Mentalizing

Carla Sharp, Ph.D.

Agenda

09:00-10.30: Mentalizing: A common factor across disorders and modalities

10.30-11:00: Break

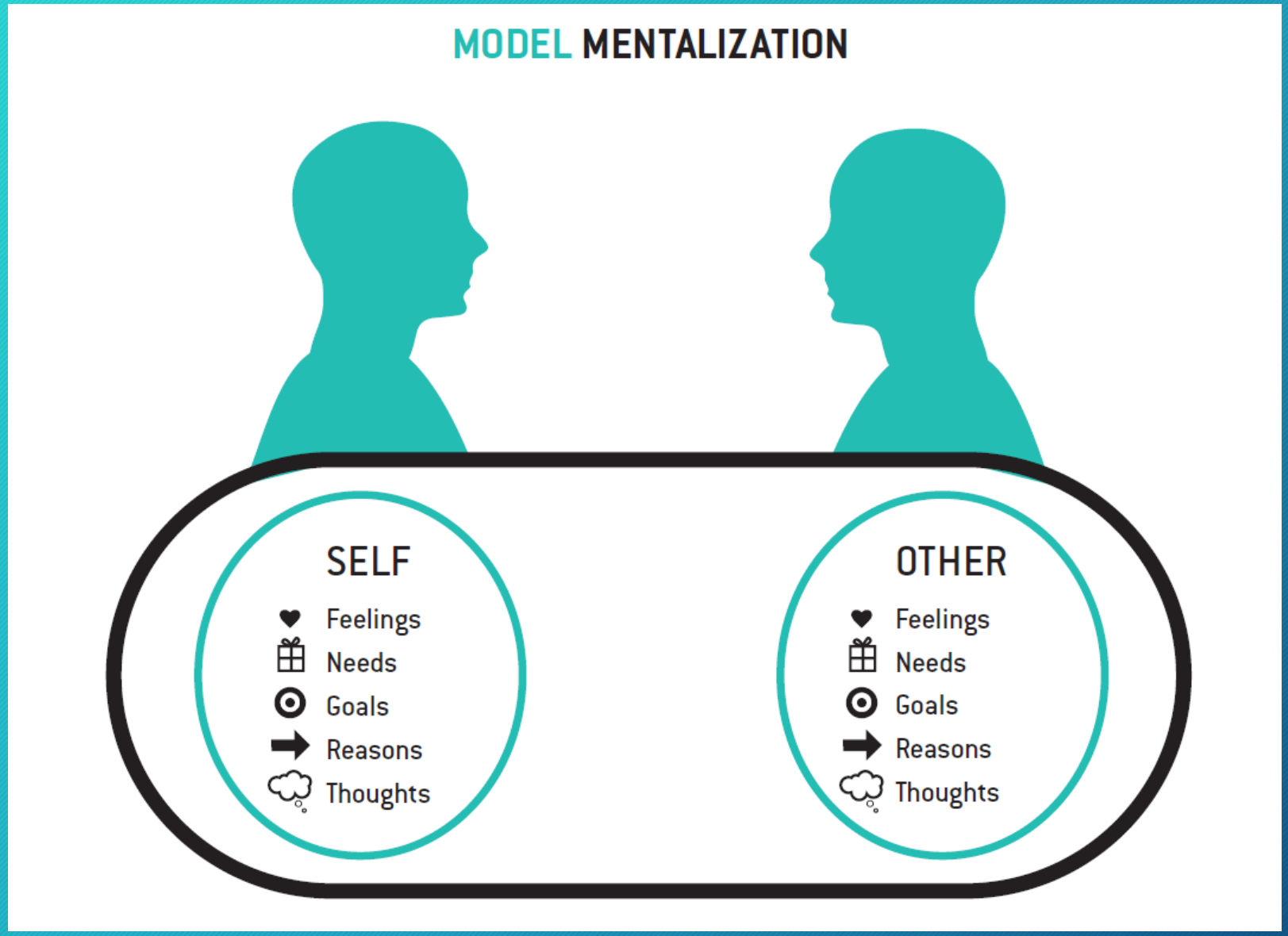
11:00-13:00: Mentalizing: Its importance in working with adolescents

13:00-14:00: Lunch

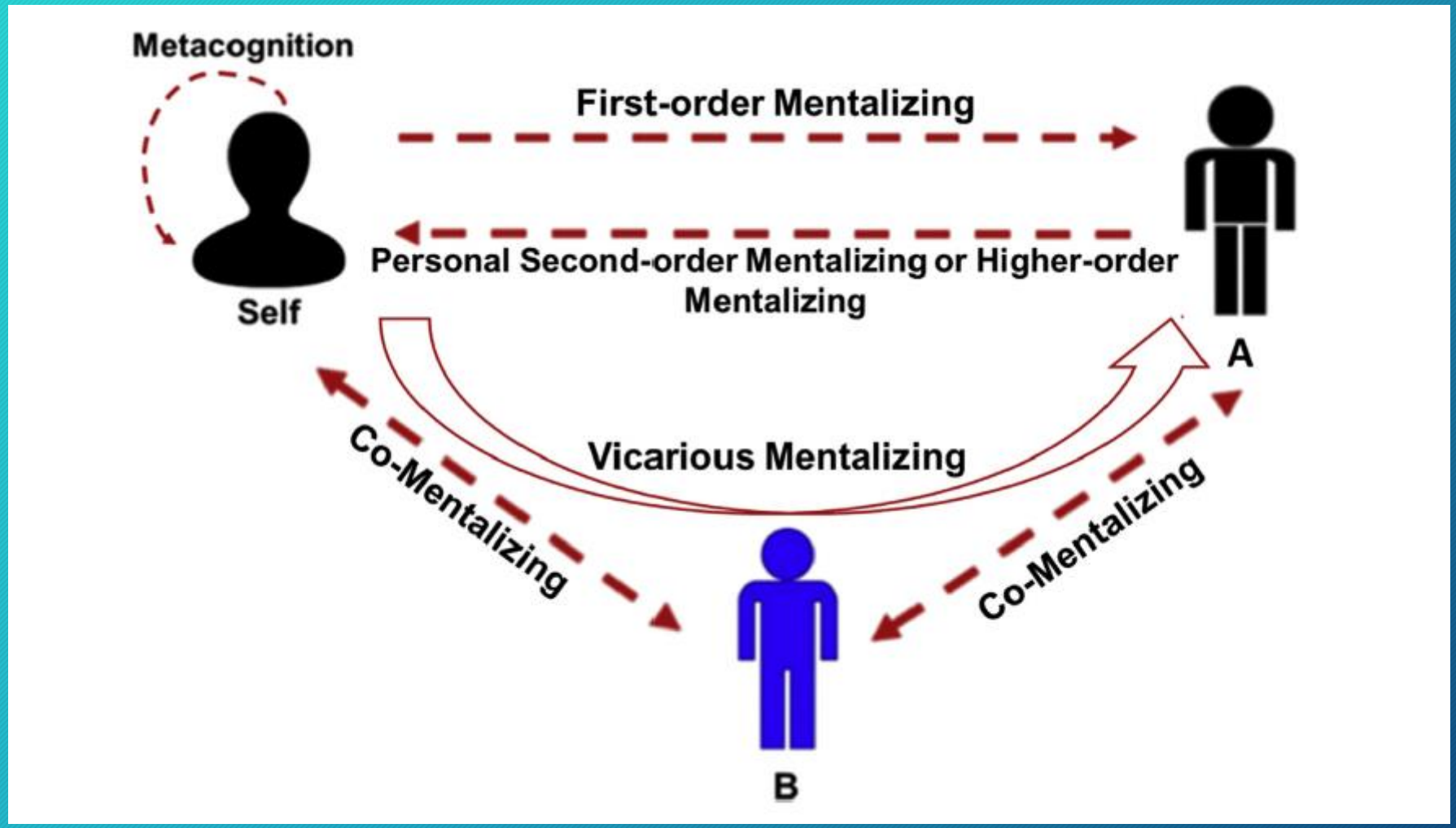
14:00-16:00: Distilled components

Mentalizing:

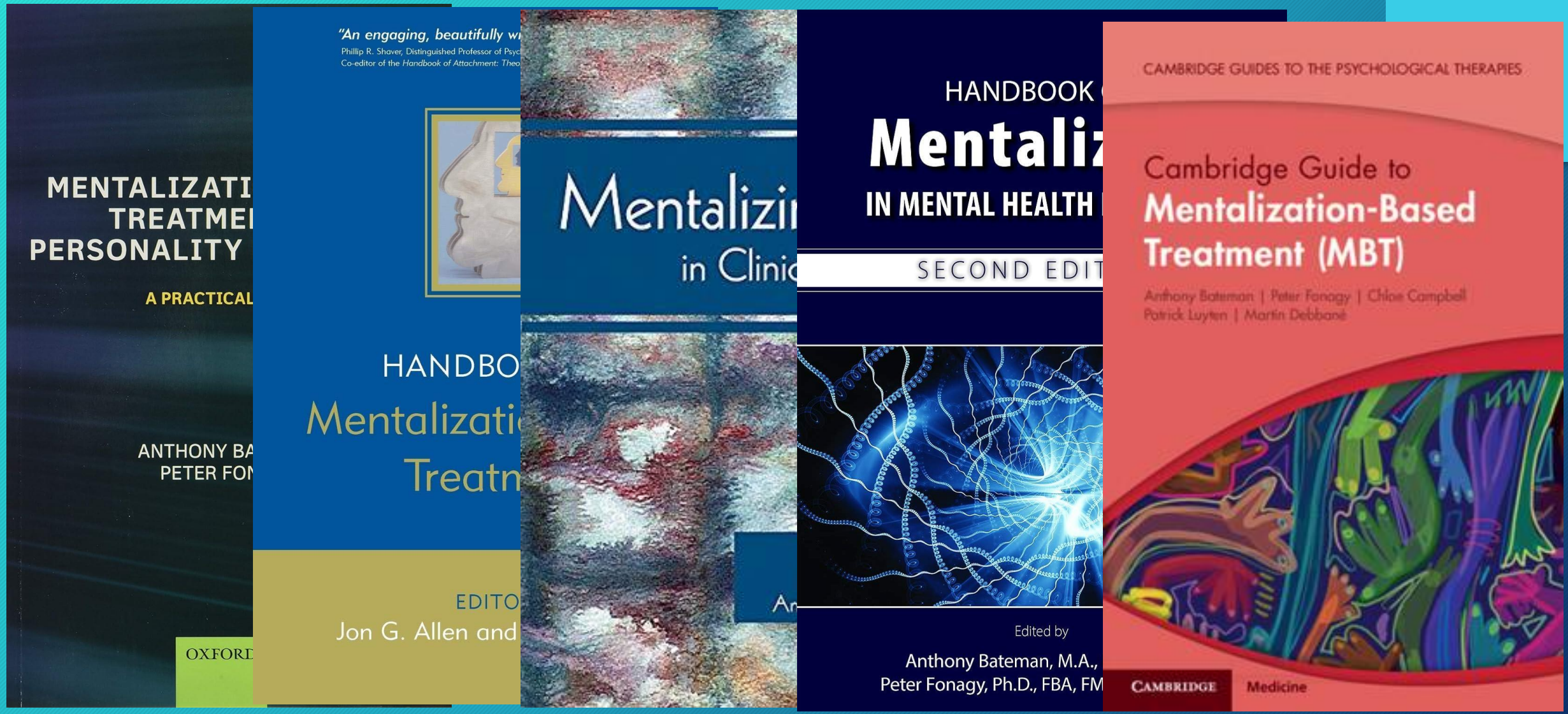
A common factor across disorders and modalities



