Personality and Personality Disorders

Summary Final Exam

CONTENTS

LECTURE 1

McAdams: "The Psychological Self as Actor, Agent, and Author"

The **psychological self** is a reflexive arrangement of the subjective *I* and the construct *Me*, which evolves and expands over the course of life. Research suggests that **semantic** (trait-based) and **episodic** (event-based) **knowledge** about the self are functionally independent. Rating oneself on traits does not typically activate recall of specific events that indicate the trait (e.g., rating oneself as extravert does not require recall of specific moments where one showed extraverted behaviour). Rather, information from concrete personal experiences is summarised into general semantic categories (trait labels) that one can retrieve.

Integrative theory of self

The **actor-agent-author framework** is an integrative theory of the self that asserts that humans (the *I*) understand themselves (the *Me*) from three different standpoints (actor, agent, author) which emerge at different points in their developmental trajectories. Importantly, these layers are not autonomous things or distinct roles that a person might play. They all exist at any given time and place. The self begins life as a social **actor**, struggling to regulate itself to perform effectively in the social stages of human life. As the person moves into middle childhood, the motivated **agent** emerges, which broadens focus to the future in the form of goal pursuit. In late adolescence and adulthood, the autobiographical **author** joins the actor and agent, creating a story about the *Me* in order to integrate the past, present, and future.

Over the course of life, people reflexively observe their own performances as social actors and monitor the reactions of others: these reactions determine one's **social reputation**. Behaviours that are reinforced will be repeated over time, while those that are punished or ignored may decrease or even extinguish. People, including infants, act in purposeful and goal-directed ways, expressing agency. However, the self as a **motivated agent** only develops when we consciously set goals and plans for our daily lives and organise our behaviour and self-understanding to be consistent with them (see *mentalising* later on). Children will internalise a theory of mind and gradually integrate their goals with roles of the social actor. People create meaning and purpose in their lives by constructing self-defining stories. The *I* becomes the author of the story of the *Me*, aiming to integrate the past, present, and future (**narrative identity**). The development of narrative identity begins with autobiographical memory but also requires autobiographical reasoning. **Autobiographical reasoning** is a wide set of interpretive operations through which people draw on autobiographical memories to make inferences about who they are and what their lives mean. Over the lifespan, narrative identity continues to develop, becoming more nuanced and integrative as one grows older.

Each of the layers of the self has central **psychosocial problems** or challenges for selfhood. These problems overlap and interact in many ways and can be understood from the three different perspectives:

> **Self-regulation** (actor): the extent to which the self (the *I*) has reflexive control over its (the *Me*'s) feelings, thoughts, impulses, and behaviours in social settings. It is the way the self keeps itself in check to minimise social punishment and maximise social reward.
>
> **Self-esteem** (agent): the extent to which the self (the *I*) feels good about itself (the *Me*). It involves the evaluative attributions that the *I* makes regarding the *Me*'s worth. The extent to which one is able to achieve goals appears to be a large determinant of self-esteem.
>
> **Self-continuity/identity** (author): the extent to which the *I* apprehends the *Me* to be continuous in space and time. Generally, the *I* may construct a different *Me* for many different situations, while it aims to construct continuity over time in two forms:

- **Phenomenological continuity**: a basic, moment-by-moment feeling that the *I* continues to exist as the same locus of feeling, thought, and consciousness (you expect to wake up as the same person as when you went to bed).
- **Narrative continuity**: a constructed sense of self as a character in one's life story. In this form, continuity is demonstrated by a narrative of how the self has changed and how it remained the same over time. In narrative discontinuity, one might not know who they really are or want to be.

Culture relates to selfhood in different ways for the different layers:

> **Behaviour expression** (actor): culture provides norms and constraints for the behavioural expression of an actor's traits and roles. Social roles entail different behaviours, duties, and customs in different societies.
>
> **Articulation of goals** (agent): culture provides timetables, scripts, and strong priorities for the agent's articulation of goals and values. Different cultures emphasise different types of goals.
>
> **Psycho-literary menu** (author): culture provides the psycho-literary menu off of which the author chooses the images, metaphors, and narratives that can be used to make narrative identity. Narrative identities are constructed to make sense in one's own culture, while it might not make sense in another. Further, there are differences in autobiographical memories between cultures.

Tomasello: "Two Key Steps in the Evolution of Human Cooperation"

Compared to other primates, humans are extremely cooperative, especially with nonrelatives. According to the **interdependence hypothesis**, at some point in evolution, humans created situations in which collaborating with others was necessary for survival and procreating, inevitably leading to altruism.

Summary Table 1
Layers of the self

	Social actor	**Motivated agent**	**Autobiographical author**
Self's contents	Social roles, skills, traits, and reputation	Personal goals, plans, values, hopes, and fears	Life narrative
Developmental emergence	Early childhood	Mid- to late childhood	Adolescence and emerging adulthood
Temporal emphasis	Present	Present and future	Past, present, and future
Mechanisms of self-definition	Self-attribution and categorisation, built on observation of social performances	Exploration of and commitment to life projects; planning; prioritising investments for the future	Autobiographical reasoning skills; construction of integrative life story
Psychosocial problems	Self-regulation	Self-esteem	Self-continuity
Culture provides	Performance norms, display rules, behavioural constraints	Scripts for goal content, timing, and goal pursuit/disengagement	A menu of images, metaphors, and stories for life

The interdependence hypothesis proposes two key **steps through which human cooperation evolved**:

1. **Obligate collaborative foraging**
   In the context of collaborative foraging (acquiring good), humans had to create various coordination strategies together which they could communicate to others within and across generations. This led to the evolution of new skills and motivations for collaboration. Importantly, this collaboration was small-scale, only existing during the collaboration itself but not after the foraging trip was over. Very young children already have a strong tendency towards joint intentionality. Humans have a great capacity for shared goals and shared mental states (**intersubjectivity**).
2. **Group mindedness**
   Small-scale cooperation worked well for foraging groups but as populations started to grow and there was increasing competition between groups, there was a growing need for a) **large-group coordination** (coordination with relative strangers, while still knowing they were from within the group (and therefore trustworthy), and b) **large-group social selection** (control of free-riding and cheating). Thus, group identification became critical, resulting in cultural conventions, norms, and institutions (**collective intentionality**). Children are born in a world of pre-existing conventional structures that they grow into and only later and partially become aware of. In this, they are introduced into a pre-existing **symbolic order** – the universe of signs and meanings typical for human societies.

Lecture

Clinical problems can be understood as expressions of negative experiences in the relation between epople and the world they inhabit. When such problems have a certain pervasiveness and persistence, they may be regarded as personality problems or diagnosed as disorders.

Historical origins of personality

Human groups get cultural histories due to the continued transmission of conventions. Cultures develop orally and through written traditions and stories about who we are and how we came to be. Histories of individuals can be located within these larger histories of the multiple *we*'s to which we belong. According to **Rhee's perspective on personality**, there are three levels: universal human nature, particular human cultures, and singular human lives. Some common confusions and mistakes made when studying this area are:

1. Naturalising cultural categories (e.g., treating race as a natural category)
2. Reducing every aspect to cultural narratives
3. Forgetting about the cultural and subjective position from where the author speaks
4. Treating all accounts as equally subjective opinions

LECTURE 2

Arntz: "Comorbidity of Syndrome Disorders and Personality Disorders"

Comorbidity of **personality disorders** (PDs) with other disorders is a rule, rather than the exception. Comorbidity occurs within and between PD clusters, but also with other syndrome disorders (e.g., depression, burnout, PTSD, anxiety). There are various treatment models available for the treatment of comorbid syndrome and personality disorders:

- **Psychodynamic model**: every syndrome disorder is the result of underlying personality problems, so treatment should focus on the personality disorder.
- **CBT model**: (initially) denied the existence of personality disorders, so treatment should focus solely on the syndrome disorder.

- **Parallel treatment**: rarely, highly specialised parallel treatments are offered.
- **Stepped care**: currently, (presumed) syndrome disorders are treated first. Only when this does not provide sufficient improvement, patients are offered a treatment for the specific PD. In cases where personality problems are so pronounced that they overshadow any syndrome disorder, treatment is directly aimed at the PD.

Treatment

To determine the right treatment in case of comorbid disorders, it is important to consider which disorder is the primary disorder. In general, **psychosocial treatments** can be used when a syndrome disorder is the primary disorder. However, it is recommended that this treatment does not continue for too long: if it's unsuccessful, the problem might not be sufficiently independent of the PD. When the PD is the main focus, **specialised psychotherapy** is the treatment of choice. These therapies are based on specific theories about the development and maintenance of PDs. For Borderline PD, these treatments include a) dialectical behaviour therapy, b) schema therapy, c) transference-focused therapy, and d) mentalisation-based treatment. For the other PDs, they include schema therapy, and specialised types of CBT and psychodynamic psychotherapy. There are currently no **pharmacological interventions** that can cure personality disorders, but they might be used for comorbid disorders or specific symptoms in combination with other therapies.

The treatment-guidelines are based on several results from empirical studies. Specialised psychotherapies for PDs systematically outperform treatment as usual, while more generic treatments do not. Notably, the number of studies is still too small for a meta-analysis. There is no (strong) evidence for a negative impact of comorbid PDs on the effects of treatment for syndrome disorders. Patients experience more severe problems at the start of treatment, but they show either parallel improvement or very small differences. The same results were found for the influence of comorbid depression on specialised psychotherapies for PDs. Furthermore, syndrome disorders were found to improve, too, when treatment was directed at PD.

Lecture

What defines personality disorders?

Personality disorders are psychopathology connected to our personality. They have become part of our character/are who we are (egosyntonic). They usually originate in our early development and start being present in early adulthood. They are often defined by rigid, inflexible thoughts, feelings, actions, and impulse regulation. They are sometimes only experienced by others, and related to high healthcare costs, healthcare consumption, societal costs, and low quality of life.

The **prevalence** of at least one PD in the general population is 9-13%. In outpatient care, it is 30-50%, and in inpatient care 50-70%. The prevalence is particularly high in addiction and forensic settings. Regarding the **course**, it was found that it typically develops in adolescence. Pathology improves during development, and PDs are treatable (much better than previously assumed). **Life expectancy** is on average 18 years shorter (excluding suicide!). Cardiovascular diseases because of lifestyle, chronic stress, and medication are common.

Ideas about **normal personality** changed over time. Generally, personality is seen as habitual ways of thinking, feeling, and acting. People used to think that this was consistent across situations. However, it was later found that there is large situational variance. Another outdated idea is that personality is shaped around 18 years and remains unchanged.

According to the **DSM-5**, dysfunction has to manifest in two or more of four domains: cognition, affect, interpersonal functioning, and impulse controls. PDs are often described with the **three Ps**: pervasive

(across most situations), problematic (causes distress and/or impairment), and persistent (stable and long duration, since early adulthood). There are three **clusters**:

1. **Cluster A**: strange, bizarre; often seen as a variant of psychosis; includes paranoid PD, schizotypal PD, and schizoid PD
2. **Cluster B**: dramatic, emotional, impulsive; often seen as a variant of externalising disorders; includes histrionic PD, narcissistic PD, borderline PD, and antisocial PD
3. **Cluster C**: fearful, anxious; often seen as a variant of internalising disorders (neurosis); includes avoidant PD, dependent PD, and obsessive-compulsive PD
4. **Other categories**: personality change due to another medical condition, other specified PD, unspecified PD

There are different **types of diagnosis**:

- **Monothetic**: members must mee the same properties of criteria
- **Polythetic**: members must meet a minimal number of symptom criteria from one criteria set (developed by Wittgenstein for biological classifications/family resemblance)
- **Categorical versus dimensional**: most disorders are dimension, but we still use categorical diagnoses because dimensional diagnosis is very difficult

Personality disorders are dimensional. Taxa (categorical) are only supported for schizotypy, autism, and SUDs.

Aetiologically, **childhood trauma** seems to be an important **risk factor**. Childhood abuse and neglect are common, with around 11% experiencing sexual abuse and 26.7% emotional abuse. There is a general and unique correlation with childhood trauma types for PDs (see table). Explanations for that are insecure attachment styles, deficient emotion regulation and coping skills, and distortions in and fragmented memories.

Path coefficients, adjusted for other traumata

Personality disorders	Sexual abuse	Physical abuse	Emotional abuse	Emotional neglect	Physical neglect
Cluster A					
Paranoid	.17*	.05	.15	.08	-.02
Schizotypal	.07	.10	.19*	.01	-.008
Schizoid	.11	.08	.09	.10	-.006
Cluster B					
Histrionic	-.04	.12	.02	.14	.03
Narcissistic	-.008	.14	.03	.07	-.02
Borderline	.26**	.07	.19*	.17*	-.07
Antisocial	.04	.29**	-.12	.12	-.01
Cluster C					
Avoidant	.11	-.06	.28**	.01	-.01
Dependent	-.001	-.09	.30**	.14	-.05
Obsessive-Compulsive	-.006	-.07	.25*	.02	-.004

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However, around 70% of adults experienced some aversive childhood events, but not everyone develops psychopathology. The upbringing/behaviour of the caregiver might have an effect on vulnerability. The more problematic parent behaviours are, the bigger the chance for a PD to develop.

Diagnosis can be difficult because clinical expertise is often biased due to stereotypes having a big influence (e.g., more antisocial PD in homeless people), premature closure, and confirmation bias. That is why semi-structured interviews such as the **SCID-5** are often used.

LECTURE 3

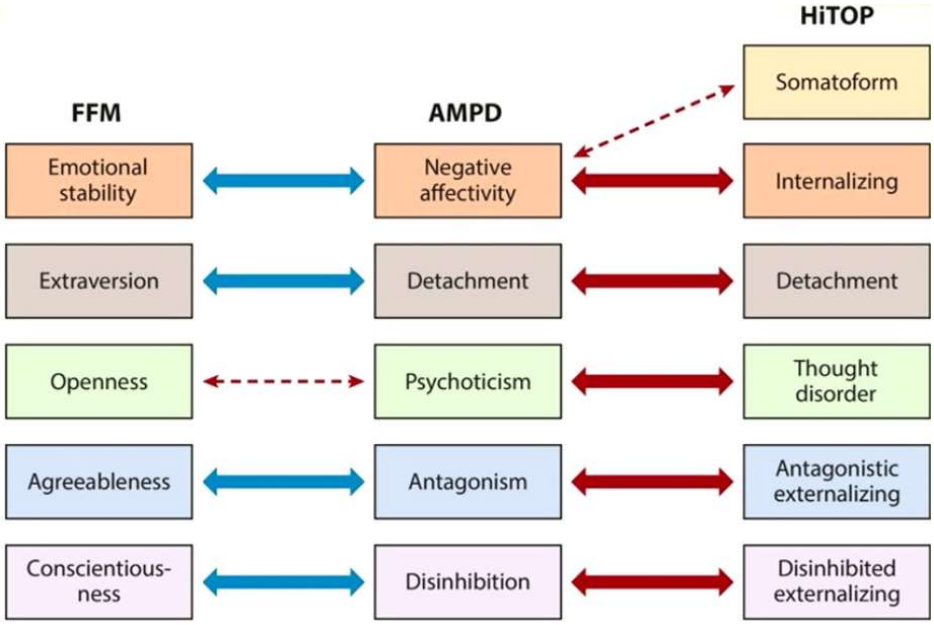
Lecture

Measuring self-reported traits

The **five-factor model of personality** (FFM) is based on the **lexical hypothesis**, which is itself based on three hypotheses:

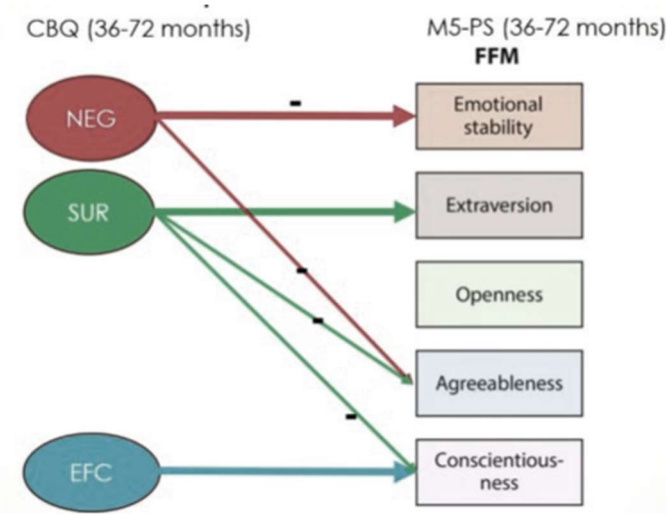
1. Those personality characteristics that are important to a group of people will eventually become a part of that group's language.
2. More important personality characteristics are more likely to be encoded into language as a single word.
3. Principle component analysis of the covariance-structure of traits can be used to extract the most important aspects of variation in a population.

The FFM is related to the **alternative model of personality disorders**:



Interpreting covariance structures

One can define a **trait** as an inferred organismic structure underlying an extended family of behavioural dispositions. These dispositions are not meant to be viewed as generalised action tendencies, but as inclinations to behave in certain ways in a set of trait-relevant situations.



The **multidimensional personality questionnaire** boils down to three domains: positive emotionality, negative emotionality, and constraint. It is a realist model because we have an idea of what psychobiological functions the domains relate (e.g., they might be related to infant temperament). There is some continuity from temperamental traits to personality traits (see graph).

Situationism is the strong position that people behave only based on situational factors. This is no longer compatible with evidence, but a weaker version may be maintained. There is evidence for both situations and personality, so it can be assumed that both are correct. Traits are best regarded as person-specific distributions of certain states of mind. Thus, they indicate the likelihood of such states over a certain time period. These person-specific distributions are quite stable. The specific outcomes at any particular moment vary a great deal.

Network stability means that the interaction of particular acts, feelings, and thoughts leads to covariance and thereby to the emergence of generalised traits.

The **self as a social actor** encompasses semantic representations of traits, social roles, and other features of the self that result in and from repeated performances on the social stage of life. Actions are perceived and judged by others. The reactions lead to self-judgement. This leads to_a-ctions again which leads to the emergence of a stable character of an actor.

Coding narratives

Two examples of how to code a narrative are by using the concepts of **agency** (self-protection, self-assertion, self-expansion) and **communion** (being at one with other organisms, lack of separations). Agency is based on the urge to master, and can lead to separation, isolation, alienation, and aloneness. Communion is based on contractual cooperation and can lead to contact, openness, and union. They are elaborated more in the following:

Agency

Agency encompasses a wide range of psychological and motivational ideas, including the concepts of strength, power, expansion, mastery, control, dominance, autonomy, separation, and independence:

- **Self-mastery** (SM): the story protagonist strives successfully to master, control, enlarge, or perfect the self. Through forceful or effective action, thought, or experience, the protagonist is able to strengthen the self, to become a larger, wiser, or more powerful agent in the world.
- **Status/victory** (SV): the protagonist attains a heightened status or prestige among their peers, through receiving a special recognition or honour or winning a contest or competition.
- **Achievement/responsibility** (AR): the person reports substantial success in the achievement of tasks, jobs, instrumental goals, or in the assumption of important responsibilities.
- **Empowerment** (EM): the subject is enlarged, enhanced, empowered, ennobled, or made batter through their association with someone or something larger and more powerful than the self. The self is made even more agentic by virtue of its involvement with an even more powerful agent of some sort.

Communion

Communion encompasses psychological and motivational ideas concerning love, friendship, intimacy, sharing, belonging, affiliation, and so on. At its heart, communion involves different people coming together in warm, close, caring, and communicative relationships:

- **Love/friendship** (LF): a protagonist experiences an enhancement of erotic love or friendship toward another person.
- **Dialogue** (DG): a person experiences a reciprocal and non-instrumental form of communication or dialogue with another person or group of others.

