MBT Basic Training
MBT-I Leaflets

We are grateful to Robert Green colleagues from the Mindsight MBT programme in Christchurch New Zealand and to Robert Drozek and colleagues from the MBT programme at McLean Hospital in Boston USA for their kind permission to share their excellent leaflets for the MBT-I programme.

It is not our intention that you should simply copy these leaflets. We suggest that you use them to develop leaflets that are tailored to your own client population. So please consider generating your own information leaflets as part of an exercise during this MBT Basic training.

Mentalization-based Treatment Introductory (MBT-I) Group

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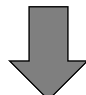
Mentalization-based Treatment (MBT) Theory of Personality Disorders

Attachment-related trigger

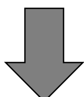
Rejection, criticism, abandonment, potential for closeness or connectedness, isolation, specific interpersonal scenarios or contexts



Activation of typical attachment strategies

Attachment anxiety, attachment avoidance, mix of both

Attachment styles: secure, enmeshed/preoccupied, fearful-avoidant, dismissive-avoidant



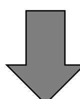
Inhibition of positive mentalizing

Narrower range of emotional experience; alexithymia

Decreased "mentalized affectivity" – the ability to be IN an emotion while reflecting ON the emotion

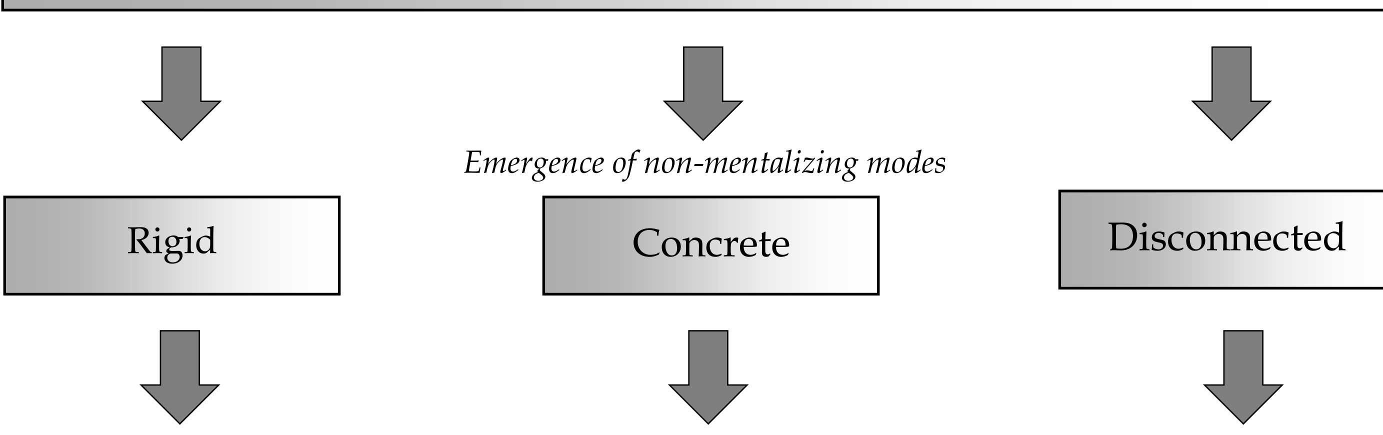
Difficulty understanding of "why" we are feeling a certain way

Impaired ability to "read" internal states in others; decreased emotional empathy



Imbalanced dimensions of mentalizing

Implicit vs. explicit; self vs. other; internal vs. external; cognitive vs. affective; certainty vs. doubt; general vs. specific



Experience of self-discontinuity; problem behaviors to restore coherence of Self

Self-injury, aggression, grandiosity, devaluation of others

Mentalization or "mentalizing"

The ability to "read," experience, and reflect on internal states (e.g., thoughts, emotions, desires, attitudes) in oneself and others

<u>Formal definition</u>

"The mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons" (Bateman & Fonagy, 2004, p. xxi)

<u>More "experience-near"</u>

- Attending to mental states
- Holding mind in mind
- To **make mental**—"mental" "-ize"
- Seeing others from the inside and ourselves from the outside
- The ability to think and feel at the same time, in a nuanced way, about what takes place in oneself, in others, and between people.

<u>What does "good mentalizing" look like?</u>

Of others:

- Sense of humility and tentativeness about others' mental states, without being completely confused/puzzled about other people's minds
- Appreciation that minds are not static entities—*they can be changed*
- A feeling of curiosity and interest about others' internal states
- Recognition that the same event can be interpreted quite differently based on a person's perspective and history
- Openness to discovery about others' minds

Of oneself:

- Appreciation that our perception of ourselves can change and evolve, based on new information and interpersonal experience
- Recognition that our internal worlds can often be jumbled or confusing
- A "not knowing" stance towards our own minds—we can never have complete and authoritative access to all of our thoughts, emotions, and desires
- Awareness of contradictory and conflictual dimensions of our experience
- Genuine curiosity about our thoughts and feelings
- Awareness of situational factors on our own interpretations—strong emotions and interpersonal conflict can affect the way that we experience ourselves and others

In general:

- Mentalizing concerns mental content, or the "what" of the mind—thoughts, emotions, desires, attitudes, personality traits, etc.
- Mentalizing also involves the "why" of mind—the impact of history, non-conscious processes and states, and current situation on how a person is thinking and feeling

- Mentalizing also concerns mental *process*, or "how" we relate to the content of mind—flexibly vs. rigidly, psychologically vs. concretely, disconnectedly vs. authentically emotionally engaged
- Good mentalizing recognizes the reciprocal relationship between MIND and CONTEXT—
  - Our minds are always influenced by our interactions with others
  - Other people are often affected by how we are feeling, and how we are treating them—sometimes "what we see" in another person is a reaction to how we are behaving in a given situation

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(1) What are some situations in which you feel like you are able to do a good job mentalizing other people? Provide at least one recent example.

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(2) What is happening in these situations? What is happening in you?

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(3) What are some situations in which you feel like you are able to do a good job of mentalizing yourself? Provide at least one recent example.

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(4) What is happening in these situations? What is happening in you?

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Attachment-related trigger

Rejection, criticism, abandonment, potential for closeness or connectedness, isolation, specific interpersonal scenarios or contexts

Our ability to mentalize—that is, to *"read," access, and reflect on internal states in oneself and others*—is directly related to how we feel in our relationships and interactions with others. MBT suggests that, for people with personality disorders, mentalizing can often get destabilized when they experience challenging and stimulating emotions in their relationships (e.g., rejection, insecurity, anger, attraction, excitement, love), which then can lead to some of the emotional and interpersonal instability associated with personality disorders. By working to identify the relationships, situations, and interactions that tend to trigger patients' challenges with emotional instability, MBT attempts to help patients "hold onto" their minds in scenarios of emotional unrest.

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(1) How have you struggled with emotional dysregulation or emotional instability in your life?

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(2) What situations typically trigger your difficulties with emotional instability?

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(3) List some *specific* relationships where your emotions have become particularly intense.

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(4) In these relationships, what have other people **said** or **done** that has been particularly upsetting to you?

Activation of typical attachment strategies

Attachment anxiety, attachment avoidance, mix of both
Attachment styles: secure, enmeshed/preoccupied, fearful-avoidant, dismissive-avoidant

Attachment refers to our tendency to seek out psychological connectedness with other human beings. Attachment theory suggests that infants need to develop an emotionally-attuned relationship with at least one primary caregiver for their successful development, especially in order to learn how to regulate emotions in relationships. Attachment "strategies" or "styles" refer to our characteristic manner of experiencing and regulating closeness in our relationships, influenced significantly by our interactions with early caregivers. MBT helps patients to identify and recognize their patterns in relationships. By encouraging patients to reflect on these patterns in a deeper and more adaptive way, MBT strengthens patients' ability to develop a greater sense of freedom, flexibility, and self-control in their interactions and relationships with others.

Types of attachment strategies in relationships:

- Attachment anxiety—*the tendency to attach to others easily, quickly, and intensely; often involves feelings of fear, anxiety, and panic that other people will judge, criticize, or abandon you*
- Attachment avoidance—*the tendency to use emotional distancing and avoidance to manage emotions and closeness in relationships; can involve judgment or criticism of other people, focusing on how "different" you are from others, or disconnection from emotions in yourself and others*
- Mixed strategies—*some idiosyncratic combination of attachment anxiety and attachment avoidance*

(1) What does attachment anxiety look like for you? Please provide at least one example.

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(2) What general situations trigger attachment anxiety in your experience?

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(3) What does attachment avoidance look like for you? Please provide at least one example.

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(4) What general situations trigger attachment avoidance in your experience?

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(5) Which of the above strategies (e.g., attachment anxiety, attachment avoidance, mixed) is your baseline or "default"? What does this look like for you?

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Attachment styles:

		Model of Self (Dependence)	
		Positive (Low)	**Negative** (High)
Model of Other (Avoidance)	**Positive** (Low)	SECURE *Comfortable with intimacy and autonomy*	PREOCCUPIED *Strives for self-acceptance by gaining the approval of others*
	Negative (High)	DISMISSING *Protects self by avoiding closeness* *Sense of independence, invulnerability*	FEARFUL *Fearful of intimacy; socially avoidant* *Protects self by avoiding relationships*

(6) Which attachment style feels most applicable to your experiences in relationships? How has this presented itself in your life?

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Inhibition of positive mentalizing

Narrower range of emotional experience; alexithymia
Decreased "mentalized affectivity" – the ability to be IN an emotion while reflecting ON the emotion
Difficulty understanding of "why" we are feeling a certain way
Impaired ability to "read" internal states in others; decreased emotional empathy

As we have seen, mentalizing involves *our ability to "read," access, and reflect on internal states in ourselves and others*. When we are experiencing intense emotions, or when we are engaged in interactions that are particularly exciting or upsetting to us, it can be challenging to mentalize in a flexible, adaptive way. This is especially true for people with personality disorders, who can be much more sensitive to emotional and interpersonal stress. By helping patients to recognize and understand their difficulties with positive mentalizing, MBT attempts to help patients *continue* mentalizing, even when they are under emotional stress.

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(1) *Alexithymia* is the difficulty identifying, experiencing, and expressing emotional states. What emotions and desires are more challenging for you to experience?

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(2) Alexithymia can be more global and "across the board," or it can worsen under particular circumstances. How does your alexithymia present itself?

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(3) *Mentalized affectivity* is the ability to **feel** an emotion while **reflecting** on the emotion. Some people "feel too much," without the ability consider "what, how, or why" they are feeling in a certain way. Other people "think too much," and find it more difficult to actually feel their feelings. Where do you think you fall along this spectrum? What are some examples of this?

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(4) Positive mentalizing involves appreciating the relationship between *mind* and *context*—the idea that what we are feeling is always affected by what is going on INSIDE of us and OUTSIDE of us. Do you ever struggle with understanding "why" you are feeling a certain way? Please provide at least one example.

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Cognitive empathy refers to our ability to accurately perceive and "read" the internal states (e.g., thoughts, emotions, desires) in other people. *Emotional empathy* refers to our capacity to *feel* what others are feeling, to care about and be motivated by other people's internal states.

(5) Do you struggle with any general deficits in either cognitive or emotional empathy? If so, please explain the shape that this takes for you.

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(6) What are situations when you have found it difficult to experience cognitive empathy with other people? Please provide at least one example.

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(7) What are situations when you have found it difficult to experience emotional empathy with other people? Please provide at least one example.

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Inhibition of positive mentalizing—Empathy supplement

Impaired ability to "read" internal states in others; decreased emotional empathy

Definitions

Cognitive empathy—our ability to accurately perceive and "read" the internal states (e.g., thoughts, emotions, desires) in other people.

Emotional empathy—our capacity to *feel* what others are feeling, to care about and be motivated by other people's internal states.

Common challenges with empathy associated with personality disorders

- *Global challenges with cognitive empathy*—the tendency to misread, make reflexive assumptions about, or draw incorrect conclusions about the internal states of others
- *Global challenges with emotional empathy*—difficulties emotionally resonating with, caring about, and being genuinely motivated other people's needs, wants, and desires
- *Context-dependent empathic deficits*—when **YOU** are feeling or wanting a particular thing, disruptions in the ability to "read" or care about other people's subjective states
- *Constrained cognitive empathy*—selective or "biased" attentiveness to (and awareness of) certain subjective states in others, with difficulties perceiving other subjective states
- *Constrained emotional empathy*—selective or "biased" ability to be motivated by (and to care about) certain subjective states in others, with difficulties being motivated by other subjective states
- *Misuse of cognitive empathy*—the tendency to "use" awareness of others' subjective states primarily in order to achieve one's own ends

Imbalanced dimensions of mentalizing

Implicit vs. explicit; self vs. other; internal vs. external; cognitive vs. affective; certainty vs. doubt; general vs. specific

Neuroscientists have identified multiple *dimensions* of mentalizing, each of which consists of two "poles" of experience. To mentalize effectively, individuals must be able to maintain a balance across these dimensions—not simply "switching" between each pole but able to move flexibly along each dimension, in an adaptive way and appropriate to the context or situation.

Individuals with personality disorders tend to become "stuck" on one pole of these dimensions, either as their default mode of experiencing their worlds, or in response to interpersonal and emotional triggers they encounter on a moment-to-moment basis. While different personality disorders are often associated with particular impairments in these dimensions, each person usually struggles with challenges in these areas that are unique to the individual. By understanding our idiosyncratic difficulties with imbalanced mentalizing, we will be better equipped to move towards more balanced, flexible forms of relationship and experience.

Dimensions of Mentalizing	
Implicit *Impulsive, reflexive, quick assumptions about mental states in Self and Other; involves minimal attention, awareness, effort, or intention*	**Explicit** *A gradual, progressive, relatively slow process of reflection about mental states; typically verbal and requires attention, awareness, and effort*
Self *The ability to reflect and focus on one's own experiences, including one's thoughts, emotions, desires, behavior, physical sensations, etc.*	**Other** *The ability to consider the experiences of other people, including their thoughts, emotions, desires, behavior, physical sensations, etc.*
Internal *The capacity to attend to subjective factors—thoughts, beliefs, emotions, desires, non-conscious processes, etc.*	**External** *The tendency to focus on observable, concrete factors (actions, physical appearance, facial expressions, posture/physicality, events in the world) when considering mental states*
Cognitive *The potential to name, recognize, and reason about mental states*	**Affective** *The ability to access, experience, and feel emotional states and desires*
Certainty *The capacity to feel confident and secure about one's impressions/ideas/beliefs about mental states, AKA to "go with your gut"*	**Doubt** *The ability to take a humble, curious, and "not knowing" stance towards mental states*
General *The propensity to abstract and generalize from specific mental states to arrive at a "big picture" perspective on subjective experience*	**Specific** *The tendency to identify, consider, and attend to SPECIFIC experiences in arriving at one's broader perspectives on mental states*

(1) On the preceding table, for each polarity of mentalizing, please circle the specific dimension that tends to be your "default," your most common manner of experiencing your life and relationships.

(2) For each dimension of mentalizing, explain further what it looks like for you to be imbalanced in this particular way.

Dimension of mentalizing	What are you more focused on?	What do you tend to minimize or ignore?	What problems has this imbalance caused in your life?
Implicit vs. Explicit			
Self vs. Other			
Internal vs. External			
Cognitive vs. Affective			
Certainty vs. Doubt			
General vs. Specific			

Non-mentalizing Modes of Experience

- When mentalizing fails, individuals with personality disorders are more likely to revert to *non-mentalizing* forms of thinking
- Non-mentalizing modes parallel ways that young children tend to experience the world prior to the full development of the capacity for mentalization
- These modes do not concern the "content" of experience (e.g., what, when, where, why) but the *process* of experience—HOW the person relates to his/her own thoughts and feelings
- 3 non-mentalizing modes:
    - Teleological mode—externally-focused and "concrete"
    - Psychic equivalence mode—rigid and inflexible
    - Pretend mode—disconnected from authentic emotional experience in Self and Other

Teleological mode: Externalized and "concrete"

External reality becomes the main vehicle for understanding or expressing mental states

Characteristics of teleological mode

- Significant focus on what is physically observable—"the outside" determines "the inside"
- Understanding Self and Other in terms of external factors—physical actions, observable qualities, appearance, and visible events and circumstances
- Only actions are taken as a "true" indication of another person's mental states – "If s/he [does/does not take a certain action], that means s/he [does/does not feel a certain way]"
- Often accompanied by a strong, persistent desire for some event to happen— "If [positive event] does not occur, then I cannot feel OK"—or to *not* happen—"If [negative event] does occur, then I cannot feel OK"
- A person's intentions are judged based on consequences – "If his/her action made me feel this way, that means s/he *wanted* me to feel this way"
- Frequently involves an intense focus on **behaviors** of Self or Other—for example, other people's "wrong" or "unjust" behaviors, or a personal compulsion to take a certain action (e.g., self-harm, attention-seeking, etc.)
- From a "big picture" perspective—self-esteem can become based mainly on visible factors
- Can involve "positive" as well as "negative" beliefs and experiences

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(1) What are common examples of teleological mind states you encounter regarding yourself?

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(2) What are common examples of teleological mind states you encounter regarding other people?

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(3) Are there specific actions or behaviors that you have felt *compelled* to take, even possibly against your better judgment?

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(4) What are some teleological ("extrinsic") sources of your self-esteem or self-worth?