Center for Mentalization, Denmark



Wu et al. (2020), Cortex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Edited by
Anthony Bateman, M.A.,
Peter Fonagy, Ph.D., FBA, FM
CAMBRIDGE GUIDES TO THE PSYCHOLOGICAL THERAPIES
Cambridge Guide to
Mentalization-Based
Treatment (MBT)
Anthony Bateman | Peter Fonagy | Chloe Campbell
Patrick Luyten | Martin Debbané
CAMBRIDGE
Medicine

Research

BJPsych The British Journal of Psychiatry (2022)
221, 538–552. doi: 10.1192/bjp.2021.204

PLOS ONE

RESEARCH ARTICLE

Psychological therapies for adolescents with borderline personality disorder (BPD) or BPD features—A systematic review of randomized clinical trials with meta-analysis and Trial Sequential Analysis

Mie Sedoc Jørgensen[1,2,3]*, Ole Jakob Storebø[1,2,4], Jutta M. Stoffers-Winterling[5], Erlend Faltinsen[1], Adnan Todorovac[1], Erik Simonsen[1,3]

Challenges

- Dense and complex terms
  - What does mentalizing really mean?
  - How is it different from sibling constructs?
  - “Psychic equivalence”; “teleological stance”; “pretend mode”
- Generic therapeutic stance → no “skills”/implicit
  - How do I do it?
  - How do I know when I’m doing it?
  - How do I teach it?
- Relying heavily on expert supervisors
- Therapists get trained, but feel insufficiently prepared to apply knowledge in everyday clinical settings – they WANT a manual!

Certainty

Uncertainty

Benefits of certainty

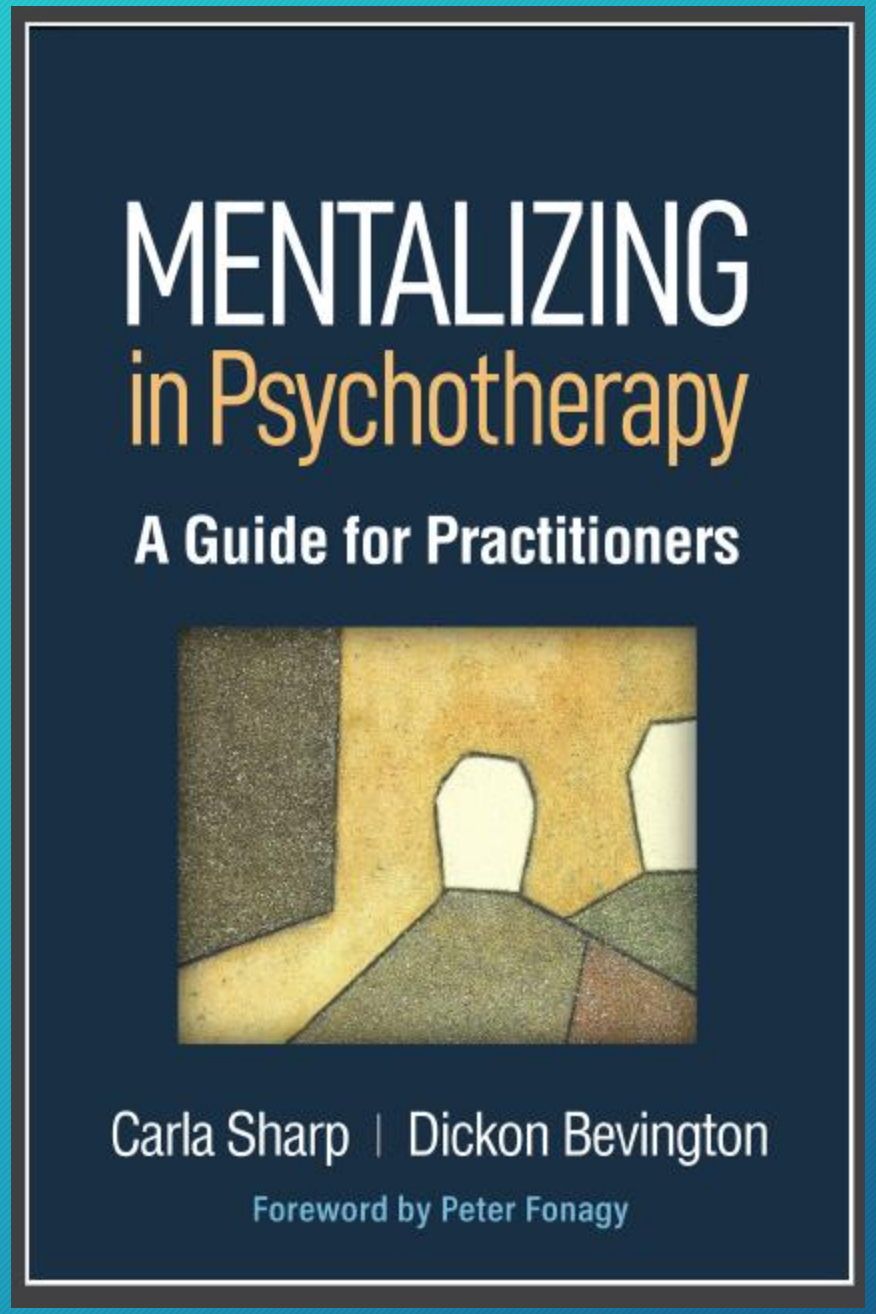
- Reduces anxiety
- Feels like an expert
- Feels like an authority
- Know what to do

Benefits of letting go of certainty

- Refocus on client's mind instead of my own
  - Stay emotionally close even in time of crisis
  - Stay emotionally close when feeling overwhelmed, tired, distracted, worried
  - Stay emotionally close when experiencing counter transference
- Equalizes the power differential
- Enhances collaboration
- Opens the epistemic highway
- Creates the we-mode → collective mentalizing
- Ownership
- Agency
- Relaxing
- Joy