- **Caring/helping** (CH): the individual reports that they provide care, assistance, nurturance, help, or support for another, thereby contributing to the physical, social, material, or emotional welfare or well-being of the other.
- **Unity/togetherness** (UT): whereas the communal themes of LF, DG, and CH tend to specific relationships between the protagonist and one or a few other people, the theme of UT captures the communal idea of being part of a larger community.

Variation in narrative identity is associated with trajectories of mental health over several years.

LECTURE 4

Feinstein Chapter 22: "Avoidant Personality Disorder"

Avoidant personality disorder (AVPD) is a psychiatric condition characterised by shyness, hypersensitivity, loneliness, rejection sensitivity, and low self-esteem. Individuals are desperate for human contact but avoid involvement with others out of fear of disapproval and sensitivity to rejection. The following are the seven **most relevant descriptors**:

1. **Triggering event**: the triggering even is most commonly the demand for close interpersonal interactions or social and public appearances.
2. **Behavioural style**: chronic tenseness and self-consciousness, controlled speech and behaviour, awkward or apprehensive appearances are common, as well as self-critical behaviour and playing down or discounting of achievements.
3. **Interpersonal style**: patients are keenly sensitive to rejection. They desire acceptance but distance themselves from others and require unconditional approval before opening up. They 'test' others to determine who can be trusted.
4. **Cognitive style**: they are hypervigilant, continually scan the environment for potential threats, and show distracted thinking and hypersensitivity to perceived criticism, disapproval, or rejection. They overemphasise shortcomings and downplay triumphs which leads to low self-esteem.
5. **Affective style**: they show shyness and apprehensiveness, as well as loneliness, sadness, and tension. When experiencing marked distress, they feel labile, empty, and depersonalised.
6. **Attachment style**: their attachment style is both preoccupied and fearful.
7. **Optimal diagnostic criterion**: the optimal diagnostic criterion is avoidance of occupational activities that involve significant interpersonal contact for fear of criticism, disapproval, or rejection.

The **DSM-5** defines AVPD as unremitting patterns of social inhibition, feelings of inadequacy, an oversensitivity to negative evaluations from others, and viewing oneself as socially inept, unappealing, and inferior to others. They avoid work activities that require close interpersonal contact and unless they have a high certainty of being accepted, they will not engage or get involved with others. They are uncomfortable and often act with restraint for fear of being ridiculed or shamed in ongoing relationships and they avoid activities that involve personal risk or may prove to be embarrassing.

Prototypic description
These individuals tend to be frightened and interpersonally awkward, and experience extreme sensitivity to rejection and criticism. Fear of humiliation and embarrassment surfaces with the prospect of meeting someone new. Therefore, it is simpler to avoid different or new work, social engagements, or responsibilities that could threaten their established sense of interpersonal safety. On the other hand, they crave interpersonal connections, especially to those with whom they have established trust. They may have one or a few special friends or relatives whom they can trust and with whom they feel safe.

The **prevalence** is around 2.4% in the general population and estimated between 5.1-55.4% in clinical populations.

When comparing AVPD to **social anxiety disorder** (SAD), there are two views:

1. SAD is a symptom disorder that differs qualitatively from AVPD, a personality disorder.
2. AVPD is on a spectrum with SAD, with AVPD being at the most severe end.

Recent studies found evidence that a continuum of severity does not explain the differences between the two disorders, as there were no global severity index differences in SAD groups when compared to AVPD groups. There is a higher deficit in metacognitive skills for AVPD patients. Other major differences are avoidant behaviour, early attachment, attachment styles, and self-concept.

Conceptualisations of AVPD

According to the **psychodynamic** case conceptualisation, avoidance, shyness, and shame are to be understood as defence mechanisms against humiliation, embarrassment, rejection, and failure. It stems from self-perceptions of weakness, incompetence, defectiveness, disgusts, and inability to control bodily functions. Behaviour is motivated by a shame of failure to live up to the ego ideal.

The **biosocial** case conceptualisation holds that aetiology and development represent a constellation of biogenic environmental factors. Vigilance is explained by a combination of a dominant sympathetic nervous system and lowered autonomic arousal threshold which allows for the intrusion of irrelevant impulses on logical association, diminishing control, and direction of cognitive processes and memory. Parental and peer group rejection is a major environmental influence. Given their hypersensitivity, even when no rejection is intended, minor snubs tend to be interpreted as evidence of rejection.

According to the **cognitive-behavioural** and **schema therapy** case conceptualisations, those with AVPD maintain the core belief of rejection which explains their fearfulness when they attempt to initiate relationships as well as their fearful response when others attempt to relate to them. Social rejection is so intolerable that they resort to avoidance of social situations and engage in cognitive and emotional avoidance by attempting to reduce thoughts and internal experiences that could cause discomfort or dysphoria. Maladaptive schemas or long-standing dysfunctional beliefs about self and others also underlie these avoidance patterns. They see their selves as socially inept and incompetent in academic and vocational settings. They make predictions likely interpreted as solely caused by personal deficiencies and lack internal criteria to form positive self-judgements which leads to misreading neutral or positive reactions as negative. This creates a compounding effect that heightens their sensitivity toward rejection and avoidance.

The **interpersonal** case conceptualisation is based on the idea that development begins with appropriate social bonding, attachment, and nurturance which is why this is continued to be desired throughout development. As they are subjected to relentless parental control toward creating a certain social image, visible flaws become the subjects of humiliation and embarrassment, especially within the family. Individuals experience mockery and social retribution for shortcomings and failures which has the consequence that as adults, they are expected to perform flawlessly and avoid any potential for humiliation or embarrassment. The anticipation of rejection is thereby internalised. Even though rejection and ridicule from families was rampant, they internalised the belief that their family is their main source of support which means that they stay loyal but harbour fear towards others.

The **integrative** case conceptualisation argues for an interplay of three domains:

1. **Biology**: individuals are commonly hyperirritable, fearful, and demonstrate a ‘slow to warm’ temperament as infants. They are difficult to soothe.

2. **Psychology**: patients have self-views of inadequacy and fear of rejection. They see life as unjust, and people as critical and rejecting. They often use fantasy as a defence mechanism (e.g., watching soap operas).
3. **Social**: parental ridicule and rejection contributed greatly.

Treatment approaches and interventions

The **essential goals** of treatment are expanding the capability to tolerate feedback and selectively trust others, and encouraging taking some risks in their social interactions which may mean assertively communicating needs, wants, and wishes, or taking the risk of requesting feedback from those who were previously supportive of them. Individual therapy can aid to recognise patterns of avoidance and social withdrawal. CBT and schema therapy are supported the most.

For more on treatments, see the corresponding lecture.

Feinstein Chapter 23: "Dependent Personality Disorder"

There is considerable conceptual and empirical overlap between the more pathological manifestations of dependency and normally distributed interpersonal dependency. **Dependent personality disorder** (DPD) poses a unique clinical challenge since patients have a great number of pseudo emergencies. Even though it is associated with passivity and submissiveness, patients are capable of behaving actively and even aggressively in certain situations. They have an increased risk for perpetrating domestic abuse.

Epidemiology

The **prevalence** is around 5-10% in inpatient units, 2-3% in outpatients, and about 1% in the general population. Two thirds of patients are women.

The **DSM-5** defines DPD as a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation. Patients need to show at least five of the following symptoms:

- Difficulty making decisions without excessive advice and reassurance
- Needing others to assume responsibility for most major areas of life
- Difficulty expressing disagreement
- Difficulty initiating projects or doing things on one's own
- Going to excessive lengths to obtain nurturance and support
- Feeling helpless when alone
- Urgently seeking another source of protection when an important relationship ends
- Preoccupied with fears of being left to care for oneself

DPD is **comorbid** with depression, somatisation disorder, SAD, agoraphobia, as well as with borderline, histrionic, and avoidant PD. Substance abuse is also common, but this can be challenging to diagnose as underlying dependency strivings also play a role in other syndromes.

Aetiology of pathological dependency

DPD is approximately 30% accounted for by **genetic factors**. Infantile temperamental variables (e.g., withdrawal, low adaptability, high reactivity) are early signs. During early and middle childhood, problematic dependency is manifest most prominently as **insecure attachments**, such as difficulty tolerating separation form the caregiver, along with an absence of age-appropriate increases in autonomy and self-sufficiency. School refusal is common.

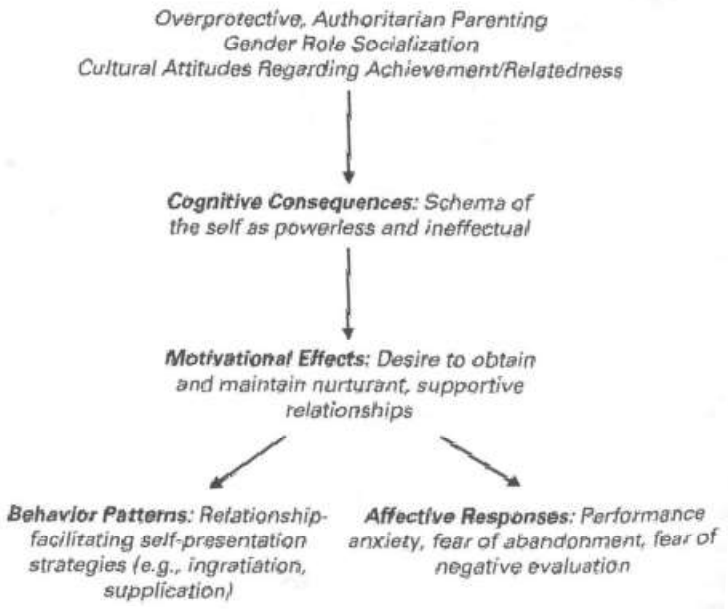
Overprotective parenting teaches children that they are vulnerable and weak. **Authoritative parenting** is also associated with increased dependency because the rigid, inflexible, rule-oriented parent

teaches the child that the way to get by in life is to accede to others' demands and expectations while simultaneously limiting trial-and-error learning opportunities. There is higher dependency in more collectivistic cultures.

Contemporary definitions of dependency emphasise **four components**:

1. **Motivational**: characterised by a marked need for guidance, support, and approval from others
2. **Cognitive**: perception of oneself as powerless and ineffectual, couple with the belief that other people are comparatively confident and competent
3. **Affective**: tendency to become anxious when required to function autonomously
4. **Behavioural**: use of broad array of social influence strategies to strengthen ties to potential caregivers and preclude abandonment

The **cognitive/interactionist model of interpersonal dependency** looks as follows:



The C/I model conceptualises dependency-related responding as proactive, goal-driven, and guided by beliefs and expectations regarding the self, other people, and self-other interactions. The locus of stability in dependency is shifted from surface situational responding to underlying personality beliefs in thought and motive.

Adaptive manifestations of dependency are characterised by strivings that, even when strong, are exhibited selectively (i.e., in some contexts but not others) and flexibly (i.e., in situation-appropriate ways). For a comparison, see the table.

A realistic and achievable **treatment goal** is to promote healthy dependency, and help the patient express dependency needs in a way that is more likely to lead to positive outcomes, with fewer relationship conflicts and disruptions. There are however also certain **treatment challenges**. When patients become attached to the clinician, anxiety regarding rejection and abandonment increase, and behaviours designed to minimise the possibility of relationship disruption begin to dominate and interfere with the therapeutic progress. One way to prevent dependency-related fears from undermining treatment is to explore the patient's transference reaction and the therapist's countertransference

Table 23.2. Contrasting Dynamics of Maladaptive and Adaptive Dependency

Domain	Maladaptive Dependency	Adaptive Dependency
Self-Concept	Separate/Isolated	Relational/Interdependent
Attachment Style	High abandonment fear Anxious/ insecure attachment	Low abandonment fear Secure attachment
Defense Style	Immature/Maladaptive Inflexible	Mature/Adaptive Flexible
Core Personality Traits	High neuroticism	Low neuroticism
	Low extraversion	High extraversion
	Low conscientiousness	High conscientiousness
Alexithymia	High	Low
Affect Regulation	Poor	Good
Resilience Following Relationship Disruption	Weak	Strong
Empathy	Low (rigid self-focus)	High (self- and other-focus)
Well-Being/ Quality of Life	Low life satisfaction	High life satisfaction
	Poor relations with parents	Good relations with parents
	Poor self-care	Good self-care
	Low baseline distress	High baseline distress
Risk for Victimization	High	Low
Relations with Health Care Providers	Frequent requests for help	Adaptive help-seeking
	High provider ambivalence	Positive provider attitude

response. Common **transference** patterns include idealisation, possessiveness, and projective identification. Common **countertransferences** include frustration at the neediness, hidden hostility, overindulgence, and pleasurable feelings of power and omnipotence.

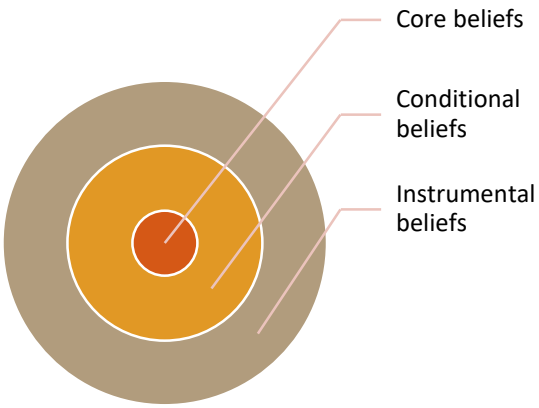
Different **treatment strategies** may be required for patients whose problematic dependency preceded the onset of other syndromes and those whose dependency was secondary to one or more clinical disorders. It may be useful for the clinician to help the patient to express their dependency in healthier, more adaptive ways. Rather than aiming for rigid autonomy, a relationship-facilitating blend of autonomy and connectedness, coupled with situation-appropriate help- and support-seeking should be a central goal of therapeutic work with dependent patients.

Livesley: "Cognitive Structures and Processes in Personality Disorders"

Cognitive theories of PDs are theories that propose that cognitive structures (schemas) and processes (biases) underlie the development and maintenance of personality disorders. These are assumed to result from the interaction between temperament and environmental influences in early development.

Schemas

A **schema** is a generalised knowledge structure that is represented in memory and governs information processing, including attention, interpretation, and memory. Schemas can be verbal and nonverbal. **Schema modes** are transient state-related patterns of schematic activation, which are a combination of an activated schema and coping with this activation. Schemas and information processing are the basis for our subjective experience. They colour our



experience, without our awareness. In other words, the experienced emotions and cognitions are the truth for many people, instead of being seen as the result of processes governed by schemas. Thus, this can explain the egosyntonic nature of PDs. Central to PDs, there are three important **belief layers** that are part of schemas:

1. **Unconditional** (core) **beliefs**: beliefs that represent the basic assumptions about the self, others, and the world
2. **Conditional beliefs**: beliefs about conditional relationships in terms of "if…, then…"-structures
3. **Instrumental beliefs**: beliefs about how to act to avoid bad things and acquire good things

There are beliefs that are general across all PDs, as well as specificity of beliefs for specific PDs. Schemas for PDs are assumed to develop during childhood, from the interaction of biological and environmental influences. Children differ in their innate sensitivity to the environment and how they respond to stressors. Schemas are strongly influenced by relationships of the child with the caregiver, and later peers, and by emotional experiences and how they are processed. They are often adaptive in the child's developmental environment but can become dysfunctional when environmental circumstances change in later (adult) life. Schemas are triggered by specific internal or external stimuli. It is important for clinical practice to look into these trigger stimuli, so that corrective experiences can be effective.

Schema theory is the idea that PD-related schemas arise from experiences during early childhood when basic needs are not met. There are several coping styles that individuals use to deal with the activation of **early maladaptive schemas** (EMSs) which help understand PDs:

- **Overcompensation**: the person behaves and thinks in a way that is the opposite of the triggered EMS, to keep it out of awareness as much as possible.
- **Avoidance**: the person tries to prevent triggering EMSs or avoids the emotions and thoughts that are aroused when they are triggered.
- **Surrender**: the person submits to what the EMSs dictate, leading to them completely believing it's true.

Cognitive bias

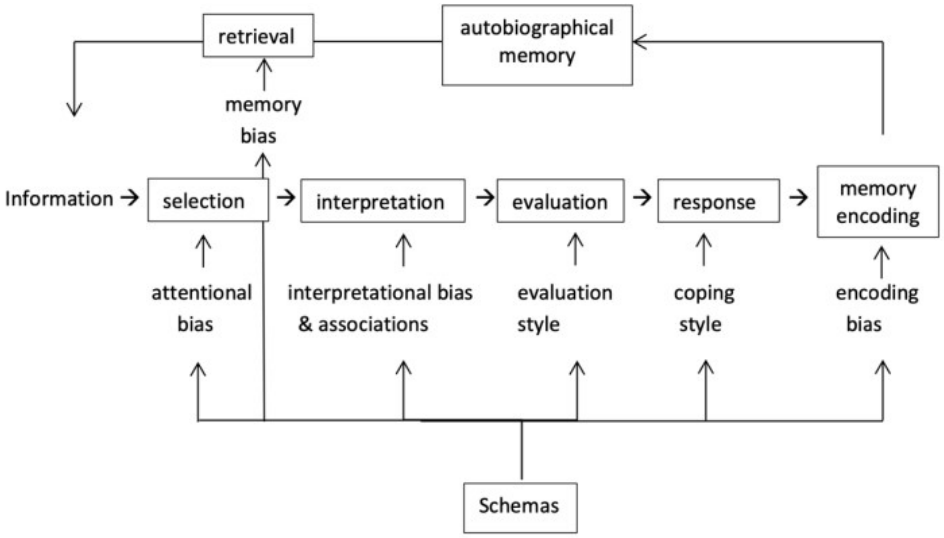
Once activated, schemas govern information processing and often cause cognitive biases. **Cognitive biases** are systematic deviations in information processing, from the norm, or from what is logical, based on existing schemas. There are several common biases:

- **Attentional bias**: allocating attentional resources to certain stimuli, at the expense of other stimuli
- **Interpretational bias**: interpreting information in a biased way
- **Evaluation bias**: evaluating information in a biased way, depending on one's evaluation style (e.g., overgeneralisation, dichotomous thinking, negativity)
- **Response bias**: responding to events in a way that reflects habitual coping consistent with one's instrumental beliefs
- **Encoding and memory bias**: retaining information and retrieving that information in a biased way, depending on existing schemas

Information processing

There are different phases of information processing, which are influenced by different cognitive biases:

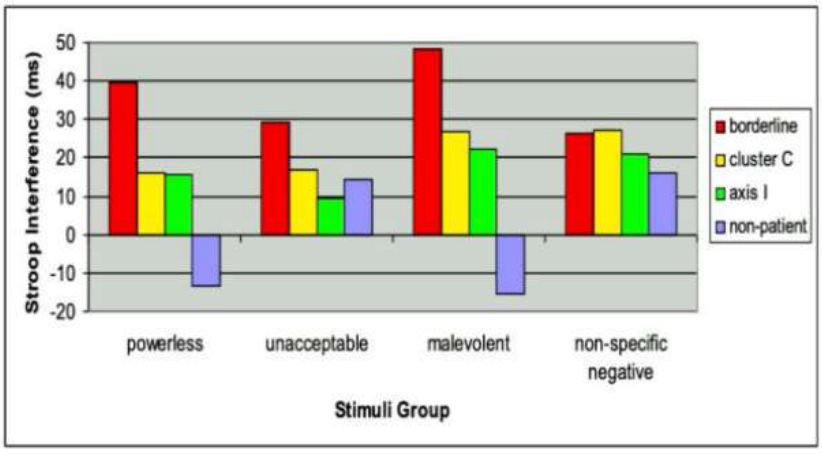
	Description	Possible bias
Selection	Select which incoming information is important	Attentional bias
Interpretation	Give meaning to the selected information	Interpretation bias
Evaluation	Evaluate the meaning of the selected information	Evaluative bias
Response	Choose a coping response	Response bias
Encoding	Encode the information in autobiographical memory	Encoding bias
Retrieval	Retrieve memories from autobiographical memory	Memory bias



When people receive new information, it can be integrated in one of two ways:

1. **Assimilation**: inclusion in already existing schema, sometimes adjusted (more common process)
2. **Accommodation**: adjustment of the schema according to new information (difficult)

The attentional bias in PDs can be seen in an **emotional Stroop task**:



Lecture

Experimental neurosis is when people cannot predict the outcome of exposure to a certain stimulus (approach-avoidance conflict).

