et al. (2012)</td>
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<td>Mehmum et al. (2014)</td>
<td>RCT 29 DBT vs. 10 TAU</td>
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<td>Significant drop in self-harm in DBT; DBT greater benefits on BPD symptoms and depression</td>
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<td>Quasi-experimental 29 DBT vs. 82 non</td>
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<td>Fewer hospital admissions in DBT but no difference in suicide attempts</td>
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Sharp & Fonagy (2015) JCPP
### Treatment studies

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<td>Rossouw &amp; Fonagy (2012)</td>
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<td>MBT Decrease in selfharm; improved mood in MBT</td>
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<td>11 MBT</td>
<td>MBT Decrease in symptomatic distress; improved personality functioning. QoL.</td>
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<td>23 ERT vs. 20 ERT+TAU</td>
<td>ERT No additional benefit from ERT although locus of control increases</td>
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*Sharp & Fonagy (2015)* | *JCPP*

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### What do you think?

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<th>Inter-rater reliability</th>
<th>Factor structure</th>
<th>Construct validity</th>
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<tr>
<td>Zung et al. (2012)</td>
<td>.80</td>
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<td>BPFS-2</td>
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<tr>
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<td>.75</td>
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<td>Sharp et al. (2014)</td>
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<tr>
<td>Measure</td>
<td>Internal consistency</td>
<td>Inter-rater reliability</td>
<td>Factor structure</td>
<td>Construct validity</td>
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<td>---------</td>
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<tr>
<td>MnBPD scale</td>
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<tr>
<td>DIPSI DeClercq et al., 2006</td>
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<td>NA</td>
<td>27 facets, ordered item, factor structure</td>
<td>Resembles factor structure of adult personality pathology, cross-sectional and prospectively predicts key outcomes.</td>
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<td>MnBPD-adolescent version Archer, et al., 2005</td>
<td>41 (0)</td>
<td>36 items (trait level), 9 factors (trait level)</td>
<td>Factor structure</td>
<td>Good congruence between MnBPD and MM-RRT scale items, internal support for diagnostic BPD profile, useful for differential diagnosis.</td>
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<tr>
<td>ProQ DeClercq et al., 2012</td>
<td>&gt;40% of 30 out of 25 facets</td>
<td>NA</td>
<td>25 facets, 5 factor</td>
<td>Fair similarity between this and PID-5 factor structure observed in US adult sample as well as US and Flemish student, Correlates with DIPSI.</td>
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<td>BPI-BPD</td>
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<table>
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<tr>
<th>Measure</th>
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<th>Inter-rater reliability</th>
<th>Factor structure</th>
<th>Construct validity</th>
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<td>CI-BPD Zanarini (2003)</td>
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<td>Unidimensional</td>
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<td>Four-factor</td>
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<td>PARS-BPD</td>
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<td>Four-factor</td>
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<td>Unidimensional</td>
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<td>PAI A BOR Morey (2007)</td>
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<td>BPFS-C</td>
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<td>Not reported</td>
<td>Sensitivity .85, specificity .84</td>
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<td>BPFC-11 Sharp et al. (2013)</td>
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<td>Correlates with BPFS-C, internalizing and externalizing problems.</td>
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<td>BPFS-C Sharp et al. (2013)</td>
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<td>BPFS-P Sharp et al. (2013)</td>
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<td>BPFS-P Sharp et al. (2013)</td>
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<td>Not reported</td>
<td>Correlates with BPFS-C, internalizing and externalizing problems.</td>
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<tr>
<td>BPFS-C Sharp et al. (2013)</td>
<td>.90</td>
<td>N/A</td>
<td>Not reported</td>
<td>Correlates with BPFS-C, internalizing and externalizing problems.</td>
</tr>
</tbody>
</table>

**BPPQ-C (11)**

Instructions: Think about some statements about the way you feel about yourself and other people. For each item, pick the one that best describes how each statement is about you.