Implicit

Explicit


MENTALIZING
in Psychotherapy
A Guide for Practitioners
Carla Sharp | Dickon Bevington
Foreword by Peter Fonagy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Cambridge Guide
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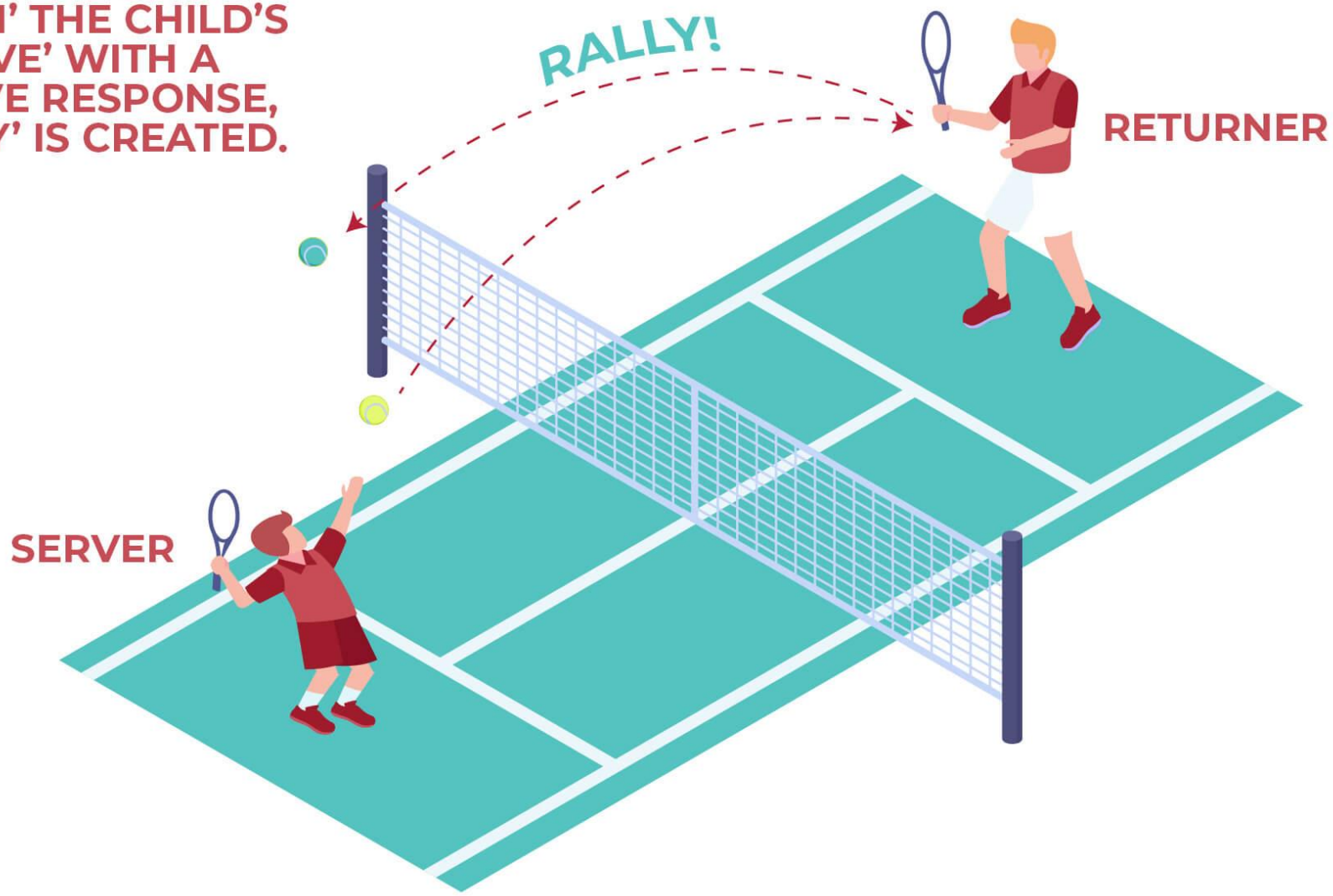
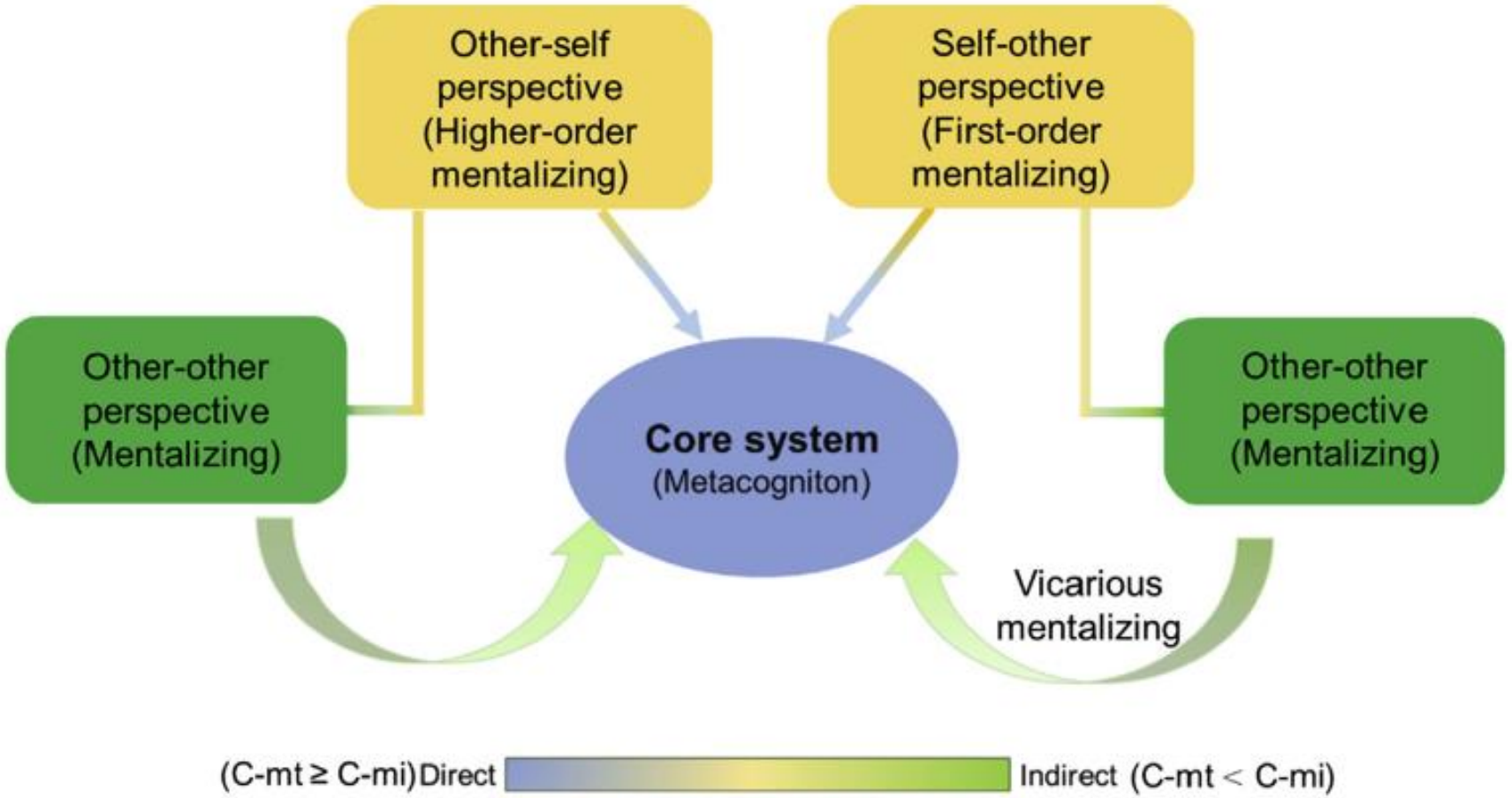
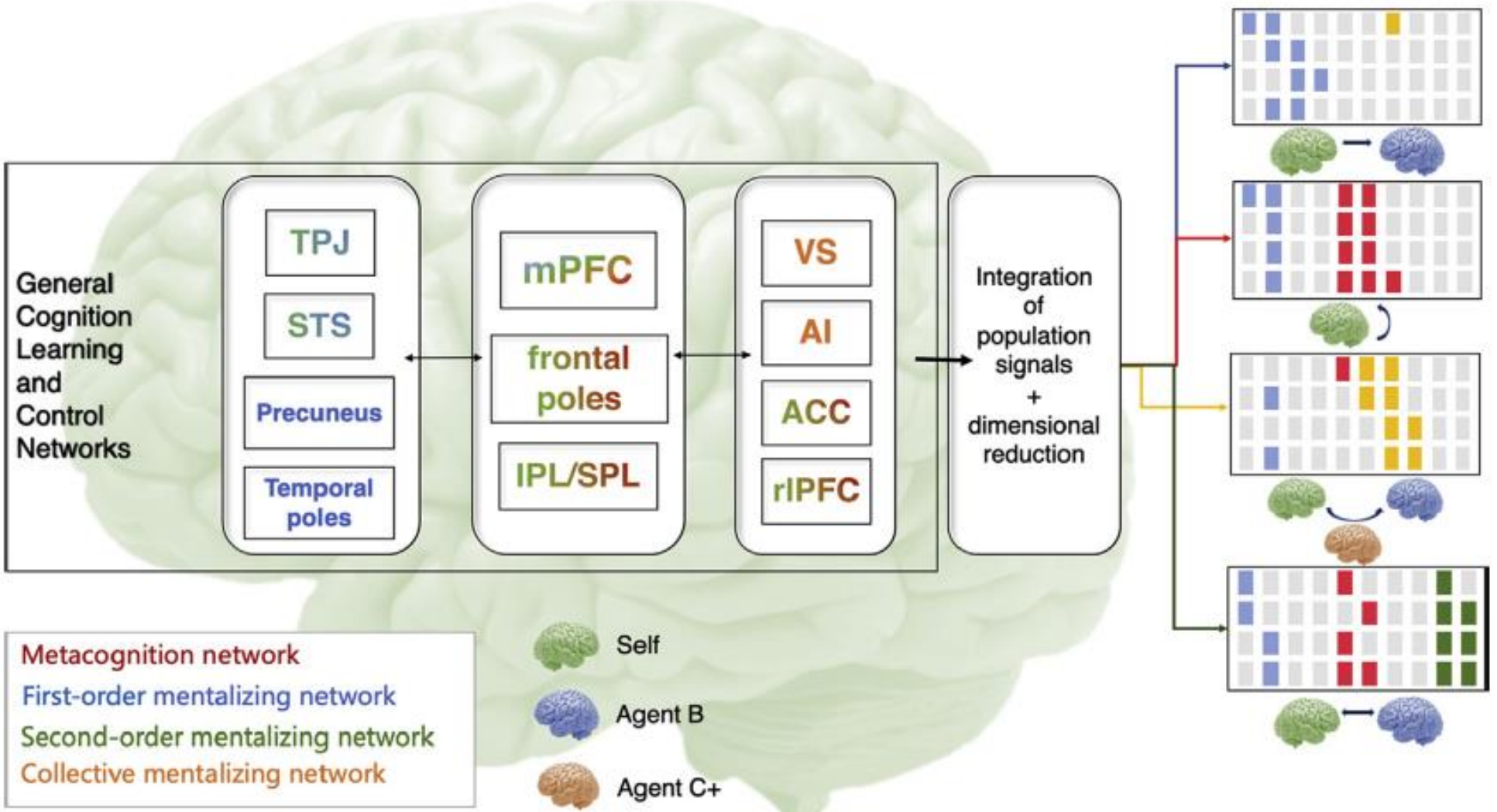
THERAPY
FOR PERSONALITY PATHOLOGY
TREATING SELF AND INTERPERSONAL
FUNCTIONING
Video
Illustrated
Eve Caligor, M.D.
Otto F. Kernberg, M.D.
John F. Clarkin, Ph.D.
Frank E. Yeomans, M.D., Ph.D

WHEN ADULTS ‘RETURN’ THE CHILD’S ‘SERVE’ WITH A POSITIVE RESPONSE, A ‘RALLY’ IS CREATED.





Wu et al. (2020), Cortex



Wu et al. (2020), Cortex

Clip 1

Clip 2

Why the need for common factors?