Obsessive-compulsive personality disorder

Obsessive-compulsive personality disorder (OCPD) is marked by the following:

- Preoccupation with details, rules, schedules, and organisation
- Controlling and perfectionism
- Devotion to work and productivity to the exclusion of leisure activities and friendships
- High moral standards
- Unable to discard worn-out or worthless objects (with functional attachment)
- Reluctant to delegate tasks
- A miserly spending style
- Rigidity and stubbornness

Patients are extremely rational and often workaholics. OCPD is related to increased wealth and higher statues since their pathological traits are valued by society. Relatively few patients seek help for OCPD. **Aetiological factors** are a lack of emotional expression, a lack of relaxation, fun, and playtime, rigid rules, punitive parenting styles, overprotection, emphases on achievements, too much responsibility early in life, and parentification. The prevalence in the general population is around 2%, while it is around 10% in clinical populations. It is more common in women and in people with *higher* socioeconomic status.

OCPD is **comorbid** with depression and other mood disorders, anxiety, and eating disorders, as well as a low comorbidity to AVPD and DPD. The symptom overlap with OCD makes correlation analyses difficult, but OCPD is not causally related to OCD.

LECTURE 5

Feinstein Chapter 19: "Borderline Personality Disorder"

Borderline personality disorder (BPD) is a mental disorder characterised by instability in interpersonal relationships, affective lability, intense and inappropriate aggressivity and hostility, identity disturbance, and impaired impulse control. It commonly cooccurs with mood disorders, anxiety disorders, and SUDs. It leads to a high level of psychosocial impairment relative to other disorders. Patients are 50 times more likely to die by suicide than the general population.

Epidemiology, gender, and ethnicity

BPD has a 2.7-5.9% **lifetime prevalence**. In psychiatric clinics, the prevalence is between 15-28%. There is an eight-year **remission rate** of 79% and a two-year remission rate of 99%. Symptoms of anger and self-destructive behaviour in BPD remit over time, while older adults remain impaired in terms of emotion regulation, impulsivity, and social functioning.

The prevalence appears equal between **men and women** in several population-based epidemiologic studies. Women reported greater levels of hostility, relationship disruption, symptoms of depression, anxiety, and somatisation than men. There is an interaction between gender and ethnicity: it is more prevalent in Native American men and less prevalent among Asian women. Sexual minority individuals are more likely to suffer from BPD than heterosexuals.

BPD patients complete **suicide** more often than individuals in the general population. BPD patients may account for between 9-33% of all completed suicides. Rates of **non-suicidal self-injury** in BPD are estimated to be as high as 90%.

Common cooccurring disorders

Approximately 75% of BPD patients also met the criteria for **mood disorders**, mostly MDD. MDD and BPD exhibit distinct phenomenology, course of illness, treatment response, and biomarkers. Those with both MDD and BPD are more likely to attempt suicide than those with MDD without BPD.

Around 20% of patients also have **bipolar disorder**. Studies found differences between the disorders in hippocampal morphology.

Anxiety disorders are nearly as common as mood disorders in those with BPD. The relationship between anxiety sensitivity and BPD suggests that they may have shared underlying trait anxiety.

31.6% of patients meet the criteria for **PTSD**. They are distinct disorders with unique patterns of symptoms. Due to symptomatic similarities, clinicians can often have difficulty differentiating BPD from PTSD.

ADHD often cooccurs. Impulsivity and emotion dysregulation are overlapping symptoms.

Approximately half of all BPD patients have a cooccurring **substance use disorder**. Both impulsivity and emotion regulation may play a role in the development of both.

There is also substantial overlap between BPD and other **personality disorders**. BPD is most strongly associated with schizotypal and narcissistic PDs.

40% of patients have cooccurring **psychotic disorders**. BPD is also associated with **health conditions** such as cardiovascular disease, stroke, diabetes, obesity, gastrointestinal diseases, arthritis, chronic pain, venereal diseases, HIV, and sleep disorders.

Genetic, biologic, and neural underpinnings

Genetic and environmental factors interact in the development of BPD. **Heritability** is estimated to be around .4. There are no big enough genome wide association studies, but brain scanning studies found **abnormalities in areas of the brain** involved in social-emotional processing, including **amygdala** and **insula**, as well as **frontal brain regions** involved in regulatory control. There is reduced grey matter volume along with hyperactivity of the left amygdala relative to controls. Amygdala hyperactivity was moderate by the individuals' medication status. Studies found impaired amygdala habituation when presented a series of negative affect inducing images. Processing of social stimuli such as faces and other nonverbal cues are negatively biased in BPD, leading to impairments in appraising trustworthiness. Impaired appraisal of trustworthiness is associated with less frontal activation relative to controls, suggesting impaired top-down decision-making with regard to trustworthiness appraisal specifically. The neuropeptide **oxytocin** may play an important role in rejection sensitivity and attachment difficulties of individuals with BPD. Women with BPD have reduced oxytocin concentrations, with a negative relationship between their levels of plasma oxytocin and the number of traumatic childhood experiences they reported. The **HPA axis** has been implicated due to its role in stress response. This led to mixed results: some studies reported increased levels of cortisol concentration and others no differences. A potential model is that early life stress affects the maturation of the HPA axis with mild stress later on resulting in increased impulsivity and issues with habituation and social interactions.

Psycho-social-cultural risk factors

Patients with BPD report more **adverse childhood experiences**. Childhood sexual abuse has a small but significant association with BPD. It is also associated with low SES. BPD patients often have

insecure and disorganised attachment styles which develop from a childhood marked by erratic or inconsistent caregiving. Disorganised attachment styles are associated with lower plasma levels of oxytocin and increased amygdala activation.

Interviewing, assessment, case formulation, and treatment

For **assessment**, the clinician should clarify presenting problem(s) including a chief complaint and an initial mental status examination after gathering identifying information. They should not just focus on symptoms but functioning in life more generally. The clinician should ascertain functioning in 1) love and sexual relations, 2) work, career, and vocation, and 3) creative pursuits and leisure activity. They should consult with former treaters and family members to get a full clinical picture, and assess suicidality.

Most patients exhibit some form of depressive symptomatology, which is why BPD is often mistaken for a mood disorder. Some clinicians avoid disclosing the BPD diagnosis, citing concerns about stigma or inducing hopelessness in patients.

A diagnosis of psychodynamically informed **personality organisation** and character style can greatly aid in evaluating prognosis, treatment planning, and anticipating predominant transference and countertransference dynamics. Facets of personality functioning that can greatly aid assessment and treatment planning include:

- Assessment of identity
- Quality of object relations
- Defensive operations
- Moral functioning
- Aggression
- Reality testing

Those with BP organisation exhibit rapidly shifting, polarised, and rigid mental representations of the self and others. Identity diffusion is a consequence of these 'split' mental representations. Patients often have a superficial understanding of mental life of the self and others and poor capacity to reason about them. There is usually intact reality testing except under stress.

Transference and countertransference

Patients can elicit intense and polarised transference dynamics and countertransference reactions. **Transference** is often emotionally intense, conscious, and either negative (paranoid) or positive (idealising) from the earliest first clinical encounters. A **paranoid** transference is present when a patient fears that if they are open about their problems, the clinician will be critical, rejecting, or cruel. **Narcissistic** transference is dominant when the patient expresses depreciation of the therapist and a corresponding entitlement and inflated self-worth in relation to the therapist. **Erotic** transference is when sexual interest or desires emerge toward the therapist or the patient attributes sexual desire to the therapist. **Depressive** transference may emerge as the patient begins to work through the loss of 'idealised' images of others.

A full range of **countertransference** feelings needs to be tolerated. **Distressing** countertransference arises when working with patients can confuse therapists and disrupt their ability to empathise with their patients and communicate effectively with them. **Overwhelmed/disorganised** countertransference occurs when the clinician feels dread towards or threatened by a patient, leading to feeling overwhelmed and confused. **Special/overinvolved** countertransference is the feeling that a patient is special and perhaps a 'favourite'. **Sexualised** countertransference means having erotic feelings or desires towards the patient. **Criticised/mistreated** countertransference means feeling undervalued, helpless,

criticised, inadequate, or incompetent. **Parental** countertransference means taking on maternal/paternal nurturing roles that go beyond typical genuine warmth.

Feinstein Chapter 20: "Histrionic Personality Disorder"

Histrionic traits, such as attention-seeking behaviour, shallow affect, and seductive appearances or behaviours often stem from family trauma, emotional abuse, parental neglect, or inconsistent discipline, and inherited genetic factors. Somatic symptoms, such as headaches with no clear underlying medical pathology are common. Patients with histrionic personality disorder (HPD) are either unaware of social boundaries or choose to ignore them because the drive for attention is simply greater than the drive to adhere to social norms. Extreme emotional expression, a shallow affect, fear of dependency, and an unstable identity may impact the patient's ability to form long-term relationships because the need for attention or drama eclipses the underlying desire for acceptance, deep emotional connections, or love. Behaviours often do not disturb clients themselves. They mostly seek help when their behaviour poses a significant threat to their lifestyle, interpersonal relationships, or at the urging of others.

Diagnostic considerations

Patients are flamboyant, sexualised, aggressive, and unpredictable. To mee the criteria, they must demonstrate a pervasive pattern of excessive emotionality and attention-seeking behaviours by early adulthood across multiple life domains. There are several **HPD subtypes**:

- **Appeasing**: attention-seeking behaviour coupled with a desperate need for friendship and acceptance driven by fear and anxiety
- **Vivacious**: charming, seductive, but emotionally empty, sometimes similar to hypomania; struggles with complex emotional attachment
- **Tempestuous**: emotionally labile, quick to anger, will engage in conflict if it serves perceived attention needs
- **Disingenuous**: attention-seeking behaviour is grounded in a desire to manipulate or control others for the patient's personal amusement
- **Theatrical**: self-promoting and seeking praise and adulation for superficial features such as clothing or appearance
- **Infantile**: shares features of its tempestuous counterpart, but behaviours do not match developmental age

Hypomania, **mania**, and some presentations of **delusional psychoses** may look like HPD, as they often have hypersexuality as apart of their common presentation. Both can appear with grandiosity, excessive talkativeness, distractibility, and risky behaviours. However, manic patients are more likely to have racing thoughts and a decreased need for sleep. Personality disorders are pervasive, whereas mood shifts in bipolar disorders are episodic. When contemplating differential diagnosis with a psychotic disorder, exploring reality testing is useful. **Narcissistic personality disorder** differs from HPD in that the narcissist's motivation for attention, praise, and power is to reaffirm their grandiosity, not for the pure sake of attention. A patient with **borderline personality disorder** may seek attention fuelled by anxiety and fear, but the need to tether their unstable identity to others and their fear of abandonment are primary motivations. Histrionic patients may have hyperbolic accounts of their activities but they are reasonable within the context of their life.

There is a **prevalence** of around 2-3% in the general population. Women are more likely than men to be diagnosed, but this may also be due to gender bias.

HPD patients sometimes have an additional personality disorder (mostly NPD, BPD). It is often **comorbid** with depression and bipolar spectrum.

Heritability is modest to moderate. Babies with an inherited 'histrionic' temperament may be genetically primed for HPD and then be environmentally activated as a teenager or adult.

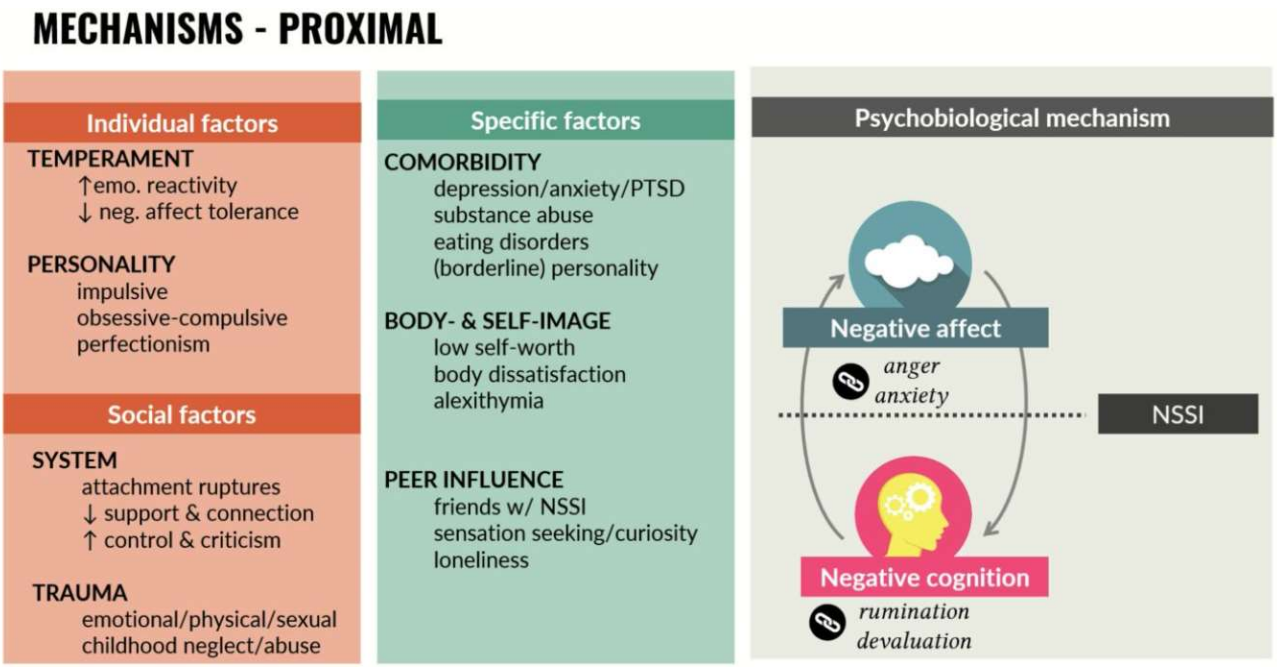
The **environmental context** has to be considered. In some careers and environments, these personality traits are valued. Cultural considerations must be nuanced, as the level of emotionality varies widely by culture and country. What is considered abnormal behaviour in one culture may be perfectly acceptable in another.

The main goal of **treatment** is to improve meaningful interpersonal dynamics. Patients are often unable to sustain deep and meaningful relationships as their superficial emotional style, attention-seeking behaviours, and dependency often become tiresome to others.

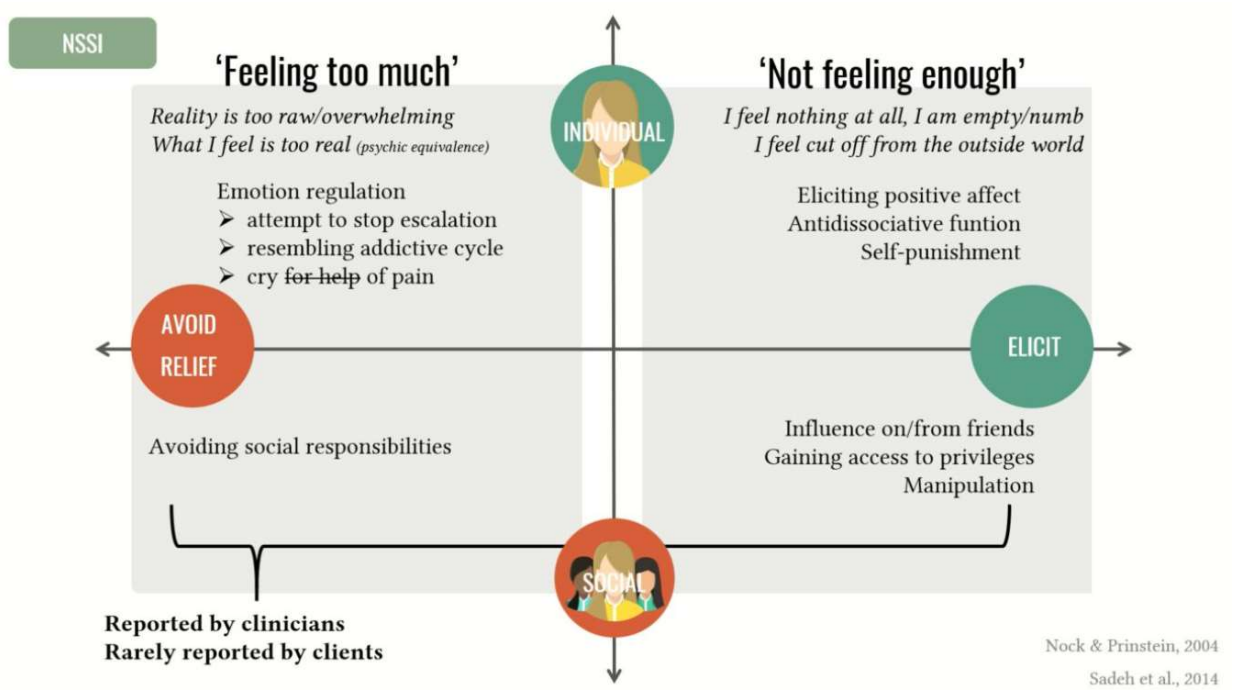
Lecture

Non-suicidal self-injury

Non-suicidal self-injury (NSSI) is a socially unacceptable behaviour where a person intentionally damages bodily tissue without the intent to die. There is a 61-90% NSSI prevalence in **BPD**. It is the most commonly met diagnostic criterion for BPD in adolescence and the hardest symptom to treat. The proposed **mechanisms** for NSSI are depicted in the following graph:



The vicious psychobiological cycle of negative affect and negative cognition can be effectively interrupted with NSSI. However, that effect is short-lived. In the long term, increases in negative affect and cognition in association with NSSI were found, so it has to be redone and becomes a sort of 'addiction'. Affect/anger, abandonment, emptiness/identity, and impulsivity are common factors across the mechanisms. The functions can be conceptualised using **avoidance/relief** and **elicitation** (see graph). Having full control over physical pain can soothe a fragile sense of self ("I need to see blood to know that I'm alive"). You cannot force your patient to stop engaging in NSSI. If we try to suppress or take away self-injury, we take away the patient's autonomy. This often leads to symptom shifting, which means that the function is taken over by another behaviour (e.g., substance use).



Unstable relationship

Another characterising feature of BPD is **unstable relationships**. **Splitting** is the inability to hold opposing thoughts; positive or negative attributes of a person or event are not weighed/cohesive. Patients go from idealisation to devaluation. This sort of black/white thinking can apply to situations, oneself, others, or the clinician. Affect fluctuates with splitting. **Idealisation** comes from a fear of abandonment and the attempt to keep the fantasy of perfection intact. **Devaluation** comes from a (imagined) sense of ambivalence (i.e., leaving before they get left). Splitting is linked to intense anger. When an all-good person makes a slight misstep, patients feel betrayed because that is something they never saw coming. Splitting is linked to complex childhood trauma/abuse/neglect. As a baby, we all engage in splitting; everything is either all good or all bad. Later, this usually develops into **healthy ambivalence**. This cannot develop when the all-bad side is seriously incompatible with the all-good side (e.g., mum abuses/neglects/hurts me).