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(5) Are there particular circumstances that can "trigger" you to enter teleological mode?

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Psychic equivalence mode: Rigid and inflexible

Thoughts and feelings are conflated with reality: "I think or feel it, therefore it's true"

Characteristics of psychic equivalence mode

- Mental reality = outer reality: "the inside" determines "the outside"
- Thoughts and emotions do not *feel* like thoughts and emotions—they feel like **reality**
- Frequently accompanied by a subjective sense of confidence and certainty about one's own viewpoint
- The inability to truly consider alternative perspectives on a situation
- Thoughts/emotions can be terrifying and overwhelming (e.g., flashbacks, certain memories)
- A person's emotional states exert considerable power over thinking and experience
- Can concern beliefs about Self, other people, the world, the future
- Like teleological mode, can be "positive" as well as "negative"
- Often concerns perceptions of other people, and beliefs about oneself, others, and the world

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(1) What are common examples of psychic equivalent beliefs you hold about yourself?

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(2) What are common examples of psychic equivalent beliefs you hold about other people?

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(3) Are there specific emotions that you tend to experience in psychic equivalence mode?

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(4) Provide one recent example of when you entered into a more rigid, inflexible mode of experience. What brought this on, and what did this look like?

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(5) Share an example when you entered into a more "positive" form of rigid thinking about yourself or other people. What brought this on, and what did this look like?

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(6) Are there particular circumstances that can "trigger" you to enter into psychic equivalence mode?

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Pretend mode: Disconnected or dissociated

Marked disconnection from authentic subjective experience in Self and Other

Characteristics of pretend mode

- Ideas do not form a bridge between "the outside" and "the inside"—the mental world is severed from outside reality
- Overreliance on cognition, intellectualization, jargon, rationalization, excessively detailed narratives
- Apparent disconnection from emotions and desires
- Frequently, emotions do not "match" the content of thoughts
- Person uses psychological language but cannot elaborate on meaning, context
- Often involves cognitive empathy without emotional empathy—the person "knows" what someone else is feeling without *feeling* it, or caring about it
- Can exist along a continuum—the person is disconnected from *certain* emotions in oneself (e.g., sadness, insecurity); or the person is "in touch with" some emotions or desires, but others are quite confusing or unformulated
- Does **not** imply willful dishonesty or misrepresentation

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(1) What are common examples of pretend mode in your life?

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(2) Do you ever rely largely on "thinking," intellect, or talking? What does this look like for you?

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(3) Are there specific emotions or desires that are difficult for you to access or feel?

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(4) Have you ever found it difficult to feel authentically connected to others' emotions or desires?

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(5) Are there particular circumstances that can "trigger" you to enter pretend mode?

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Non-mentalizing Modes Wrap-up

(6) Many individuals with personality disorders tend to have their baseline or "default" non-mentalizing mode. Where you do you think that *you* spend much of your time? (e.g., rigid, externalized, disconnected)

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(7) When you are interpersonally triggered or extremely upset, is there a particular non-mentalizing mode that is your "go-to," to which you often revert?

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Experience of self-discontinuity; problem behaviors to restore coherence of Self

Self-injury, aggression, grandiosity, devaluation of others

We have been reviewing typical "non-mentalizing" experiences of individuals with personality disorders—namely, the tendency to experience themselves and others in externalized, rigid, and disconnected ways. When in the midst of these forms of thinking, they often also feel highly unstable, incoherent, fragile, and even as not fully *existing*. This state is the psychological "breeding ground" for typical problem behaviors.

MBT suggests that, while these behaviors of course cause negative consequences in people's lives, they often serve as a psychologically necessary attempt to restore a person's sense of stability and self-coherence. By working with patients to strengthen their ability to mentalize even when they are under stress, MBT helps them to feel more stable and in control of their own minds, which reduces the need to engage in the problem behaviors associated with personality disorders.

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(1) Please list the behaviors that have caused the most trouble for you and other people throughout your life. These can be things that you have engaged in by yourself (e.g., self-injury, addictive behaviors), or patterns that you have played out with other people (e.g., dependency on others, arguing, overachieving).

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(2) Identify one of those behaviors that has most interfered with your life. How do you usually feel *before* you take this action? How do you feel *while* you are doing it? How do you feel *afterwards*?

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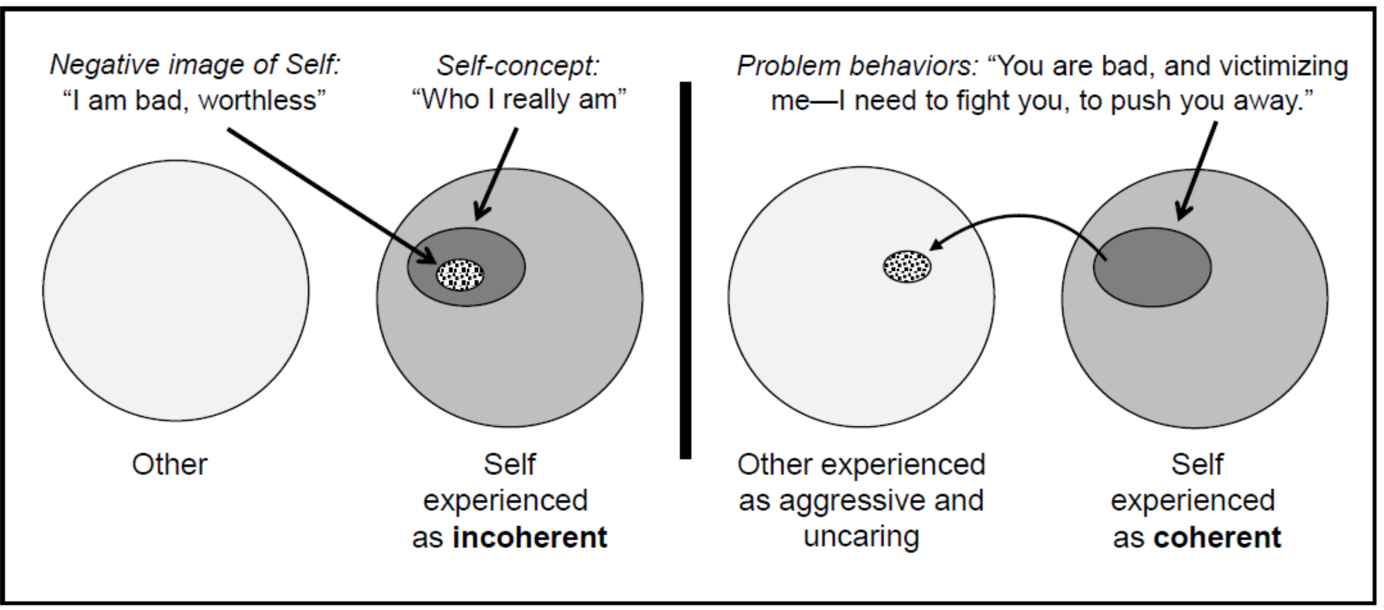
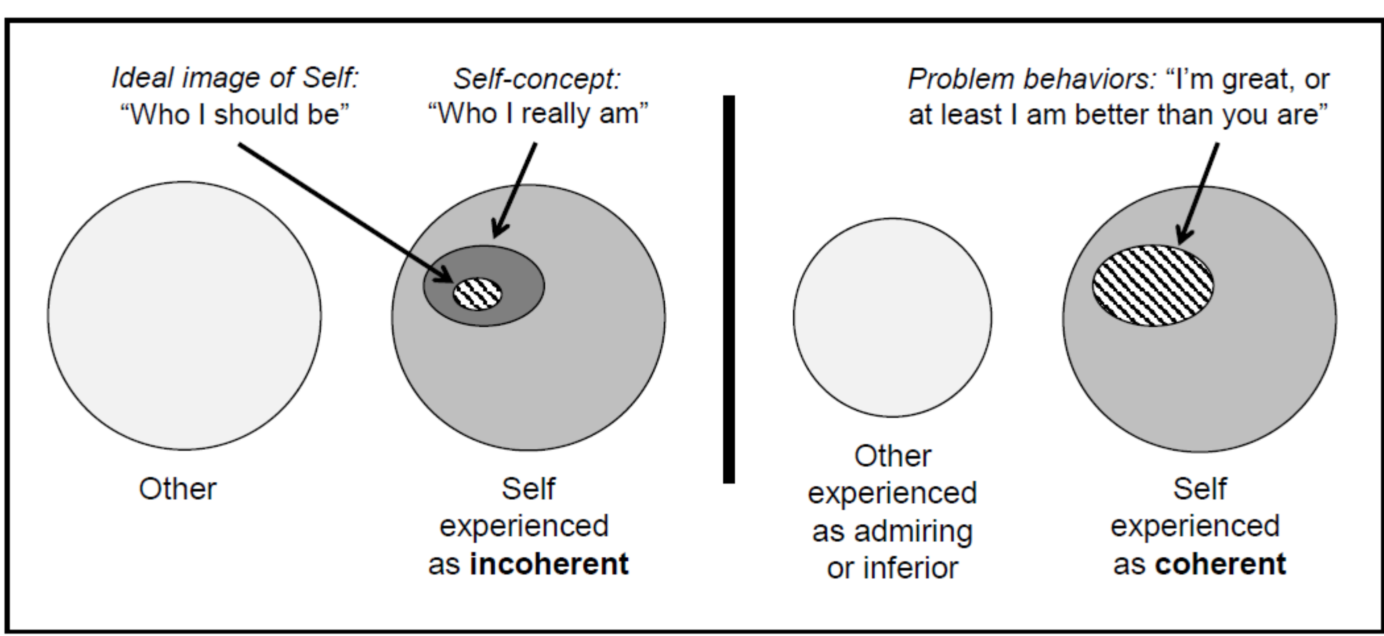
<u>Problem behaviors associated with borderline and antisocial personality disorders</u>
Self-injury; suicide; anger and aggression; devaluation of others; impulsive behavior



<u>Problem behaviors associated with narcissistic personality disorders</u>
Grandiosity; attention-seeking; competitiveness; perfectionism; pursuit of success, power, wealth, and fame



Notes

Homework for Week One

Take note of examples in everyday interactions where you or someone else appears to use their ability for mindsight (mentalising). That is, you or they attempt to understand the other person and/or themself as driven by underlying motives, thoughts, wishes and emotions.

OR

Note examples where you or someone else did not appear to use their ability for mindsight (mentalising);
i.e., did not attempt to understand underlying motives, emotions, etc.

Examples of mentalising

Examples of lack of mentalising

MindSight Contacts

Sector Team	
Consultant	
Case Manager	
Therapist	
Group Leaders	

SESSION 01

Introduction & Orientation

contents

Introduction to MindSight **P1**
The MindSight Programme **P2**
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Welcome to MindSight

Congratulations on your decision to join the MindSight programme - a treatment option of the Christchurch Community Mental Health Service for people with Borderline Personality Disorder.

Problems of unstable emotions, longstanding feelings of emptiness and unhappiness, painful crises, problems in relationships, self-harm, and suicidal thinking are best helped by treatment that does more than just respond to each problem separately. In this treatment option, members of your sector team will work with you to address the underlying issues with individual and group psychotherapy over the course of a reasonable period of time.

An important part of this treatment is the three-month MBT-i psycho-educational course exploring useful ideas about emotions and minds. For each session in the course, a handout will be provided with a summary of the group lesson, to give you a record of the training.

MindSight

Enormous areas of our brains are devoted to making sense of emotions, including making sense of other people. These processes are central to successful living. The human mind has the ability to perceive minds - to know one's own mind and to be able to perceive the minds of others.

This ability is called "mindsight"; or (the more technical name) *mentalising*.

It is the ability of the human mind to see itself, and to be able to perceive the minds of other people. That is, when we attribute intentions to each other, when we understand each other and ourselves as driven by underlying motives and recognise that these take the form of thoughts, wishes and various emotions, etc.

From the moment we're born, our most important relationships shape neural circuits of the brain that allow us to understand and empathise with others and feel their feelings.

When this fundamental capacity to understand what is going on in one's own mind and in the mind of others is disrupted, the result is emotional instability, inner emptiness, chronic despair and isolation, and the use of desperate measures such as self-harm, impulsivity and substance misuse in an attempt to manage this unhappiness.

The MindSight programme is about developing this ability so that there is emotional stability and inner strength and happiness.

MINDSIGHT
TREATMENT PROGRAMME FOR BORDERLINE PERSONALITY DISORDER

The MindSight Programme is a treatment service that operates within Community Mental Health Teams. The programme adds to what is offered in teams but does not replace usual treatment processes. You will still have regular Psychiatric reviews with a Consultant Psychiatrist, have a Case Manager, etc., but your treatment will be coordinated through this programme.

The aim of the programme is to provide a period of time during which there is more support and input to help you make a start at understanding and changing how you cope with unstable emotions. Involvement in the MindSight Programme is expected to provide the sort of input that will help you to take significant steps in your recovery, so that at the conclusion of this treatment period, you might well be discharged. For some, the programme will be one step of many.

The programme provides treatment based on the Mentalisation-Based Treatment (MBT) approach. This treatment approach focuses on improving emotional awareness of oneself and others so that responses to situations and people are less automatic and reactive, and more reflective and flexible.

At regular intervals (every 6 months), a number of questionnaires will be completed. The questionnaires are a way to record your experiences in detail and help you and the MindSight team to monitor changes in symptoms.

All therapy sessions will be recorded so that the work of the therapists can be reviewed. Supervision of therapists is a guarantee that people in the programme are getting the best treatment we can deliver. The recordings will only be reviewed by therapists and supervisors in the MindSight Programme and not by other members of sector teams. They will be stored securely and erased after review.

The programme is coordinated by a Clinical Supervisor (Robert Green) who works with the treatment teams and therapists as additional clinical input. Robert can be contacted (at North sector—363.1950) if you have suggestions or concerns about the programme generally.

The goal of the group is to learn about mindsight (mentalising), emotions, attachment, interpersonal interaction and mental health. There will be a total of twelve groups. Some reading material and homework activity will be used.

These groups are educational. You will not be asked to go into depth about personal problems. Such work is undertaken in individual therapy and the group therapy sessions that follow later.

Everyone in the group comes with a history of hurt in relationships, and fear of being hurt again. It is very important that the group works to develop the type of environment that supports growth and change, and does not recreate hurtful experiences . In these groups, the leaders will be active in encouraging constructive interactions. The focus is on observing one's own reactions and mind, and on understanding the reactions and mind of others.

Regular attendance is expected. Always notify ahead of time of any absences (sickness, holiday, etc.). It is important for group cohesion that everyone is present at every session.

Information shared in the group needs to be kept in confidence by members of the group. Group leaders will liaise with other team members as required.

Violence and threats are not acceptable and may result in time-out or discharge from the programme.

Group members are discouraged from developing intimate/sexual relationships with one another as such relationships can cause emotional difficulties and tension within groups.

Self-harm that needs medical attention is to take priority over group attendance and group members are asked to be mindful of the impact of self-harm on others in the group.

MAKING THE GROUP WORK FOR YOU

Actions that build group cohesion:

- turn up to meetings and stay to the end
- be willing to get to know others in the group
- listen carefully to others
- ask questions to clarify ideas and emotions
- comment on interactions in the group
- be willing to self-disclose
- communicate opinions in a way that respects others
- pay attention to the feelings of others
- give and receive feedback
- be willing resolve misunderstandings and conflict
- help each other learn
- give support when someone is under pressure

Homework for Week Two

Notice when people assume they know what you are thinking and how you are feeling. Also notice times when you do the same to other people. (You will be practicing noticing mentalising in yourself and other people). Bring examples back to group next session.

Examples of assumptions about you

Examples of assumptions about others

SESSION

02

The Amazing Ability of MindSight

Harnessing the Power of MindSight

In this treatment programme, we will concentrate on learning –

- how to recognise **reactions** as *just that* – automatic signals that tell us about an old pattern of understanding,
- how to calm the emotional **responses** triggered by reactions and use them as information that can be helpful to ourselves and those we are interacting with,
- and how to take the time to **reflect** on what is behind our experience (thoughts, feelings, wishes, etc.) and the experience of others

... so that there are fewer emotional ups-and-downs, less need to use harmful methods to manage upsetting feelings, and more rewarding communication with others.

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How Minds Work

The brain is essentially three brains - the brainstem, the limbic system, and the cortex. These three brains are quite different.

The **reptilian brain** is at the base of the brain (the brain stem). It regulates basic body functions to maintain life, adjusts arousal level, and reacts (instinctively) to basic sensory patterns. Its primary directive is survival and its basic functions are concerned with avoiding danger, finding food and procreation.

The **emotional brain** is deep in the centre of the brain (the limbic system) It processes, interprets and integrates emotions. Its primary function is to monitor, comprehend and build emotional connections to improve our chances of survival as part of a social network.

The **thinking brain** is the wrinkly cortex that surrounds the limbic system. It has 50% of all neurons in the brain. It interprets and appraises both outside information (eg understanding the situation) and inside information (eg, evaluating feelings and emotional reactions). It is the centre of thinking and reflection. Its primary directive is to process, analyse and store information.