Bo et al.
Borderline Personality Disorder and Emotion Dysregulation (2022) 9:16
https://doi.org/10.1186/s40479-022-00187-9

Borderline Personality Disorder and Emotion Dysregulation

CASE REPORT Open Access

Improving treatment outcomes for adolescents with borderline personality disorder through a socioecological approach

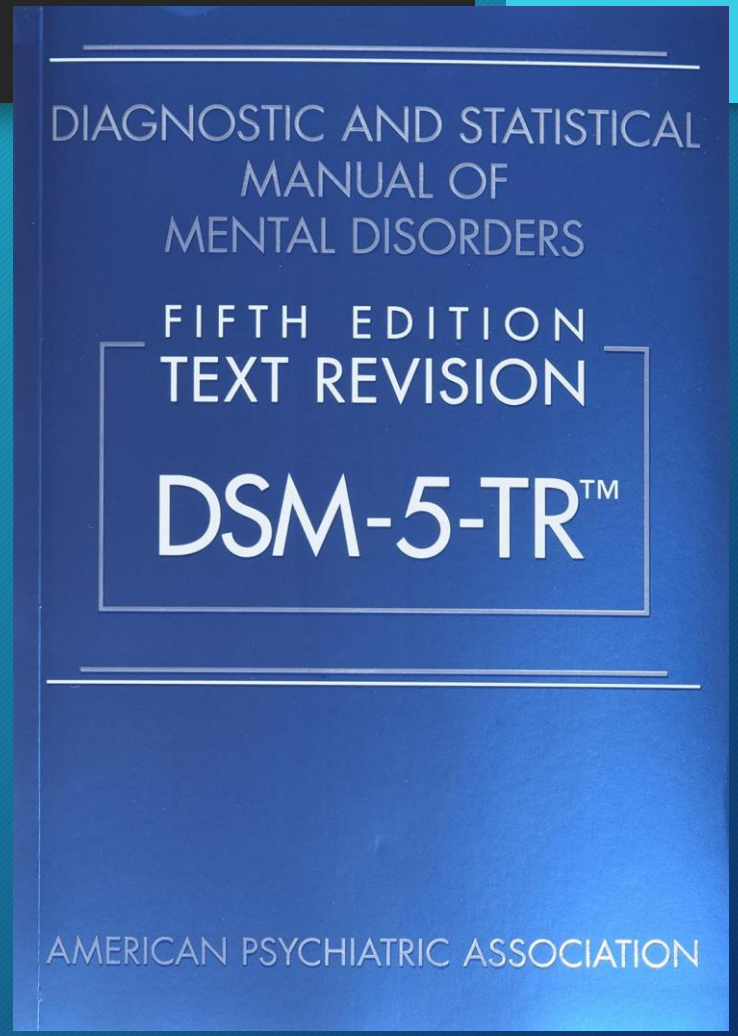
Sune Bo[1,2*], Carla Sharp[3], Mickey T. Kongerslev[1,4], Patrick Luyten[5,6] and Peter Fonagy[6,7]

1. CBT revolution

- 1960s/1970s in response to concerns
- By 2012 (Norcross & Rogan, 2013):
  - 45% CBT
  - 18% psychodynamic
  - 22% eclectic
  - 14% humanist, systems or interpersonal

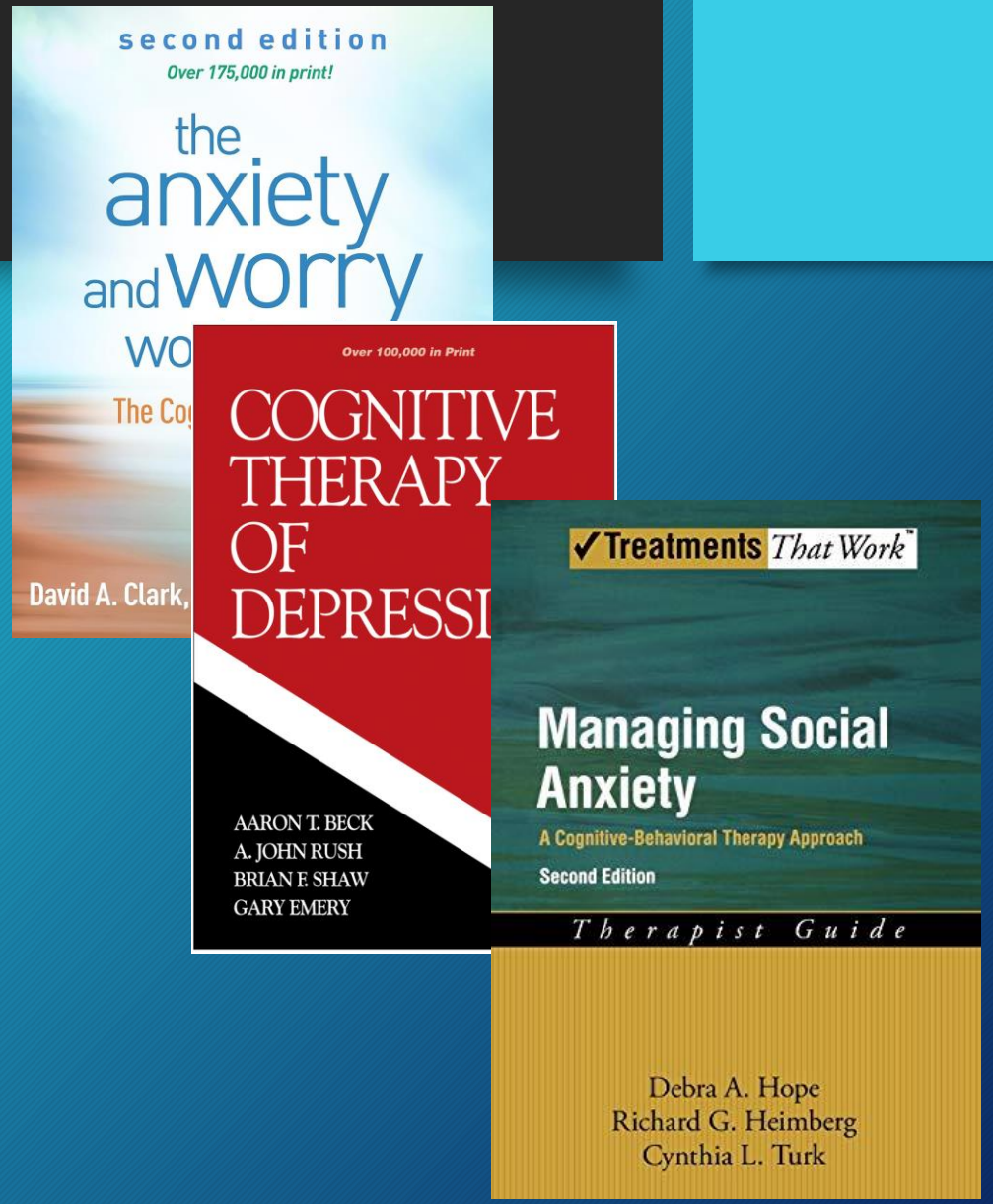
2. Descriptive psychiatric nosology

- Move away from prototypical description including etiology
- Splitting (vs. lumping)
  - DSM-1: 128
  - DSM-5: 541 organized into 22 diagnostic categories
- Despite well-known problems with the idea of categorically distinct disorders:
  - High heterogeneity within disorders
  - High comorbidity between disorders
  - Within-person variability over time
  - Lack of specificity in external validators
  - Lack of test-retest reliability
  - Lack of inter-rater reliability



3. A manual for each category

- Empirically supported treatment (ESTs):
  - At least 2 RCTs showing superiority compared to control condition
  - Well-defined population
  - Using treatment manual



CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

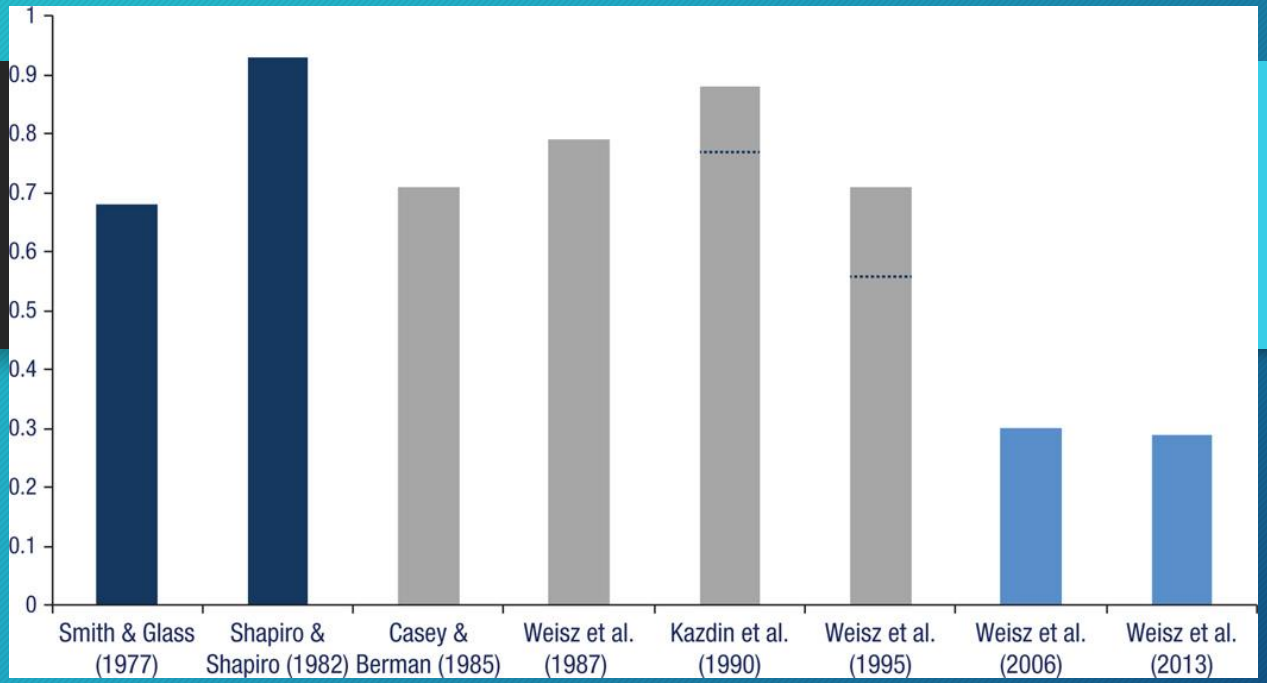
Evidence-Based Treatments for Children and Adolescents: An Updated Review of Indicators of Efficacy and Effectiveness

Bruce F. Chorpita, University of California, Los Angeles
Eric L. Daleiden, PracticeWise, LLC
Chad Ebesutani, University of California, Los Angeles
John Young, University of Mississippi
Kimberly D. Becker, Johns Hopkins Bloomberg School of Public Health
Brad J. Nakamura, University of Hawaii
Lisa Phillips, PracticeWise, LLC
Alyssa Ward, University of California, Los Angeles
Roxanna Lynch, University of Hawaii
Lindsay Trent, University of Mississippi
Rita L. Smith, University of California, San Francisco
Kelsie Okamura, University of Hawaii
Nicole Starace, University of California, Los Angeles

This updated review of evidence-based treatments follows the original review performed by the Hawaii Task Force. Over 750 treatment protocols from 435 studies were coded and rated on a 5-level strength of evidence system. Results showed large numbers of evidence-based treatments applicable to anxiety, attention, aut- expanded considerably since the previous review, yielding a growing list of options and information available to guide decisions about treatment selection.