Self-other distinction is the ability to distinguish one's own body, actions, and mental states form those of others, which is essential to interacting with others while maintaining a stable sense of self. This is impaired in people with BPD.

The **frontoparietal mirror neuron system** (MNS) is where the mirror neuron system is located. The **shared representation system** is responsible for experiencing a mental state ourselves and observing others experiencing the same mental state (being in someone else's shoes). The **mental state attribution system** (MSA) develops with increasing healthy interpersonal experience and makes more

cognitive and controlled reflection on mental states possible. In BPD patients, the MNS might be over-activated and the MSA under-activated.

LECTURE 6

Montag: "Primary Emotional Systems and Personality: An Evolutionary Perspective"

Because **primary emotional systems** are the oldest parts of human personality, we need to understand individual differences in emotions to understand personality. Emotional parts drive personality and behaviour in a bottom-up affective fashion. Thus, individual differences in emotional processes in combination with genetics and environmental influences result in unique personality patterns.

Seven emotional systems

Seven primal emotional systems have been demonstrated across mammalian species, making it likely that these animals also exhibit comparable personality dimensions:

1. **Seeking**: general appetitive-exploratory-investigatory system which provides mammals with psychological energy (enthusiasm) to explore the environment and find environmental resources that are needed for survival and reproduction
2. **Lust**: promotes sexual desire and engagement, which is important for reproduction
3. **Care**: promotes the care for offspring, urging to nurture and protect and promotes care for those of one's social group
4. **Play**: promotes social play urges, which is needed for social competence in adulthood
5. **Fear**: signals danger and help us escape dangerous life-threatening situations
6. **Rage/anger**: helps us defend our lives and other resources, also in situations of frustration when an expected reward is absent and in territorial conflicts
7. **Sadness/panic**: signals a situation of having lost contact with an important person or being lost in the environment

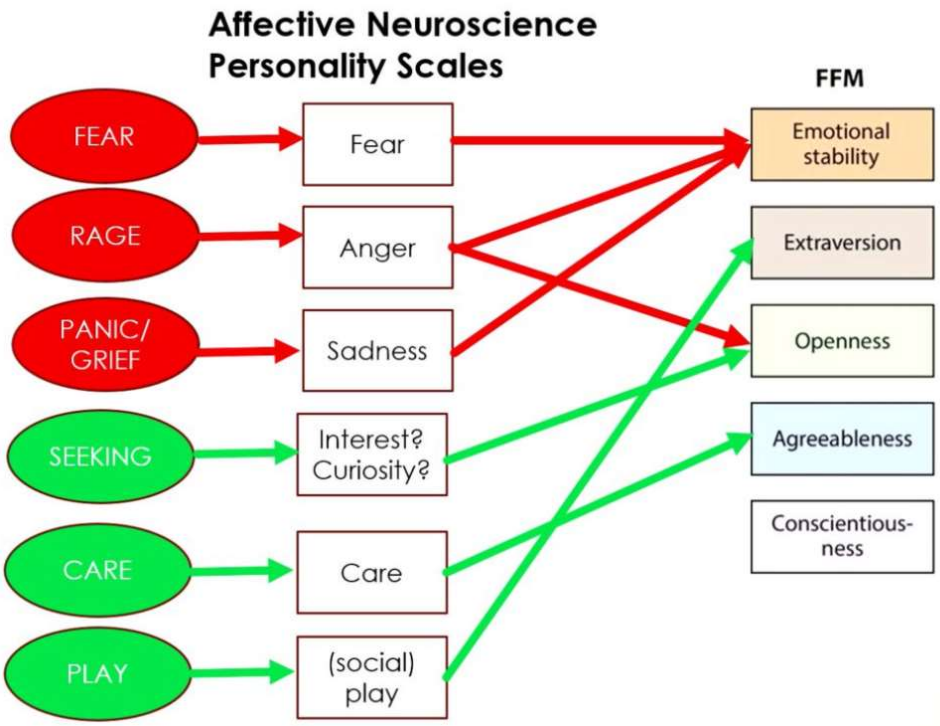
Motivational and emotional processes are highly overlapping concepts. All our need states operate through the general seeking system which motivates all appetitive behaviours. This seeking urge is of great importance for personality traits such as eagerness and enthusiasm.

Five-factor model of personality

The **five-factor model of personality** (FFM) consists of openness to experiences, conscientiousness, extraversion, agreeableness, and neuroticism. Brain research into the correlations between primal emotional systems and FMM dimensions has found several consistent correlations across different cultures. This points to a global ancestral neurobiology, as the cultural environments differ strongly in the countries compared. The following primary emotional systems are proposed to underlie the FFM dimensions:

FFM dimension	**Primary emotional system**
Openness to experience	High seeking
Extraversion	High play
Agreeableness	High care, low anger
Neuroticism	High fear, sadness, and anger

Conscientiousness is not included because it cannot be observed in most mammals.



Lecture

Emotional systems in humans and other animals

Before *I* start to have a self (a *me*), there are already bodily movements and sensations. Affective experiences are always taking place within this context of a body that moves and is being moved. Therefore, **movement** and **affect** seem like a good place to start when trying to grasp something of the development of the experiential basis of personality or self.

The following are the **primary emotional systems**:

System	Description	Affective experience	Possible clinical problems
Seeking	Provides animals with "energy" (enthusiasm) to explore the environment; necessary to find mating partners as well as food to nourish both brain and body	High: interest → euphoria Low: disinterest/lack of motivation → anhedonia and apathy	High: manic states, drug abuse Low: anhedonic, depressed, detached states
Fear	Promotes the avoidance of dangerous situations and careful monitoring of the safety of the environment	High: flight or freeze → panic Low: safe → recklessness?	High: anxiety disorders, cluster C, PTSD Low: psychopathy, risk-taking
Rage	When in need to defend oneself but also in situations of frustration, when an expected reward is absent	High: irritation → exploding Low: trusting → naivety	High: intermittent explosive disorder, oppositional defiant disorder, narcissistic rage Low: lack of assertion
Lust	Important for procreation and social functions	High: feeling attraction → orgasm Low: low interest → asexuality	High: problematic sexual behaviours Low: impotence, lack of pleasure

Care	Assures that young children grow into adults and themselves have families; in social groups, care might extend to non-family members	High: tenderness → parental love Low: carelessness → detachment	High: self-sacrifice Low: antisocial features, parental failures, postnatal depression
Panic/grief	Reflects separation distress and signals a situation of having lost contact with an important person or being lost in the environment;	High: longing or loneliness → panic (high seeking) or grief (low seeking) Low: safety → detachment	High: separation anxiety, trauma, borderline, etc. Low: schizoid, detached states, psychopathy
Play	Important to learn social competencies and motoric skills; via play, friendships emerge	High: friendly joy, comradery → laughing, playfighting Low: satiety or quietness → boredom, loneliness	High: difficulty concentrating, ADHD Low: obsessive patterns, joylessness, depressed personality

Once activated, emotional systems tend to remain active for some time. They 'colour' the world as experienced and 'shape' the movements in the world. They present strong motivating force by activating certain 'modes of being in the world'. The **neural definition** of the emotional systems is that they reflect the full operation of a system that includes the following components:

1. Intrinsic inputs
2. Coordinate physiological and behavioural outputs
3. Gating of inputs
4. Positive feedback (including auto-activation)
5. Cognitions instigate emotions (top-down influence)
6. Emotions control cognitions (bottom-up influence)
7. Affect reflects the full operation of such processes

Forms of vitality and sense of self

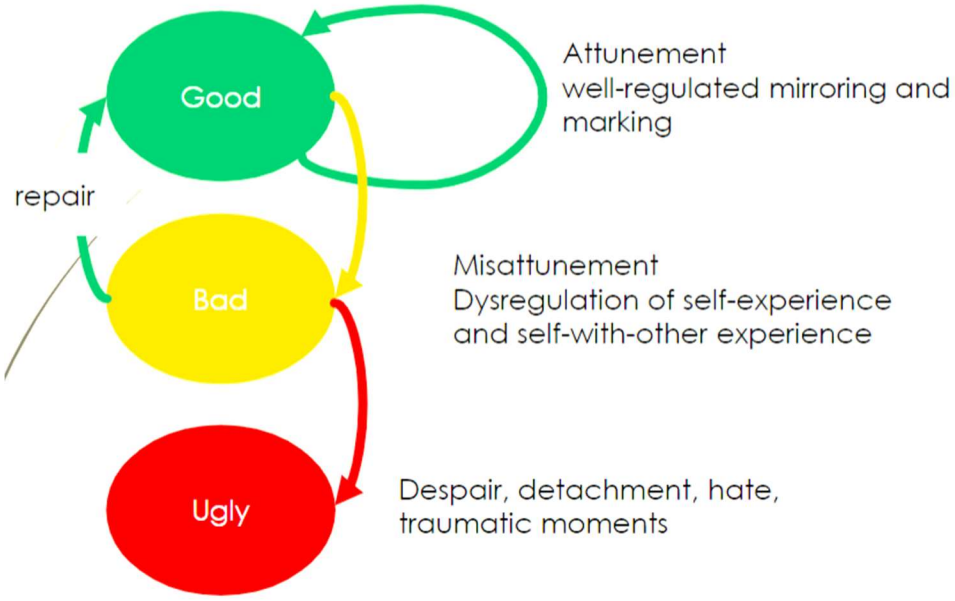
Forms of vitality are patterns of arousal that are associated with certain sensory experiences and movement. They are generally cross-modal, that is, we do not experience them only in vision or hearing, but in any modality of sensory experience. They translate between them. Hence, music and dance, poetry and being 'touched' are intrinsically related. Vitality forms are perceived as a whole. They are Gestalten originating from **five components**: movement, force, temporal contour, space, and directionality/intentionality. They are not emotions. Rather, they are structures of dynamic behaviour which can contain emotions as well as fantasies, streams of thoughts, desires, and so on. Thus, a content (desire or emotion) can have an exploding form, or a fantasy can have a surging form. It seems plausible to suggest that infants precociously represent other people's emotional manifestations mainly as forms of vitality.

Because of the possibility to share forms of vitality, we can move(**regulate**) each other. **Mirror neurons** are probably involved. Parents can use gestures, voices, and movements to down- and up-regulate the states of mind their child is in. This gives rise to all kinds of vital experiences of embodied being-with-another. In their repetition and memorisation, these represent persisting 'internal modes of being with another'.

Mirroring generally refers to aspects of sameness in the reaction of the parent to the child. This is also called **attunement** (being 'in tune'). In complete mirroring, there would be almost no difference

between the movement and sound of the child and that of the parent. The child then would have a more difficult time distinguishing self and other.

Marking is an aspect of differentiation in response to the child. For example, the child may utter a voice that goes upward and the parent a voice that goes downward, or there may be variations on the pattern of the child, or responses in a different modality like making a sound that mirrors the movement of the child. In development, the amount of variation and differentiation tends to increase. If the difference is too large, the connection may be lost. This is called a **misattuned** response.



LECTURE 7

Luyten: "The Mentalising Approach to Psychopathology"

Mentalising is the quintessential human capacity to understand the self and others in terms of intentional mental states, such as feelings, desires, wishes, attitudes, and goals. It enables people to navigate the social world they live in. It appears to be present only in humans and in a rudimentary form in our nearest primate relatives. The article reviews four **main assumptions**:

1. Neuroscience suggests that mentalising is evolutionarily prewired. Normatively developing children typically show joint attention and shared intentionality from the beginning of life.
2. Developmental research suggests that considerable environmental input is needed to develop a fully balanced capacity for mentalising. They stress the role of epistemic trust both facilitated by and facilitating mentalising which in turns fosters resilience to adversity through a health-generating process of social learning and deriving maximal benefit from the stream of relevant information accessible through the social environment.
3. Mentalising is transdiagnostic and transtheoretical and implicated in a wide range of psychological problems and disorders.
4. Mentalising may be commonly found as a factor associated with recovery in a range of psychotherapies.

Neurobiology

Even in the first months of life, infants show **joint attention** and **joint intentionality**. From age 3 onward, children develop the capacity for **collective intentionality** (the ability to function in a group based on shared principles, norms, and conventions). Mentalising enables complex collaboration and cooperation.

Mentalising is **multidimensional**. It can be organised around four dimensions or polarities, with each pole subserved by relatively distinct underlying neural circuits:

1. Automatic versus controlled mentalising
2. Mentalising with regard to the self versus about others
3. Mentalising based on externs versus internal features of the self and others
4. Cognitive versus affective mentalising

Different types of psychopathology reflect different imbalances in these dimensions. Automatic mentalising involves fast, parallel, and reflexive processes that require little effort.

Mentalising is an **umbrella concept**. It encompasses and subsumes a wide range of related concepts that are focused on various aspects of social cognition, including empathy, mindfulness, theory of mind, psychological mindedness, alexithymia, and insightfulness. It is thus a broad concept that refers to processes involved in reflective functioning about self-other and cognition-affect based on internal and external features.

A developmental psychopathology approach to the emergence of mentalising

The notion that the capacity for mentalising is first acquired in the context of **attachment relationships** has been a key feature of the mentalising approach to both normal and disrupted development since its inception. The capacity for parental mentalising (**parental reflective functioning**, PRF) is assumed to play a key role. Caregivers with high levels of PRF are assumed to be able to respond with contingent and marked affective displays of their own experience in response to the child's subjective experience, thus enabling the child to develop second-order representations of their own subjective experiences. A socialising context that focuses on mental states is assumed to foster the development of secure attachment and reflective functioning in young children.

Table 1 Relationships among secondary attachment strategies, arousal, and mentalizing

	Threshold for switch from controlled to automatic mentalizing	Strength of activation of automatic mentalizing	Recovery of controlled mentalizing
Secure attachment	High	Moderate	Fast
Hyperactivating strategies	Low: hyperresponsivity to stress/arousal	Strong	Slow
Deactivating strategies	Relatively high: hyporesponsive, but downregulation fails under increasing stress	Weak, but moderate to strong under increasing stress, reflecting failure of the deactivation strategy	Relatively fast
Disorganized attachment	Incoherent: hyperresponsive but with often frantic attempts to downregulate	Strong	Slow

This view implies a loose coupling among attachment, emotional sensitivity, or availability and PRF. Parents' mentalising capacities may fluctuate markedly even in securely attached individuals, although in general, these capacities can be expected to be positively related. It is very unlikely that insecurely attached caregivers will have high levels of PRF because disruptions in early attachment relationships typically impair individuals' capacity to mentalise, particularly in emotionally intense relationship contexts.

Attachment-hyperactivating and **deactivating** strategies are assumed to play a key role in explaining the relationships among stress/arousal and mentalising in different arousal/interpersonal contexts. They influence a) the threshold at which the switch form controlled to automatic mentalising occurs, b) the strength of the relationship between the severity of stress/arousal and the activation of neural circuits involved in controlled versus automatic mentalising, and c) the time to recovery when controlled mentalising is lost under stress/arousal.

The mentalising approach proposes a heuristic to help recognise when individuals appear limited in their capacity for mentalising. These **modes of experiencing subjectivity** reflect ineffective mentalising that developmentally antedates the capacity for full mentalising:

1. **Psychic equivalence mode**: thoughts and feelings become too real. The individual can consider no perspectives other than their own and believes that theirs is the only one possible. There is a domination of the self over the other, external over internal, and emotion over cognition.
2. **Teleological mode**: only real, observable goal-directed behaviour and objectively discernible events that may potentially constrain these goals are recognised. This mode reflects an extreme exterior focus and momentary loss of controlled mentalising.
3. **Pretend mode**: thoughts and feelings are severed from reality and the individual becomes entangled in endless cognitive or affectively overwhelming narratives that have no connection to reality and may lead to feelings of derealisation and dissociation. This mode reflects domination of explicit mentalising by implicit mentalising, inadequate internal focus, poor belief-desire reasoning, and vulnerability to fusion with others.

Mentalising has been shown to have both **trait** and **state features**. It is to a large extent relationship specific, and controlled mentalising tends to be inhibited with increasing arousal or stress. The propensity of caregivers to treat their infant as a psychological agent is known to be conducive to the development of secure attachment in children. Studies also converge to suggest that higher levels of parental mentalising foster mentalising in children and adolescents. There is good evidence from studies in children and adolescents to suggest that secure attachment in children is associated with higher levels of mentalising.

Impairments in mentalising in childhood have been related to a wide array of cognitive and socioemotional problems which range from attentional control, effortful control, and academic achievement to emotion regulation and interpersonal problems, as well as internalising and externalising problems. Developmental psychopathology and neuroscience studies have generally supported the hypothesised associations between attachment dimensions, mentalising, and stress and arousal regulation. Studies have documented associations between impairments in mentalising and psychic equivalence functioning as observed for instance in the rigid, highly simplistic, and often defensive narrative indicative of hypomentalising in patients with BPD. Impairments in mentalising are strongly associated with teleological mode functioning.

Toward a broad socioecological evolutionary perspective

There are some **limitations** of the mentalising approach. Although there is good evidence for the role of parental attachment and parental mentalising in the intergenerational transmission of mentalising, meta-analyses suggest that cross-generational associations are typically small. Developmental research increasingly points to the complex, multifactorial nature of human developmental processes, particularly in the field of attachment. Evocative person-environment correlations play a major role in these processes. There are five **major challenges for contemporary attachment theory** from developmental research:

1. The **relationship between attachment in childhood and developmental outcomes** is less strong than may be expected from some traditional assumptions within attachment theory.
2. Meta-analyses suggest only **moderate stability of attachment** across development. The stability (or lack thereof) seems to be largely a function of the stability of the environment, as also shown by simulation studies.

3. **Historical, sociocultural, and environmental factors** may determine the role and function of the attachment-behavioural system, which challenges Bowlby's original formulations of attachment as an innate, universal behavioural system.
4. **Parental sensitivity**, which is considered to play a key role in intergenerational transmission of attachment, explained only a small proportion of the variance in the association between parent and infant attachment.
5. There is increasing evidence for **genetic factors** in determining the course of attachment, suggesting that genes may play an important role in resetting development trajectories associated with attachment.

Humans possess a species-specific capacity for the fast intergenerational transmission of cultural knowledge. Although the capacity for mentalising is essential in this context, an even more fundamental role seems to be played by the capacity for **epistemic trust**, the capacity to identify knowledge conveyed by others as personally relevant and generalisable to other contexts. Instead of having to work out **cultural knowledge** oneself, the recipient of information can, through epistemic trust, rely on the authority and perceived trustworthiness of the person communicating that information. It thus involves encoding knowledge offered by others as significant, relevant to the recipient, and socially generalisable. **Ostensive cueing** has been suggested to play a key role in this specific form of learning; verbal and nonverbal ostensive cues are thought to trigger a pedagogic stance in the recipient, priming them that forthcoming communications are significant. Furthermore, ostensive cues typically lead the recipient to feel recognised as a subjective, agentive self.

Epistemic trust is not the default mode of functioning. Studies suggest that **epistemic vigilance** (the ability to identify and filter out information conveyed by others that is perceived to be misleading, inaccurate, or deceitful) has to be overcome in the course of development. Infants show appropriate scepticism and distrust toward knowledge conveyed by others from very early on. Here, early attachment experiences play a crucial role. Primarily in the context of early attachment experiences, children learn to recognise who is trustworthy, authoritative, and knowledgeable. Other social contextual factors and learning processes also influence the development of epistemic. This broader perspective allows us to accommodate the role of the wider social context and differing cultural norms and their influence on the development of epistemic trust and mentalising. From this perspective, insecure attachment and associated concepts such as disturbed personality functioning, personality disorders, and in fact most types of psychopathology can be conceptualised as manifestations of **communicative strategies underpinning social learning** to ensure adequate adaptation to changing social situations.