While each has its own specific primary function, they work together

CORTEX

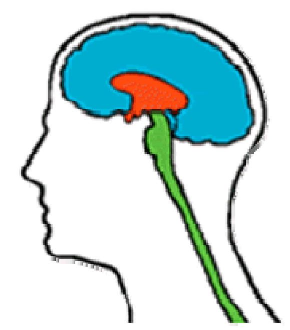
Analytical mind

LIMBIC

Emotional mind

BRAIN STEM

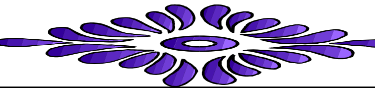
Instinctive mind



rational thinking, planned action, foresight, abstract thought, reflection

emotions, attachment, sexual behaviour, motor regulation

arousal level, appetite, sleep, blood pressure, heart rate, body temperature

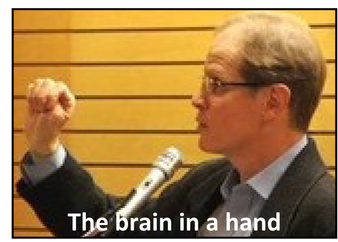


Our actions emerge from the interplay of the instinctive, intuitive **reaction** of the brain stem, the impulsively emotional **response** of the limbic system and the rational **reflection** of the cortex.

Mentalising involves understanding and reflecting on emotional responses and the automatic reactions behind our responses; as well as reflecting on what responses and reactions might be behind the behaviour of other people.

Each of the three brain systems becomes most organised at different stages during our development. The way they grow and change depends on how much they are exercised.

Functions controlled by the


The brain in a hand

instinctive mind are affected by impacts at the earliest stage of development. Functions controlled by the emotional mind are affected by impacts during our formative years, when we are most dependent on our earliest relationships. Functions controlled by the analytical mind are affected by experiences later in development and are most open to change through experience.

As the brain develops, it analyses and processes events, creating memories (or templates – patterns by which we make sense of experiences). These templates simplify the interpretation of experiences – helping us to survive by immediately recognising danger signals. The brain tries to match information against previous templates rather than analyse each new situation from scratch. Our earliest experiences provide the first templates by which the brain analyses on-going experiences.

If we only ever react to the template, and don't reflect on it to see if it is an accurate interpretation, the template gets stronger. However, if we take time to reflect on the present moment as *it is*, not how we think it is, the template can be altered—freeing us from past hurts.

EMPATHY & SYMPATHY

When we mentalise ourselves, another person or a situation, we use our capacity for empathy to recognise emotions. This is different from sympathy.

In sympathy, we share distressing feelings that someone is expressing, (usually with which we agree). In empathy, we also sense feelings not being expressed and attempt to understand feelings with which we might not agree. Sympathy is our own emotional reaction to the feelings of another while empathy is *feeling into the experience of another in order to understand them*.

"You never really understand a person until you consider things from his point of view, until you climb inside of his skin and walk around in it."

Atticus Finch in *To Kill a Mockingbird* (1962)

Our ability of MindSight is like a mental muscle. To develop it and keep it strong, it requires *exercise*. That is, we need to use it to strengthen it—which requires us to practice mentalising whenever we can. You can practice (and strengthen) your ability to mentalise by regularly picking an interaction with another person where you answer the following questions in your mind -

1. What sensations am I experiencing? (What's my automatic reaction?)
2. What emotions am I feeling in response to the interaction?
3. What emotions can I sense or imagine in the other person?
4. What assumptions, attitudes or beliefs do I have about the other person?
5. Can I come up with at least 3 different "takes" on what is happening and why ?

How would you like it if the mouse did that to you?

Empathy

“How can we know what is in the mind of another person?” One powerful tool for understanding other people is empathy - recognising and understanding the emotions of others.

Empathy has two sides – **tuning-in** (watching the facial expressions and body language and noticing how we feel in response to what we notice) and **imagination** (using our imagination to *put ourselves into the shoes of another person* to see how things look and feel from their perspective).

TUNING-IN

The sense called intuition has a real physical basis. Human (and primate) brains have special nerve cells called “mirror neurons”. These react whenever we watch another person do something that has intention behind it – whether an action or an emotion. This means that the same part of our brain is active as in the brain of the person we are watching – allowing us to gain some sense of what is in their mind.

Take a look at the picture below—do you find yourself yawning or wanting to yawn? That’s the effect of mirror neurons working.

When we attend to a person’s face, we can start to read the emotional experience behind their words and actions. As we tune-in to their emotions, we can understand what might be behind their actions and experiences.

IMAGINATION

We have the capacity to imagine ourselves in situations different to our actual experience. Every book, film, play, or song uses imagination to create a fantasy about a person’s experiences.

When we use our imagination to place ourselves inside the experience of another person (ie, imagine what it would be like to be in their situation, with their outlook), we can then feel something of how the world feels and looks to them – giving us a direct physical experience of what they might be experiencing.

To use our imagination to “put ourselves in the shoes of someone else”, we have to temporarily suspend our own view of the world. This is the hard part – to temporarily put aside how we see things to imagine a different perspective.

BRAIN, MIND & BPD

In the triune brain, the upper parts of the brain are responsible for organising the lower parts. This ability develops with age.

A three year old has a relatively newly formed and disorganised cortex. At this age, a child has a difficult time organising the reactive emotions driven by the brain-stem and may throw things, kick or bite when frustrated. In contrast, an older child with a more developed cortex, may feel like throwing, biting or kicking, but will have developed the capacity to express these emotions in more organised ways (eg with words).

For some people, experiences with their family have not shown them effective ways to handle and respond to emotional difficulties. They lack adequate templates or automated ways of responding that effectively deal with such problems – ie these abilities have not been fully ‘built in’. They might work well-enough when things are going well, but when presented with stressful situations, crises or perceived threats, emotions quickly escalate as they lack adequate templates for how to manage emotions.

Because it is much harder to access problem-solving information when we are highly upset or feel threatened, the high emotional arousal disrupts mentalising and people turn to <u>external</u> coping mechanisms to reduce the emotional arousal in the absence of <u>internal</u> coping mechanism. External coping mechanisms may include self-harm, overdoses, drug and alcohol abuse, abuse of medication, or impulsive behaviour such as excessive shopping or promiscuous sexual behaviour.

In some cases, these actions further inhibit the cortex, making the brainstem and limbic reactions more dominant. eg most people are familiar with alcohol producing “Dutch courage” – a temporary but unrealistic increased sense of confidence that results from the cortex being inhibited.

It is not that people with BPD do not have coping mechanisms. It is that their coping mechanisms go ‘off line” when they are highly aroused, and become much harder to access. BPD is thus a type of disruption to normal development.

Discovering that everyone has a mind

It seems people take for granted that everyone has their own mind. Though sometimes we forget this and act surprised when someone likes or wants or does something different from what we like, want or do!

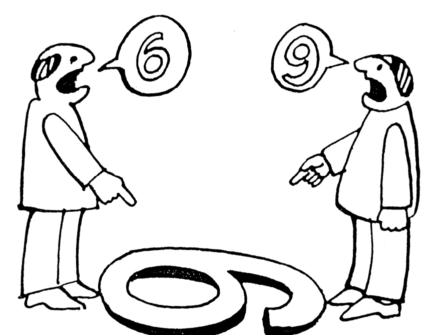
We say, “I don’t understand why you want to do that!” or “What do you mean you don’t want to come?” – as if it is incomprehensible to us that something different is in the other person’s mind. And yet we easily recognise that a child, or even a baby, can think differently when we say things like, “she’s definitely got a mind of her own!”

Despite this, it turns out that we start out in life assuming that all minds think alike; and it is very hard for us as young children to understand that another person might have a different mind from ourselves.

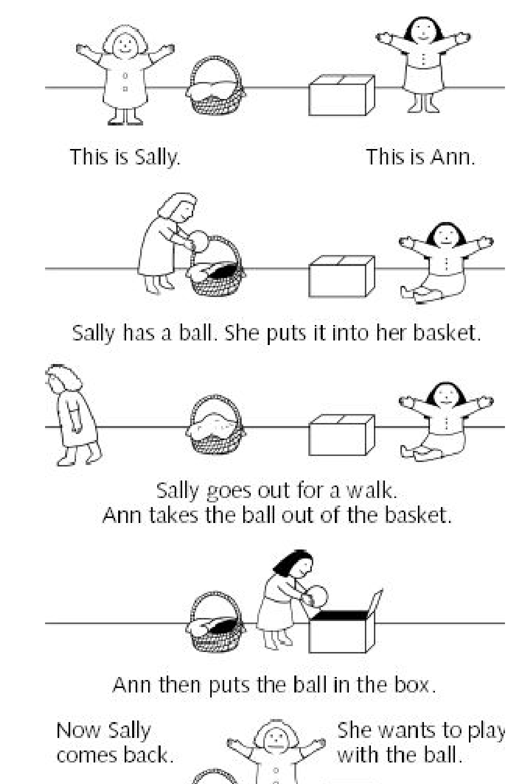
The beginnings of mentalising seem to emerge around 4 years of age, when a profound change occurs and we start to understand that another person might have a different idea in their mind from what is in our mind. As this new ability emerges, we begin to problem-solve situations using not only what we know in our mind, but are able to take into account that the another person might have something different in their mind - when we are working out what they might do or how they might react.

So, the first thing to recognise about mentalising is that it involves seeing that another person has a separate mind from yourself - that what they are thinking, what they like, what they want, what they are feeling, is different from yourself.

One of the first things we need to pay attention to as we learn to cope with emotional ups and downs, is learning to remind ourselves that everyone has a separate mind; and that we can’t assume we know what is in the mind of another. Rather, to figure out what another person might do or how they might react, we need to find out what is in their mind.



How to test if a child understands that other people have their own mind



Children change in how they react to watching this story. A child lacking in mindsight will only see the situation from her own point of view, and suggest that Sally will look for the ball where it actually is: in Ann's box. A child with mindsight will realise that Sally doesn't know that Ann has played a trick on her, and will therefore look in her basket for her ball, and discover it missing. Very small children are not able to solve this test, since it takes time to develop the understanding that what is in your own mind is not necessarily what is in the mind of others—minds are separate. But most children are able to do this by 6 or 7 at the latest (and some as young as 3).

Homework for Week Three

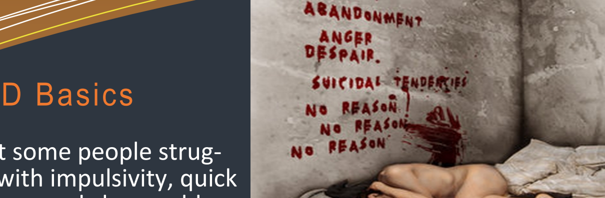
Over the coming week, make a note of the BPD symptoms that you find to be most problematic for you; as well as noting which symptoms are not problematic during the week.

Symptoms that were a problem

Symptoms that were not a problem

SESSION 03

Understanding BPD



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BPD Basics

That some people struggle with impulsivity, quick temper and changeable moods has been recognised since the early Greeks. In the 1600's such problems became a recognised medical disorder that 100 years ago was given the name "Borderline" - as the symptoms overlapped with *neuroses* (mood problems) and *psychoses* (thought disturbances).

In some parts of the world, BPD is called *Emotionally Unstable Personality Disorder*, and in China it is called *Impulsive Personality Disorder*.

In the West , it occurs in about 1—3% of the population, and is 3 to 4 times more common in women.

The suicide rate is from 8 to 10%. Alcohol abuse doubles the risk as it increases impulsiveness.

Once, people took over 14 years to overcome the disorder. Now, if suicide is prevented, people can recover in half that time. Faster still with the right treatment.

What does the diagnosis mean?

BPD is one of a number of personality disorders that can be diagnosed. There are several symptoms that might indicate BPD. For the diagnosis to be made, at least 5 of the following must be present as part of prolonged disturbance of personality functioning (ie, not as short-term problems).

1. Difficulties with being alone and distress associated with being abandoned.
2. Intense and unstable relationships, alternating between extremes of idealisation and devaluation.
3. Identity problems such as fluctuating self-esteem, unstable self-image, constant changes in life-goals, difficulties in holding on to one's inner core self.
4. Impulsive risk-taking that can be self-destructive.
5. Self-destructive acts such as self-mutilation and suicide attempts (to reduce painful emotions).
6. Unstable mood.
7. Recurrent feelings of inner emptiness and meaninglessness.
8. Intense anger that is difficult to control.
9. Reacting with suspiciousness or a feeling of being outside of oneself when stressed.

TREATMENT PROGRAMME FOR BORDERLINE PERSONALITY DISORDER

Who says my personality's disordered?!

ANSWERING DIFFICULT QUESTIONS ABOUT BPD

Why do we have to call these problems a mental disorder?

Over the years, physical and mental problems have been understood in a number of ways. In early societies, unusual behaviour and experiences was taken as a mark of divinity or special power. Sometime later, the same things were taken to mean the person was possessed or cursed. Later still, it was taken as a sign of moral failure. It is only in recent centuries that that physical and mental problems are understood to be the result of something wrong with the body/mind.

Attempting to understand mental problems this way is called the "medical model". It has helped to identify common patterns and name problems so that people can study and understand them, as well as helped identify treatments to specific disorders. Just as important, this approach has removed personal stigmatisation – people aren't possessed or evil or morally weak for having mental problems, they have an illness.

If my personality is disordered, doesn't that mean there's something wrong with me as a person?

This is an easy misinterpretation to make and it happens because the words *personality* and *disorder* have technical meanings in science as well as having everyday meanings. The term *personality disorder* has a specific meaning in science that does not imply a judgement about a person. It means that the problem lies in the way the personality of a person has formed, and that the problems are long-term issues.

Plus, the diagnosis is made by reference to only nine specific problem areas. A person has many hundreds more facets to them as a person than just these few experiences. So, while it is so that having any five of these experiences indicates the presence of BPD, there are hundreds of other aspects of a person that are strengths, resources and positive traits. Whether there is something "good" or "bad" about you as a person overall comes down to your choices you make about expressing these traits.

A group of French psychiatrists have noticed a remarkable similarity between Anakin's problems and the symptoms of BPD, giving a new twist on understanding his troubled life story.

In their view, Anakin seems to meet several criteria, enough to be diagnosed as BPD -

Criteria 1—abandonment
Losing his mother seems to be the basis of all his actions. He wanted to become so powerful that he'd be able to keep people from dying because he couldn't tolerate losing them.

Criteria 2—unstable relationships
His relationships with his masters (Jedi) swung from love to hatred. He swung from adoring Padme to being willing to kill her.

Criteria 3—identity problems
Unsure of who he was and what he wanted.

Criteria 4—self-damaging impulsivity
Pod racing as a child. Unnecessary risks in battles. Impulsive actions.

Criteria 8—anger problems
Uncontrollable anger after his mother died. Frequent arguments with Council members.

Criteria 9—transient paranoia or dissociation
Dissociated after his mother's death and when his wife abandoned him.

Just as when a group of psychiatrists diagnosed Princess Diana as having BPD, this suggestion has caused quite a debate amongst fans. What do you think? Do his actions and problems match the symptoms well-enough?

Interestingly, even the fans who dismiss this analysis agree that he meets criteria for a diagnosis of Narcissistic Personality Disorder! (Anakin displayed behaviour consistent with all criteria for NPD—he had a grandiose sense of self-importance, was preoccupied with fantasies of unlimited power, believed he was special, required excessive admiration, expected favourable treatment and automatic compliance with his wishes, took advantage of others to achieve his own ends, lacked empathy, was envious of others, and was arrogant).

Treatment for BPD

There are no quick cures for BPD. And there is no medication that will *fix it*. But there are now several therapies that have good evidence to show that they help resolve BPD symptoms.

The therapies that work all take time—from 1 to 3 years before the most serious problems are helped. It seems that short-term treatments generally don't help at all.

Because BPD is really about normal personality development being slowed-down by negative factors (such as abuse, neglect, invalidation, etc.), the main role of a treatment programme is to get personality growth back "on track". This is mainly by replacing coping patterns that are self-destructive and isolating with ways of coping that don't interfere with growth and which encourage relationships. Once things are on track again, people can enjoy their lives and, over time, their personality development catches-up—with growth continuing after completing a treatment programme.

Currently, there are four therapies with solid evidence that they bring meaningful changes to people with BPD.

The two that have been most studied are Dialectical Behaviour Therapy (DBT) and Mentalisation-Based Treatment (MBT). These are the two therapies in use in NZ mental health teams.

The other two therapies are Schema-Focussed Therapy (SFT) and Transference-Focussed Therapy (TFT). These are not in use in NZ as no teams have been trained in their use. However, some individual therapists have been trained in SFT and offer this in private practice.

In addition, there is also good evidence that follow-up by a community mental health team who have staff trained to understand BPD is also helpful. One to two years of such support can help stop self-harm and stabilise mood.

The key factors for good treatment are: 1) that the therapist is trained to work with BPD; 2) that their involvement is long enough to support change (1-2 years); 3) that they follow a consistent approach that fits the individual; 4) that there is support to manage crises; 5) that any factors related to the development of BPD are addressed at the appropriate time (eg, past trauma, emotional neglect).

Sometimes, depression, anxiety, and other disorders can be assisted by medication, but this is not always

If my problems are about how my personality was formed, doesn't that mean that I am going to be like this forever?

Not at all—because another part of the technical meaning of *personality disorder* is that the disorder has to do with personality development being held-up or delayed. Over time, the personality is still growing and changing and many aspects of personality can "catch-up" - even if it takes longer than for people without these problems. As long as the harmful side-effects of the disorder are reduced (i.e., self-harm, suicide, anger, withdrawal), basic personality functions will slowly grow/mature.