Key words: **children, dissemination, evidence-based, services.** ***[Clin Psychol Sci Prac 18: 154–172, 2011]***

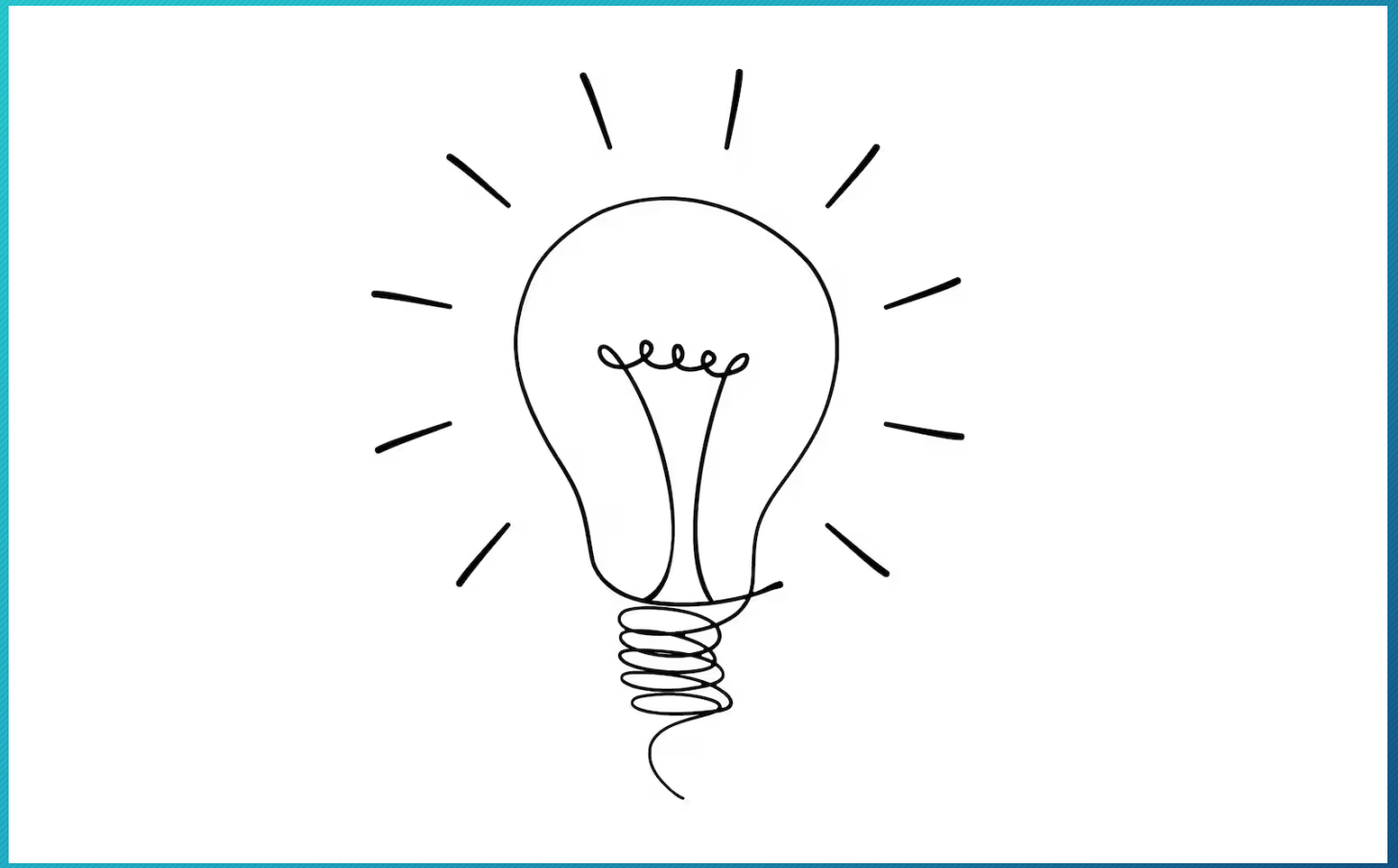
Fast forward 50 years….



- SAMHSA: 192 EBTs for youth.
- Mostly lab settings.
- Mostly non-referred youth – only 2.1% are clinically referred.
- Effect size drop to around .30 when compared to usual care (not waitlist).
- Probability of .58 (vs. chance at .50) that a youth randomly selected for EBT would be better off than youth in usual care.
- EBTs do not outperform usual care among referred/more severe youth

Weisz (2015), *Pers Psych Science*

Lessons learnt….



Lesson 1

Psychiatric disorders are not categorical entities but rather dimensional constructs

Symptoms lie on a continuum

- 20 (14.7%) findings exceeded the taxonic threshold (CCFI >0.5).
- According to more conservative guidelines, 102 (75 %) findings were clearly dimensional (<0.4), 17 (12.5%) were clearly taxonic (>0.6), and 17 (12.5%) were ambiguous.

Haslam et al., 2012

Table 3. *Distribution of taxonic findings and use of the CCFI across construct types*

Grouping	Findings	Taxonic (%)	Number (%) CCFI	Mean CCFI
Mood disorder	36	13 (36.1)	12 (33.3)	0.39
Anxiety disorder	60	16 (26.7)	32 (53.3)	0.33
Eating disorder	21	13 (61.9)	4 (19.0)	0.40
Substance use	12	7 (58.3)	12 (100)	0.57
Externalizing	29	6 (20.3)	24 (82.8)	0.31
Schizotypy	29	21 (72.4)	4 (13.8)	0.37
Other PD	12	1 (8.3)	9 (75.0)	0.25
Normal personality	41	8 (19.5)	11 (26.8)	0.34
Other individual difference	49	18 (36.7)	24 (49.0)	0.41
Miscellaneous	22	18 (81.8)	4 (18.2)	0.50
Total	311	121 (38.9)	136 (43.7)	0.37

CCFI, Comparison curve fit index; PD, personality disorder.

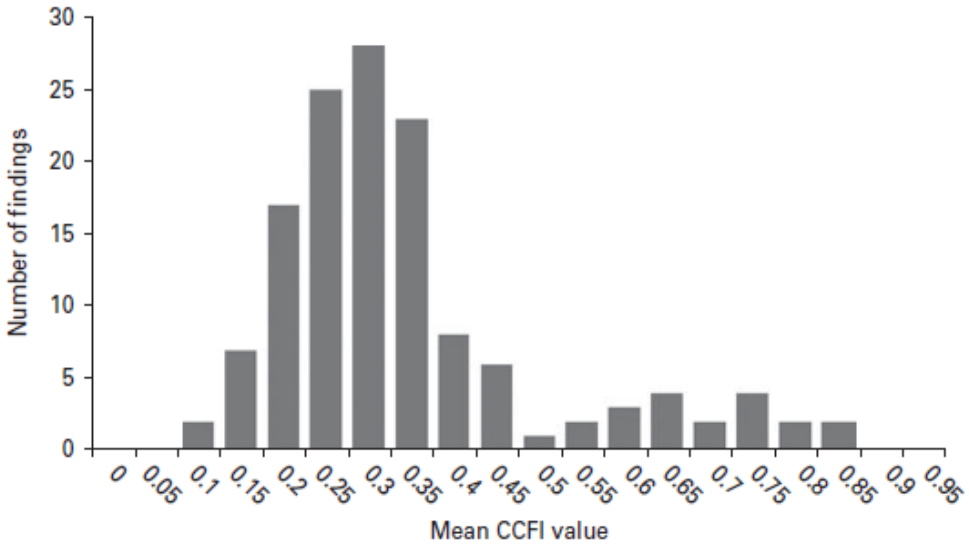
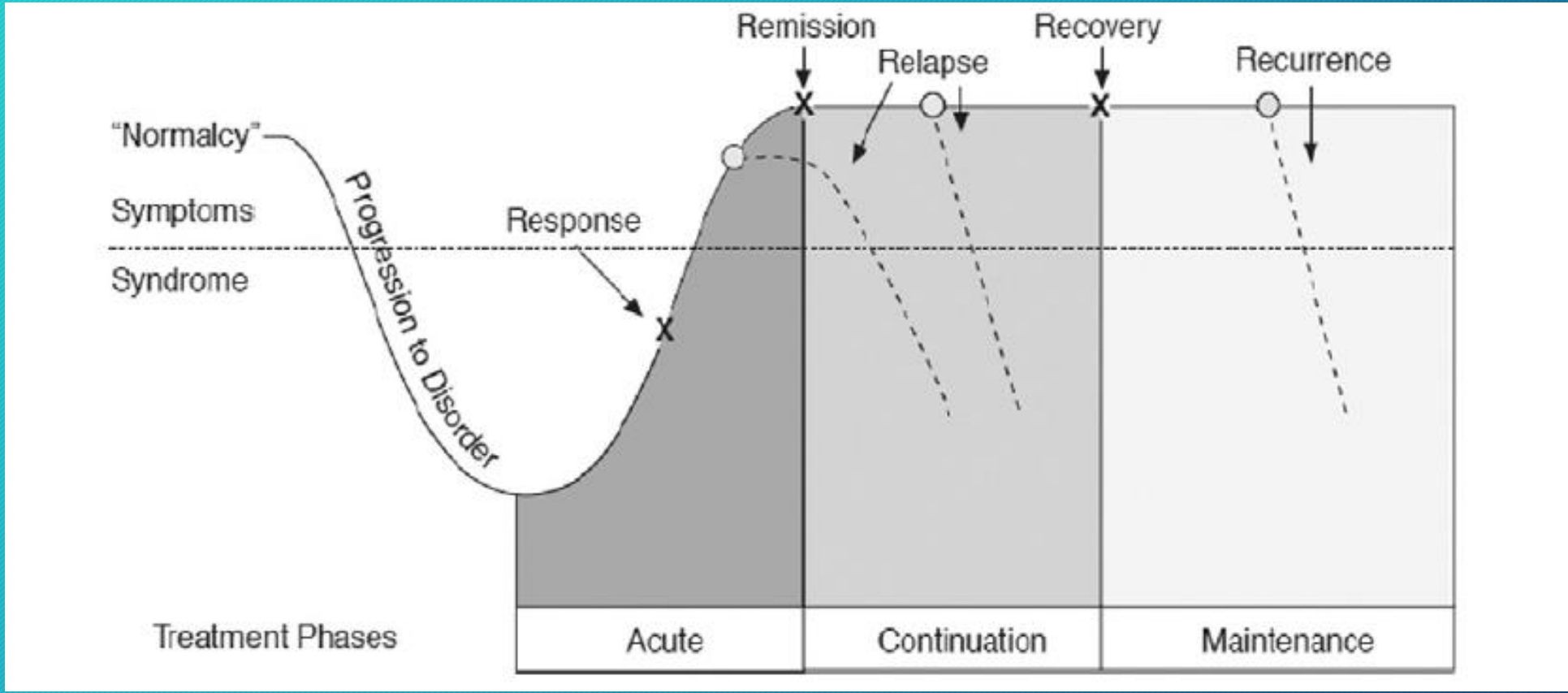