The authors propose that changes resulting from psychological interventions are the outcome of particular forms of social learning from the patient's environments, and *effective treatments are in essence a form of social relearning* fostered by changes in what they conceptualised as three **communication systems**:

1. **Lowering of epistemic vigilance**: all effective psychological treatments convey a particular model of mind to the patient that feels meaningful and self-relevant, often with the therapist using specific ostensive cues that ideally activate social learning in the patient. Mutual mentalising plays a key role because the therapist needs to tailor their intervention to the specific patient, demonstrating their ability to see the patient's problems from their perspective, and the patient needs to be able to recognise that the therapist is able to consider the patient's perspective (i.e., joint intentionality).
2. **Enabling mechanisms of social learning**: this is activated by the patient's increase in epistemic trust. The reactivation of the patient's mentalising capacity is fostered by the background of trust and the social experience of therapy. Re-emergence of mentalising further facilitates epistemic trust. The goal is for increased mentalising to open up the patient's potential for

learning and thus help the patient benefit from the communications from the therapist, learn new skills, acquire self-knowledge, and restructure internal working models.

3. **Reengaging with social world**: this last communication system reflects how being mentalised by another person frees the patient from their state of temporary or chronic social isolation and (re)activates the capacity to learn. This frees the person to grow in the context of relationships outside therapy.

Mentalising and personality disorders

High levels of preoccupied attachment and disorganised/unresolved patterns of attachment have been found in patients with **borderline personality disorder**. Insecure attachment has also been associated with impairments in mentalising that are typical for BPD patients. These are typically expressed in terms of patients' overly simplistic or overanalytic/hyperactive accounts of their own mental states and those of others. Research findings have also reported apparently superior mentalising capacities in BPD patients compared with normal controls, a phenomenon termed **empathy paradox**. These seemingly conflicting findings can be understood when considering the typical imbalances between the four dimensions of mentalising. The **characteristic pattern of mentalising** in BPD is a rapid loss of controlled mentalising and overreliance on fast, automatic mentalising, followed by problems with cognitive mentalising, particularly in complex interpersonal situations. They also show overreliance on affectively dominated and highly externally based mentalising at the expense of mentalising that is directly focused on mental interiors and a tendency to conflate mental states of the self and other (**identity diffusion**) leading to increased susceptibility to emotional contagion. BPD patients often might 'get it right', but the flipside is that they often jump to conclusions about others' internal mental states. They also show a **negativity bias** (e.g., when interpreting a neutral face). The tendency to conflate mental states of the self and others can be seen as another consequence of fast, automatic, affect-driven mentalising which is also consistent with evidence of overaction of neural circuits. Currently, there is only indirect evidence for a role of epistemic trust in BPD.

The spectrum of mentalisation-based treatment interventions

Psychological interventions that are rooted in the mentalising approach have three features in common:

1. Consistent with their theoretical roots, mentalising-based treatments (MBT) interventions focus on **improving mentalising capacities** through a focus on the patient's mental states as they are experienced moment by moment, and by emphasising the therapeutic alliance with active repair of ruptures in the patient-therapist relationship.
2. MBT interventions are **structured, manualised interventions** that focus on delivering treatments that are coherent, consistent, and continuous over time.
3. Based on the socioecological model outlined in this review, MBT is increasingly emphasising the fostering of the **capacity for salutogenesis** and thus resilience in patients.

The efficacy of MBT in BPD patients is supported. It has low dropout rates and may be more effective than nonspecialised interventions in patients whose symptoms are more severe.

Hopwood: "Interpersonal Dynamics in Personality and Personality Disorders"

Both basic personality and applied clinical researchers are interested in how personality can be more or less adaptive. However, the models used to conceptualise and assess the maladaptive aspects of personality in basic personality science and applied clinical research have historically been quite different. Researchers focused on hierarchical **trait models** (e.g., FFM) while clinical researchers often use **categorical PD concepts**. The two have become more aligned but PD concepts provide information about personality that cannot be accounted for by traits.

Personality disorders as traits

Problems with the PD classifications in the DSM include:

1. **Diagnostic thresholds** are arbitrarily chosen without any empirical basis, so prevalence rates from epidemiological research are specious.
2. There is substantial **between-diagnosis comorbidity**.
3. There is substantial **within-diagnosis heterogeneity**.

These problems reflect a fundamental issue: personality traits are not taxonic categories, and DSM PDs do not align with evidence-based models of personality structure and development. Evidence-based trait models focus on general dispositions or tendencies for certain patterns of thoughts, feelings, and behaviour. Based on such models (such as the FFM), several **conclusions** have been established relying on these models:

1. Personality traits are relatively **rank-order stable** in adulthood, and their stability tends to increase over the transition to adulthood.
2. Traits have predictable patterns of **mean-level stability and change** across the life course that is driven by nature and nurture.
3. They are connected to a range of **neurobiological correlates** and predict a host of important **life outcomes**.
4. Traits are also **systematically related to clinical variables** including PD diagnoses, other forms of psychopathology, and treatment effects.

Despite the empirical convergence between trait models and PDs, there are two important differences: a) normal range assessment of broad traits such as those of the FFM do not include sufficient maladaptive content for clinical diagnosis, and b) FFM variables may not capture the optimal level of breadth in personality traits for a given clinical question.

The superiority of trait approaches has moved the field from categorical to dimensions PD diagnoses. The **alternative model for PD diagnosis** in the DSM-5 was a milestone in this transition. This model has two parts: criterion A defines the PD and indicates the overall severity of dysfunction. Criterion B articulates the particulars of personality-relevant dysfunction. Criterion B features are similar to traits from basic personality science: it includes 25 facets organised into five higher-order factors with a close resemblance to the FFM.

Personality disorder dynamics

Clinical descriptions of PDs have historically emphasised dynamics, even though clinical assessments of PDs have tended to focus on relatively stable attributes. **Dynamics** is a relatively broad term that indicates variability in some systems:

- **Longitudinal dynamics**: relatively slow-moving trends in mostly stable dispositions over extended periods of time. It is suggested that personality tends to change the most during young adulthood, and, on average, personality traits change in the direction of maturation.
- **Between-situation dynamics**: variation from one situation to the next. Between-situation dynamics have been associated with specific PD types (e.g., variability in self-concept across situations in narcissism).
- **Within-situation dynamics**: even narrower level of dynamics within situations. Within-situation patterns have historically played a role in clinical descriptions of PDs.

Dynamics in basic personality psychology

Given that personality traits are somehow malleable during adulthood, and these changes have to do with what happens to people, personality psychologists have been increasingly interested in the

dynamic processes that might account for those changes. The following progression led to a **focus on dynamics** in personality psychology:

- **Identifying the variables**: establishing a relative consensus about how to organise personality variables in the form of a hierarchical FFM.
- **Establishing that environmental factors impact personality stability and change**: determining that normative and individual changes in traits are driven, at least in part, by environmental factors. An important model is the **social investment theory** (most significant personality changes occur in young adulthood since this is the period where one's social clock sets the stage for major transitions into what become, for most people, relatively stable roles).
- **Deconstructing traits**: contextualising traits in specific environments has compelled theorists to distinguish between aspects of personality that tend to get lumped together in more abstract, cross-sectional, nomothetic conceptions.
- **Specifying the sequences in proximal social environments**: distinguishing between elements of personality that are relevant for depicting proximal processes enable models of the temporally dynamic relations among these elements. Thus far, most empirical work on temporal dynamics has assessed personality states between situations. However, several theories have elaborated sequences that occur within situations. Overall, models propose a sequence linking situations, goals, perceptions, responses, and consequences.

What is the mechanism by which specific situations could give rise to relatively enduring patterns of personality? Personality develops as a function of shorter-term situational changes in habits that are learned and repeated. According to the **TESSERA model**, triggers lead to expectancies, which cause states and state expressions, and reactions. These situational changes can be understood as a recursive sequence because the reactions from self or others can be reinforcing or punishing, and thus make certain types of future situations and reactions more or less likely. This led to specific hypotheses about how goal-motivated intraindividual variability in behaviours that occur in a social context and are coloured by perceptual processes can give rise to recursive patterns of behaviour and ultimately trait-like consistency.

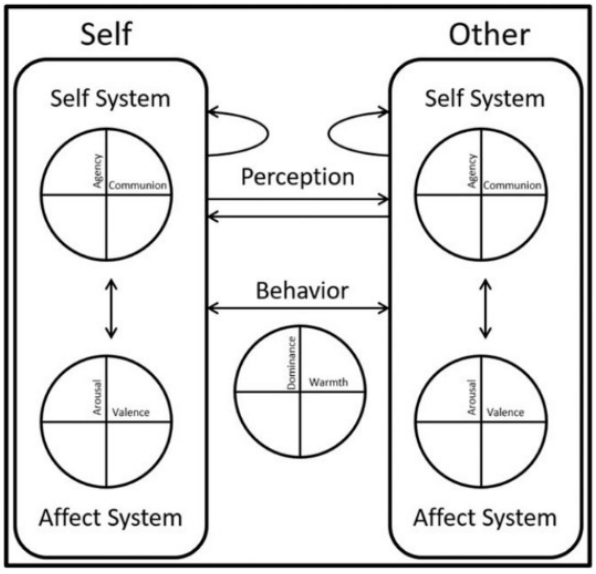
An interpersonal model of personality dynamics

Researchers aimed to develop a **model of interpersonal situations** to account for the dynamic concepts described in clinical theories of PD. They focus on personality as it manifests in interpersonal situations specifically.

Interpersonal theory conceptualises personality in terms of recurrent patterns of **interpersonal situations**. There are two general points how this model is similar to and different from other contemporary schemes:

1. **How is personality understood?** Most assume either that personality is something that exists within individuals or that it is something that exists between individuals. However, one can think of traits from an **interactionist perspective** given that the origins of modern trait psychology lie in the lexical hypothesis, which assumes that the reason we have trait descriptive terms in the first place is to describe others. A basic assumption of interpersonal theory is that personality is understood as a **recurring pattern of dynamic processes** that occur between a self and another.
2. **Structure of variables within the interpersonal situation**: it is common to attempt to organise personality variability along Big Five dimensions. However, there has also been a longstanding interest in demarcating different aspects of personality to provide a more comprehensive portrait of people. Contemporary integrative interpersonal theory was developed to **synthesise the structure and dynamics** of personality, psychopathology, and psychotherapy.

There are four **personality systems** that meaningfully interact in interpersonal situations:



1. **Self system**: this captures the variation in what a person wants (i.e., motives, goals) in an interpersonal situation. This system is structured by **agency** and **communion** dimensions. Self-dysregulation refers to chronic motivational conflicts, rigidity, or instability in self-concept that is associated with distress and/or dysfunction.
2. **Affect system**: the variation in how a person feels. It is structured by **arousal** and **valence**. Affect dysregulation is signified by a chronic pattern of intense, rigid, or unstable affect states that is associated with distress and/or dysfunction. People's feelings are impacted by goal achievement and conversely, emotional disturbance prompt motivation.
3. **Interpersonal behaviour field**: between the self and other, this depicts the actual behaviour that occurs between the self and another during an interaction. It is structured by interpersonal circumplex dimensions of **dominance** and **warmth**. Interpersonal behaviour dysregulation involves a chronic pattern of rigid, unstable, or non-complementary interpersonal interactions that is associated with distress and/or dysfunction.
4. **Perception**: interpretation of interpersonal events plays a critical role in interpersonal theory. It is assumed that it is important to perceive the other (**person perception**) and oneself (**self-insight**) relatively accurately to achieve goals, feel good, and behave adaptively. Pathological interactions are characterised by misperception in the form of either misunderstanding between the self and other or a lack of insight on the part of the self, or both.

In essence, the interpersonal situation model assumes that four **critical questions** need to be answered to understand a certain interpersonal situation:

1. What does each person want?	***Self***
2. How does each person feel?	***Affect***
3. What is each person doing?	***Behaviour***
4. How does each person see themselves and the other?	***Perception***

Maladaptive personality is thought to involve some combination of dysregulation from all of these.

Personality disorders as maladaptive interpersonal signatures

Interpersonal theorists conceptualise personality as predictable, coordinated, and sequential within-situation patterns of thoughts, feelings, motives, and behaviours across time. Based on this, interpersonal signatures can be generated to describe prototypical PDs as well as idiographic patterns that might characterise a particular individual whose behaviour is not neatly described by an existing PD category. **Perceptual distortion** is a core feature of personality pathology and a precipitating event for maladaptive interpersonal sequences. These distortions are thought to trace back to a mismatch between the representation of a situation in an individual's mind that reflects some learned experience and the actual contours of the situation. Distortion gives rise to various forms of affect dysregulation which promotes a motivation to protect the self in some way, which leads to behaviour that is extreme and dysregulated and again does not match the actuality of the situational context. This mismatch

creates unpleasant affect in the other which would tend to arouse some self-protective motive, leading to a behaviour on the part of the other that reinforces the original distortion.

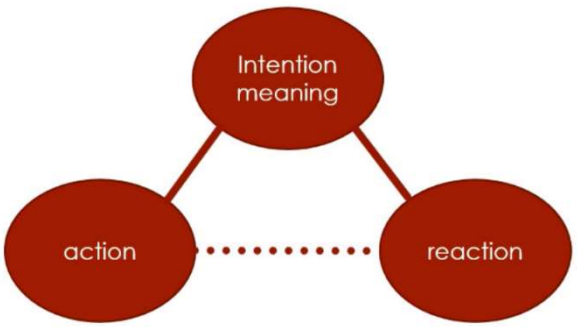
The **interpersonal signature** of **borderline personality disorder** is that the patient experiences a close attachment figure abandoning them by being cold despite warm invitations for closeness (perceptual distortion). This gives rise to intense anxiety (affect dysregulation), leading to a desire to be both close (original motive) and distant (self-protective motive) to the other (self-dysregulation). Affective agitation and motivational conflict is resolved through aggressive behaviour (behaviour dysregulation) which is confusing and upsetting (other affect) to the other who will respond with cautious trepidation (other motivation) and withdrawal (other behaviour).

The **interpersonal signature** of **narcissistic personality disorder** is that the patient perceives a status threat (perceptual distortion) which leads to them becoming envious and anxious (affect dysregulation) which arouses the motive to assert themselves that does not fit the situation well (self-dysregulation), leading to displays of grandiosity coupled with the fantasy that the other will submit and admire (behaviour dysregulation). The other may become annoyed (other affect) and competitive (other motivation). Cold-dominant behaviour (other behaviour) would recreate the patient's initial perception and reinforce status concerns. This recursive sequence would lead to chronic misperceptions between situations and an enduring tendency to be antagonistic.

Lecture

Intersubjectivity and mentalisation

Intentionality was introduced into psychology as the mark of mental phenomena. That is, mental phenomena are about something (intended at something). This is called the **intentional stance**. Mentalising is attributing intention to someone (or something). It refers to:



1. The movement from a dyadic to a triadic perspective
2. The introduction of the 'intentional stance'
3. The process of learning and applying a theory of mind

Human babies are particularly sensitive and attuned to the forms of vitality they can share with others. In secure attachment, parents use parental reflective functioning to interact with their child giving rise to joint intentionality. Via this process, the child learns to distinguish the (joint) intention from the particular acts of the participants. From the distinction between the self and other, it learns about the difference in intentions between self and other.

Humans possess a species-specific capacity for the fast intergenerational transmission of cultural knowledge (**natural pedagogy**). Instead of having to work out cultural knowledge oneself, you can rely on the authority and perceived trustworthiness of the person communicating that information. Epistemic trust thus enables a particular kind of species-specific learning.

LECTURE 8

Feinstein Chapter 11: "Dialectical Behaviour Therapy"

Dialectical behaviour therapy is an evidence-based psychotherapy developed to treat complex patients who are self-injuring, suicidal, or who have BPD. It is a third-wave CBT that is principle-based

and philosophically rich. It is specifically founded on principles of behaviourism and enriched through the philosophy of dialectics. It has been extended to other clinical conditions, such as PTSD, mood, anxiety, substance use, and eating disorders, as well as other PDs. The concept of **suicide prevention** is crucial and diverges from the status quo in the field, favouring the time-intensive work of guiding patients toward their 'life worth living' rather than frequent, short-term hospitalisations.

DBT conceptualises psychopathology more broadly than the dominant biomedical perspective. It views many problems as stemming from **skills deficits** that can be remedied through new learning. The '**wise mind**' is the first skill taught in DBT because effective DBT is only possible when therapists and patients collaborate as equals, each brining their own wisdom to the task of transforming patients' lives. Therapy is **dialectical**, a method derived from a philosophy where 'truth' is discovered iteratively through a synthesis of seemingly opposing dialectics. The primary dialectical tension was acceptance-based approaches (e.g., Roger) versus change-based strategies (e.g., Beck).

Aetiological model

The **biosocial theory** is the guiding aetiological model. Its core premise is that severe emotion dysregulation emerges when a **biologically vulnerable** child is reared within a **chronically invalidating environment**. It is founded on the principle that day-to-day transactions between child, caregiver, and other environment/social forces gradually **reinforce ineffective behaviours** while simultaneously punishing effective strategies. Neither parent nor child can reliably get their needs met and the child fails to develop more skilful strategies for managing distress, navigating relationship conflict, maintaining focus, and regulating emotions. The model is intended to be judgement-free (no family member is blamed). A biosocial formulation also identifies specific characteristics of the client that may have increased their vulnerability to psychopathology. **Experiences of invalidation** play a big role. They do not have to be from the parents but can also be from the environment.

Assumptions of DBT

There are several **explicit assumptions**:

- Patients with PDs are doing the best they can, *and* they need to do better, try harder, and be more motivated to change.
- Patients may not have caused all of their problems, but they have to solve them anyway.
- The lives of those with a PD in DBT are unbearable as they are currently being lived.
- Patients must learn new behaviours in all relevant contexts.
- Patients cannot fail in therapy.
- Therapists need support.

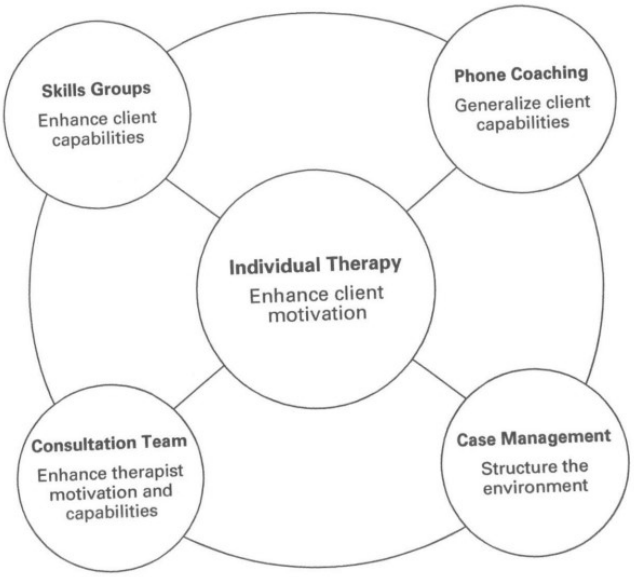
The assumptions are designed to be provocative, deliberately challenging therapist and client to think about their work collaboratively and dialectically.

Functions and modes of treatment

There are **five functions of comprehensive DBT**:

1. Improve client motivation to change
2. Enhance client capabilities
3. Facilitate generalisation of client capabilities to their natural environments
4. Enhance therapist motivation and capabilities to treat clients effectively
5. Help structure the environment to bolster client and therapist capabilities

The first **mode of treatment** is **individual psychotherapy**. Weekly therapy supports the function of improving client motivation to change and serves as the hub for all other treatment modes. Through individual psychotherapy, clients are introduced to a weekly tracking sheet, or **diary card**, so that they can record their daily emotions, thoughts, urges, behaviours, and skills used.