BPD is often known as "the good outcome diagnosis". Provided harm is minimised and support is available, the majority of people with BPD recover to the point that they would no longer meet criteria for the diagnosis. Plus, recovery is faster if you engage with a proven treatment . In particular, the changes that come about by developing and strengthening basic personality functions such as mindsight (mentalising), enable personality growth to occur. In overseas studies, people followed-up for 5 years after completing mentalising treatment continued to improve until almost all symptoms were no longer present.

Why do my problems have to be called BPD? Isn't that negative?

The descriptive labels used in Psychiatry help separate one type of problem from another so that the right treatment option can be provided to each one. But the diagnostic labels used today are still evolving and might well change in the future. A label is useful but it is just a label. New labels have been proposed—eg, Post Traumatic Personality Disorder, Emotional Instability Disorder, etc. Whatever we call it, this disorder of personality development is a real psychiatric disorder for which there are now useful treatments.

Why do people with a personality disorder get different treatment from people with Depression or Anxiety?

Researchers have discovered that the major groups of mental health disorders differ from each other in important ways. Psychotic disorders are different from anxiety disorders which are different from mood disorders, etc.

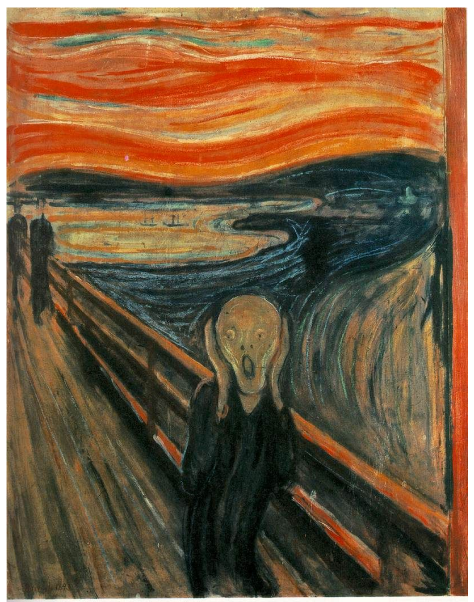
Personality Disorders are different again in that they arise from a combination of genetic influences (temperament, tolerance of stress, etc.) and negative environmental influences during childhood that affect the way a personality develops through adolescence and adulthood. Normally, "good enough" family conditions help us develop certain core features of personality (eg, sense of trust, ability to attach emotionally, self-confidence, self-worth, self-efficacy, emotional regulation, communication skills, mentalising) that enable us to withstand the usual challenges and problems of life.

However, negative experiences (such as early trauma, emotional neglect, sexual

abuse, family disruption) can disrupt the development of these basic personality functions, especially in families where emotional intelligence (mindsight) is low. And in some cases, certain inherited traits in temperament can make a person more vulnerable to these negative effects.

When some of the basic functions of personality are disrupted (trust, attachment, self-confidence, self-worth, emotional regulation, etc.), it causes problems in relationships, schooling, work, etc. that in turn, generate more problems and negative experiences (eg, being extremely shy, suspicious, dependent, volatile, avoiding all conflicts - resulting in negative beliefs about oneself and others, and desperate ways of coping that alienate a person more). Consequently, in a *personality disorder,* the development of a person's personality is "off-track" and they are stuck in ways of coping that disrupt their development from getting back "on track". This can't be fixed with a pill, It requires new experiences that help the person to learn trust, self-worth, self-awareness, emotional regulation and mentalising.

People with BPD are often also depressed or anxious. However, the depression or anxiety comes from and the things that are not working in their life; so medication (while sometimes useful) will not resolve depression and anxiety until the underlying issues are resolved.



S T I G M A

It has to be faced that BPD has been associated with stigma in the minds of some people. Stigma has arisen for a number of reasons –

Stigmatising people who are different from the social norm is a primitive way of coping with difference and appears to have been a common social defence in societies that are not psychologically-minded. All sorts of sub-groups of people have been stigmatised – eg, Jews (in Nazi Germany), Christians (in ancient Rome), certain castes (in India), gay and lesbian people, etc. Stigmatising people with mental health problems is part of this longstanding social problem.

Since it wasn't until recently that a reasonably sound understanding of the causes of BPD was uncovered, some of the stigma appears to have arisen because people didn't understand the disorder (ie, they avoided/rejected what they couldn't understand; just as with any stigmatising).

Studies have shown that stigmatising is more associated with a belief that mental illness is a fixed genetic condition and is dangerous, than when people understand that mental problems are explained by social and environmental factors. It has taken a while for this understanding of BPD to develop.

In addition, for many years there wasn't a treatment that worked for BPD. Mental Health staff felt helpless and some blamed the patient for the lack of change.

Finally, the symptoms of the disorder (anger outbursts, impulsive and changeable decision-making, rapid changes in mood, etc.) create problems in everyday relationships (including relationships with professionals). Not all professionals are trained to see these relationship problems as part of the disorder.

Stigma against mental health problems, or any specific type of mental health problem, is the result of ignorance and prejudice. It indicates a less-than-professional attitude. Stigma of any sort (eg, against race, sexual orientation, religious faith, etc.), needs to be challenged and overcome by education.

In the end, avoiding the diagnosis because some people misunderstand it will only end-up reinforcing stigma.

Homework for Week Four

Over the coming week, make a note of how you react if you experience being let down, misunderstood, or overlooked, (by someone in the group or by someone close to you).

Experiences of being let down, misunderstood, or overlooked

SESSION

04

Understanding MBT

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Confidentiality

It is important that there is safety regarding the things disscussed in therapy.

- Don't disclose anything discussed in group that relates to another person to people outside the group.
- Group therapists will not ordinarily mention in the group anything that was raised in individual therapy. It's up to each person what and when to raise things (except high risk issues).
- Be aware that all therapists in the programme will share information from any treatment session so that treatment is coordinated.
- Therapy will often be recorded for supervision of therapists. Recordings are only reviewed by MindSight team members . They are stored securely and erased promptly.

Mentalisation-Based Treatment

There is now increasing research indicating that difficulties with mentalising are the central problem in BPD. In MBT, the work in individual and group therapy is aimed at strengthening these abilities.

Improved mentalising ability means that the person will have a more inner stability. That is, be more able to keep the reflecting part of their brain active when emotions arise, and more able to re-engage their reflecting skills if emotion overpowers their reactions. This makes a person less vulnerable to interpersonal conflicts, and better able to deal with challenging situations.

Mentalising improves by paying attention to emotional reactions in oneself and in others, and reflecting on the meaning of emotions with an open mind, in order to understand the reasons behind the actions of others and ourselves, and so communicate better.

In MBT, reflecting on interactions between therapist and client, and between clients in the group, provides here-and-now opportunities to practice mentalising, which strengthens the circuits in the brain that are involved in mentalising. In this way, blocks to the growth of personality are overcome and personal strengths develop to aid emotional self-management and resolve hurtful experiences.

How Treatment Works

What is it about talking that can make such profound changes through psychotherapy?

For people with BPD, there has often been a lot of talking but little change. Some of this arises because they have learnt not to trust people or their feelings are frightening—so they don't talk about the things they really need to talk about. Some of it arises because helping services offer advice, problem-solving, or control that doesn't engage the person's reflection on their emotional difficulties. However it has occurred, people with BPD often don't have much faith that further "talking" will help. So it is reasonable to look into *how therapy works* in order to understand how to make the most of it.

There is increasing evidence to show that the brain is changed in important ways by psychotherapy. It seems the changes occur because the talking is not "just talking", but is instead a special kind of talking that engages circuits in the brain that are under-developed – involving them in new ways that help the circuits to strengthen and function more automatically. As in an earlier session, circuits in the brain that fire together, wire together. So when we increase the use of brain functions that have been under-utilised, we are actually strengthening the connections in the brain

The type of "talking" that helps this process is based on research information about how minds and brains normally develop. First, we know that minds require other minds to develop. "Feral" children raised by animals never develop normal human minds and the full capacity for communication. We arrive in the world barely able to survive physically and without a mind. Relationships with care-givers are essential not only for physical survival, but also for psychological development.

Is About Relationships

both the different reactions we have to being in therapy as well as reactions to the therapist.

It is also important to focus on how the reactions between client and therapist can interfere with taking an interest in what is going on in one's own mind and the mind of others. So therapy will also involve talking about how therapist and client experience the interaction happening in the room.

INDIVIDUAL CHALLENGES

The central focus of mentalising relationship experiences can be challenging because of past experiences in relationships. In this therapy, this is understood and this difficulty is itself a focus of the treatment—taking care to explore with sensitivity how your personal history of relationships might shape your perception of relating to therapists and group members.

There are many reasons why this focus of MBT therapy might be challenging -

- Past relationships might have inevitably "gone wrong" in ways that interfere with being open to new relationships.
- The lack of relationships , or the traumatic ending of past relationships, may make the prospect of a treatment relationship that is planned to end at some point seem both pointless and painful.
- Feeling connected and caring about someone might create worries that they might care too much about the therapist or group members, or create worries about how much they are cared about.
- The feeling of being connected might lead to wanting more, and fears about becoming dependent.
- Having a working relationship with people might seem to require liking that person, which might not always be possible.

For treatment to go well, it is important that you discuss your thoughts and feelings about these themes with the group and your therapist.

Mentalising Therapy

Psychotherapy works on multiple levels. Along the way, through the process of talking about experiences and reflecting on reactions, changes occur in a range of areas – new information is learnt, difficult feelings are faced, new skills are learnt, automatic defences become less reactive, and fixed ways of perceiving oneself and the world become more flexible, etc.

MINDSIGHT NEEDS HUMAN INTERACTION

In this treatment approach, the central aim is to develop the capacity for mindsight; to re-start the growth of your ability to perceive minds (the thoughts, intentions, motives, emotions, etc. behind actions).

Mentalising only develops in the context of relationships, so relationships are central to how we can grow and strengthen this ability of our social brain.

While for some problems, it is possible to undertake a self-help course to learn useful skills for managing a problem (eg, anxiety), we can't grow our mentalising ability on our own. For the circuits in the brain that are part of this ability to fire and strengthen, we need to have our mind reflected to us, as well as engage our mind in understanding other minds.

For this reason, the relationship you have with your therapist and the relationships you have with members of the group are central to your treatment.

What do we mean by relationship? The usual meaning of the word relationship is tied-up with romantic attachments, family connections or close friendships. But this does not mean that relationships in treatment will be highly significant, powerful connections; possibly involving dependence. Perhaps a better word to use is experiences; or, experiences of interacting. So, a better way of describing the focus of therapy could be –"the experiences of interacting with your therapist and the experiences of interacting with members of the group are central to your treatment".

EXPLORING HOW WE ATTACH TO PEOPLE

Because these experiences of interacting take place over an extended period of time (at least 18 months of the treatment programme), this triggers our inbuilt programme to form connections. Just as "neurons that repeatedly fire together, wire together", so humans who interact together repeatedly form connections – also called attachment bonds.

Psychotherapy will automatically stimulate "attachment feelings" (both positive and negative). This is a normal process that can be very central to treatment – for how one feels about attachment, and the pattern of attachment that has developed as a way of coping in the past, will become apparent in therapy. Thus, it is important to reflect on

In order for mindsight to develop in childhood,

- We need someone to show interest in our mind (i.e., our thoughts, feelings, experiences, and our understanding of these).
- We need someone to reflect our inner life so that we can perceive it.
- We need a sense of safety around us so that we can risk not worrying about dangers and instead focus on understanding our experiences.
- We need manageable challenges to extend us beyond what we already know into new territory.

It turns out that providing the same things in a therapy setting also enables mentalising to grow. That is, a therapist who focuses interest on your thoughts, feelings and understandings; a therapist who helps you identify your feelings and reactions so that you can perceive them; a therapist who you can trust so that you can risk sharing innermost problems without fear; and a therapist who will gently push you to consider alternative explanations, information or experiences "outside the rut" of old habits.

How Individual Therapy assists Mindsight

Individual therapy provides an opportunity to talk about one's innermost problems with a person who will listen and respond in ways that encourage the development of mentalising. In this way, one becomes more aware about oneself and one's feelings and how one relates to others. Usually, a person with BPD has been left on their own to figure this out. Without an adequate "mirror" to help them see themselves, thoughts and feelings about their worth and how to relate to others can get "off-track". Individual treatment sessions provide a context in which the experiences that have shaped the development of one's mind can be explored and understood. As well, how relationships in one's life impinge on the person, and how they are understood, can also be explored.

But therapy also involves getting closer to others, and letting others into one's inner life; ie, daring to trust others, to make connections, to let someone become significant in one's life. This is not an easy process after experiences of hurt and mistrust in the past. Reconnecting requires careful attention to what is happening in one's own mind and in the mind of others. eg, How am I reacting to this person? Are they ready to accept me and my experience? Do they understand, accept and support me? Etc.

The mentalisation treatment approach focuses on developing the ability to perceive

and understand our own mind and the minds of others. Consequently, your therapists will provide little direct advice., but will focus on helping you develop your own solutions. MBT is a collaborative effort in which your therapists join you on the mentalising journey.

How Group Therapy assists Mindsight

People learn best by doing rather than just theoretical knowledge. To be good at something, you need to practice it. Mentalisation-based treatment is based on practicing mentalising skills together with the therapist and other group members.

Group sessions provide a context in which the experience of interacting with others can be explored; a place in which you can work at understanding how you operate as a person in relationships. In the interactions in the group, you can explore how misunderstandings occur, and learn how to discover different perspectives. Plus, the need for support and understanding, along with fear of closeness and hurt, is central to living. The group provides a useful medium to explore how to relate safely with other people.

As a training arena for mentalisation, the group requires the following from each group member -

- regularly talk about events from your own life; preferably recent events, that have resulted in poor mentalising (strong or confusing feelings, impulsive actions poor conflict resolution, etc.), or in which you have been subjected to stress (particularly in relation to other people) that put high demands on your mentalising ability.
- try to understand more about these events using a mentalising stance (exploratory, curious, open for alternative understandings, etc.).
- other group members will participate in this process by exploring their own problems and those of others through a mentalising stance.
- work at bonding to the group, its members and the therapists.

The first 3 months of group meetings is an educational group exploring topics related to mentalising. After that, the group focusses on mentalising what takes place in the here-and-now – both mentalising of past experiences as well as interactions in the group.

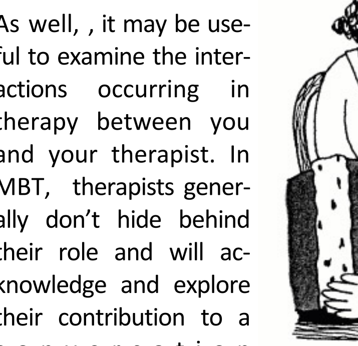
While some sharing of personal experiences will occur, MBT group therapy usually doesn't involve an intensive exploration of past personal history nor the sharing of common experiences as in a support group. In stead, the focus of the group is exercising our mentalising ability in understanding each other to strengthen mind-

THE JOB OF THE MBT THERAPIST

The focus of therapy in MBT is understanding your experience and helping you to mentalise more fully in an experience.

To do this, your therapist will be like a curious onlooker, exploring with you how you make sense of your experiences and relationships, or a coach, encouraging you to exercise your mentalising ability to its maximum.

The first priority will be to develop your ability to mentalise experiences in everyday life. Usually, life brings plenty of opportunities for exploration in therapy. Your therapist may contribute something from how they see or experience an issue – as an alternative for consideration.



As well, , it may be useful to examine the interactions occurring in therapy between you and your therapist. In MBT, therapists generally don't hide behind their role and will acknowledge and explore their contribution to a conversation (particularly if there is a misunderstanding).

MBT doesn't necessarily focus on part traumas. Sometimes, though, these hurts need to be mentalised and this might become part of therapy; but only when a person can *keep their mentalising on-line* in the face of strong emotions,

In order to focus on mentalising in the group situation, the therapists will sometimes stop further discussion and try to find out what is going on beyond the spoken words – eg, slow things down if things are going too fast; rewind to an important point so that it can be explored; create space for everyone to have a say; etc. It is important to listen to the therapists in such situations. In addition, the group leaders might focus the theme on aspects of how the group discussion is occurring – eg, common reasons for not opening up, avoidance of something obvious, etc. - as well as clarifying misunderstandings and emotional reactions (a central element in mentalisation-based treatment).

Homework for Week Eight

Take time to notice emotions - in others' eyes and faces; (eg, TV, films, magazines ,etc.); and your own emotions.

Make a note of at least one occasion during the week when you are able to effectively regulate an upsetting emotional state.

Observations of Emotions

Example of Regulating an Emotion

SESSION

08

Mentalising Emotions

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Perceiving Emotions P1
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Managing Emotions

The ultimate goal of treatment in MBT is to be able to make sense of emotional experiences whilst in the midst of them.

Once a person can make sense of their emotional experiences in real time, feelings become much more stable and a sense of connection develops that counters old feelings of isolation and distress.

This requires that people first pay attention to sensing emotional experience, identifying their emotions and communicating about that experience .

Along the way, it is also important to pay attention to one's level of emotional arousal, so that mentalising is not pushed "off-line" by too much distress.

PERCEIVING EMOTIONS

Mentalising emotions means listening to the information provided to us in our emotional reactions, rather than just "having emotions".