1. I feel very close to
   - From very close to
   - Not very close to
   - Completely opposed to

2. I feel very happy
   - From very happy to
   - Not very happy to
   - Completely opposed to

3. I feel afraid when my parents or friends break up
   - From very afraid to
   - Not very afraid to
   - Completely opposed to

4. I feel things that other people consider pleasant
   - From very pleasant to
   - Not very pleasant to
   - Completely opposed to

5. I feel that people don’t like me all the time
   - From very liked to
   - Not very liked to
   - Completely opposed to
BPFSC-11

1. I feel very lonely
2. I want to let some people know how much they've hurt me.
3. My feelings are very strong. For instance, when I get mad, I get really really mad. When I get happy, I get really really happy.
4. I feel that there is something important missing about me, but I don't know what it is.
5. I'm careless with things that are important to me.
6. People who were close to me have let me down.
7. I go back and forth between different feelings, like being mad or sad or happy.
8. I get into trouble because I do things without thinking.
9. I worry that people I care about will leave and not come back.
10. How I feel about myself changes a lot.
11. Lots of times, my friends and I are really mean to each other.

Cut-off: 34
Internal construct validity

- CFA: 1-factor model showed adequate fit
  - $\chi^2(27) = 55.22, p < .001$
  - RMSEA = .07
  - CFI = .96
  - TLI = .94
- CFA: Standardized factor loadings ranged from
  - unstable relationships (.79)
  - identity disturbance (.75)
  - abandonment fears (.74)
  - affective instability (.74)
  - uncontrolled anger (.73)
  - sexual entitlement (.69)
  - internalized shame (.68)
  - impulsive self-harm (.63)
- Internal reliability: Cronbach's alpha = .80
- Inter-rater reliability (15%): Kappa = .89
Internal construct validity

• CFA: 1-factor model showed adequate fit
  - $\chi^2(27) = 55.22, p < .001$
  - RMSEA = .07
  - CFI = .96
  - TLI = .94

• CFA: Standardized factor loadings ranged from
  - unstable relationships (.79)
  - identity disturbance (.75)
  - abandonment fears (.74)
  - suicide ideation (.74)
  - uncontrolled anger (.74)
  - shame empathy (.60)
  - intrusive thoughts (.60)
  - impulsivity (.60)

• Internal reliability: Cronbach’s alpha = .80

• Inter-rater reliability (15%): Kappa = .89

Criterion validity

• Clinician diagnosis: Kappa = .34; $p < .001$

• Higher means on the PAI-A Borderline Features scale ($t(165) = -7.15; p < .001$)
  - affective instability ($t(165) = -6.79; p < .001$)
  - identity problems ($t(165) = -5.13; p < .001$)
  - negative relationships ($t(165) = -5.32; p < .001$)
  - self-harm ($t(165) = -5.37; p < .001$)

What do you think? Watch a CIBPD with me and rate it using the CI-BPD tool.
Agenda

9.30-10.30: Beliefs (myths?)

11.00-12.15: Assessment of BPD in adolescents

12.15-13.00: Developmental theories

14.00-15.30: MBT-A: The basics

16.00-17.30: Putting MBT to work
Crowell et al. (2009), D&P

Constitutional Factors

Early Caregiving Context

Stress/Arousal

• Dysfunctional relationships
• Affect dysregulation
• Impulsivity

Pre-mentalizing modes of social cognition

Attachment disruptions

• Identity diffusion
• Dissociation
• Feelings of inner pain and emptiness

Poor self-other differentiation

Impairments in integration of cognition and affect

Low threshold for attachment activation and controlled mental deactivation

Hypersensitivity to mental states

Fonagy & Luyten, 2009
1. What is Sandra feeling?

a. her hair does not look that nice
b. she is pleased about his compliment
c. she is exasperated about Michael coming on too strong
d. she is flattered but somewhat taken by surprise
Empirical study 1

\[
\begin{align*}
&\text{Hypermentalizing (dMASC)} \\
&\text{Emotional Regulation (CERQ)} \\
&\text{BPD (BPFSK)}
\end{align*}
\]

\[0.38^{*}\] (0.195) \\
[0.27^{*}] \\
[0.70^{*} (0.438)]