Weekly **skills classes** support the function of enhancing client capabilities to solve problems, such as difficulties with mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The function of skills classes is to **teach skills**, whereas the individual therapist is responsible for skills generalisation in daily life, typically via phone coaching.

Phone coaching is supposed to help generalising client capabilities to their natural environments. It is one of the most important and misunderstood components of DBT. Client and therapist engage via text messaging and phone calls. Phone coaching is the most effective when used for clear and specific reasons, such as asking for **validation**, requesting **assistance** with skills use, or providing **updates**. Clients are asked to call the therapist before a crisis to seek strategies for avoiding problem behaviour. If they engage in self-harm or other life-threatening behaviours, they are required to wait 24 hours before phone coaching is resumed. It is intended to be brief, structured, and within a therapists' pre-established limits. Contacting them too frequently or infrequently may be considered a therapy-interfering behaviour.

The **consultation team** supports the function of enhancing therapist motivation and capabilities to treat clients effectively. A weekly or biweekly consultation team is where therapists support each other in becoming more skilful, knowledgeable, capable, compassionate, and DBT-adherent. Four characteristics of the DBT consultation team differentiates it from other evidence-based treatment consultations:

1. The DBT consultation team is a **community of therapists treating a community of clients**. Individual therapists treat not only their individual client, but support the care of every client on the team.
2. Whereas most consultation teams focus on clients' behaviours, DBT consultation teams focus on **client *and* therapist behaviour**. They use DBT principles on each other.
3. **Therapist vulnerability** is encouraged.
4. There is an **emphasis on dialectics**. Team members acknowledge polarisations in their ideas and opinions and seek synthesis.

Case management serves to structure the therapeutic environment in order to bolster client and therapist capabilities. They are often managed by a team social worker or administrative support person. Case managers can support clients and teams by facilitating ease of scheduling, obtaining signed releases, letting clients know about group homework, and so on.

Stages of therapy

Therapy starts with **pre-treatment commitment** which takes up anywhere from two to six sessions. It begins by orienting the client to the biosocial model and building a therapeutic alliance and ends when therapist and client agree to sign the **DBT contract**. The therapist obtains a commitment from the client to target and hopefully stop life-threatening or other problem behaviour. 'Life worth living' goals are identified, and skills groups and phone coaching being.

Stage 1: Improving behavioural control and increasing skills use

The primary treatment targets are to improve behavioural control and increase skills use. Each sessions follows a structured format beginning with diary card review, which establishes the session agenda that loosely follows this order:

1. Self-injurious or life-threatening behaviours (SIB)
2. Therapy-interfering behaviours (TIB)
3. Quality-of-life interfering behaviours
4. Skills acquisition

Stage 1 can be completed in six months, but there is more support for a 12-month duration.

Stage 2: Improving emotional regulation and experiencing

This can be completed sequentially or concurrently with stage 1 treatments. It typically begins after clients achieve sufficient behavioural control over SIBs, address TIBs, and reliably complete diary cards and skills homework. It aims to enhance and improve emotional experiencing among clients after they consistently demonstrate effective emotion regulation.

Stage 3 and 4: Bolstering overall quality of life and improving capacity for joy

Higher-level DBT stages focus on continuing to help clients solidify and generalise DBT skills, bolstering their overall quality of life, and improving their capacity for joy. Here, more traditional cognitive-behavioural and acceptance-based therapeutic skills are used. Regular mindfulness practice is also cultivated. Stage 3 focuses on improving the client's life through goal attainment and developing meaningful and fulfilling relationships. Stage 4 focuses on improving the capacity for joy. It works to rerate meaning and feeling connected to the work.

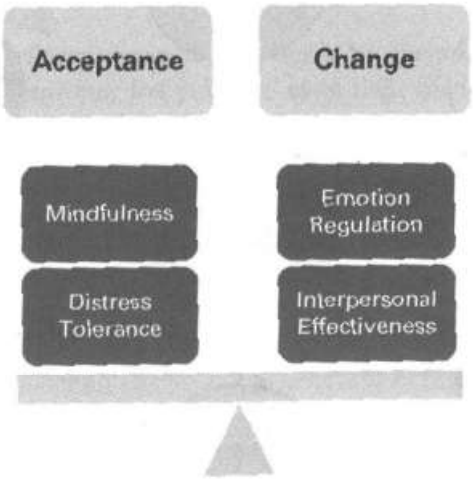
Treatment targets

The treatment targets **self-harm** and **life-threatening behaviours**. **Therapy-interfering behaviours** are addressed openly and non-judgementally in individual or group therapy sessions. **Quality-of-life interfering behaviours** are also targeted, as well as **skills acquisition** (e.g., mindfulness, interpersonal effectiveness, emotion regulation, distress-tolerance techniques).

The philosophy of **dialectics** is that reality is made up of nearly constant contradictory and polarising forces, and change occurs only through tension and synthesis of these polarities. There are three **central principles**:

1. **Wholeness**: emphasises the entirety of a situation over individual parts. No single element of a dynamic system is ever 'at fault'.
2. **Polarity**: reality is never in perfect balance but comprises seemingly opposing forces, each offering their own truth to a situation.
3. **Continuous change**: synthesis leads to a new set of polarities and the process continues.

The primary dialectic is between **acceptance** and **change**. Moving toward a life worth living involves constantly dancing between acceptance and change.



Under the overarching dialectic of acceptance and change, three additional **dialectical dilemmas** were identified that describe common behavioural patterns exhibited by DBT clients:

Emotional vulnerability and self-invalidation
This reflects clients' vacillating experiences with extreme emotional sensitivity and socially influenced self-invalidation of these emotional experiences. **Emotional vulnerability** can be extremely unpleasant for some clients. In some way, however, emotional vulnerability may be safer than what is experienced on the other side: **self-invalidation**. On this side, clients may oscillate between intense self-loathing whereby they view themselves as broken, damaged, or at fault for their vulnerability, and unrealistic perfectionism which stems from their environments oversimplifying what it takes to solve their problems.

Active passivity and apparent competence
This pertains to help-seeking communication. **Active passivity** is when clients exhibit both demanding and wilful help-seeking behaviours, as well as helplessness that is reinforced intermittently by others offering assistance. **Apparent competence** has the potential to be quite dangerous. The therapist may assume that the client is doing well when there is apparent competence. It typically presents when clients fear ridicule or criticism in response to asking for help, or when others assume that they should be capable of coping with their problems.

Unrelenting crisis and inhibited grieving
This concerns clients' experiences with trauma and experiential avoidance. **Unrelenting crises** may result from 1) common life situations that morph into crises due to lack of resources and support, 2) devastating life events, or 3) crisis-generating behaviours (e.g., impulsivity, emotion dysregulation). **Inhibited grieving** is when clients avoid painful emotions associated with traumatic experiences and loss. DBT clinicians must go beyond helping clients to experience emotions and help them tolerate and live with their pain and grief.

Behaviourism, chain analysis, and solution analysis

Behavioural theory provides means to conceptualise client problems through concrete, observed mechanisms. Factors that lead to, mitigate, and maintain psychopathology can be understood through behavioural models. Behavioural case formulations aid in discerning the most effective strategies.

Chain analysis helps clients and therapists detect patterns and sequences that lead to problematic behaviours, which can be any targets deemed relevant to treatment. Once problem behaviours is identified and described, therapists can guide clients through chain analysis, diving into what led to the problem behaviour (i.e., chains) and why each element of the chain led to the next (i.e., links). They discuss vulnerability factors, links, precipitating events, and short- and long-term consequences.

Therapists and clients work collaboratively toward alternative behaviours, developing **solution analyses**. Clients are taught that when faced with a problem, they can either solve it, change their emotional response, tolerate or accept it, or do nothing (and potentially make it worse).

LECTURE 9

Feinstein Chapter 18: "Antisocial Personalities"

Antisocial personalities can be conceptualised as a group of disorders that reside on a continuum from least pathological to most disturbed. At the top of the continuum is the phenomenon of antisocial features in other personality disorders. The next step down are cases of narcissistic personality disorder that feature antisocial behaviour as a major problem (they are ruthlessly exploitative but can experience guilt and concern). True **psychopathy** features individuals who cannot imagine altruism of any sort and who are incapable of investing themselves in nonexploitative relationships.

Epidemiology

Antisocial personality disorder (ASPD) has a 3.6% lifetime prevalence in the US. Many will manifest a downward drift as they fail repeatedly, and some appear to burn out at some point in their lives. Many patients show severe alcohol or other drug use. Some manage to thrive despite their dishonest behaviour by moving from town to town as needed. Large proportions (42%) show no improvement in their condition after 30 years. Studies of comorbidity of substance abuse and ASPD range from 42-95%. Other comorbid illnesses include depression, anxiety, ADHD, sexual deviancy, and pathological gambling. The male-to-female ratio is 4:1 but that might also reflect a diagnostic bias. Psychopathic women are often labelled histrionic or borderline.

Diagnostic considerations

A variety of terms are used: psychopaths, sociopaths, character disorder, antisocial personalities. The point where ASPD transitions into NPD is difficult to identify. **Malignant narcissism** is a category that is one step up on the continuum from ASPD. Patients show paranoid orientation and ego-syntonic sadism. However, they still have concern for others and a capacity for loyalty, and they are able to imagine that other people have moral convictions and concerns. There is also some degree of antisocial behaviour in many patients with **NPD** who are no considered malignant narcissists. They lack paranoid and sadistic qualities but are still capable of exploiting other people to meet their own needs. They are able to experience concern and guilt while struggling with commitment to deep relationships. **Psychopathy** is much more severe, both in clinical manifestations and treatment-resistance, compared to ASPD. It consists of more substantial neuropsychological problems. Patients are more ruthless and more incapable of any type of emotional attachment, with the exception of sadomasochistic interactions based on power. Certain traits observable in children may be linked. **Callous-unemotional traits** are defined by reduced guilt and empathic concern, and fewer displays of appropriate emotion. They are linked to a lack of fear of consequences, reduced bonding, a lack of significant attachments, greater gun violence, and atypical social affiliation.

Biological and psychological underpinnings of antisocial personalities

Children who have one **antisocial parent** have approximately a 16% chance of developing antisocial traits. In addition to genetic factors, environmental **neglect** and **abuse** appear to be part of the pathogenic picture. A functional polymorphism in the genes responsible for the neurotransmitter metabolising the enzyme **MAO-A** was found to moderate the effect of maltreatment. Males who had high MAO-A activity did not have elevated antisocial scores even when they had experienced childhood maltreatment. Males with low MAO-A activity genotypes who were maltreated had elevated antisocial scores. The MAO-A genotype appeared to have no effect on criminal activity when the genotype was considered without adverse environmental factors. The Genotype may moderate a child's sensitivity to environmental stressors.

Approximately 60% of variance in adolescent antisocial behaviour could be accounted for by negative and conflictual **parental behaviour** directed specifically at the adolescent. Certain heritable

characteristics of the children (e.g., ADHD, temper outbursts, physical violence) may evoke harsh and inconsistent parenting. The **family response** to these characteristics tended to take one of four forms:

1. Exacerbate troublesome aspects of the child
2. Enhance desirable features of the child
3. Protect the child from negative outcomes related to difficult behaviour
4. Lead the parents to back off from the difficult child in an attempt to protect the sibling with better prospects

The interaction of genotype with both parental negativity and low warmth predicted overall antisocial behaviour, but not depression. There appears to be a strong biological origin of callous-unemotional traits, lack of empathy, and absence of guilt. When boys with these traits are compared with control subjects of the same age, they much less **amygdala reactivity** to fearful faces. There is a clear linkage between physical **abuse**/neglect and antisocial traits. Sexual abuse is the most related. **Maternal variables** include low maternal care and high overprotection. ASPD is argued to be a neurodevelopmental disorder that may be recognised early in childhood. Fronto-limbic abnormalities are a key feature. The three main brain regions affected are the PFC, the amygdala, and the striatum.

Countertransference reactions to antisocial patients

Antisocial patients are known to not be likely to respond to treatment. There is no rigorous data that would allow to discern which patients are likely to be responsive to treatment and which are hopeless. A feeling of hope itself may be an example of **countertransference** in the therapist. Patients are known to steal from other patients and staff members, sexually exploit patients, lie to staff and patients, or even assault those who are in their way. True psychopaths are agreed upon not to belong in general psychiatry units because they will not benefit from the treatment and are likely to disrupt that of others. Another countertransference reaction is giving the patients the benefit of the doubt which may lead to downplaying the extent of sadism and cruelty in patients who are on the antisocial to psychopathic spectrum. Another countertransference is the tendency to regard oneself as capable of treating the 'untreatable' patient. Another is to conceptualise the patient's antisocial behaviour as growing out of the influence of drugs and alcohol. Another is the fear that staff feel unsafe which may lead staff members to try to please the antisocial patient as a way of placating the patient and managing their own anxiety. The most difficult issue is to accept that a psychopath is fundamentally different than them.

Treatment strategies

There is no convincing data that antisocial patients respond to psychiatric treatment. Some patients at the higher end of the continuum may be treatable under certain circumstances. Comorbid conditions may also make the prognosis somewhat better. Short-term hospitalisation is unlikely to treat the underlying personality pathology. Only **long-term hospital treatment** has a chance of dealing with the deceptiveness, impulsivity, violence, theft, substance abuse, lack of mentalising, and sexual exploitation that characterise this diagnostic picture. It has to be made clear that patients are given a trial of treatment only. Treatment should be considered an evaluation to determine if the patient is suitable for it. The emphasis should be given to faulty thought processes. When a patient has an impulse, staff members must encourage them to think through the consequences before acting.

Feinstein Chapter 21: "Narcissistic Personality Disorder"

Narcissistic personality disorder (NPD) is difficult to define and thus difficult to measure. The prevalence is around 0-6.2%. 50-75% of patients are male. It is more prevalent in younger groups of people than in older groups.

Diagnostic considerations

There is no agreement among clinicians or scientists as to how to formally diagnose NPD. According to the **DSM-5**, it is a pervasive pattern of grandiosity, need for admiration, lack of empathy with a grandiose sense of self-importance, preoccupation with fantasies of unlimited success, beliefs that one is special, and envy of, exploitative use of, and arrogance toward other people. NPD defies diagnostic categories based on checklists for several reasons:

1. It is confused with those aspects of narcissism that are considered 'healthy'.
2. Cultural factors confuse the diagnosis (what is 'healthy' self-esteem?).
3. Life stage has a lot to do with diagnosis.
4. There appears to be a paucity of research on NPD compared to other PDs.

Three **types** are distinguished today:

1. **Grandiose/malignant** or **oblivious type**
2. **Fragile type** (hypervigilant, vulnerable; grandiose defences have been punctured, leaving a pervasive sense of inadequacy or low self-esteem, negative affect, and loneliness/emptiness)
3. **High functioning/exhibitionist type** (outgoing and energetic, interpersonally adept, and often highly charming)

Grandiose	Vulnerable
• Dominance • Self-assurance • Immodesty • Exhibitionism (center of attention) • Aggression	• Introversion • Negative emotions • Interpersonal coldness • Hostility • Need for recognition • Entitlement • Egocentricity

NPD is frequently comorbid with MDD, bipolar I, anxiety disorders, and SUDs, as well as histrionic PD and ASPD. BPD is also frequently present.

Biologic, neuropsychiatric, and genetic factors

There are **differences in brain regions** compared to healthy controls: the left **anterior insula** as well as other **fronto-limbic structures** have a smaller grey matter volume. These areas are related to emotional empathy, as well as low self-esteem, empathic processing, anxiety-producing stimuli, and social rejection. The anterior insula, along with the **anterior cingulate cortex** are important to the salience network which helps switch between an internal state and an external state, as well as integrating sensory and emotional stimuli. **Skin conductance** studies show that patients with NPD have similar responses to those of psychopathic individuals when expecting an aversive stimulus. That is, they show low physiological activity which may be suggestive of an impaired ability to inhibit their behaviours or impulsivity. They show larger cortisol outputs following social stressor. HPA axis hyperreactivity is associated with sensitivity to stressful event. Heritability estimates are between 24-79%.

Cultural and psychosocial considerations

Some argue for a rise in narcissism due to changes in parenting to a more permissive style and the increased use of social media. Young people are almost three times more likely than people over 65 to meet criteria for NPD.

Developmental origins and theories of narcissistic pathology

One theme that runs across all types of NPD is a concern about being seen by others and a wish to avoid the consequent shame and humiliation. This wish to avoid shame at all cost leads to a pursuit of perfection. There are two **models of narcissism**:

> **Kernberg's defence model**
> The grandiose self is a defence against dependency on others. The self is comprised of a pathological grandiose structure. Aggression is inborn and results in significant envy. Idealisation is a defence against aggression. This model typically reflects the malignant grandiose or oblivious narcissists.
>
> **Kohut's deficit model**
> The grandiose self is the result of a deficit originating from empathic failures of the caregiver. The grandiose self is non-defensive, "normal" and developmentally appropriate given caregiver deficits in empathic mirroring from childhood. Aggression is secondary to empathic failures of caregivers. Idealisation is a "normal" process given their arrested developmental phase. This means their need for an exalted or admiring object is necessary in order to bolster their own development of their self. This typically reflects the vulnerable narcissist.

Parental styles, such as parental coldness, overvaluation, and overindulgence have been looked at as potentially impacting the development. Parental coldness may be more associated with vulnerable narcissism while parental overindulgence/overvaluation may contribute to both kinds. Childhood adversity is also associated with narcissism.

Patients are more likely to have **dismissive** or **cannot-classify attachment**. The grandiose subtype is more likely to have secure or dismissive rather than fearful or preoccupied styles. The vulnerable subtypes are more likely to be fearful or preoccupied.

The relationship, transference, and countertransference with patients

Narcissistic transferences can be explained from the **mentalising perspective**. It was hypothesised that due to the caregiver's incongruent mirroring of the child's affective experience, a child will start to internalise the caregiver and begin to project self-enhancement onto themselves (as opposed to BPD patients who project badness onto others). This leads to a sense of discontinuity and fragmentation and creates a 'narcissistic alien self' of the caregivers' overvalued conceptualisation represented onto a child's actual affective experience. The type of transference and countertransference that develops will likely depend at least in part on the specific type of narcissist one is treating.

Creating a good **therapeutic relationship** is a challenge. From the very beginning, the patient is often struggling with profound shame and humiliation at needing assistance and feelings of dependency toward another person. They may not want to admit that they need help or be concerned that the therapist does not really care about them and feel that they need to be on the look-out for exploitation.

Typical **transference** patterns tend to emerge at some point, usually depending on the subtype. The grandiose subtype may seem to ignore the therapist almost entirely and spend the session arrogant and self-centred, name-dropping and difficult to interrupt. The vulnerable type may present as self-loathing, full of shame, and trying to avoid feeling slighted in some way. They seem to be carefully sizing up the therapist and appear exquisitely sensitive to the therapist's words or behaviour. Patients can also oscillate between these two presentations. Idealisation and devaluation are frequently utilised by patients and can be expressed from a grandiose stance or a vulnerable one. **Idealisation** can be the patient's way of shoring up their own self-esteem by creating a connection to an admired object, but it's fragile and can be quickly turned into contempt. **Devaluation** may be a way of inflating

their self-esteem by putting down the other, or it may be a response to perceived slights or insults. **Narcissistic rage** can be a response to a feeling of shame or inferiority. Vulnerable narcissists may also erupt when slighted or retreat further into a depression. Ultimately, they think that *either the patient or the therapist is superior*. They want to maintain their own superiority over the therapist, even if they are also defensively idealising them at the same time. They often experience tremendous shame which can lead to them using strategies to avoid their feeling of shame. They also seek to avoid humiliating dependency and therefore may try to control the treatment and the frame. Envy may emerge when the therapist is insightful about their difficulties.