The first step in mentalising emotions is to pay attention to our own feelings and the emotional reactions of others.

Sensing our own emotions involves paying attention to bodily reactions and physical sensations. This often take efforts and patience to attend to body sensations and understand what they indicate.

To perceive the emotions of others, we need to attend to external signs of emotion – facial expression, body language, voice tone, as well as what is said. In addition, we can also perceive the emotions of others through empathy.

We learn this from our caregivers - ie, other people teach us about the meaning of our emotional experiences through empathy and understanding as we grow-up. So how we identify feelings is affected by the experiences we had growing-up. Some feelings might have been mislabelled as other emotions; or some feelings might not be acceptable to experience. For example, in some families, feelings such as anger, sexual desire, sadness, curiosity, pride are not viewed positively. The expression of these feelings is sometimes criticised or ignored. Learning that our emotions are valid is often the first step.

Blocks to Perceiving Emotions

Good emotional perception involves the ability to identify emotions accurately, to recognise emotions in others, and to identify false or manipulative expressions of emotion. If the person we are observing is masking what they are feeling with a different emotion, we might not perceive their emotions accurately. Or, if they inhibit their expression of emotion – usually by stilling or reducing the expression on the face - we may be confused by what we see.

Perceiving Our Own Emotions

Emotions are sensed by paying attention to body sensations. Particular sensations are often associated with certain feelings – eg, “lump in one’s throat” goes with being upset or emotionally moved; “pressure behind the eyes” goes with sadness or wanting to cry; “weak at the knees” goes with anxiety or apprehension; “hairs standing on end” goes with fear or excitement; “butterflies in the stomach” goes with anxiety or anticipation; “gritting one’s teeth” goes with anger or determination; “pressure in the head” goes with feeling overburdened; “sinking feeling the stomach” goes with loss; and so on.

Of course, people differ in how they register their feelings and how easily they can name emotional experiences - some people do so more easily than others. Regardless of your starting ability, taking time to attend to your feelings during the day, particularly in response to interactions and events, strengthens this ability. Stopping to ask yourself “how do I feel right now?” can be the first step to improving the ability to accurately assess your own emotions.

Identifying our own emotions might seem relatively straight forward - surely we all know how we feel! However, unlike other animals, humans have the ability to suppress their awareness of emotional reactions and/or mask the expression of what they are feeling.

Because of their upbringing, some people can be distanced from their natural, emotional reactions. This means a person can react emotionally, but not necessarily feel their emotions. That is, a person can be emotionally activated, but at the same time be unaware of the specific nature of the emotions involved. One can for example, feel heart palpitations or bodily unease without knowing why.

It is not uncommon for people to not recognise the early sensations of tension and emotional upset. Instead, they only realise they are stressed when they experience an extreme symptom (eg, headache, stomach ache) or find themselves behaving in an unhelpful way (eg, lashing out or withdrawing). Recognising early signs of emotions such as stress, hurt, anxiety or anger can allow us to develop more effect ways of managing our emotions.

This is often what contributes to the generalised distress experienced by people with BPD. Their bodies are reacting with physical signals but the meaning of the signals is not being received or understood. The physical arousal is distressing – firstly, because the state of balance is upset; and secondly, because the meaning of the signal is missing (ie, you know something is wrong but you don’t know what).

Perceiving the Emotions of Others

Clearly, we can’t perceive another person’s feelings directly (thinking that we could would be a sign of non-mentalising). But we can perceive emotion in others in two ways. First, we can perceive the body-language of another person and read the outward signs of what is

(so that we can stop and attend to that), and signals to those around us that we need caring for. When we were small, this was very important for our survival because it brought other people to our aid. An important avenue for emotional regulation is through interacting and sharing with others. Almost everyone has an innate knowledge of how to comfort, support, soothe, calm, reassure, encourage, other people. So an important avenue for emotional regulation is contact with others.

Sometimes though, the level of distress may be so high that it’s very difficult to engage in self-reflection. What might be needed is action to reduce the level of arousal. It’s OK to remove yourself from the situation as a way to lower the emotional intensity. A list of possible activities to bring some positive experiences and pleasure can be useful. As can taking time to recall to mind past pleasurable experiences, achievements, successes, etc. Switching to problem-solving mode to find solutions to a problem engages a different mode of thinking that can often disengage the emotional impact of a situation. Generating ideas that might resolve the problem (brainstorming and weighing up their worth) uses your rational thinking skills and this can calm emotional reactions; partly because it also re-establishes mastery in the situation.

As we discussed in an earlier session, the brain more quickly recalls negative experiences (which brings back negative emotions) – simply because it is hard-wired to quickly learn which things are dangerous (bad). So sometimes, we just have to redirect our minds to not stay stuck on negative memories, so that we can *in the moment* escape the tyranny of the past. Making a conscious decision to use distracting tasks to manage your mind when it won’t stop thinking about certain things is a mentalising action – it is you thinking about your mind and what you need, and you taking action to look after your mind.

Of course, if the only way of coping was to distract from emotions, that would be a superficial way of coping and living. But as a strategy to use from time to time, everyone needs this. For example, when the excitement of something prevents us getting to sleep, people read boring books to shut their mind down and make themselves drowsy; when people feel stressed and start to worry too much, they do an activity (play a computer game, watch a movie, listen to music) to “take their mind off it”; etc.). Learning to “manage your mind” is part of mental control that is essential to mentalising.

Whatever we do to manage our emotions, the key principle is to be guided by the aim to minimise harm to ourselves and maximise the opportunity for mentalising, or regaining mentalising. ie, the test of whether a physical action/activity is a mentalising way of managing our mind involves three questions –

a) Is it freely chosen (it is not impulsive or compulsive)?
b) Does it minimise harm (it is beneficial)?
c) Does it help restore mentalising?

Using this as a guide, choosing to go for a run to burn off high levels of adrenalin can be a helpful way of coping with intense anger so that we can be calm enough to reflect on a conflict with someone. Using medication to stabilise neurotransmitters affected by depression or abuse can be a way to increase mentalising ability.

REGULATING EMOTIONS

In BPD, emotional reactions are triggered more easily, are more intense, and last longer. As a result, emotions seem frightening and uncontrollable. People then avoid engaging their emotions; but this underuses their mentalising abilities and so these brain circuits don't get exercised.

Because emotions are more unregulated, the message from other people is often – "Get control over your emotions!" or "Stop being so emotional". However, simply avoiding or suppressing emotions is not a helpful strategy. In fact, it seems to produce even more distress. Rather, the opposite is true. Emotions are regulated by attending to them - by using mentalising to understand minds (thought and feelings).

However, the stronger our emotions, the more our mentalising ability can go "off-line". So we first must pay attention to our level of emotional arousal and the signs of non-mentalising in case we need to explore ways to lower distress so that we can start mentalising again

The simplest way to do this is to pause and reflect on what is happening – whether with another person (someone we can trust, like a good friend, therapist or in the group) or with ourselves. For as soon as we start to think/talk about our mind and what we are feeling, we have actually started to mentalise again.

Questions to re-start self-reflection include –

- What am I experiencing/feeling/thinking?
- What might the other person be experiencing/feeling/thinking?
- What could be the motives, intentions, beliefs, wishes behind the other person's actions? Can I think of several possibilities?
- Is there another way I can understand this situation?
- What are the things I automatically think or assume about this situation or event and what feelings do they create? Are any of these old experiences that shape how I react? Can I explore some of the things I automatically assume to see how accurate they are?
- What are my needs in this situation? How can I get them met in an assertive manner?
- Can I just attend to what I feel and accept that this is what I feel, without having to act on it?
- Is this an experience I often face in some form or another? What might I need to do differently to master the challenge?

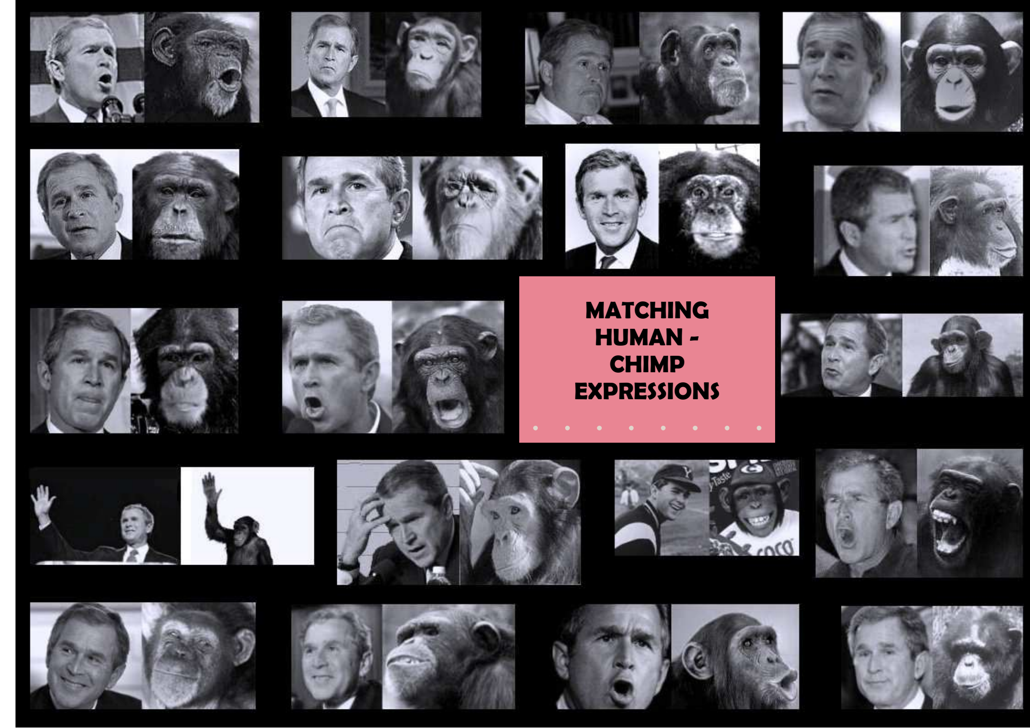
The purpose of distress seems to be that of signalling our need for support or comfort – it tells us that something is emotionally wrong

being experienced internally. It turns out that body posture, gesture and facial expression are very similar across all cultures for the basic emotions – especially facial expressions (which are even, to a degree, common across species – well, chimpanzees at least!).

The face has been called "the mirror of the soul" because facial expressions so powerfully reflect our emotions – allowing other people to read what we are feeling with just a glance. Indeed, there are special areas in the brain devoted to recognising and interpreting faces, allowing us to do this in the blink-of-an-eye. Because the expressions for the basic emotions are so similar across all cultures, it is possible to describe the key markers for several emotions.

Second, we can understand emotions of other people with empathy. Our brains have special neurons called "mirror neurons". These neurons fire whenever we observe another person doing something that is goal-directed or expresses an emotion. So, although we can't actually feel what another person feels, we can feel a *reflected* emotion created in our minds that resonates with the person we are watching. These nerve cells enable us to experience what someone else is experiencing when they do or feel something. eg, when we see another person feeling sad, we become sad ourselves. Through this , we can figure out what someone is feeling is by noticing our own reactions.

However, this may not be precise, because we can have our own **reaction** to the emotion of another person - and that emotion can distort our perception. So when we mentalise others, we need to keep an open mind that we might not perfectly know what they are feeling.


MATCHING HUMAN - CHIMP EXPRESSIONS

STRENGTHENING EMOTIONAL PERCEPTION

Emotions are the signals from the fastest processing in the brain that guide us about survival issues – to approach or to run, to enjoy or to reject, etc. Emotions are the values attached to experiences that make things important and memorable. Consequently, being able to perceive and understanding emotional signals in ourselves and in others is vital to communication and relationships. Before we can effectively use, express and regulate our feelings, we need to develop our ability to perceive emotions.

For most people, this happens naturally through "good enough" family life. But when there is rejection, neglect, abuse, invalidation, there can be gaps in one's automated emotion sensing system. As noted in an earlier session, this need not be a permanent deficit, as it is more that some brain systems are underdeveloped than that they are missing. So what is needed is a conscious effort to practice emotional awareness to strengthen the innate emotion sensing system.

The following are some steps you can take to strengthen your ability to read emotions.

STEP ❶ Become aware of your own emotions. By recognising what you are feeling and it's impact on you, you increase your ability to read emotions—in others too. Take time to ask yourself – "What am I feeling?" "What sensations am I experiencing?" "How am I reacting?"

STEP ❷ Practice empathy – allow your body to attune to and reflect the emotion in others, and listen to what your body tells you. Empathy gives you the ability to understand another person (seeing it from their point of view, trying to put yourselves in their emotional shoes). Once you've done that, you are better equipped to know what they are experiencing and what is behind their actions.

STEP ❸ Pay attention to the facial expression and body language of people around you. ie, actually look at people's faces. Make guesses about which of the basic emotions might be closest to the non-verbal cues you are observing. eg, a nervous person might bite their lower lip, fidget or shake his/her leg; relaxed muscles in the face are a sign of happiness; smiling a lot may be expressions of contentment.

STEP ❹ Listen for tone of voice. It is not just what people say that gives us meaning, but how they say it and in what tone, the volume, timbre, etc.

STEP ❺ Ask questions to get more information. Try to find out if they are feel OK or have a problem. Ask what they are feeling. Help them express their emotions – this will make their actions and motivations clearer.

Expressing Emotions

While animals can only express emotions through a combination of facial expressions, gestures and sounds, we have an additional way of expressing our feelings - words.

Mostly, this makes emotional expression more accurate. However, we also need to match body language, facial expressions, gestures and tone of voice to what we say to express emotions clearly. If our words and body language don't match, there is a risk of being misunderstood. eg, if a person who is sad shows this feeling and talks about it, others are drawn to offer support. Whereas, if a person calmly discusses their loss, this can be perceived as lack of caring, as being phoney or even as threatening.

Many things can make expressing feelings difficult. Cultural expectations (what is and isn't appropriate) plays a role. Plus, how our caregivers responded to our earliest expression of emotion shapes our confidence about expressing feelings now—leading to missing-out on opportunities to be understood in the present.

Sometimes we can have unrealistic assumptions about the expression of feelings that results in avoiding direct sharing of what we feel. People sometimes expect their *nearest and dearest* to "mind read" what they are feeling; even though they may be actively concealing their emotions. The belief that true love or true understanding means never having to explain yourself is unrealistic. Of course, we want (perhaps need) sensitivity and understanding in a close relationship. But this needs to be about openness to hearng what you are expressing rather than mind-reading what you are not sharing.

For all these reasons it can be challenging to start expressing feelings. The first step is to accept that feeling vulnerable is part of sharing feelings. But this does mean you have to choose trustworthy people to share with. The next step is to change from indirect methods (using non-verbal signals of emotions) to direct (assertive) statements about our feelings. eg, from slamming doors to saying what you are angry about). Assertive statements also replaces blame (eg, "You made so angry") with "I-statements" (eg, "I feel angry that ... *filling in the details*)".

Finally, we mostly experience several emotions together; and sometimes have conflicting emotions. If we communicate only one of the many feelings we experience, this will narrow the conversation and reduce the opportunity for understanding. Taking time to notice other aspects of our emotional reactions (by asking ourselves, "what else do I feel?") can help improve the accuracy of how we express our feelings. For example, being rejected or criticised can result in us feeling angry and defensive. But often we are also hurt by these experiences. Sharing how someone has hurt us lets them know the effect of their words; whereas anger alone drives them away and prevents re-solving the misunderstanding.

Homework for Week Nine

With someone you trust, pick 1 or 2 characteristics of yourself that you identified in Handout H7 that this person may not know about you. Share with them how this characteristic shows in your experiences. Invite them to identify a characteristic that they think you might not realise about yourself (and give an example of why they think that, if they can).

Observe interactions with others during the week. Consider the possible motivations underlying their behaviour; and reflect on motives underlying your own actions in a specific situation.

Consider over the week what attitudes you are holding towards something or someone. Reflect on how that attitude impacts on your behaviour or colour your interaction with the person?

Experiences involving personal characteristics

Experiences involving motives

Experiences involving attitudes

SESSION 09

Understanding People

What makes people tick?

Whenever we try to make sense of someone's mind in relation to their feelings, motives, beliefs, wishes, thoughts, intentions, etc., we are mentalising. There are a number of things we can attend to in order to understand their mind.

One is to notice their traits, strengths, qualities, etc. Just one or two words can sum-up a whole range of experiences and expectations about the mind of another person.

Another is to try to figure-out the intention of another person - their motives; or why they are doing or thinking what they are doing or thinking.

And another is to pay attention to the attitudes they hold—of attitudes shape the way we understand things .

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Discovering Yourself P2
Examining Motives P4
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Mentalising Personal Characteristics

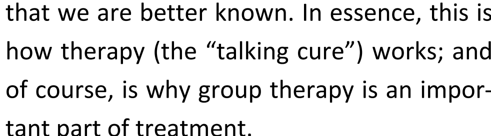
One of the ways we can understand other people is to see what personal characteristics (traits, strengths, qualities) they have. A few words can sum-up a whole range of experiences and expectations about the mind of another person. To do this though, we would need to take a broad perspective of the person over a considerable time period.

Personal characteristics are short-hand phrases that summarise how someone might have behaved in the past, why they might have behaved that way, and how they might behave again. Knowing something about a person's personality can help you mentalise in the present moment, because it gives you some clues about possible reasons for the actions of a person.