Sharp et al., 2011, JAACAP

Empirical study 2

\[
\begin{align*}
&\text{N = 259 (mean age 15.42, SD = 1.43)} \\
&63.1\% \text{ females} \\
&\text{CAI, MASC, DERS, BPFSC}
\end{align*}
\]

\[\text{MZ: F = 76.11; p < .001} \]
\[\text{BPD*MZ: F = 5.30; p = .02}\]

Sharp et al. (2013), JPD

Empirical study 3

\[
\begin{align*}
&\text{Change in Hypermentalization between Admission and Discharge}
\end{align*}
\]

\[F = 7.63, p < .05\]
\[F = 5.80, p = .03\]

Sharp et al. (2013), JPD
Course: admission to 18m after discharge

ER and HMZ as predictors of intercept and slope

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Parent report</th>
<th>Youth report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>87.73 (2.45)*</td>
<td>25.55 (1.48)*</td>
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<tr>
<td>Var (SE)</td>
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<td></td>
</tr>
<tr>
<td>Intercept (SE)</td>
<td>25.43 (1.88)*</td>
<td>103.63 (10.88)*</td>
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<td>Var (SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-0.01 (0.03)</td>
<td>-0.24 (0.04)*</td>
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<tr>
<td>Var (SE)</td>
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<td>Intercept (SE)</td>
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<tr>
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<td>56.41 (14.26)*</td>
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<td>-0.48 (0.58)*</td>
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ER and HMZ as predictors of intercept and slope

<table>
<thead>
<tr>
<th></th>
<th>Parent report</th>
<th>Youth report</th>
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<tbody>
<tr>
<td><strong>Growth intercept</strong></td>
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<tr>
<td>Mean (SE)</td>
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<td>129.13 (11.09)*</td>
<td>101.61 (10.69)*</td>
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<td><strong>Emotion Dysregulation</strong></td>
<td>0.01 (0.02)</td>
<td>0.39 (0.02)*</td>
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<tr>
<td>Hypermentalizing</td>
<td>0.85 (0.09)*</td>
<td>0.70 (0.09)*</td>
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<tr>
<td>Variance (SE)</td>
<td>122.64 (20.85)*</td>
<td>125.31 (27.86)*</td>
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<td><strong>Emotion Dysregulation</strong></td>
<td>0.01 (0.03)</td>
<td>-0.24 (0.04)*</td>
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<td>-0.38 (0.15)*</td>
<td>-0.47 (0.27)*</td>
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<tr>
<td>Intercept slope covariance (SE)</td>
<td>-35.05 (13.26)*</td>
<td>-54.46 (14.29)*</td>
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<tr>
<td>Intercept slope correlation (SE)</td>
<td>-0.28 (0.09)*</td>
<td>-0.48 (0.08)*</td>
</tr>
</tbody>
</table>

RMSEA = .04; CFI = .98; TLI = .97; SRMR = .06

**Summary**

- Statistically and clinically significant reduction in borderline features across 5 timepoints over 18 months.
- HMZ predicts both parent- and self-report intercept, but not slope (noteworthy due to use of experimental task).
Definition of hypermentalizing

- Excessive theory of mind (Dziobek et al., 2006)
- Social-cognitive processing that involves making assumptions about other people’s mental states that go so far beyond observable data that the average observer will struggle to see how they are justified (Sharp et al., 2012).
- Overattribution of mental states to others and their likely misinterpretation (Sharp et al., 2012).
- Overactive and exaggerated resonance with the mental states of others due to confusion between self-and other-mental states (Sharp & Vanwoerden, 2015)