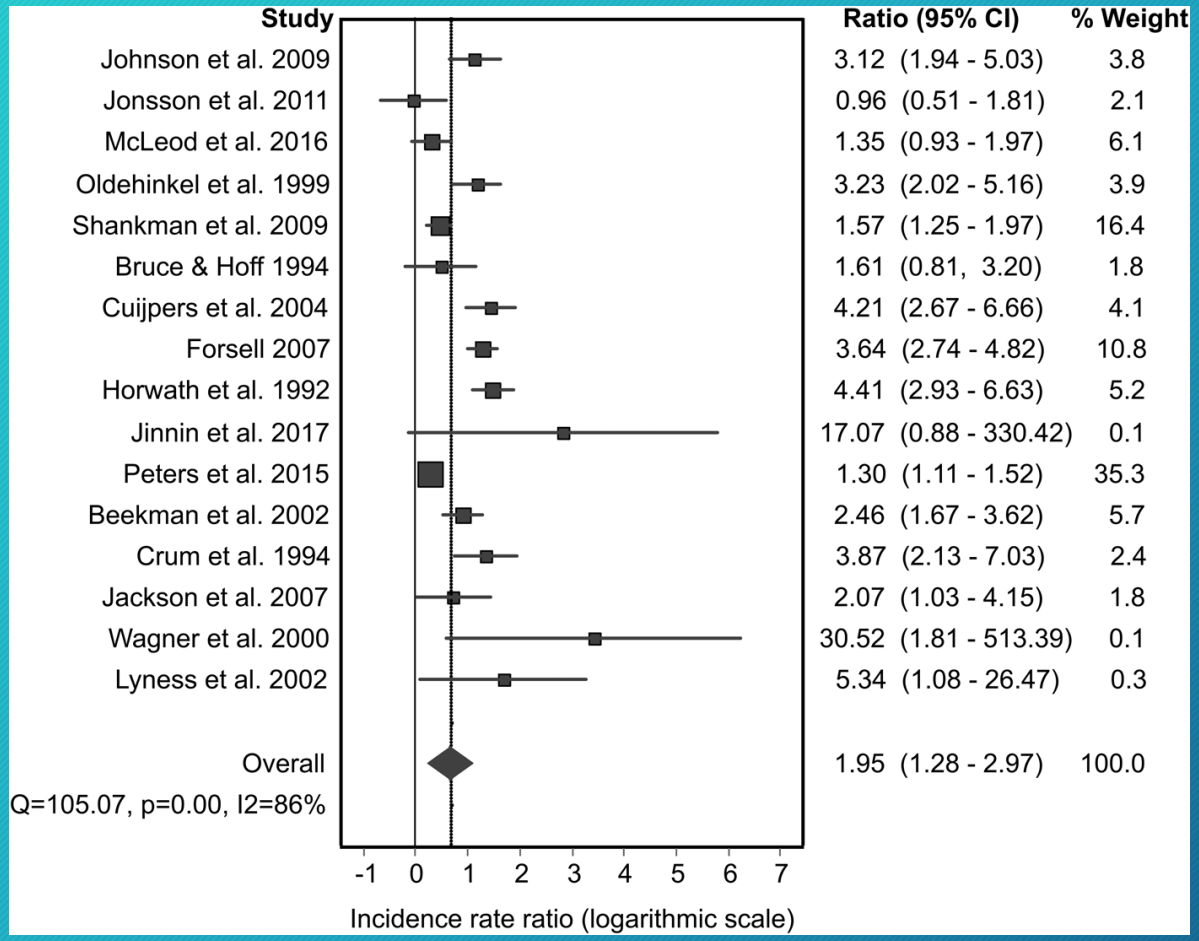
Fig. 2. Distribution of mean comparison curve fit index (CCFI) values for findings reporting them ($n = 136$).

Patients move in and out of clinical threshold



Blockting et al., 2015, Clin Psych Review

Patients below clinical threshold are as much at risk as someone who meets diagnostic threshold



Lee et al., 2018, *Psych Medicine*

Sub-threshold are as much at risk for developing depression as above threshold

Analysis and variable	k	No. StD (No. MD)	No. Nondepressed (No. MD)	IRR (95% CI)	P value for difference
Search terms					0.0003
Minor depression	10	2243 (275)	13450 (440)	3.97 [3.17-4.96]	
Subthreshold depression	6	3878 (388)	39347 (1701)	2.21 [1.68-2.89]	
Subsyndromal depression	2	3310 (628)	23484 (1305)	3.11 [2.37-4.09]	
Subclinical depression	1	514 (10)	2656 (45)	1.14 [0.57-2.27]	
Subthreshold depressive sysptoms	0				
Subclinical depressive condition	0				
Case definition					0.499
Diagnostic manual	17	9735 (1276)	77005 (3435)	2.91 [2.26-3.73]	
Other criteria	2	210 (25)	1932 (56)	3.50 [2.17-5.64]	
Setting					0.392
Community	17	9810 (1284)	78461 (3477)	2.89 [2.26-3.68]	
Primary care	2	135 (17)	476 (14)	4.03 [1.96-8.31]	
Age group					0.698
Youth (<18)	5	704 (210)	3602 (437)	2.53 [1.71-3.74]	
Adult (18-60)	10	8855 (1021)	74226 (2956)	3.05 [2.21-4.23]	
Elderly (>60)	4	386 (70)	1109 (98)	3.21 [1.89-5.47]	
Average length of follow up					0.991
More than 5 years	6	960 (219)	5018 (363)	2.95 [1.87-4.68]	
Less than 5 years	13	8985 (1082)	73919 (3128)	2.96 [2.24-3.93]	
Overall	**19**	**9945 (1301)**	**78937 (3491)**	**2.95 [2.33-3.73]**	**<0.001**

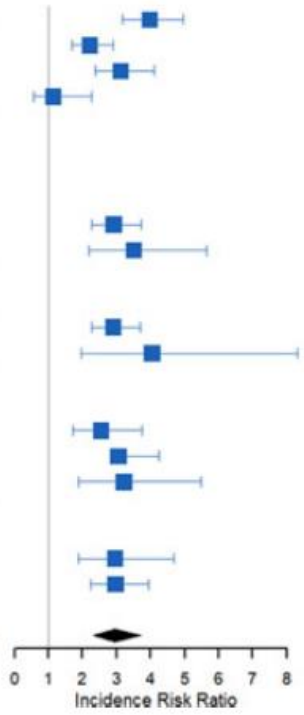
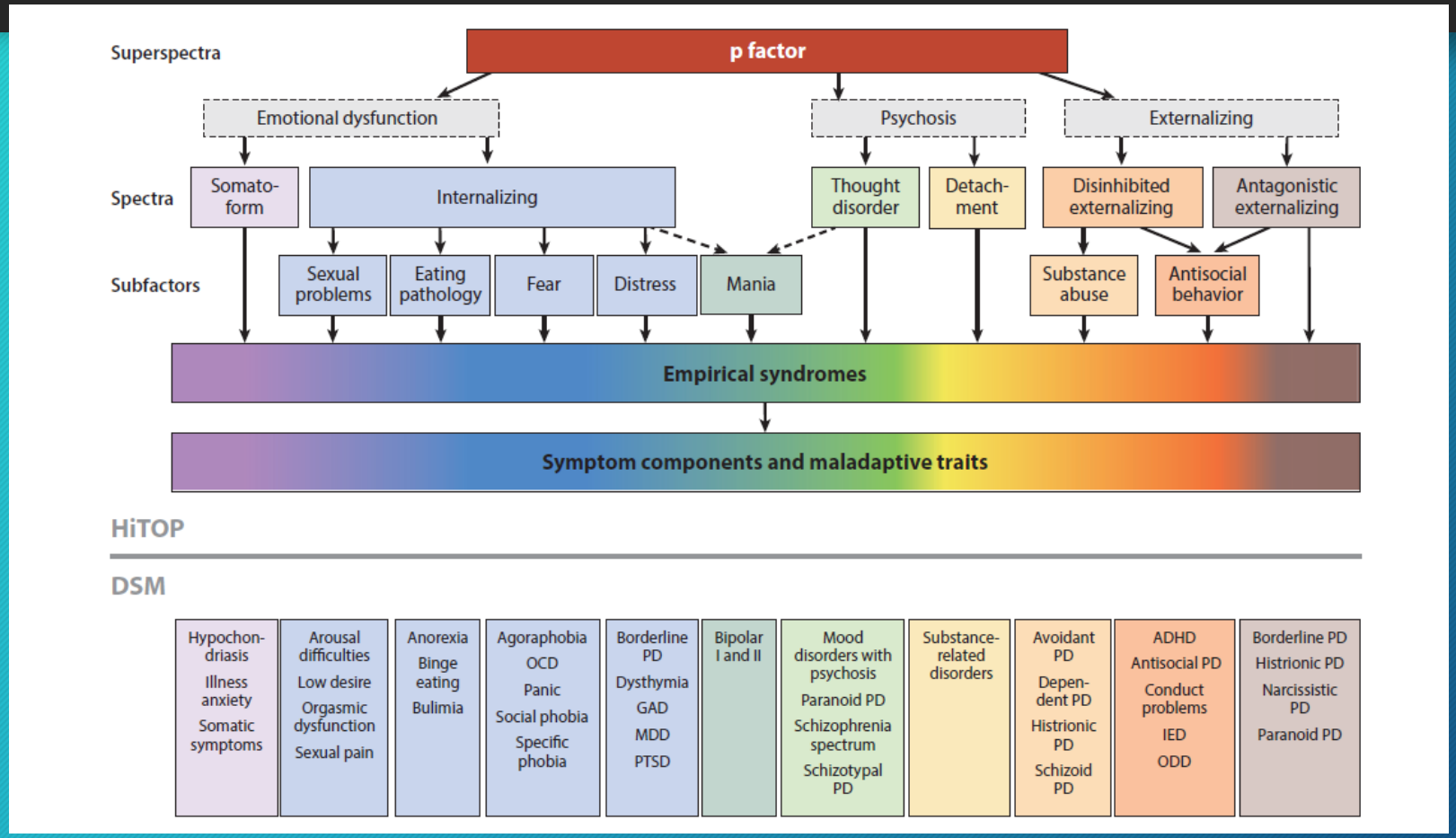