Accurately identifying the characteristics of other people can help us understand the motives and reasons behind their actions. eg, if we can see that someone is shy, their lack of speaking with us isn't rejection, but something we could perhaps find a way to overcome by approaching them .

It also works the other way around—When we can see how they see us, it helps us to understand things that might be affecting their interaction with us; plus, it can help us understand ourselves better. For example, if we come to see that someone sees us as competitive, when we only feel ourselves to be enthusiastic, we can understand why they might avoid us.

Personal characteristics can be seen as "positive" or "negative". However, this depends on one's perspective and the situation. A characteristic might be a strength in one situation (ie, have advantages); whereas in another situation, the same characteristic might be a limitation (ie, have disadvantages). For example, being competitive could be a positive characteristic for someone who is fit and loves sports. But being competitive as a facilitator for Victim Support could lead to arguments with clients and colleagues in order to prove who know best. Which would not be very supportive!



We will always have things about ourselves that we never fully understand – things we just don't know (the unknown), our private self (things that are not for sharing), and our blind spots (things we don't easily admit to, even though other people see them). However, psychological health and good relationships are associated with reducing these three areas and maximising our self-knowledge and transparency to others.

Put another way, this is about knowing your own mind (thoughts and feelings) and allowing your mind to be understood by others—what we have been calling *mentalising*. This involves, on the one hand, inquiring of others about what they perceive, (and we don't), about ourselves; as well as sharing our experience and awareness with other people so that we are better known. In essence, this is how therapy (the "talking cure") works; and of course, is why group therapy is an important part of treatment.

A common experience for people with BPD is feeling unsure of who they are. That is, the degree to which things about themselves are known is relatively limited. It may be that there has been too much fear for them to open up. It may be that they have been isolated from the feedback from others. It may be that no-one has been a reliable *mirror* to reflect their emotional experiences in a way that would help them understand themselves. The diagram opposite shows that the path to self-knowledge involves sharing, receiving feedback and exploring reactions—in other words, mentalising ourselves.

that supports your attitude. In this way, attitudes continually impact on your relationship with the people in your life. Understanding the "coloured glasses" that you and others bring to interactions is an important part of understanding relationships with people. These "glasses" may prevent you from seeing the mind of others.

Because our attitudes express the sense we have made of our world, we often feel them to be a truth that shouldn't be questioned. Our attitudes (personal feelings and interpretations) toward objects, people and events in the real world) express a sort of special relationship with the real world – that there is agreement between what we feel reality to be and what reality really is. However, these same objects, people and events are part of other people's minds; and these other people might have different attitudes toward these things – ie, different realities. Consequently, it can be very frightening or threatening when attitudes clash. In effect, it can be experienced as a challenge that one's grasp of reality is in question.

To avoid this fearful experience, people sometimes act as if their reality is the only reality – they assume that everyone shares their attitude. Or, to avoid the threat on their grasp of reality, some people experience a need for everyone to have the same attitude as them, and force their attitudes on others. Either of these reactions is a failure to mentalise the mind of another – ie, to understand another's mind.

So, if our own attitudes feel to us "the way the world is", how can we understand the minds of others without losing our own mind? The answer to this paradox lies in understanding that our interpretation of the world is very selective. There is so much information bombarding us that we have to pay more attention to some information and less to other information. If we always waited to form an opinion only when we had all the information to hand, we could never act in a purposeful way. Knowing that we form our opinions on very selective information, and that everyone is also very selective, we can see that different people might attend to a different selection of information; and so form different opinions. But each will feel their grasp of reality is correct.

So when we encounter a different attitude (a different grasp on reality), we can learn about the mind of the other by exploring what information they attended to in the making of their attitude. That is, being inquisitive about differences – which is at the heart of mentalising.

The Impact of Attitudes

Another aspect of a person that provides some clues about possible reasons for their actions is their attitudes. An attitude is more than just a particular belief we have about something or someone. It is a collection of beliefs that are organised into an overall judgement about people, objects or experiences. Attitudes show in the way a person thinks about something, feels toward it, and acts around it or towards it.

Attitudes influence the way we understand things. They are like a pair of glasses that tint our perception of the world. Just as two people with different coloured sunglasses will see the colours around them differently, so different attitudes result in different responses to the same thing. (eg, for yellow and red glasses, if both look at a blue object, one will see a green object and the other a purple object).

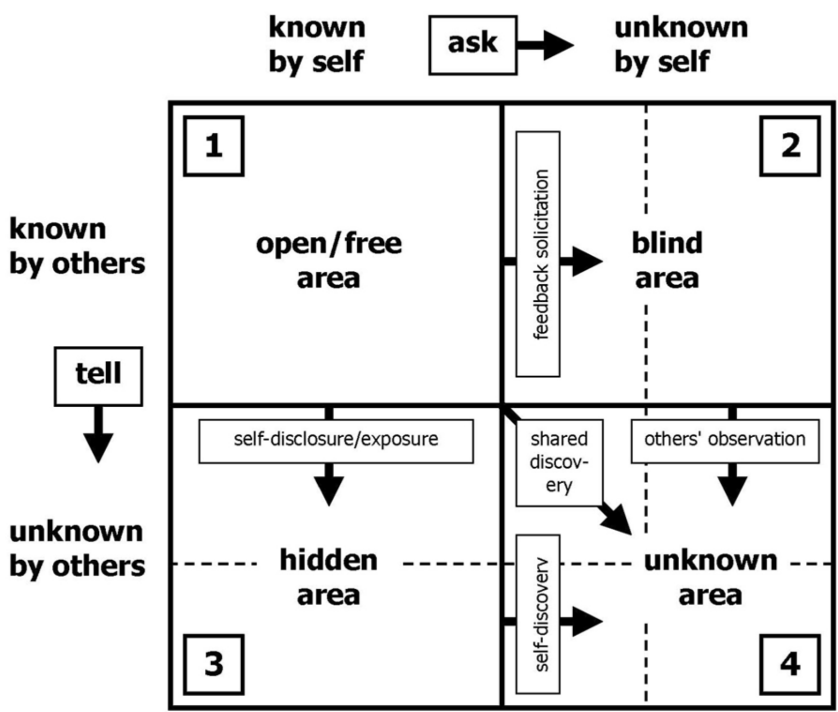
With different coloured sunglasses, it's usually obvious why the object will look different, so people usually don't argue over the colours they see. They just remove their glasses to check. But with attitudes, we might not be aware how they are shaping our perception, and so unquestioned and unaware attitudes usually lead to misunderstandings.

While we are forming an opinion about something, we are pretty open to new information. But once we've made up our mind, it is very hard for new information to change our decision; and any information received after making our decision is evaluated in a biased way. ie, we accept things that agree with our decision, and view things that disagree with it with scepticism.

As well, attitudes become stronger the more we use them and the more we talk about them. As our attitudes become stronger we are more likely to use the attitude to evaluate new experiences rather than use new experiences to evaluate the attitude. This can ultimately make us resistant to changing our attitude; for we interpret new information to fit our attitude. eg, if we have fixed negative attitudes toward teachers; and we then meet a teacher who is warm and helpful, we are more likely to excuse this as an exception rather than challenge our attitude.

The attitude you hold towards someone will then go on to bias your perception of interactions with them. You are more likely to notice information that supports your attitude, and you are more likely to interpret neutral information in a biased way

Open Self	Blind Self
Information about yourself that you and others know.	Information you don't know but others know about you.
Hidden Self	**Unknown Self**
Information you know about yourself but others don't.	Information about yourself that neither you or others know.



Through the actions associated with the arrows, our sense of self grows (expands to the dotted lines).

Examining Motives

In everyday relationships, we face the challenge of understanding the purpose and effect of people's behaviour – trying to figure-out the intention of another person. We are often asking, "Why did that person do that?" Often, the answer to that question involves understanding motives.

A motive is an emotion, desire, physiological need, or similar impulse that triggers action. It provides the energy for behaviour and directs it towards a specific goal. In everyday experience, we think of "motive" as the reason for a certain course of action. Usually, a motive gives expression to some need, drive or goal. Hence, a motive may be anything which energises us towards an activity. Motives cannot be observed directly. Unless the motives are shared in words, they can only be inferred.

A large part of understanding people involves understanding their motives. Most often, the motives behind an action are multiple and multi-layered. That is, sometimes there are motives behind motives. For example, a person might point-out a mistake you have made; embarrassing you in front of a class. Their motive might be to make people around them seem less intelligent than they are. But behind this motive, there might be a desire to protect their own deficits from being exposed; by putting the attention on someone else. And behind this, they might be desperately trying to preserve some sense of worth by maintaining a façade that they are fault-free.

When attempting to figure-out the motives of another, it's best to look for multiple reasons. Often, the word "just" can be a warning bell that we are viewing motives too narrowly. To tell someone that they "just" want any one thing (eg, they just want attention), assumes that you know their motives better than they do. And to tell them that they "just want … " oversimplifies them.

Everyone feels insulted, minimized, hurt and offended when they are oversimplified or have incorrect assumptions and judgments made about their motives. We feel that way when it is done to us, and others will feel the same if we misjudge their motives.

To help someone feel understood, and thereby help them feel less alone, try to understand their motives. Don't make assumptions. Don't judge what they tell you. Most people will explain their motives to you if they don't feel judged and afraid of disapproval or rejection. You can really get to know someone by understanding all of their various motivations.

But if you start judging them, they will eventually stop sharing things with you.

Similarly, when people do not understand our motives, we can feel more alone and isolated.

It has been suggested that motives boil-down to a few basic themes -

- to **achieve** or to compete - to test yourself against the environment and attain high standards or excellence.
- to **acquire** - to have money, goods, social status, possessions.
- to **belong** - to bond; to enter into relationships and be connected (not for gain or influence); to feel part of a cohesive group or community.
- to **influence** others - to effect or impact another person.
- to **learn** - to satisfy our curiosity; to understand the world around us.
- to **master** - to control situations and/or people.
- to **defend** - to guard yourselves, your family and friends, and your valued accomplishments against external threats.
- to **depend** - to trust and rely on others; and to be taken care of.

If you are having difficulty figuring-out the motives of another person, it may help to reflect on this basic list for clues as to what may be motivating them.

Homework for Week Ten

Make notes of some examples in the week where you respond to people in ways that indicate **security** (e.g., seek comfort, rely on support), **avoidance** e.g., feign self-sufficiency) or **ambivalence** about the relationship (e.g., signal a need for support but feel anxious receiving support).

Make a note of something that is difficult to talk about in a close relationship during the coming week; and why it was difficult.

Examples of Relationship Style

Example of a Difficult Topic to Talk About

SESSION

10

Understanding Relationships

contents

The Importance of a Safe Base P1
Patterns of Connecting P3
Relationships and Mentalising P4
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Week 10 homework P8

Relationships and Mentalising

Unlike most other animals on this planet, humans are far from being fully developed at birth. Humans require the most time to reach full development; and have the longest period of dependence on parental care to shape the development of brain and mind.

We survive these helpless years through being emotionally connected to caregivers who respond to our emotional needs—a function called attachment or bonding. Attachment ensures there is always a protective adult around to protect an infant from danger and to comfort distress.

But attachment provides more than physical protection – it is crucial for the development of the mind, and sets the scene for how we approach relationships.

We need to be physically safe to feel emotionally secure. Having a safe place to return to means that when we feel distressed, injured, endangered or in pain, we know there is a way to provide for our emotional well-being. Feeling safe provides a secure base from which to go out and explore the world and gradually learn how to be self-reliant—playing and exploring confidently; and when there are problems, feeling confident to seek help and problem-solve.

Part of this sense of security is knowing that distress can be soothed. Whether it arises from something threatening in the environment, or simply from being separated from the parent, a strong sense of attachment provides the confidence to face the distress because there is the reassurance that the parent will calm emotions. Over time, this external regulation of emotions gradually becomes internalised self-regulation as we learn to understand and regulate our emotions.

In addition to attachment providing the secure base for the development of independence and emotional self-regulation, it also supports the exploration of the inner world – the world of minds.

We mainly learn about minds – emotions, intentions, motives, etc. – not through being taught information about minds, but

through a process of *social feedback*. As with learning any complex skill, we need feedback on our attempts. The emotional responses of our caregivers reflect our emotional states – in facial expression and tone of voice. This enables us to develop an awareness of what we are experiencing and to make sense of what we are thinking and feeling.

Teaching by example is also important. Just as having a coach show you how to do something helps you learn the skill, it seems that mentalising develops well in families where there is lots of discussion about feelings, and attempts to understand what everyone is experiencing.

It might seem that learning about minds requires absolute safety or perfect parenting, but this is not true. In reality, what is required is "good enough" parenting – ie, parents who mostly "get it right" and who repair the misunderstanding when they "get it wrong". Perfect responsiveness would inhibit growth of mentalising and the personality. Children also need challenges to rise to, problems to solve, difficulties to overcome; as well as opportunities to learn that mistakes and hurts can be healed.

We now know that people with BPD have problems with mentalising—usually that their mindsight switches off too easily when emotions are stirred. The more people study how mentalising develops, the more it seems that how securely we felt ourselves to be attached in childhood is linked to the development of mindsight. So it makes sense that studies have also found that people with BPD also have had problems about feeling securely attached.

On the one hand, this is good news. It means we now understand the central problems behind the emotional dysregulation that is central in BPD; and these are not things that can't be changed. But on the other hand, while we do know a bit about the sorts of things that disrupt attachment and mentalising, we don't know all the ways these can be disrupted.

It's important to not use the limited knowledge we have about how mentalising develops to try blame people for having BPD. There are many factors that contribute to secure attachment—inherited temperament, culture, family backgrounds, economic opportunities, biochemical changes, etc. Many of which a person is not aware of and/or is unable to control. (Even if what might be behind problems in attachment and mentalising can never be known for sure, knowing that these factors need to be developed points the way ahead).

On the other hand, experiences that obviously disrupt a sense of safety and secure attachment are likely to disrupt the development of mentalising—which is why major traumas sometimes disrupt mentalising (though usually not if the family can support the victim and talk about what happened). It seems that the majority of people with BPD have had significant negative experiences of one kind or another. Addressing the impact of these experiences is often a necessary part of the journey forward.

But the bigger picture is that the opportunity to *reflect on minds in safety* is the key factor that will develop the underdeveloped neural circuits involved in mentalising. Growing the ability to mentalise requires (relatively safe) relationships. Hence the focus of treatment is mentalising the relationships you are in—working with a therapist you can trust to do this, engaging with others in a group to practice these skills, and applying mindsight in your everyday relationships.

Fearfulness

In this relationship pattern, closeness and intimacy is frightening. Based on what happened in close relationships in the past, distrust becomes pervasive and a range of fears dominate – eg, being injured, exploited, dominated, controlled, trapped, intruded upon, smothered, humiliated, betrayed, abandoned, etc.

Dependency

Alternatively, when attachment needs are very strong, some people are driven to be in any relationship in order to have some affection, protection, nurturance or intimacy. This can involve being in harmful relationships just to have some of these needs met some of the time. Unfortunately, this perpetuates a feeling of being abused. As well, the fear of losing the relationship may result in feelings of being trapped or vulnerable, or guilt over burdening a partner with intense needs.

Victimisation

Those who have been hurt by abuse, neglect or violence are, in fact, very real "victims" (ie, innocent targets of someone else's wrongdoing). Different from this is the attitude of seeing yourself as "a victim". That is, whenever things go wrong in relationships, the person sees themselves as a passive recipient, where blame is always attributed to others. This attitude is damaging because it erodes self-efficacy and results in learned helplessness.

Controlling

A troubling part of trauma is feeling helplessness and out of control. One way of never feeling this vulnerable again is to always be in control. This can make it difficult to comply, to follow instructions, etc. Consequently, there are often power-struggles and things have to be "my way or the highway!" This can give a false sense of safety but it results in more losses.

Aggression

In the final relationship pattern, a person follows the guideline – "the best defence is a good offence". In order to never be abused again, they attack first. Being angry or threatening creates emotional distance, and brings feelings of power and control; a way of not feeling vulnerable. But, aggression begets aggression – resulting in confirmation that others can't be trusted. At its most extreme, the anger and aggression is targeted at others who are vulnerable. Facing the reality of one's abusive past (mentalising) prevents such repetitions.

Just as negative relationship models are learnt in relationships, so are nurturing models. Abusive relationships set up a vicious cycle - the more you're mistreated, the more you feel devalued, and the more mistreatment you tolerate and feel you deserve. Healthy relationships turn the tide, creating a benign cycle: the more you're treated with kindness and respect, the more you feel confident and worthy, and the more you'll assert your needs and be treated accordingly.

To learn new relationship models, you need to find good teachers—persons who are kind, trustworthy, and reliable. The possibilities for healthy relationships are endless. Developing healthy relationships across different levels of closeness can build new patterns for relating that will gradually replace defensive patterns. eg, social contacts, friendships, romantic relationships, family relationships, work and school relationships, relationships with professionals, etc.

RELATIONSHIP PATTERNS

In addition to affecting the development of mentalising, our relationships in our childhood years shape how we view the relationships we have in later life.

As we said earlier, the brain is a pattern-making machine—it creates templates so that it can predict what will happen. Based on the recurring patterns in our early relationships, we develop models of how relationships appear to work.