Hypermentalizing in session

Therapist: So tell me about the difficult situation when you met with your ex-boyfriend. It seems to me that it was a bit frustrating for you to meet with him, is that right to put it that way?
Gina: He met with me just to see that I was still in pain...
Therapist: What did you like to meet with him?
Gina: Awful...I mean...I spent two hours in hell...he kept telling me about his life, and that he is going out and has a lot of new friends...so annoying...I hate him and he doesn’t respect me, just want to bug me...
Therapist: That doesn’t sound nice...did you feel anything in particular in that situation?
Gina: I fucking told you I HATE HIM...what is it you don’t get? (Gina talks very loud, and seems agitated)
Therapist: Wow...it seems to me that you are affected with what happened there...sorry, it wasn’t my intention to annoy you...
Gina: You all say you are sorry, but it is a lie (talks really loud and very fast)...John (ex-boyfriend), says he is sorry that we could not stay together...bullshit...He is not sorry about anything...Lisa (Gina’s contact person at the institution) says she wants to help me and tries to understand me all the time...she is not trying to understand anything or help anyone...you and all this mentalizing...
Therapist: Hold on, hold on for a second Gina, this goes really fast, and I can’t quite figure it all out...can we please pause for a second, and look at what happened here...
Gina: I don’t want to pause anything...I know what you are up to...you want to blame me, tell me it is my own fault that there is no way we work that out...I should’ve and had it together...please...a fuckin’ (Gina talks very fast and agitated)
Therapist: OK (Bo, Sharp, Fonagy, & Kongerslev (in press), PD:TRT

Developing a new measure

Five components

1. **Overconcern** with the mental states of others
2. **Overinterpretation** of others’ mental states
3. **Inflexible certainty** in own beliefs about others’ mental states
4. **Acting** impulsively on assumed mental states of others
5. Second-guessing/over-interpretation of **own** mental states
Construct validity

Tukey tests showed that all groups were significantly different from each other.

Agenda

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A working definition of mentalization

Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).

Successful mentalizing of people and relationships

The person:

- Is relaxed and flexible, not ‘stuck’ in one point of view
- Can be playful, with humour that engages rather than hurting or distancing
- Can solve problems by give-and-take between own and others’ perspectives
- Describes their own experience, rather than defining other people’s experience or intentions
- Conveys ‘ownership’ of their behaviour rather than a sense that it ‘happens’ to them
- Is curious about other people’s perspectives, and expect to have their own views extended by others’
Our sense of **self & capacity for self-regulation** are acquired through **interpersonal interaction**

Caregiver’s marked mirroring of baby’s constitutional self-states enables him to begin to form representations of his experience, laying the foundation for mentalizing.

---

The development of the ‘mentalizing self’

- The capacity to mentalize emerges through interaction with the caregiver:
- The quality of the attachment relationship
  - If the parent is:
    - Able to reflect on infant's intentions accurately
    - Does not overwhelm the infant
  - Then this:
    - Assists in developing affect regulation
    - Helps develop child’s sense of a mind and of a reflective self

---

How Attachment Links to Affect Regulation

- **Down Regulation of Emotions**
  - **BONDING**
  - The forming of an attachment bond
Shared neural circuits for mentalizing self and others

A biobehavioral switch model of stress and controlled vs. automatic mentalization

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

- Attachment and mentalization are loosely coupled systems existing in a state of partial exclusivity.
- Mentalization has its roots in the sense of being understood by an attachment figure,
  - it can be more challenging to maintain mentalization in the context of an attachment relationship (e.g. the relationship with the therapist) (Gunderson, 1996).
- BPD associated with hyperactive attachment systems as a result of their history and/or biological predisposition
- But without activation of the attachment system in therapy borderline PD patients will never learn to function psychologically in the context of interpersonal relationships.