Grandiose patients elicit classic **countertransference** reactions such as feeling bored, tired, or uninterested in what they are saying. The clinician may feel like more of an audience and a vehicle for self-esteem regulation. They may elicit feelings of competition, annoyance, or frustration. Vulnerable patients may cause the therapist to feel identification with suffering and be more invested. This can be good to build a connection. Vulnerable patients may also attempt to elicit a very specific empathic response, wanting admiration and praise for their specialness. This can be very emotionally draining. Following idealisation/devaluation, the therapist may feel idealised/devalued (no shit) but it may often feel fake. Patients may seek to control treatment. Therapists often feel interchangeable, as if they could be anyone to the patient.

Howard: "Antisocial Personality Disorder Comorbid with Borderline Pathology and Psychopathy is Associated with Severe Violence in a Forensic Sample"

Violence is much more likely in individuals with PDs. **Comorbidity** seems to play an important role. ASPD and psychopathy together are associated with significant increases in severity and versatility of violent offending. Comorbidity of ASPD and BPD is also associated with a broad spectrum of antisocial outcomes. However, using the word comorbidity is not supposed to imply that ASPD and BPD represent true disorders (discrete clinical entities). ASPD and BPD can be seen as representing a complex network of causally interlinked thoughts, feelings, and behaviours that are linked not just with each other but also with traits and symptoms of other disorders. Traits and symptoms that are shared are said to act as **bridge symptoms** that connect the two disorders and enable causal relationships between their symptoms and traits. Two **higher-order dimensions of PDs** were identified based on factor analysis:

1. **Acting out** (externalising): this is equivalent to psychopathy. ASPD loads strongly on this dimension.
2. **Anxious inhibited** (internalising): BPD loads strongly on this.

Cooccurring ASPD/BPD can therefore be regarded as particularly severe because it is characterised by high levels of both internalising and externalising personality traits that manifest as disturbances in affect/emotion, cognition, and behaviour. These would be expected to give rise to a propensity to engage in seriously violent criminal conduct.

The **present study** uses violence as a dependent variable in an attempt to identify those personality features that are uniquely associated with violence and could be said to characterise individuals who suffer from a particularly severe form of PD and give rise to a propensity to engage in severely violent conduct. Results suggest that both the **antisocial deviance factor of PCL-R psychopathy** and **ASPD/BPD comorbidity** are independently associated with early onset, severe violence in forensic psychiatric patients. Those who show disinhibited deviance from a young age together with ASPD/BPD comorbidity arguably manifest a particularly severe form of PD that has been described as **secondary psychopathy**. A criterion for identifying this severe type might be a combination of ASPD/BPD comorbidity with a certain PCL-R score. No clear relationship between **impulsiveness** and violence could be

demonstrated which implies that impulsiveness is not critically involved in linking ASPD/BPD comorbidity with violence. The critical factor is likely problems with emotion regulation.

Caligor: "Narcissistic Personality Disorder: Diagnostic and Clinical Challenges"

The author lists the following recommendations for **treatment** of somebody with NPD:

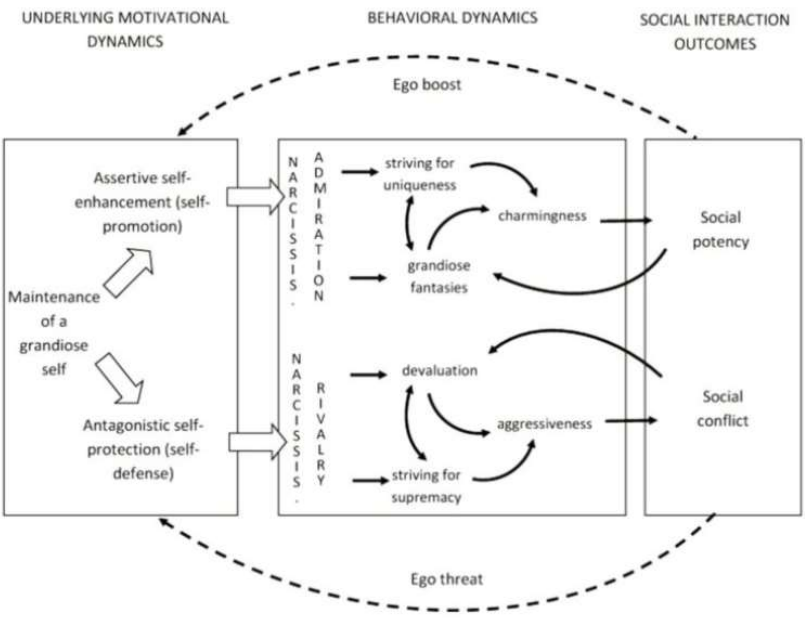
- Obtain a thorough **symptom picture** and **assessment of psychological**, **interpersonal**, and **vocational functioning** in order to make a differential diagnosis and establish the presence of NPD, especially when they present with substance abuse, mood, anxiety, and/or interpersonal or work-related problems.
- Assess for vulnerable as well as grandiose **subtypes**.
- In any patient for whom NPD is the diagnosis, assess carefully for pathology of **moral functioning** as well as frank **antisocial features**.
- It is difficult to develop collaborative goals when the clinician is reluctant to share the PD diagnosis. **Share diagnostic impressions** in the setting of providing psychoeducation and identifying treatment goals. In characterising NPD, focus on problems with self-esteem regulation, lack of satisfaction in interpersonal lives, and subjective distress and/or functional impairments. Some may benefit from an explicit discussion of the NPD diagnosis.
- Anticipate that patients will show **significant impediments** to beginning treatment and engaging fully. A clinical approach involving communicating empathy while focussing on specific treatment goals and monitoring one's own internal reactions can help foster the development of **treatment alliance**.
- Use the **patient's words** to help them more readily accept your comments and recommendations.
- For patients who present with depression, anxiety, or SUD, adopt **therapeutic interventions**.
- Attempt to maintain a **non-judgemental** and **inquisitive stance** towards their difficulties and their perception of others and steer clear of directly confronting or criticising the patient's grandiosity.
- Clinicians' reactions tend to be powerful and negative. It is helpful to anticipate that one will have to **monitor** and **contain** one's **emotional reactions**. Do not respond defensively, aggressively, or dismissively or withdraw and collude the patient's denial of pathology through passivity.
- **Attend to negative feelings** that the patient may have about treatment and clinician. If unaddressed, these feelings pose a serious threat to the treatment. If addressed in an accepting, non-judgemental fashion, it can support the development of a treatment alliance and lead to exploration of the motivations for the patient's negative response to others and ultimately to themselves.

Lecture

NPD can also be conceptualised using a **dimensional approach**:

Identity	Self-direction	Empathy	Intimacy
• Uses others for self-definition and self-esteem regulation • Exaggerated self-appraisal • Emotion regulation fluctuates with self-esteem	• Goal setting based on gaining approval • High/low personal standards • Unaware of own motivations	• Impared ability to recognise/identify • Excessively attentive to reactions of others (on the self) • Over- or underestimating own effect on others	• Superficial relationships • Restrained mutuality (little genuine interest)

Narcissists are argued to have two pathways to gain self-esteem: **admiration** and **rivalry**.



Psychopathy is defined along several **factors**:

1. **Affective/interpersonal**
   Affective: lack of guilt/remorse, emotionally shallow, callous, failure to accept responsibility
   Interpersonal: glibness/superficial charm, grandiose, pathological lying, conning/manipulative
2. **Antisocial/lifestyle**
   Antisocial: poor behavioural control, early behavioural problems, juvenile delinquency, revocation of conditional release, criminal versatility
   Lifestyle: need for stimulation, lack of realistic long-term goals, parasitic lifestyle, impulsivity, irresponsibility
3. **Other**
   Promiscuous sexual behaviour, many short-term relationships

In order to **diagnose**, there is often a need for secondary sources of information (criminal investigation, criminal records, family or other sources). There is also the **Psychopathy Checklist Revised**.

Psychopathy can also be defined using a **dimensional approach**:

Identity	Self-direction	Empathy	Intimacy
• Egocentrism • Self-esteem derived from personal gain, power, or pleasure	• Based on personal gratification • Absence of prosocial internal standards, normative ethical behavior	• Lack of concern for others • Lack of remorse after hurting or mistreating another	• Incapacity for mutually intimate relationships • Exploitation is used to relate to others • Use of dominance or intimidation

LECTURE 10

Verhaege: "What about me?"

We determine our identity by placing it alongside and, increasingly, contrasting it with other possible identities. We really want to see differences in identity because otherwise they are hard to understand.

Who am I?

On the one hand, we cherish the conviction that our self always existed and will always exist. At the same time, we need to consult someone else, preferably an expert, to find out what 'really' makes us tick. Our **identity** is a core of ideas that the outside world has inscribed on our bodies. Our psychological identity is shaped by our surroundings. **Identify formation** comes about through **mirroring**. **Marking** is the exaggerated way in which mothers communicate with babies using mirroring of facial expressions that allows babies to distinguish between what the mother is feeling herself 'I am not unhappy' (no marking), and the feelings that she suspects her child has, 'you are unhappy' (marking). But not everything comes from the environment. Right from the start, our identity is a balance of **tensions**. We are torn between the urge to merge with and the urge to distance ourselves from the other. That's because, alongside and intermingled with the initial process of identification or mirroring, there is a second process at work: a striving for **autonomy**. In the first process, we assimilate messages of others to become part of our identity. In the second process, we desire to be separate, distant from the other, and to resist and reject those messages. This opposing urge is accompanied by a fear that the other treading too close on our heels (**fear of intrusions**). This allows us to develop an individuality through opposition.

The urge for autonomy is nowadays regarded as a desirable, even necessary characteristic. The environment has a demonstrable effect on the physical development of the brain. Your brain is important for your identity, but its content is provided by the outside world. We are the product of a constant interaction between our brains (and genes, neurons, and hormones) and our environment. External factors can also affect gene expression. The author argues that genes can be seen as the **hardware** that determines and limits our **software**. The specific content of that software is another issue.

We are divided between our **body** and that of the **other**. Our body generates impulses relating to pleasure and pain, but it ~~are~~is others who teach us how to deal with it – partly because they are the focus of very many of these impulses. Our appearance, self-perception, and social mores are entirely determined by the messages we receive. We have culturally shared stories through which we shape our identities and understand the place we are supposed to have in society. This **narrative whole** encompasses religion, art, and science, each of which informs answers in their own way.

The fact that the words self-confidence, self-respect, and self-hatred all incorporate the word 'self' supposedly indicates that the self comprises certain essential **innate characteristics**. We forget that such characteristics are determined by the way others observe us and interpret our behaviour. Such characteristics are better understood in their original context which is how you were trusted, esteemed, or respected as a child. Our attitude to authority figures forms an important part of our identity.

Our identity is not a neutral assortment of personal characteristics but has everything to do with the norms and values that have (or have not) espoused. Every identity stems from a coherent **ideology**. Ideologies are often devised in opposition to other ideologies. All ideologies regulate access to pleasure but differ greatly in the way they do.

Someone who too closely resembles us makes us want to distance ourselves in order to differentiate ourselves. And when someone is too different, we either want to make them like us or we want to be

like them. Identity is determined by this **balancing act** between merging with and distancing from. Identity-forming can go wrong in two ways, both leading to **aggression**:

1. If identification (**sameness**) is taken too far, a uniform group arises, headed by an authority figure who makes sure that aggression is given external focus by targeting another group.
2. If the focus comes entirely to lie on **separation** and individualism, group forming suffers, leading to competition, social isolation, and loneliness.

In a stable environment, identity changes gradually. Since identity-conferring messages come from the other, **individual identities** within a group show a marked degree of similarity. **Collective identities** are also formed by interaction, albeit in a broad setting and on a greater timescale, and they are never competed or static.

De Kesel: "Subject of Language"

The field in which psychoanalysis operates is that of **language and speech**. People with mental health problems should not be told what is wrong with their brains or with how they react to stimuli, they should be given the opportunity to talk. Therapy should never look for things beyond language. What is helpful for the patient must be sought in talking solely: the way they give themselves a place within the language they produce and the way that they relate to their own speech. The line of argumentation starts with the **axiom of psychoanalytic theory**: life is not simply ruled by the preservation principle but also by the **pleasure principle**. Reacting upon stimuli, the organism not only wants to preserve itself, it wants, at the same time, to have pleasure, even if this might be at the cost of self-preservation. Pleasure may often go together with self-preservation but it is not reducible to it. At the principle level, pleasure subverts self-preservation. Pleasure subverts the biological function so that the function is being lived, not merely for what is meant for biologically, but also for its own sake.

The new-born baby's premature state is doubly traumatic, for it is not only unable to react properly to its biological needs but it is also unable to satisfy its demand for pleasure, incapable of doing so because it does not yet have a **self**. That is why the child is not interested in the other or in anything else: the world is perceived as immediately satisfying its pleasure requirements. The child does not want to face reality, but immediate pleasure.

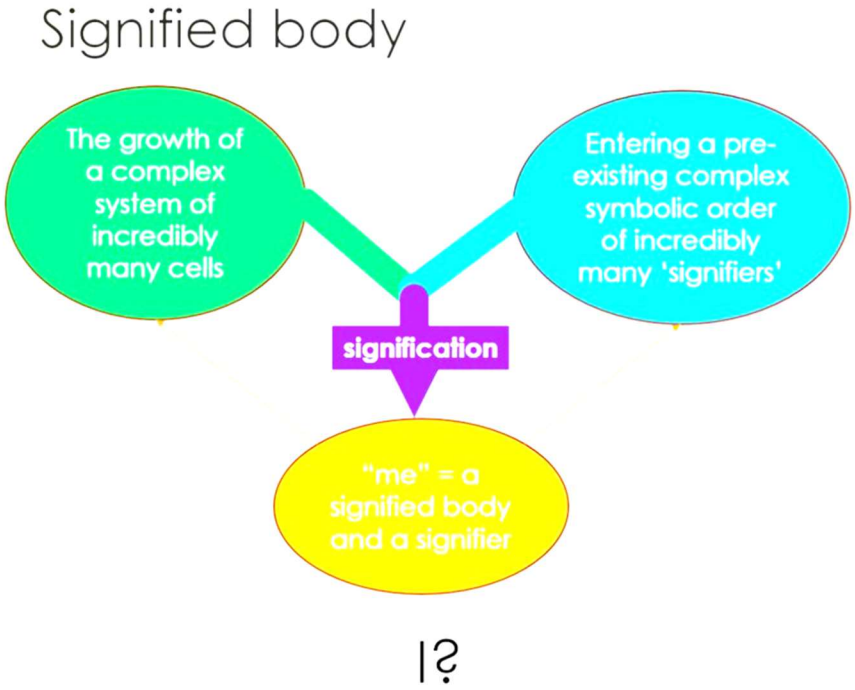
Living by pleasure, man is not able to live on the level of real being. He is a **lack of being**, surely longing for being, but without ever really becoming it. Man lives his identity as a wish to be identical to himself and never as definitely realised. We only desire for completion and being real, but actually, we are constantly shifting, desiring, and not feeling complete.

Just like human beings, language is characterised by **lack**, by an impossibility to become identical with the reality it relates to. But unlike the baby's lack of being, the lack of language is productive and operational, it works thanks to its lack. It is the impossibility of words to coincide with what they represent that makes them refer endlessly to other words and makes language an appropriate universe to live in. This implies that the one who wishes or desires is always already wished and desired himself. Our desires and those of the others are very much intermingled. It is thanks to language that we are able to construct an **agency** holding together its economy and supposing itself to be the owner, the ego, the subject of the whole system.

The baby's wishes are immediately satisfied by others who are willing and wishing to do so. But once the bay can no longer deny that he lives by others and will be forced to live by himself, it is language that will give him a perfect way out. All the baby wants is **immediate** (attuned) **satisfaction** but since immediate satisfaction becomes impossible, the only way out is to rely on mediation, that is, on the stream of words which he is washed over anyway. The child will construct his first self by identifying with what others tell about him, with the **subject** of their discourses. The first self is an imaginary one

(his majesty, the baby). Soon, the child will realise that he is neither the answer to all others' questions nor the sense of the world.

The full or **real self** in this theory does not exist but is something we long for and fantasise. The strong unified agentic self (ego) can be regarded as one of the most powerful myths. That is why, for the analyst, the most difficult things is not so much the patient's but his own desire for he ist constantly seduced to operate as the filling in of the lack of desire that his patients is struggling with. It is with language and speech that the patient denies his **symbolic condition** (subject of desire) and tries to use the analyst to support this strategy but only within the realm of language can the analyst lead the patient to a confrontation of the fundamental lack that characterises him as a subject of desire.



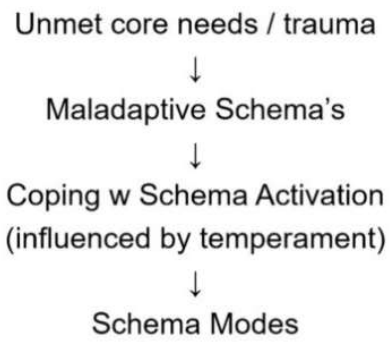
LECTURE 11

Feinstein Chapter 12: "Schema Therapy"

Schema therapy (ST) is a major evidence-based treatment for patients with personality disorders. It assumes that aversive childhood experiences and the frustration of basic needs in early childhood, in interaction with biological and cultural factors, leads to the development of dysfunctional schemas (**early maladaptive schemas**, EMS). When an EMS gets activated, this leads to emotional distress. In order to prevent or deal with this emotional distress, the individual develops specific coping strategies that help to reduce emotional pain. These coping strategies also block access to primary feelings and needs, and result in unmet needs and problems that persist into adult life. ST is an integrative therapy based on a cognitive model that integrates cognitive, behavioural, psychodynamic, and experiential therapies with insights, methods, and techniques from attachment and other developmental theories. There is a specific focus on the therapeutic relationship as well as the use of experiential techniques such as chair dialogues and imagery rescripting. It has proven effective in the treatment of PDs in several studies (mostly with BPD).

Origin and theoretical background

When trying to figure out why certain patients did not profit from CBT, it was discovered that they seemed to have developed **coping strategies** as a response to **adverse experiences** in their past which led to difficulties in the therapeutic relationship and process. Some learned to suppress or avoid their emotions or thoughts and were therefore not able or willing to follow CBT. Many had trouble engaging in a collaborative relationship with their therapists. A lack of psychological flexibility made them less responsive to CBT techniques and prevented changes in the short treatment period characteristic for CBT.