Early relationship models serve as a foundation for later relationship patterns. These basic models govern how we experience relationships and also how we behave in relationships; which in turn affects how people behave toward us. Perhaps not surprisingly, this results in relationships following the pattern we expected.

For example, if you expect others to mistreat you, you will most likely keep them at a distance. This will in turn effect how they will respond to you – in this case, it's likely they might not include you in actions and decisions, since you distance them. This results in the feeling of being mistreated. And so, a person ends-up experiencing relationships exactly as they expected them to be; but doesn't realise how they contributed to shaping the relationship to become that way.

When our internal models of relationships lock us into fixed outcomes, and we don't realise how this is happening, we describe this as having *controlling models* of relationships.

On the other hand, when we are aware of what we bring to a relationship, and can hold our models in mind in a flexible manner that can adapt from moment to moment, we describe this as having a *working model* – ie, it is like a hypothesis but remains open to being changed by new experiences. (eg, you might expect to be criticised by remain open to receiving praise).

Understanding how you typically approach relationships (your usual relationship pattern) can help you avoid being trapped by expectations that arise from old hurts.

There are perhaps seven main relationship patterns experienced by people who have experienced emotional hurt in their childhood years .

These are -

Isolation

In this relationship pattern, the person maintains distance from other people – preferring solitary activities, keeping interactions on a superficial level. However, isolation can feel very vulnerable and depressing (lonely).

Yearning

This relationship pattern arises from the need for safety and comfort that is triggered by mistreatment. The emotional hurt increases the need for attachment, resulting in longing for much-needed caring, closeness and intimacy; as well as sacrificing one's own needs for other—caring too much!

Patterns of Connecting

Our brains are pattern-making machines, continually organising the vast array of experiences confronting us. The early patterns are organised around attaching to a caregiver and significant others in our life, and our on-going experience of those attachment relationships in relation to our feelings, our needs and our safety.

Different patterns develop according to a range of factors. When all goes well, a child grows–up to feel secure in relationships. Other times, different patterns of relating develop. The attachment pattern that develops in childhood often shapes how a person relates to others. New relationships tend to be viewed in light of earlier experiences - influencing one's relationship patterns as an adult. The challenging aspect of these patterns is that they are established at a time when we aren't aware of what is happening, and they are passed on via a process that occurs below our usual level of awareness. So they end-up feeling entirely natural to us, even though we are reacting to current relationship opportunities on the basis of old experiences.

A person who feels **secure** in their relationships reaches out for contact and comfort in times of distress, confident that another person will be accessible and emotionally responsive. Feeling secure in the relationship, they anticipate that the attachment figure will have their mind in mind - the relationship will be calming and restoring, emotionally and physiologically. ie, they'll be able to make sense of their distress - they'll mentalise and be mentalised.

A person who is **avoidant** of close relationships is dismissive of attachment. They adopt a self-sufficient stance, with a sense of not needing anyone to provide comfort. This avoidant or dismissing stance works reasonably well, as long as the distress remains within bounds. But it isn't an effective strategy for coping with high levels of distress.

A person who is **ambivalent** about attachment is often preoccupied with relationships. They are highly ambivalent, feeling anxious and in need, yet feeling vulnerable to abandonment and resentful of the other person's failings. Hence their attachments are marked by a combination of dependency and hostility, and, fraught with conflict and discord. Their attachment relationships tend to be stormy.

Finally, a person can end-up with a **disorganised** pattern of relating because a history of traumatic attachment relationships may have left them with no workable strategy for maintaining relationships. They only know that relationships make them highly anxious and that they feel isolated from attachments.

A person's predominant attachment pattern determines to a large extent how the person deals with close relationships - particularly in situations that cause pain or when there is danger or fear of being abandoned . However, our predominant attachment strategy is not fixed - it can change through taking risks in new relationships – sharing instead of avoiding; letting someone's warmth and attention in, instead of hardening against it; trusting instead of sus-

Relationships and Mentalising

The development of mindsight, our natural ability to understand emotional messages, relies heavily on having safe attachment relationships in childhood. In fact, feeling secure in relationships and developing mentalising ability are intertwined—each supports the development of the other.

That is, in order for mentalising to develop, a child needs a secure attachment relationship where the caregivers mentalise the child. As well, being raised in a mentalising family culture provides the type of environment in which a person develops secure attachment. On a day-to-day basis, a child needs the *safe base* of secure attachment to explore minds (their own and their parent's). And having someone show interest in your mind and understand your emotional reactions - a mentalising interest - is the mechanism that develops security in relationships.

Attachment relationships are thus very important for a person to become aware of their own emotional states, to be able to put words on these states, find out the reasons for them, and use emotions to guide the way they relate to others. There can be negative consequences for a person's mentalising abilities if the relationship to their caregiver(s) feels unsure, and if they cannot use them to understand feelings and relationships between people. This is sometimes what is behind the feeling of being very much alone or empty.

Sometimes, learning that mentalising is affected by early relationships is misunderstood to mean that someone is to blame for mentalising problems; or that a person is doomed forever because their early relationships did not have the sort of security that fostered mentalising. In reality, this information points not so much to the past, but instead offers hope for the future.

The development of mentalising is not something that stops at the end of childhood. Rather, mindsight is something that we use every day. And if we exercise it , mentalising grows and develops throughout our life.

It is only while we are children that we are so dependent on our caregivers for the development of ment alising. This is because, as children, it is difficult to think about the attachment relationship. A child lacks a separate reference-point to reflect on that relationship and adjust for any problems in understanding. Over time, as one grows-up and gains other references, it becomes possible to see things from the outside and compare them with other experiences.

While relationships generally help the development of mentalising throughout our lifespan, the problem arising for people with BPD is that relationships don't work smoothly. Sometimes, they are very stormy—which doesn't help the need to feel secure. Sometimes, there have been intense feelings of being hurt that lead to withdrawing from relationships. And sometimes, with mindsight underdeveloped, relationships are avoided because they are so confusing or threatening.

It must also be noted that in some cases, there have been experiences of trauma. It is particularly difficult to think about a relationship (develop mentalising) if it is characterised by violence and abuse. How can a person begin to understand why a person (who should be treating them with care and love) is behaving with complete disregard for their well-being?

When the person who should be the source of comfort and safety is also the source of fear or distress, there is a state of conflict. That is, the natural impulse to be close to another is inhibited by something else (eg, fear of punishment or hurt).

As a result, a person might come to inhibit or exaggerate the signals about their emotional state because they are fearful or insecure about what will happen if they call for support or comfort from the attachment person. Attachment conflicts like this inhibit a child's mentalising abilities right from the start, and leave behind emotional scars and confusion that can disrupt on-going, everyday mentalising. This is why early trauma can undermine a child's ability to deal with relationships, and conflict in relationships, later in adult life.

Relationships, then, are critical for mentalising. So it is not surprising to discover that most people with BPD are not securely attached. This link between attachment and mentalising seems to be part of how BPD develops, as well as being a large part of how people can move on to greater health. The critical ingredient is to be in an environment where there is an open, enquiring interest in exploring mental states (feelings, thoughts, attitudes, motivations, etc.).

The treatment programme strives to create a mentalising environment – both in the groups and individual sessions; where there is a constant effort to find out about one's own mind and minds of other people. This provides the type of environment where mentalising can be practiced and strengthened.

Homework for Week Eleven

Over the coming week, pay attention to any experiences of anxiety. If you feel anxious about something, make an attempt to approach someone for support – to share what is happening with you, to ask for comfort, to explore in discussion with them what is happening and why, etc. Make notes about whether this helped your anxiety or did not help it; including your thoughts about why it succeeded or failed.

Experiences of Anxiety

Experiences of Coping with Anxiety

SESSION

11

Mentalising Anxiety

contents

What is Anxiety? P1
Types of Anxiety P2
Responding to Anxiety P3
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Week 11 homework P8

Anxiety, Depression & BPD

With unstable emotions, questions about identity, and problems in relationships with other people, experiences of depression and anxiety are to be expected when most areas of life are problematic.

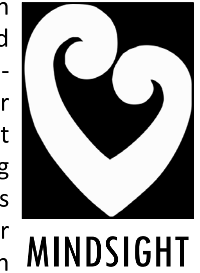
In the context of wider problems relating to sense of self, communication and relationships, it is often not entirely possible to address anxiety and depression as targets in themselves. This is why usual treatments for depression and anxiety sometimes do not work so well for these symptoms – because the anxiety and depression arises from the distress that is part of the wider problems involved in BPD; and will not resolve until the underlying problems that drive the BPD are resolved.

WHAT IS ANXIETY?

Anxiety is intimately connected to one of the basic emotions – fear. Fear is indispensable for survival in a dangerous world; it signals danger and turns on our "alarm button" – preparing us for fight or flight. However, while fear is short-lived, present-focused, geared towards a specific threat, and facilitates escape from threat, anxiety is long-acting, future-focused, broadly focused towards a diffuse threat, promoting caution while approaching a *potential* threat.

That is, anxiety can be considered a form of fear reaction that is triggered too easily in relation to threats that are not yet immediate. The threshold at which fear stimulates the fight-or-flight reaction, and the intensity of the response, varies between individuals. There are many factors that contribute to this individual variation, including – early life stresses that programme a more sensitive neurobiology; modelling by parents and others to be fearful; attachment insecurity (not being confident of being soothed or understood); as well as low mentalising ability (interpret and communicate emotions).

We can also experience the state we call anxiety when we are agitated, hyperaroused, or stressed in an unfocussed way. Fear prepares us for fight or flight by charging our nervous and muscular systems with adrenalin. But



it is also true that most other emotions involve an initial alerting/activating reaction in the lower brain regions that readies us for action, or for paying attention. This alerting response is unfocussed but it readies us to attend.

This leads on to a clearer perception of the emotion that is being triggered by our experience or thoughts. However, there can be times when distractions in our environment, competing emotional demands, or our own reluctance to pay attention to feelings results in the activation of our nervous system but without focus - resulting in no emotional conclusion. Being overstressed often triggers emotional arousal, but the competing demands creating the stress can also interfere with expressing a clear emotional response.

At the end of a stressful day, we might have had multiple emotions triggered – disappointment when something doesn't happen; sadness when someone lets us down; anger when we were criticised; resentment when something unfair happened; etc. But the demands of the day, or our focus on doing rather than being might have resulted in us never fully attending to our emotions – so we only get as far as being mentally activated. The end result is a messy emotional state of feeling agitated, tense, "on edge" that can prime us to over-react with flight or fight (panic or anger). This unfocussed agitated state is also experienced as anxiety. Only it isn't so much about fear as about a range of emotional experiences that have not been fully attended to.

TYPES OF ANXIETY

In addition to ordinary feelings of anxiety (strong or weak), intense long-term difficulties with anxiety can manifests in a range of disorders -

Generalized anxiety disorder involves excessive, irrational and uncontrollable worry about events or activities in daily life to the degree it interferes with daily functioning.

Phobia is a fear that is out of proportion to the situation that causes it and cannot be explained away. The person avoids the feared situation, since this reduces the anxiety.

Social Phobia involves strong overpowering fear in social situations. Those with social phobia anxiety tend to be extremely self-conscious, fearing they will be embarrassed, scrutinised or even judged in public. They also feel inferior or don't measure up with others.

Panic Disorder involves in repeated panic attacks that occur unpredictably and often without obvious causes. People often fear having another attack. This can result in a vicious cycle where the worry about having panic attacks increases their fear and chance of attacks.

Obsessive-Compulsive Disorder involves unpleasant thoughts repeatedly entering the person's mind, despite trying to stop them. Often there is a compulsive urge to undertake repetitive actions are to temporarily reduce the anxiety.

Stress-related Disorders - reactions to stressful (traumatic) events. Includes - acute *stress reaction* (immediate, resolves rapidly); *adjustment reaction* (lasts up to 6 months); and *post-traumatic stress disorder* (persists for years).

MENTALISING TRAUMA

Sometimes there is a clear connection between anxiety problems and early trauma. But this doesn't necessarily mean that traumatic experiences have to be discussed.

MBT for BPD is primarily focussed on identifying and understanding the disruptions to mentalising that occur on a moment-to-moment basis in current relationships. Usually, this means that sessions focus on examining current experiences (ie, interactions in the group and between client and therapist), or experiences in the recent past (ie, interactions with significant others in the past week). While the disruptions to mentalising experienced in these recent events might well have arisen as a response to major trauma in childhood, the interest is on how mentalising is lost in the moment, and how it can be regained. That is, therapy focuses on how past trauma affects current relationships; without necessarily having to "dredge-up" painful past experiences.

Despite the focus of MBT on the here-and-now, this treatment recognises that it is very likely, and relevant, for there to be some attention to examining and reworking traumatic memories. This is because it is recognised that unmentalised emotions results in a painful residue of feeling that colours on-going experience. However, whether this arises in the course of treatment for BPD problems, or at some later point, or resolves indirectly as mentalising abilities strengthen, is often different for each person. MBT does not require that traumatic material is addressed in treatment. Rather, it is simply open to engaging this material if it emerges as part of the loss of mentalising and there is the right level of trust and safety to mentalise these experiences without mentalising "going off-line".

If traumatic experiences are to be explored in treatment, it must be in a way that does not re-traumatise the person. This requires attention to a number of factors. First, that there is time for security to develop in the therapeutic relationship. It is not safe to address the destabilising impact of trauma if there is not a strong attachment with the therapist and a firm sense of personal safety that can contain distress. Second, preparation for the work through psycho-education about trauma and its effects is necessary so that challenging experiences can be grounded in a framework that provides reassurance and context. Third, the person needs to have developed a range of ways to modulate their emotional arousal; and have relinquished maladaptive coping mechanisms (such as self-harm, substance misuse, etc.). Sometimes this requires direct training in self-soothing and grounding. Lastly, therapy needs to have progressed to a point where mentalising can be brought back on-line, and the client has developed a genuine interest in mentalising.

Usually, this means that mentalising trauma is one of the last things to be explored in treatment. Alternatively, it can be a focus for therapy that occurs after treatment for BPD; or occurs in a parallel treatment setting at an appropriate point in the journey of healing.

ple, black-and-white thinking, making a judgment with no supporting information, catastophising, overgeneralising, labelling, personalising, etc. Essentially, we lose sight of the fact that our emotional reaction to something is a signal trying to tell us something about our experience, and instead, we treat our emotional reaction as the complete reality of the situation. ie, we stop reflecting on what we are experiencing and no longer look behind or within to understand things in depth.

Just as exposing ourselves to what makes us anxious instead of avoiding it helps overcome anxiety, re-engaging our mind instead of only responding emotionally also counters anxiety. In therapy, it really is true that "two heads are better than one" – for a therapist can engage their mind with yours to jointly bring mentalising back on-line. Mentalising an anxious response starts with accepting the feeling, and moves -on to explore what is triggering that reaction and how it might be understood and put in perspective in the actual situation.

This is not just relevant for how to resolve anxiety that is at the intensity of a disorder (eg, phobia, social anxiety, panic, etc.). It is also true for the more everyday anxieties that arise as part of BPD. That is, feelings of anxiety triggered by experiencing emotions, approaching people for support, being alone, needing comfort, feeling worthless, etc. In this programme, the attitude being encouraged is to approach another person when experiencing anxiety (instead of remaining alone).

This is particularly so in relation to therapists and group members. Developing a connection with therapists and group members, where there is a focus on understanding your mind, is the central helpful action. This requires that you talk in sessions about the things that you fear; including things that happen within the sessions that activate fear.

This is easily said, but may be difficult to do. In trying to be open with respect to your anxieties, you may experience resistance against doing this. This may be related to the fact that fear is often connected with shame, or that one gets an uneasy feeling of being childish and helpless, or that one does not trust that the other has the capacity to be helpful, etc. It is important to bring these feelings of resistance into sessions, sharing and exploring them with your therapist and/or the group.

A child's natural reaction when experiencing fear is to turn to someone they trust. The natural reaction of a caregiver is to take care of and calm the child. When these natural experiences happen repeatedly, a child learns that fear is an emotion that can be handled. But when these natural reactions don't occur reliably, a child is left feeling frightened, or feeling that it is useless to approach others – resulting in intense aloneness; which might lead to even more fear.

In general, the best remedy for anxiety is to be calmed by other person. It helps to be with a trustworthy person when in an anxiety-provoking situation. But when this support and calming is not available, the unsettling feeling of anxiety generally makes people avoid the thing that is making them anxious.

Our nervous systems are designed to make us avoid things that might be dangerous (for our survival). Unfortunately, this is a very primitive reaction and it doesn't really care whether the fear is about something that might really harm us or is an "irrational" fear. It is fear, and fear is something to be avoided. (Unless our temperament is "stimulus seeking" – in which case, fear is experienced as excitement and it attracts us!). Just as we are designed to avoid things that create negative emotional states, we are also designed to approach or repeat things that result in a positive emotional state. (Unless we are depressed, when such things no longer create positive responses). Again, this is a primitive reaction that doesn't care very much about what makes the positive experience. If there is a positive emotional reaction, we will approach what cause the positive feeling or repeat the behaviour that led to it. When we avoid something fearful, our emotions change from feeling afraid to no longer feeling afraid –by comparison, this feels positive. So the action of avoiding what we fear becomes reinforced, and very soon, avoiding the things that make us anxious becomes a habit.