Recognizing ineffective mentalizing
Ineffective mentalizing – global outcomes

- Ineffective mentalizing = poor outcomes of attempts to mentalize due to restrictions in components of mentalizing
  - No ability to consider complexity of mental states of self and other
  - Constructive and progressive interpersonal and social involvement reduced
  - Unable to calibrate self states of mind through others
  - No ability to identify and manage own emotions
  - Poorer recognition and acceptance of alternative perspectives
  - Failure to negotiate shared positions/viewpoints

Indicators of ineffective mentalizing

- Content
  - External social factors, e.g. school, neighbors
  - Focus on structural/physical labels (fixed, lazy, clever, self-destructive, short-fused)
  - Labelling others – stereotypes
  - Absence of content – paucity of thought
  - Preoccupied with rules, responsibilities, “should” and “should nots”
  - Denial of responsibility, involvement in problem
  - Blaming or fault-finding

- Style
  - Excessive details (without motivations, feelings or thoughts)
  - States of mind missing from narrative
  - Assumptions of mental states
  - Lack of appropriate emphasis on important areas; lack of integration
  - How something is thought about
    - Certainty about others’ thoughts and feelings
    - Rigidity
    - Excess perspective with no consideration of alternative viewpoints
  - Conversation is unquestioning
    - Structural progression in development of content
    - “Just”, “clearly”, “obviously”, “all”, “nobody”, “nothing”
Extremely ineffective mentalizing

- Anti-reflective
  - Hostility:
    - Active evasion: when asked why he thought his parents had behaved as they did, told the interviewer about how having been exposed to football (soccer) early in life had developed a life-long devotion to the game.
  - non-verbal reactions

- Failure of adequate elaboration
  - Lack of integration of topics
  - Lack of explanation – things just are

- Inappropriate
  - Complete non-sequiturs
  - Gross assumptions about the interviewer
  - Literal meaning of words – mentalizing means you are ‘mental’

What do you think?

- Interviewer: “Why do you think your parents behaved as they did?” Subject: “How do you expect me to know? You tell me, you are the psychologist!”

- One subject, when asked why he thought his parents had behaved as they did, told the interviewer about how having been exposed to football (soccer) early in life had developed a life-long devotion to the game.

- Getting up to make a telephone call or going totally silent.

- I think somewhere... em... what makes me feel... but what makes me feel more rejected is that she breast-fed me. And she didn’t breast-feed my sister.

- “I... I just disliked her.”

- Interviewer: “Is there a memory that conveys her emotional presence?” Speaker: “Presents, she always gave us presents!”

Imbalance of mentalization generates problems

<table>
<thead>
<tr>
<th>Implicit-Automatic</th>
<th>Non-conscious-Immediate</th>
</tr>
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<tbody>
<tr>
<td>Mental interior</td>
<td>Cognitive attitude</td>
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<tr>
<td>cue focused</td>
<td>propositions</td>
</tr>
<tr>
<td>Imitative</td>
<td>frontoparietal</td>
</tr>
<tr>
<td>mirror neuron</td>
<td>system</td>
</tr>
</tbody>
</table>

Explicit-controlled
Conscious
Reflective

Mental exterior
Cold
focused

Affective
self affect
state
propositions

Belief-desire
MPFC/ACC
Inhibitory system

BPD

Dorsolateral prefrontal cortex (DLPFC) & ACC

VMPFC, ACC, rACC, MPFC, LPFC, and the precuneus

BPD

BPD

BPD

BPD
Prementalizing Modes of Subjectivity

Psychic equivalence:
- What is in my mind is out there in nature
- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Reflects domination of self: affect state thinking with limited internal focus
- My perspective reflects reality.
- "Obama is not a citizen."

Pretend mode:
- What is in my mind is not there in nature
- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- "Dissociation of thought, pseudo-mentalizing"
- Reflects explicit mentalizing being dominated by implicit, inadequate internal focus, poor belief-desire reasoning and vulnerability to fusion with others
- Managed in therapy by interrupting a non-mentalizing process
- Using mental state words, but lacks coherence and authenticity.
- "I deeply respect and care about women’s feelings."