Fig. 5. Meta-analysis of the IRR of subthreshold depression developing into major depression under different subgroup analyses. StD, subthreshold depression; MD, major depression; IRR, incidence risk ratio.

Zhang et al., 2022, *Psych Medicine*

Common dimensions explain covariance



Kotov et al., 2021, *Annual Rev Clin Psych*

Lesson 2

Personality disorder is not a category but better understood as a unidimensional severity continuum

Three cases of Borderline Personality Disorder

	Case 1	Case 2	Case 3
Age	17 year old	54 year old	36 year old
Gender	Female	Female	Male
Vocation	Highschool	Teacher for 30 years	Out of work
Precipitating factor	Break-up with boyfriend	Therapist is retiring	Domestic violence incident with wife
Setting	Inpatient after overdose	Outpatient	Mandatory evaluation
Manifestation	Mixed internalizing/externalizing	Internalizing	Externalizing
Course	Better after boyfriend makes up	Quiet sea of desperation	Anger oscillating with guilt and despair

Bohus, et al., *Lancet*, 2021

Table 3. Categorically Defined Borderline Personality Disorder, According to the DSM-5, Section II.

Patient has pervasive pattern of instability in interpersonal relationships, self-image, and affects and marked impulsivity, indicated by at least five of the following nine personality traits:

- Frantic efforts to avoid abandonment
- Unstable and intense interpersonal relationships
- Identity disturbance
- Impulsivity in at least two areas (e.g., spending, substance abuse, reckless driving, or binge eating)
- Recurrent suicidal or self-mutilating behavior
- Affective instability
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Symptoms are relatively inflexible and pervasive across multiple contexts (i.e., symptoms do not occur only at home or during certain times)

Symptoms result in significant distress or impairment in functioning

Symptoms or patterns of behavior are stable across time, and their onset can be traced back to adolescence or early adulthood

Symptoms are not better explained by another mental disorder

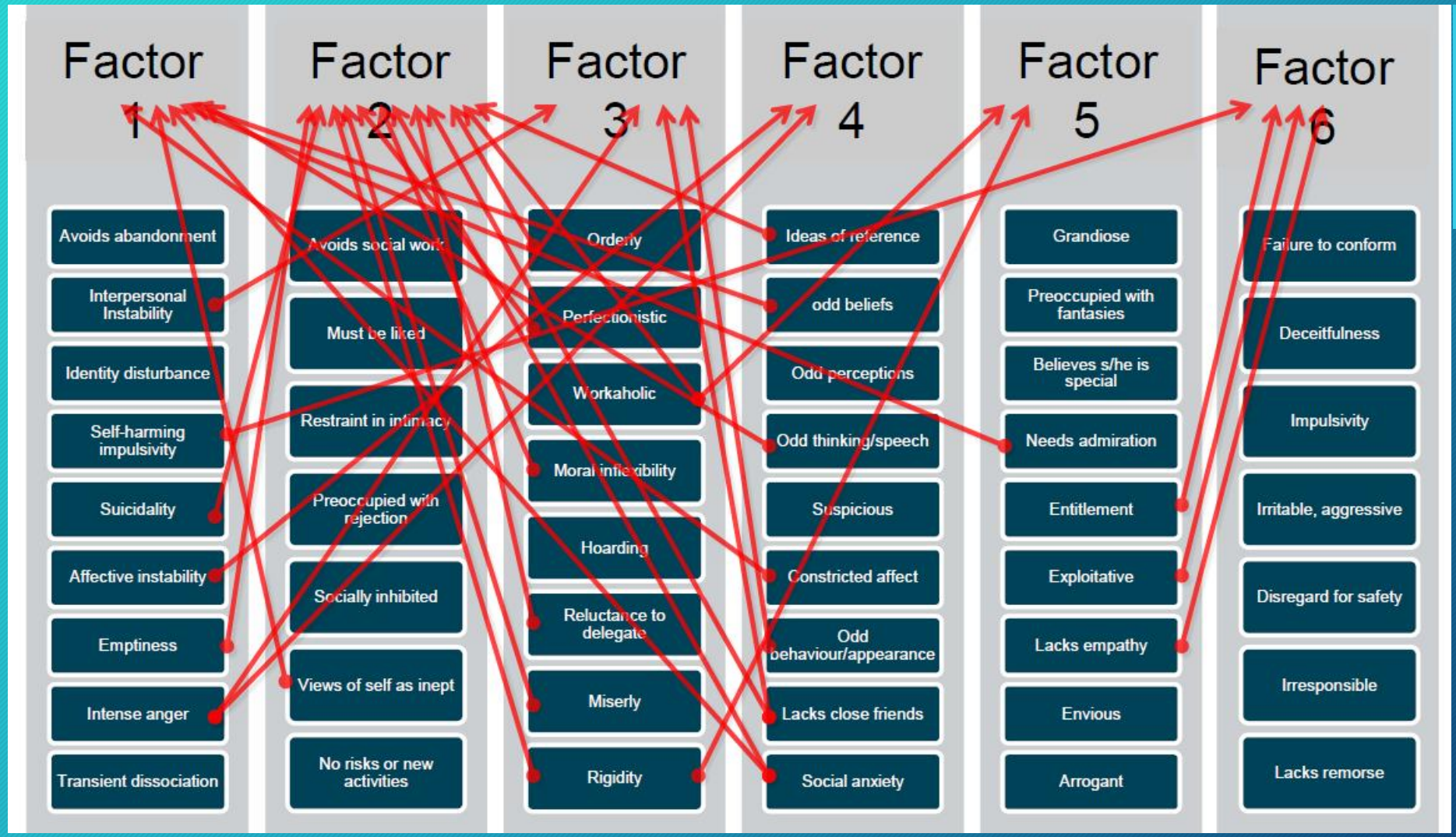
Symptoms are not attributable to physiological effects of a substance or another medical condition

Table 1. Predominant Features of Personality Disorders as Described in the DSM-5, Section II.*

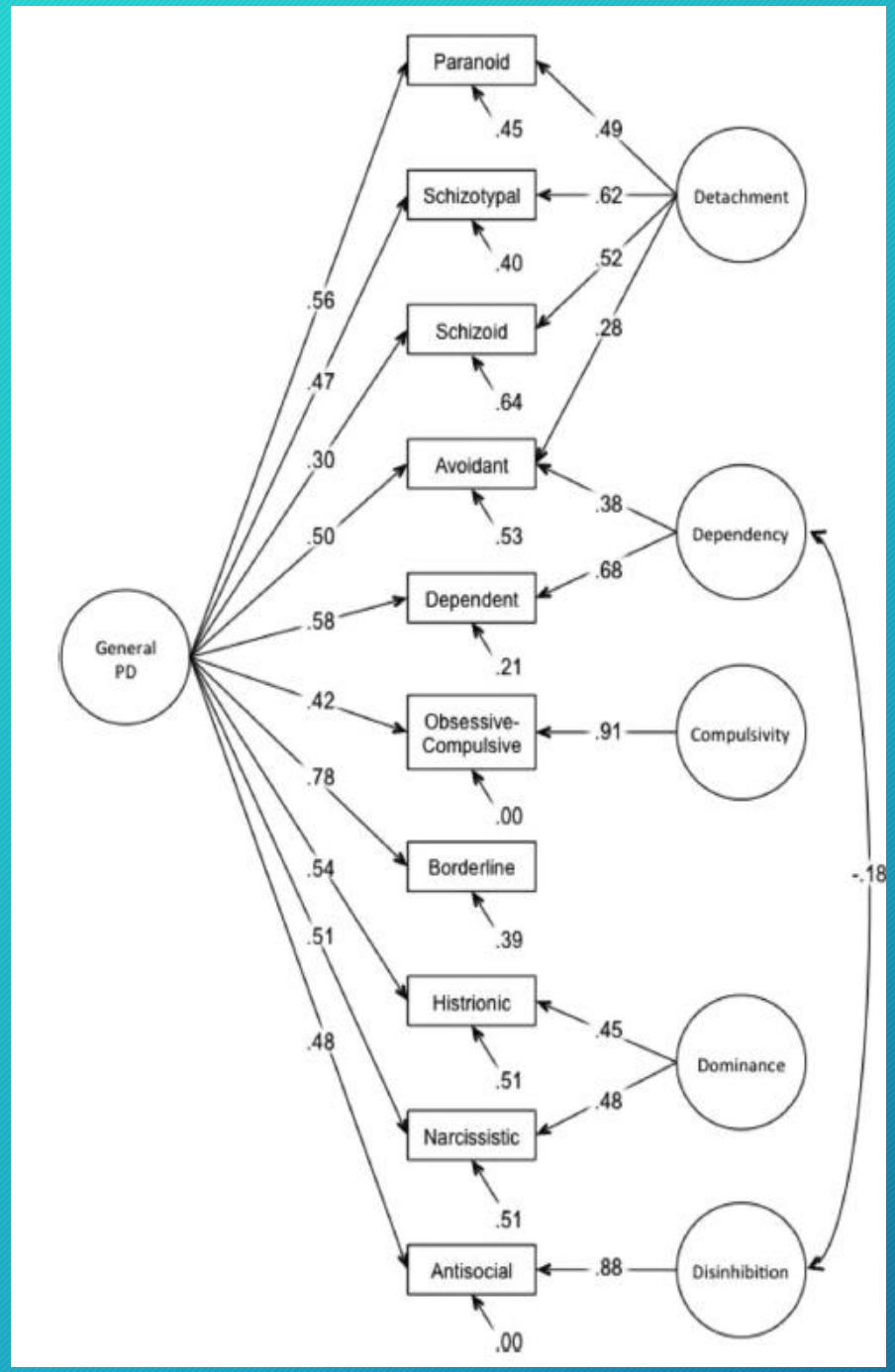
Category	Features
Paranoid	Distrust and suspiciousness, with a tendency to interpret other people's motives as malevolent
Schizoid	Detachment from social relationships and restricted range of emotional expression
Schizotypal	Acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior
Antisocial	Disregard for, and violation of, the rights of others
Borderline	Instability in interpersonal relationships, self-image, and affects and marked impulsivity
Histrionic	Excessive emotionality and attention-seeking
Narcissistic	Grandiosity, need for admiration, and lack of empathy
Avoidant	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
Dependent	Excessive need to be taken care of, resulting in submissive and clinging behavior
Obsessive–compulsive	Preoccupation with orderliness, perfectionism, and control