Mastering Anxiety

Because anxiety is an unpleasant emotion, most people first try to remove anxiety altogether. Sometimes they use distractions, such as being very busy, watching TV, etc. Sometimes they use alcohol or drugs. Often they seek a medication that will reduce anxiety. Each of these solutions can only ever bring brief, temporary relief from anxiety. And, as with avoidance, because there is temporary relief, such actions become powerfully reinforced in the brain. This can lead to dependence on temporary solutions. In reality, anxiety is not an emotion we should "remove". We need our automatic reaction of fear, and the "charging-up" of our body systems, to protect us from real danger. What is needed is to bring the amount of anxiety we experience back into a normal

range, and have it be triggered only in relation to real dangers.

Fortunately, just as we have a brain system to sensitise us to danger (*one-trial learning* – so we don't make potentially lethal mistakes twice), we also have a brain system that desensitises us to irrelevant information (*habituation* – so we don't have to attend to everything in the environment). For the sake of our survival, the *one-trial learning* trumps the *habituation*. ie, we need to learn very quickly what is dangerous, and be slow to learn what things are not dangerous. This means, though, that fear reactions are learned quickly, and unlearned slowly; and, that they will not be unlearned if the feared object/situation is avoided. For habituation to occur, we have to approach the feared object/situation so that our brain can learn that fear is no longer necessary.

This is why the treatment of anxiety disorders involves "controlled exposure". However, exposure to the anxiety-triggering situation in itself is usually not enough – because exposure alone would trigger anxiety and confirm to the brain that it should be afraid. Rather, it is necessary for the exposure to be done in a manner that conveys to the brain that this is an experience of mastery and control, not danger.

Various therapies achieve this in a number of ways. Some treatments focus on learning how to lower anxiety and calm the body's alarm reaction so that when exposed to mildly threatening examples of the feared object/situation, the person can easily learn that they are in control and can reduce their anxiety. Other approaches rely on the body's natural limits for experiencing an emotional reaction – most emotions are short-lived and fade over time. Being exposed to mildly threatening examples of the feared object/situation and "tolerating" the anxiety reaction quickly de-conditions this reaction. Once the response of anxiety is desensitised to mildly threatening examples, exposure can then be done for more threatening examples; and so on, until any example of what was once anxiety-provoking no longer triggers anxiety.

Habituation is powerful. We can unlearn even automatic fear reactions, such as our startle response. And because this happens at the level of our lower brain, it is possible to habituate animals to automatic fears. eg, Police horses are habituated to loud noises, crowds, lunging people, etc. There are all things that a horse normally reacts to with fear. But after habituation training, fear and the startle response are no longer triggered by these things.

For humans, unlearning a fear reaction is helped by two additional factors. First, as we discussed earlier, the presence of a *calming other* helps us feel secure rather than afraid. Trust and understanding in the therapeutic relationship is central to all therapies. For example, in exposure therapy, a therapist treating someone with anxiety about travelling on a bus might accompany the patient on his/her initial travels on buses. Travelling with someone who makes you feel secure, helps you to travel without anxiety. This gives an experience of mastery and control. Later in treatment, this confidence will generalise to travelling while alone, when the other person is waiting at the bus stop.

The second factor that helps us unlearn a fear reaction is our ability to reflect in words about our experiences – to make sense of emotional reactions with mindsight. Of course, initially, the reaction of fear takes control of our thinking and reflecting so that we interpret what is happening in ways that support our reaction of fear. Studies have shown that people with a phobia overestimate the size of the thing they fear. They also interpret neutral situations as fearful and predict negative outcomes more often than people who don't share that fear. In the way our brains have developed to ensure our survival, fear operates to make us safe. When there is real, significant danger, we need to immediately fight or take flight. We need our mind to be taken over by an instant reaction as it might be "the quick or the dead". But when this fight/flight reaction is triggered by things that are not major dangers to our immediate safety, (because our upbringing, past experiences, tension levels, etc. sensitise us to reacting), the loss of our mind in a "survival reaction" is a loss that limits us from responding creatively and appropriately to everyday interactions and experiences.

Earlier, we called this "when mentalising goes offline because of the alarm reaction". When the frontal part of our brain that reflects on experiences is turned-off by the panic reaction of our limbic system, we lose mental resources that are vital to handing what is happening. With mentalising offline, our mind adopts very simple ways of understanding our experience. For exam-

Homework for Week Twelve

Take time to think back over the course to identify anything not clear about mentalising.

Make a list of the things in the course that are relevant for you to follow-up in your treatment sessions.

Things to find out more about

Things to follow-up in therapy

SESSION 12

Mentalising Depression

Understanding Depression

Depression is not easy to understand - largely because the term refers to many different experiences. Most people feel depressed at some point in their life – ie, they feel very sad, a bit hopeless, worn down, and "can't be bothered". For many, this is a passing experience linked to a major disappointment, the loss of a relationship, etc. For others, this is a constant feeling that grinds them down for many weeks or months.

Feelings of depression are common in BPD because any mental disorder affects self-worth and self-efficacy. Plus, someone who experiences unstable mood, unhappy relationships, chaotic impulses, and is sensitive to rejection/ abandonment is very likely to experience everyday life as a somewhat unhappy affair.

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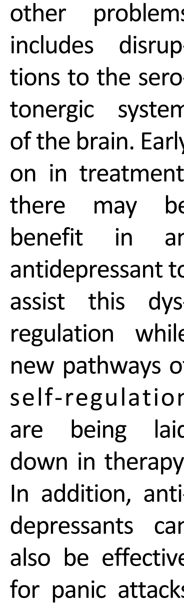
BPD & Depression

There has been a great deal of debate as to the relationship between BPD and mood disorders, but, as yet, no clear answer has emerged. It may be that they are linked in some way. Certainly, a family history of either disorder increases the risk for having the other disorder. But this may be through family and psychological processes rather than a direct biological link. e.g., depression in the mother during early childhood interferes with attachment and the development of mentalising and emotion regulation; or impulsive behaviour and anger dyscontrol in a parent results in trauma and loss for a child that predisposes them to depression. What is clear is that Depression and BPD require different treatments. There is no evidence that antidepressants alone are beneficial for BPD, and no evidence that psychotherapies that work for depression resolve BPD problems.

However, just as someone can have both BPD and an anxiety disorder (e.g., OCD, PTSD), it is possible for someone with BPD to experience an episode of Major Depression alongside the BPD. This is not difficult to imagine as we know that the risk factors for depression include childhood losses and negative life events – both of which are common for people with BPD. Thus there may be a place for antidepressant treatment if a clear episode of Major Depression can be identified as occurring separate from the mood problems in BPD.

It should be noted that just as an aspirin will not relieve a headache if the things causing the headache are not resolved (e.g., stress, tumour, etc.), an antidepressant will not relieve depressed mood if the factors maintaining the depression are not resolved as well.

Even when there is only depression present, factors such as work stress, unresolved grief, fitness, etc. need to be addressed if medication is to be beneficial long-term. When BPD is present, there are long-term problems present that may limit how much an antidepressant can improve mood (e.g., emptiness, isolation, trauma, etc.).



Does this mean that depression should be ignored if BPD is present, or is there a place for treating depression? There are many views on this question that vary from country to country and from psychiatrist to psychiatrist.

In reality, the answer is specific to each person – their clinical history, their circumstances, their individual reaction to medication, etc. Just as you had a thorough evaluation to determine whether BPD is the correct diagnosis, we recommend that your mood problems are thoroughly evaluated to be sure whether there is or isn't a separate mood disorder present. If there is, we recommend discussing the treatment options with your treating team as it is not automatic that medication is the right way to go. Medications have side-effects; antidepressants blunt emotional responses (which can interfere with treatment); and many medicines can be dangerous for people who are impulsive and suicidal.

On the other hand, the argument has been made that for some people, the neurological dysfunction that follows childhood trauma and other problems includes disruptions to the serotonergic system of the brain. Early on in treatment, there may be benefit in an antidepressant to assist this dysregulation while new pathways of self-regulation are being laid down in therapy. In addition, antidepressants can also be effective for panic attacks and anxiety symptoms, as well as reduce mood variability that is due to general emotional instability.

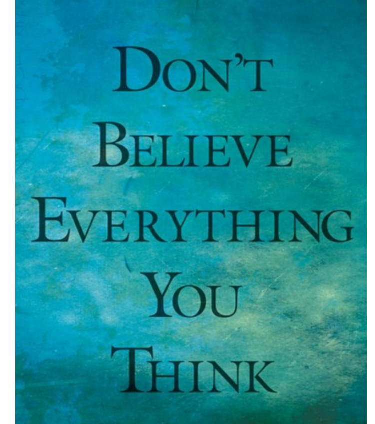
To be practical about this issue, if severe depression is also present, it is likely that any and every treatment option should be considered, so that you can get back to a level of functioning where you can benefit from the treatment programme.

Where medication is most likely to be of little benefit is where it is used in an attempt to address dysphoric mood and emotional distress that is part-and-parcel of BPD.

As with anxiety, negative thinking arises when mentalising goes off-line. The low mood shuts down the reflective mental processes that normally examine our attempts to make sense of people and the world. We lose the sense that our thoughts are attempts to make sense of our experiences and instead experience our thoughts as reality itself.

Being able to question negative depressive thoughts is an important part of mentalising. It turns out that the work done to develop mentalising as part of the treatment of BPD is also exactly what is needed to help people recover from depression. As well as changes to memory, judgement, planning, etc. it seems depression also affects mentalising—people who are depressed have diminished mindsight.

Regaining the perspective that our thoughts, however negative they are, are mental processes that we are creating, rather than observations of an external reality, frees us to let depressing thoughts pass through our mind.



One of the most damaging and isolating aspects of depressive thinking is that the person experiencing it, keeps these thoughts to themself. If a mind creating negative thoughts can only talk to itself, it won't be able to detect the distortions—as the mind listening is thinking the same negative thoughts as the mind creating them! This is why the emphasis in mentalising therapy of engaging your mind with the minds of others is so helpful. So long as you are willing to let your mind be influenced by other minds.

Other minds are like mirrors, reflecting our experience back to us. Not every mirror is a perfect reflection, but having a range of "mirrors" can help us see where our negative thinking has strayed into one or other of the form of depressive thinking (described earlier).

Mentalising - reflecting on our thoughts, talking about our thoughts with others, and listening to how other minds see and understand us - interrupts the power of negative thoughts over our emotions. Usually, negative thinking triggers negative emotions—hopelessness, disheartenment, despair. Taking a mentalising stance toward our thoughts helps us see them as "just thoughts", which can free us to examine them rather than blindly accept them—ie, to examine them from different points of view, see the distortion for what it is, and look for alternative outcomes. This is hardest when we feel low, but this is also the time when we most need to practice mentalising.

e.g., you minimize or entirely disqualify your resources, your ability to cope, possible help from others, alternative opportunities, etc.

JUMPING TO CONCLUSIONS – this has two forms: Fortune Telling (anticipate and predict future situations will turn out badly, often despite the absence of facts), and Mind Reading (assume that you know why and what others are thinking, feeling and doing, without proof).

CATASTROPHISING - focussing on what might be lost and exaggerating either how likely it is to happen or how terrible it will be when it does; e.g., "I'll probably be rejected, and that's terrible", or "it's horrible that I lost."

EMOTIONAL REASONING - reaching conclusions based only on feelings; e.g., "I feel this way so it must be", "it feels terrible, so it must be terrible", "I'll wait until I feel like doing this."

ABSOLUTE THINKING - a rigid and inflexible type of thinking that sometimes takes the form of demanding (within yourself) that things should be what they are not. You think with over-simplistic phrases such as – shoulds, musts, cants, have-tos, oughts; e.g., "I must do my best all the time", "I can't stand losing."

MENTAL FILTER - finding and then dwelling on negatives and other losses. Information that confirms your negative views are seen as proof, while facts that don't fit are seen as rare exceptions and ignored; e.g., "nothing good ever happens to me", "I will always lose", "no one cares about me."

PERSONALISATION - mistakenly believing that you are the cause of events and that you're the reason people act and feel as they do; e.g., "I was rejected because of my looks or my job."

BLAMING – (the opposite of personalisation), explaining why problems are happening by blaming what the other person is doing or not doing, overlooking other factors that contribution to the problem.

Forms of Depression

Psychiatric diagnoses are attempts to identify patterns in the symptoms that people experience where the difference in pattern relates to important differences in the course of a disorder or its treatment. It is important to note that this understanding is developing all the time and that diagnostic labels are often reviewed every decade or two as new knowledge comes to hand.

At present, depressive disorders are thought to fall into four main groups –

Major Depression

Major Depression is characterised by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes.

Unlike BPD, there is usually a history of good functioning before becoming depressed, whereas the hallmark of a personality disorder is that it manifests pervasive problems across the developmental history.

Dysthymia

Dysthymia, is characterized by long-term (2 years or longer) mood symptoms that may not be severe enough to disable a person but can prevent normal functioning or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Bipolar Disorder

Bipolar disorder, also known as manic-depressive illness, involves unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

Symptoms of bipolar disorder are severe. The emotional swings are different from the normal ups and downs that everyone experiences from time to time, and more enduring and more controlling of behaviour than the unstable mood experienced in BPD.

There is a milder form of Bipolar Disorder known as Bipolar II Disorder where the mood swings are less intense and of shorter duration. Generally the mood variability in Bipolar II is present without some of the key features of BPD (such as identity problems, emptiness, fear of abandonment, self-harm).

On occasions, the diagnosis is unclear; or people are diagnosed as one when in fact the other diagnosis is more the case. A detailed investigation for both disorders is required to make a clear diagnosis. Usually, how people respond to treatment indicates whether the diagnosis is correct.

Seasonal Affective Disorder

Seasonal affective disorder (SAD) is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer.

Experiencing Depression

Just as anxiety was associated with a particular emotion (fear), depression is also associated with a basic emotion –separation anxiety and sadness. This is also a natural reaction related to a break in any attachment relationship. All children who have established an attachment relationship will respond with separation anxiety when they are abandoned and with sadness when the person they miss does not return when expected. Separation anxiety is a natural part of the *protest phase* in that it is connected to crying and screaming which are used to attract the caregiver's attention. Sadness belongs to a later phase in which the protest has not had the desired result. When this is because of the death of the caregiver or a close person, then we refer to it as a grief reaction. An intense grief reaction is quite similar to depression, although qualitatively different.

Individuals vary with regard to what triggers sorrow, how strong their grief reaction is, and how long it lasts. In most people, the emotion passes after a time and the individual is able to adapt to his/her new life circumstances relatively quickly. However, when the emotion remains intense for a longer time, we refer to it as a pathological grief reaction, and it is almost indistinguishable from depression. The person is sad and low in mood, tired and with low self-esteem and has ruminative thoughts, feels profoundly negative about life and often guilty. The person has difficulties concentrating, life seems meaningless and there seems to be little hope for the future. The thought of giving up on life may not be far away.

The relationship between depression and grief reaction is therefore quite close. The loss of someone dear is the most common trigger for depression. It does not need to be a death. It could be that someone travels away for a long period of time, that you yourself are sent away, that the attachment person is ill and unavailable, that one's parents divorce, or that one moves away and loses close friends. It may also involve the loss of work, social standing / social position, or being disgraced in public in some way.

If a person has experienced a serious loss at a young age where their grief was poorly processed, they will be more disposed to reacting with depressed feelings after a loss in adulthood. Plus, the more major losses one has had, the more depressive experiences seem to be triggered by later stresses (e.g., general stress and physical illness).

Given all that we have said about the things that contribute to the development of BPD, it is not surprising that people with BPD also experience depressed mood. That is why, in general, it is best to work on problems of depressed mood as part of the wider picture of resolving hurts, loses, threats to personal integrity, failures in mentalising, etc., rather than thinking of depression in BPD as something that needs another treatment.

DEPRESSIVE THINKING

The term "depressive thinking" refers to a set of automated thought patterns that tend to accompany depressed mood. These negative thoughts can establish themselves as part of normal thinking after repeated experiences of depression or when a depressive state lasts for a long period of time.

Depressive thinking is largely comprised of negative thoughts that pop-up as a negative on-going commentary on experiences – eg, "everything is hopeless", "nothing helps", "it's impossible for me", "I'm hopeless" etc. These depressive thoughts seem to be driven by low mood, as they quickly abate once mood improves.

On occasions, the content of the thoughts might reflect early adverse life experiences. In such instances, the low mood triggers old thinking patterns. In many cases though, such negative self-comments simply reflect how powerful emotions are in shaping our perceptions.

The main problem about depressive thoughts is that while a person might easily dismiss fleeting thoughts of self-doubt, self-criticism and negative predictions when they are not depressed, the constant inflow of negative ideas seems to match their emotional reality during depression; and so the negative thoughts make a person feel worse - prolonging depression.

Automatic negative thoughts are just one of the many forms of depressive thinking. When people are depressed, their thinking becomes skewed in a variety of ways, including –

ALL OR NOTHING THINKING - things are placed into black-and-white categories, ignoring the exceptions and subtle shades of grey; e.g., "It's perfect or defective", "I'm lovable or unlovable", "I either succeeded or failed."

OVERGENERALISATION - a few (or even a single) bad experiences makes you believe that all similar situations will turn out badly; e.g., "Since I've made several bad decisions, I'll always fail."

LABELING - overgeneralization in the form of 'name calling'; e.g., "I'm a loser", "I'm a failure", "I'm unlovable."

DISCOUNTING THE POSITIVES - positives are explained away, they "don't count."