Teleological stance:
- A focus on understanding actions in terms of their physical as opposed to mental constraints
- Cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Extreme exterior focus, unnecessary loss of controlled mentalizing
- Misuse of mentalization for teleological ends (harming others) becomes possible because of lack of implicit as well as explicit mentalizing
- "Let's build a wall."

What do you think?

- Identify pre-mentalizing mode
  - Psychic equivalence
  - Teleological mode
  - Pretend mode

- Identify location within the mentalizing cube
  - Self----------Other
  - Controlled------Automatic
  - Internal-------External
  - Affect---------Cognition
Videos
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12.00-13.00: Developmental theories
14.00-15.30: MBT-A: The basics
16.00-17.30: Putting MBT to work
Therapist/patient problem

- Therapy stimulates attachment system
- Exploration
- Discontinuity of self
- Attempt to structure by effort to control self and/or other
- Rigid schematic representation
  - Non-mentalizing (psychic equivalence, teleological, pretend mode)
  - Misuse of mentalizing (pseudo-mentalizing)

General Principles - MBT

- Primary aim is to increase capacity to mentalize self and others
- Maintain or regain mentalizing of clinician
- Monitor patient mentalizing capacity
- Manage arousal levels
- Focus on patient’s mind
- Seek out moment of mentalizing vulnerability or breakdown
- Address current events and immediate states of mind
- Step-wise intervention process starting with empathic validation

Core Summary for new clinicians (1)

- Collaborative process – keep family in mind
- Beginning phase: Formulation of patient problems early in treatment and a focus in each session
  - Trajectory of overall treatment and in each session
  - Aims linked to formulation, e.g. maintaining miz in the face of pressures and how to support adolescent’s miz capacity
- Beginning phase: Crisis plan, triggers and what to do about them
- Beginning phase: Contract: commitment to treatment from all involved
- Middle phase: Identification of non-mentalizing process
- Middle phase: General Attitude
  - Not-knowing stance
  - Active
- Middle phase: Principles for clinician
  - Aim to re-store or maintain mentalizing
  - Interventions consistent with the patient’s mentalizing capacity
  - Identification of mentalizing poles
Core Summary for new clinicians (2)

- **Middle phase: Principles for clinician (cont’d)**
  - Focus on maintaining clinician mentalizing
  - Authentic and open-minded clinician
  - Alert to breaks in mentalizing
  - Monitoring of the state of affective arousal
  - Focus on contingency and marking of interventions

- **Final phase:**
  - Increase independence and responsibility
  - Coping plan – relapse prevention

- **Trajectory of sessions:** interventions structured from empathic validation to exploration, clarification, and challenge through affect identification and affect focus to mentalizing the relationship itself

- **Explicit identification of clinician feelings related to the patient’s mental processing**

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**Theory to Practice: Contrary Moves**

<table>
<thead>
<tr>
<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>External focus</td>
<td>Internal focus</td>
</tr>
<tr>
<td>Self-reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Affective</td>
</tr>
<tr>
<td>Explicit</td>
<td>Implicit</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
</tr>
</tbody>
</table>

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**Psychic Equivalence**

<table>
<thead>
<tr>
<th>Clinical form</th>
<th>Certainty/suspension of doubt</th>
<th>Absolute</th>
<th>Reality defined by self-experience</th>
<th>Finality – It just is, Internal = external</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist experience</td>
<td>Puzzled</td>
<td>wished</td>
<td>Wished that logical but obviously over generalized</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not sure what to say, lost in argument</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Feeling fed up and hopeless</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td>Empathic validation with subjective experience</td>
<td>Curious – how did you reach that conclusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Presentation of clinician puzzlement (marked)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Linked topic (dissociation) to trigger mentalizing then return to psychic equivalent area</td>
<td></td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>Argue with patient</td>
<td>Excessive focus on content</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive challenge</td>
<td></td>
</tr>
</tbody>
</table>

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Clinical summary of momentary session intervention

- Identify a break in mentalizing – psychic equivalence, pretend, teleological
- Rewind to moment before the break in subjective continuity
- Intervention according to mentalizing problem
- 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 relationship if mentalizing remains robust
Mentalizing process