Schema therapy is based on the **basic emotional needs**:

- Secure attachment, stability, and care
- Autonomy, competence, and identity
- Realistic limits
- Expression and validation of emotions, needs, and opinions
- Play and spontaneity

Early maladaptive schemas are dysfunctional knowledge structures, acquired early in life, that govern cognitive processes such as attention, interpretation, or memory consolidation. They contain both explicit information (such as dysfunctional beliefs), as well as implicit knowledge and behavioural-procedural and emotional information. Young described 18 EMSs, organised into five domains:

Basic Emotional Needs	Schema Domain	Schema
Secure attachment, stability, and care	Disconnection and rejection	Abandonment/instability Mistrust/abuse Emotional deprivation Defectiveness/shame Social isolation/alienation
Autonomy, competence, identity	Impaired autonomy and achievement	Dependency/incompetence Vulnerability to harm and illness Enmeshment/undeveloped self Failure
Realistic limits	Impaired limits	Entitlement/grandiosity Insufficient self-control/self-discipline
Expression and validation of emotions, needs, and opinions	Other-directedness	Subjugation Self-sacrifice Approval-seeking
Play and spontaneity	Hypervigilance and inhibition	Negativity/pessimism Emotional inhibition Unrelenting standards Punitiveness

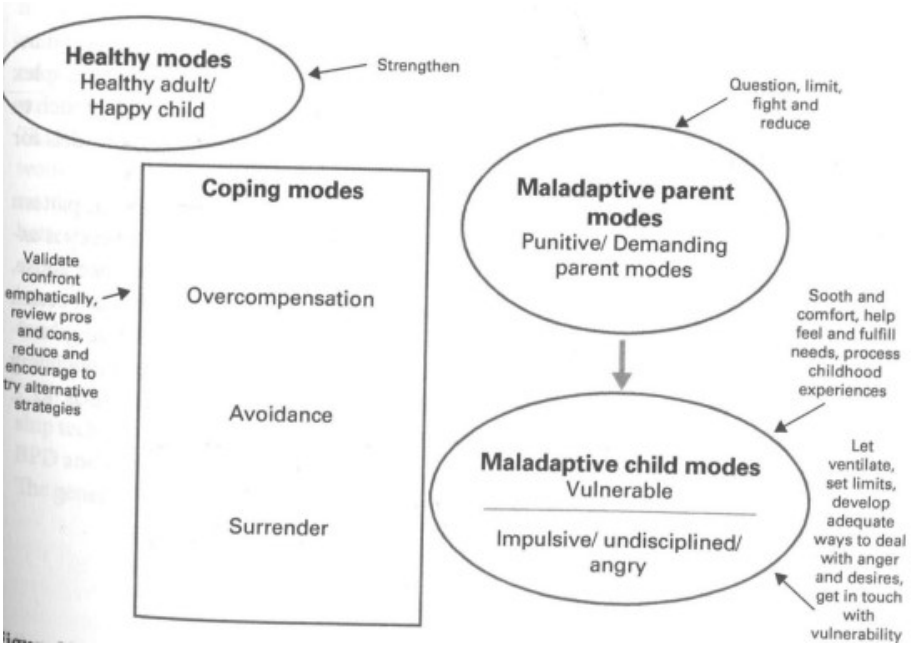
In order to **cope** with psychological distress, an individual may react with one of three types of coping:

1. **Schema surrender** (resignation): individual yields to the schema
2. **Schema avoidance**: individual avoids the full activation and awareness of the schema
3. **Schema overcompensation**: individual fights the schema by thinking, feeling, behaving, and relating as if the opposite were true

In patients with PDs, usually, multiple schemas and coping strategies are active at the same time, and patients tend to switch between schemas quickly. A **schema mode** is a combination of an activated schema and a coping strategy. It describes the moment-to-moment emotional-cognitive-behavioural state. There are four **categories of modes**:

1. **Dysfunctional child modes**: when basic emotional needs were frustrated in childhood. It is accompanied by intense emotions like fear, loneliness, helplessness, sadness, or mistrust in the vulnerable child modes.
2. **Dysfunctional parent modes**: internalised negative beliefs about oneself that are developed during childhood due to behaviour and reactions of significant others like parents, teachers, or peers. There are punitive parent and demanding parent modes. It is associated with high standards, self-devaluations, self-hatred, guilt, or shame.
3. **Dysfunctional coping modes**: when the coping strategy with the EMS activation is an avoidance or overcompensation type. They overshadow the EMS, and the experience and behaviour of the person is dominated by the coping strategy rather than by the EMS.
4. **Healthy modes**: healthy adult mode and healthy child mode: in healthy adult mode, patients can deal with emotions and needs adequately and engage in healthy relationships. In happy child mode, patients can enjoy fun, play, and spontaneity.

The **main goals** of ST are to help patients satisfy their needs more functionally, learn to cope with situations in which need fulfilment is not possible, and change EMSs and modes.



For each mode, there are **mode-specific goals** and **therapeutic tasks**:

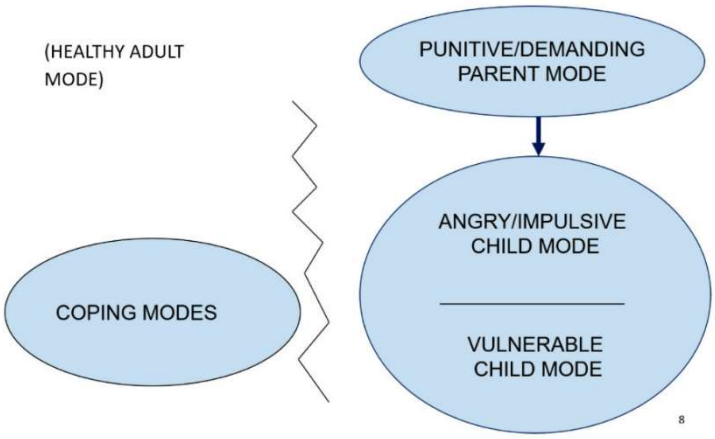
- **Child modes**: in order to heal and correct EMSs, patients are instructed to emotionally process childhood maltreatment, frustrated needs, and allow emotions.
- **Parent modes**: help patients fight, restrict, and contradict the punitive and demanding parent modes to develop self-compassion and a more adequate and healthy self-concept to replace the dysfunctional parent mode.
- **Coping modes**: these modes are acknowledged as previously adaptive, and their pros and cons are carefully weighed together with patients. Patients are assisted to replace dysfunctional coping modes with healthier, more flexible strategies.

- **Healthy modes**: help healthy adult mode to become the predominant mode.

ST is suitable for patients with long-enduring, pervasive, maladaptive emotional and interpersonal patterns which are commonly seen in people with PDs or other complex and chronic psychological problems. Patients with acute, circumscribed problems that are not part of a persistent pattern can be treated with approaches that are less complex than ST. There is limited efficacy in states that prevent **emotional learning** (e.g., substance abuse, low BMI) and for people with severe ongoing **psychosocial stressors** (e.g., contact with violent perpetrators, housing insecurity).

Techniques and treatment course

In the **first sessions**, current symptoms, important relationships, and life history are assessed. An **individual case conceptualisation** is developed in which current problems and developmental information are incorporated. When an individual's schema mode is developed, all problems that patients report as well as all distressing interpersonal situations that arise during the treatment are explained using the mode model. In most cases, **coping modes** are addressed first, as they block the access to the vulnerable child mode. As soon as the patients reduce their coping modes, therapists can get access to the **vulnerable child mode**. Therapists can validate the emotions and needs of the child mode and help patients using experiential techniques. Therapists can help patients heal emotional wounds of the past through the therapeutic relationship, thereby helping to learn new adaptive schemas. Later, behaviour-based techniques are included that help to enter and stay in the **healthy adult mode**.



Case conceptualisations

For **BPD**, the typical maladaptive schema is the abandoned, abused child mode, accompanied by feelings of abandonment and threat. The angry child mode is also common, as well as the punitive parent mode and the detached protector mode.

For **histrionic PD**, the abandoned/abused child mode, as well as the impulsive/undisciplined child mode are typical. They show the attention and approval-seeking mode as coping.

For **NPD**, the lonely child mode and the demanding parent mode are common. They use the self-aggrandiser mode as coping.

For **DPD**, the abandoned/abused or dependent child mode is common, as well as the demanding and punitive parent mode. Patients use the compliant surrender mode and the avoidant protector mode.

For **AVPD**, the lonely child or abandoned/abused child mode and punitive parent mode is coped with via the avoidant protect mode and the compliant surrender mode.

For **OCPD**, the lonely child mode and the demanding parent mode are common. This is coped with by using the perfectionistic over-controller mode, as well as the detached self-soother and self-aggrandiser modes.

Therapeutic relationship

The **therapeutic relationship** has an essential role in revealing and modifying dysfunctional interpersonal relationships. It is a source of interpersonal information and corrective emotional and

interpersonal experiences. It consists of validation, caring, and support, but also confrontation with objective reality and limit setting, as necessary.

Limited reparenting is the therapeutic attitude of behaving as a good parental figure toward patients throughout treatment, while at the same time respecting the limits of a professional therapist-patient. By adopting this attitude, therapists model appropriate parental responses and behaviours which helps them become aware of and express their emotions and needs. This may include support, empathy, praise, and providing secure attachment, but also setting adequate limits and encouraging autonomy.

Empathic confrontation is how therapists react to problematic behaviours or views of the patient. Therapists show understanding and validate the patients' feelings and needs that led to the problematic behaviour, linking them to their early life history and schema mode model. It is friendly but explicit.

Treatment techniques

Experiential techniques are used to understand and change the intense emotions that accompany schemas and modes as well as to process traumatic childhood memories. It can be used to clarify and work on present problems and to strengthen the healthy adult mode.

Chair dialogues are used to explore the different modes of patients in order to sort the problematic situations they encountered, to fight the parent modes, to empathically confront the coping modes, to soothe child modes, and to strengthen the healthy adult mode. Chairs represent different modes. By letting patients switch chairs, they can experience and express the modes that are relevant to a specific problem.

Diagnostic imagery exercises explore the origin of dysfunctional emotional-cognitive behaviour patterns. They use a current or recent emotionally disturbing situation, reported by their patients, and ask them to imagine it with their eyes closed. When the emotion is elicited, patients are asked to let go of the current situation, stay with the feeling, and 'float back' to their childhood to see if an image associated with this feeling emerges.

In **imagery rescripting**, aversive childhood memories are reprocessed in order to change maladaptive schemas. The original memory is rewritten, and the meaning associated with it is changed in two phases: 1) recalling the imagery of an unpleasant situation, and 2) rescripting it to a better ending.

Cognitive techniques are used to educate patients on schemas, coping styles, modes, needs, and emotions. All CBT techniques may be used as long as they are adapted to the mode model and ST goals (e.g., identification and reappraisal of schemas, pros and cons list of coping modes, diaries, flashcards).

Behavioural techniques are aimed at learning new behaviour, including roleplay, behavioural experiments, skills training, problem-solving, behavioural activation, or relaxation techniques. They help spend more time in healthy adult mode and are typically used in later stages of the treatment.

LECTURE 12

Livesley Chapter 30: "Mentalisation-Based Treatment"

Mentalisation-based treatment (MBT) was developed in the 1990s for the treatment of BPD patients.

Scope and focus: general or disorder-specific domains of psychopathology

The account of mentalising focuses strongly on the development of the **systems for social processes** that are considered to drive many higher-order **social-cognitive functions** underpinning interpersonal

interactions. Four of these functions are of primary importance in understanding not only BPD but also many other severe PDs:

1. **Affect representation** and related **affect regulation**
2. **Attentional control**, which also has strong links to affect regulation
3. **Dual arousal** involved in maintaining an appropriate balance between mental function undertaken by the anterior and posterior portions of the brain
4. **Mentalisation**, a system for interpersonal understanding that is particularly relevant within the attachment system

These capacities emerge in the context of the primary caregiving relationships experienced by the child. They are affected by the quality of the child's social context and particularly vulnerable to extremes of **environmental deficiency** (e.g., neglect, abuse, maltreatment). Several PDs can be conceptualised as representing different types of failures in the mind's capacity to represent its own activities and contents.

Overview of the treatment model

MBT is carefully structured, organised around the development of an **attachment relationship** with the patient, and offers a careful focus on the patient's internal mental processes, primarily of affect, as they are experienced moment by moment. It emphasises the therapeutic relationship following principles of marking and contingency of affect states, with the active repair of ruptures in the relationship between patient and clinician. One aim is Identifying the context in which serious **breaks in mentalising** occur both in personal life of the patient and in the sessions themselves, with the aim of restoring mentalising and eventually enabling the patient to maintain mentalising when, previously, it would have been lost. Treatment is delivered according to a carefully constructed protocol that informs the clinician about how to manage common clinical situations following a number of basic principles and procedures, including the **development of** the following:

- **Collaborative process**
- Formulation of patient **relational and mentalising problems**
- **General process**: identification of non-mentalising processes, monitoring of the state of affective arousal, identification of mentalising polarities (automatic versus controlled)
- **Therapist stance**: not-knowing stance of curiosity, authentic interest, responsiveness to internal states of mind; intervention consistent with the patient's mentalising capacity; focus on maintaining clinician mentalising
- **Trajectory of sessions**: interventions are structured from empathic validation to exploration, clarification, and challenge through affect identification and affect focus, to mentalising the relationship itself
- Focus on **contingency** and **marking of interventions**
- Explicit identification of **clinician feelings** related to the patient's mental processing

In the initial phase, a PD diagnosis is discussed. A crisis plan is made, focussing on what the patient can do for themselves to reduce risk behaviour and a formulation of the patient's problems is discussed and agreed upon. Diagnosis is openly discussed with a positive perspective on outcomes. Significant processes leading to non-mentalisation are discussed through detailed exploration of events in which mentalising has been lost.

Theoretical foundations

The approach is strongly rooted within **contemporary attachment theory**. BPD is associated with increased levels of insecure attachment styles, using both interview-based assessment of attachment and self-report measure. Adverse childhood experiences and genetic factors interact to create a

unique combination of biological factors and psychosocial factors. According to attachment theory, the **development of the self** occurs in the affect regulatory context of early relationships which requires consistent contingent and marked mother-infant interaction. To achieve normal self-experience, the infant requires its emotional signals to be accurately or contingently **mirrored** by an attachment. Mirroring must be **marked** (e.g., exaggerated) if the infant is to understand the caregiver's display as part of their own emotional experience rather than an expression of the caregiver's experience. Disorganisation of the attachment system results in disorganisation of self-structure. In drawing up a mentalisation developmental model of BPD in relation to childhood adversity, **two processes** (with a cumulative effect) are proposed to unfold:

1. The development of mentalisation depends on **social co-construction of internal states** between child and parents. Early neglect and an emotional environment incompatible with the normal acquisition of understanding oneself and others creates vulnerability for BPD.
2. Subsequent **brutality in an attachment context** can disrupt mentalisation as part of an adaptive adjustment to adversity when a child is in a state of helplessness in relation to those individuals.

Impaired capacity for mentalising after childhood attachment trauma may be due to:

1. **Defensive inhibition** of the capacity to think about others' thoughts and feelings in the face of the experience of genuine malevolent intent of other.
2. **Excessive early stress**, which distorts the functioning of arousal mechanisms, causing the inhibition of orbitofrontal cortical activity at far lower levels of risk than normal.
3. Any **trauma** that arouses the attachment system (seeking for protection) and **attachment trauma** may do so chronically.

Once **epistemic trust** has been lost, its absence creates an apparent rigidity which is perceived by the communicator who expects the recipient to modify their behaviour on the basis of the information received and apparently understood. In the absence of trust, the capacity for change is absent. Chronic **epistemic vigilance** limits the capacity to internalise available knowledge as something that is 'safe' to use to organise behaviour.

There might be a **general psychopathology factor** (*p*) in the structure of psychiatric disorders. Studies found that psychiatric disorders were more convincingly explained by a hierarchical model that assumed disturbance to occur at a syndromal, spectral, and overarching general psychopathology level. The *p* factor is a statistical construct. It has been speculated to be an indication of a state of **engagement with environmental influences** (general openness to environmental influence, potentially epistemic trust). A high *p* means epistemic hypervigilance and chronic epistemic mistrust.

Mentalisation in therapy is a generic way of establishing epistemic trust between the patient and the therapist in a way that helps the patient to relinquish the rigidity that characterises individuals with enduring personality pathology. **Relearning of flexibility** allows to go on to learn, socially, from new experiences and achieve change in their understanding of social relationships and their own behaviour and actions. **Feeling understood** also regenerates a capacity for social understanding (mentalising). Put simply, the experience of feeling thought about in therapy makes us feel safe enough to think more accurately about ourselves in relation to our world and how other people think of us, opening the way to learning something new about that world and how we operate in it.

Principal intervention strategies and method

MBT begins with a 10-12 session introductory group for 10 patients that combines psychoeducation with experiential group processes. Patients undertake structured exercises. Upon completion, patients are offered an individual session to review.

The use of **empathic statements** is a way to deepen the rapport between patient and clinician and a powerful way to maintain mentalisation by reducing arousal in the interpersonal interaction. An empathic intervention in MBT is a clinical translation of the process of marking, in the context of contingent responsiveness. The clinician is asked to consider two components of empathy: identification with the feelings of the patient (e.g., mirroring patient's outrage), and, if the patient feels like it, consequences of that feeling to the patient. As soon as the clinician sense a shared affective platform through the empathic process, exploration and elaboration takes place with the clarification of mental states.

MBT recommends judiciously **challenging** the patient. It is nearly always outside the normal therapy dialogue and a surprise to the patient because it is out of line with the current dialogue. The patient is supposed to be suddenly derailed in their non-mentalising process. Challenging is an effective intervention when a patient is stuck in a non-mentalising mode.

Once the clinician and patient are able to maintain a mentalising interaction, MBT suggests an increasing **focus on affect** and the interpersonal process characterised by the attachment strategies activated through the patient-therapist interaction. This has the effect of increasing emotional intensity and, if the mentalising is maintained under these conditions, the MBT clinician can move to mentalising the relationship. The purpose of focussing on affect in the interpersonal domain is to recreate the **core sensitivity** of people with BPD in the session itself. MBT starts by trying to identify an **affect focus**. The affect focus is not simply labelling feelings, even though the identification and labelling of feelings, placing them in context, and understanding their disruptive influence are all central to MBT. It is more a way of increasing the affective experience within the interpersonal relationship in the session. It is the clinical exemplification of moving the patient around one of the dimensions of mentalising. It is designed to make explicit what is currently implicit with the patient-therapist relationship.

The treatment relationship

Transference is used in the sense that discussion concerning the relationship that will contribute to the patient's well-being is used. Transference in the psychoanalytical sense is not used, though. **Mentalising the relationship** means encouraging the patients to think about the relationship they are in at the current moment. The aim is to create an alternative perspective by focussing the patient's attention on another mind, the mind of the clinician, and to assist the patient in the task of contrasting their own perception of themselves.

Mentalising the counterrelationship links to self-awareness of the clinician and often relies on the affective components of mentalising. MBT does not suggest that clinicians start expressing their personal problems or start talking about any feeling that they might have in a session. Rather, they maintain that the clinician's current experience of the process of therapy with the patient is to be shared openly to ensure that the complexity of the interactional process may be considered. Patients need to be aware that their mental processes have an effect on others' mental states.

Treatment process

MBT identifies a trajectory for each session. There is always a recommended stepwise move from a supportive position toward a more relational subjective experiential position. You start from an empathic and supportive position. Clinicians seek to demonstrate an empathic understanding and use empathic validation as the starting point. Clinicians manage process within the session by pacing the flow of the session.

Lecture

There is an **optimal level of arousal** where we are appropriately responsive. Mentalising is effective when it is within that window. **Effective mentalising** means being aware of the opaqueness of mental

states, being flexible and open, playful, turn-taking, and believing in changeability, humility, and forgiveness. **Non-effective mentalising** is marked by rigidity, lack of doubt, inability to consider other perspectives, and a focus on concrete/external factors. Mentalising comes form the context of attachment relationships. The caretaker has to reflect accurately the intentions of the child so that the child can develop affect regulation, the notion of a mind by being in mind, and agency, as well as a subjective sense of self.

The **overarching MBT principles** are:

- Collaborative process
- Highly structured (consistent, coherent, continuous)
- Active and transparent not-knowing therapeutic stance
- Interventions attuned to affective arousal levels
- Focus on (breaks in) mentalising
- Acknowledgement of what everyone brings to the table

Therapists are supposed to act like a normal person would, and use curiosity, humour, playfulness, and genuine interest.