• Not directly concerned with content/narrative but with helping the patient

  Generate multiple perspectives 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)

Spectrum of Interventions

• Empathic validation – including reassurance, support & empathy

• Basic Mentalizing - Clarification, Exploration and Challenge

• Basic Mentalizing – Affect identification and Affect focus

• Mentalizing the relationship

Interventions: Spectrum
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

Basic mz: Clarification, elaboration, challenge

- ‘Stop, Listen, Look’
  - During a typical non-mentalizing story
    - stop and investigate
    - Let the interaction slowly unfold – control it/microslice
    - 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
- When patient able to mentalize to some degree
  - 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?
  - If someone else was in that position what would you tell them to do

Basic mz: Clarification, elaboration, challenge

- Stop, Re-wind, Explore
  - Let’s go back and see what happened just then. At first you/I 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 (beware) (‘I wonder if…” statements)
  - Explore manifest feeling but identify consequential experience – You say you are anxious with others so I wonder if that leaves you feeling a bit left out?
  - ‘I wonder if you are not sure if it’s OK to show your feelings to other people?”
Basic mz: Clarification, elaboration, challenge

- **Challenge**
  - Bring non-mentalizing to an abrupt halt even if only momentarily
  - Surprise the patient’s mind; trip their mind back to a more reflective process
  - Grasp the moment – stop and stand - if they seem to respond
  - Steady Resolve

Basic mz: affect and affect focus

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

Basic mz: affect and affect focus

- Normalise when possible – ‘given your experience it is not surprising that you feel X’
- Identify, name and give context to emotion - labelling
- Explore absence of motivating emotions – relentless negativity is wearing to others
- Identify mixed emotional states
Basic mz: affect and affect focus

• Define the current affective state **shared** between patient and therapist
• Do this tentatively from your own perspective
• Do not attribute it to the patient’s experience
• Link the current affective state to therapeutic work within the session itself

Mentalizing the relationship

• All of the above

Learning/teaching to mentalize

• Focus (With patient in the here-and-now)
• Affect/Name (Emotion; Basic mentalizing)
• Expand (Cognition; Elaboration; Challenge)
• Regulate (Learn; Generalize; Mentalizing the relationship)
• Reward (Feel good; with explanation)

Sharp, Shohet, Givon & Penner, in prep
Workshop Exercise

• Patient does not feel that you understand and think you understand only his parents’ perspective. He asks to be moved to another therapist.
  • Therapist
    – Empathic position
    – Clarification
    – Elaboration and affect focus
    – Stop and stand if necessary
    – Rewind and explore
    – Work within the current 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 and/or complains about another member of staff. Therapist has to address what has been happening.
  • Therapist
    – Empathic validation
    – Clarification
    – Elaboration and affect focus
    – Rewind and Explore
    – 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 – Discuss relationship with mom
  • Therapist: Basic mentalizing
    – Stop, Look, and Listen and explore important content
    – Stop, rewind, and explore
    – Stop and stand if patient uses non-mentalizing
  • Therapist: mentalizing the relationship if appropriate
Workshop Exercise

Therapist feels that the therapy is stuck and cannot see that it is likely to go anywhere and feels that ending therapy should be considered.

– Patient has not indicated that she feels similarly
– Raise the subject with the patient and explore.

What do you think?

• Challenges in using MBT with adolescents?

Learning objectives

• Understand the barriers (myths) regarding early detection and intervention of BPD in adolescents.
• Appreciate the evidence in support of the borderline diagnosis in youth.
• Know the key developmental theories on the development of BPD.
• Understand the focus on mentalization as malleable treatment target in BPD.
• Be able to assess borderline features and mentalization in youth.
• Understand the basic components of Mentalization-based Treatment (MBT) for BPD in youth and how to apply them.
"Of course I was about here: you imagined I thought you personal I wanted you to feel."