Problems with this approach

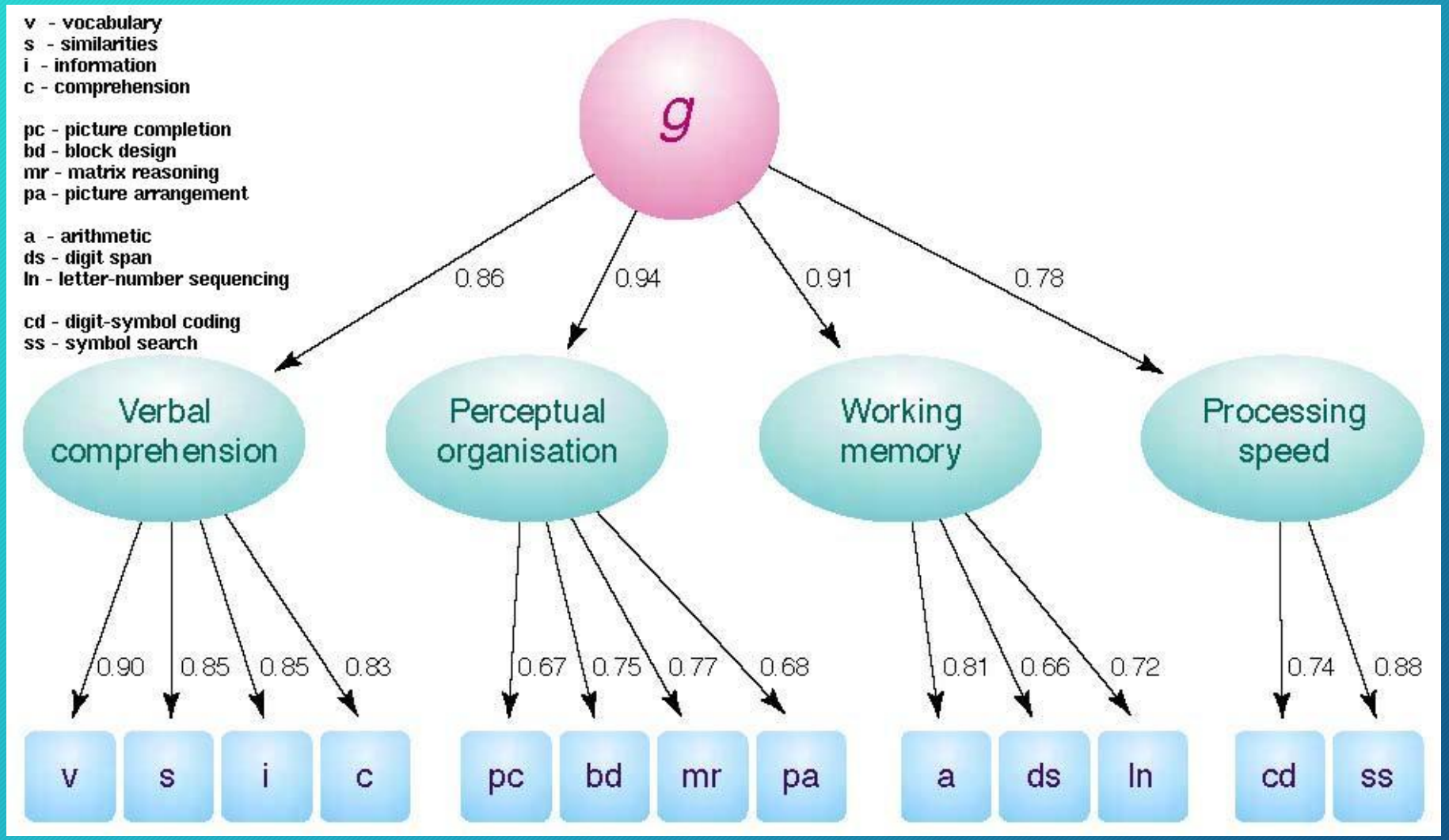
- Heterogeneity within disorder
- Comorbidity with other personality disorders
- Comorbidity with other common mental disorders
- Most often diagnose PD-NOS
- Does not acknowledge the ebb and flow of personality disorder
- Puts emphasis on dispositional traits rather than the way personality functions – difference between what the personality is vs. what the personality does.



Sharp et al., *JAP*, 2015



Sharp et al., 2015; Wright et al. (2016), JAP


v - vocabulary
s - similarities
i - information
c - comprehension
pc - picture completion
bd - block design
mr - matrix reasoning
pa - picture arrangement
a - arithmetic
ds - digit span
ln - letter-number sequencing
cd - digit-symbol coding
ss - symbol search
g
0.86
0.94
0.91
0.78
Verbal comprehension
Perceptual organisation
Working memory
Processing speed
0.90
0.85
0.85
0.83
0.67
0.75
0.77
0.68
0.81
0.66
0.72
0.74
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v
s
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New (better!) conceptualization

Common features?

Criterion A of the AMPD in Section III of the DSM-5

DSM-5 Section III
AMPD: Alternative Model for Personality Disorder

Criterion A **Level of Personality Function (0-4)** **Maladaptive self and interpersonal function**	**Criterion B** **Maladaptive trait function** **5 trait domains** **25 trait facets** ***The Big Five**	**Borderline personality disorder**
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (risk taking, impulsivity, hostility)
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

ICD-11

Impairment in self and interpersonal functioning **Level of severity** **Mild, moderate, severe**	****Optional** **Trait domain qualifiers** **5 trait domains**	**Borderline pattern**
Self (identity, self-worth, capacity for self-direction)	Negative affectivity (neuroticism)	1. Abandonment fears 2. Unstable/intense relationships 3. Identity disturbance 4. Impulsive behaviors 5. Recurrent self-harm 6. Emotional instability 7. Chronic feelings of emptiness 8. Inappropriate intense anger 9. Transcient psychotic-like features
Interpersonal (e.g. developing and maintaining close and mutually satisfying relationships, understanding others' perspectives, managing conflict in relationships)	Detachment (>< extraversion)	
Impairments in self-and/or interpersonal functioning manifest in maladaptive patterns of cognition, emotional experience and expression and behavior	Dissociality (disagreeableness)	
	Disinhibition (>< conscientiousness)	
	Anankastia	

AMERICAN PSYCHOLOGICAL ASSOCIATION

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https://doi.org/10.1037/per0000595

INTRODUCTION

Ten-Year Retrospective on the *DSM–5* Alternative Model of Personality Disorder: Seeing the Forest for the Trees

Carla Sharp[1] and Joshua D. Miller[2]

[1] Department of Psychology, University of Houston

[2] Department of Psychology, University of Georgia

ANNUAL REVIEWS

Annual Review of Clinical Psychology

DSM-5 Level of Personality Functioning: Refocusing Personality Disorder on What It Means to Be Human

Carla Sharp and Kiana Wall

Validity and reliability of Criterion A (LPF)

- Unidimensional; or higher-order 2-factor structure
- Inter-rater reliability good with higher coefficients for global scores than domain scores
- Internal consistency high for global LPFS and acceptable for domain scores
- Convergent validity: LPFS associates with traditionally defined PDs and discriminate between patients and non-patients
- Predictive validity: LPFS predicts functional outcomes and treatment dropout
- LPFS insensitive to clinician gender bias
- Learnable by laypersons
- Acceptable among clinicians
- LPF, especially self-and identity, increments traits in prediction of outcomes

Sharp & Wall, 2021, *Annual Review of Clin Psycl*

Treatment should target common core

Lesson 3

Common factors in psychotherapy account for the largest effect sizes in treatment response

Therapeutic alliance

- Therapeutic alliance (quality of the therapeutic relationship) most researched common factor.
- Meta-analytic studies: relationship between therapeutic alliance and treatment outcome is about .28 (Fluckiger, Del Re, Wampold, & Horvath, 2018), which translates to a moderate effect size of .58.

Therapist factors

- About 5–9% of the variance in treatment outcome is explained by therapist factors, which compared to other factors constitute the largest proportion of explained variance in treatment outcome.
- Therapist factors seem to explain more variance than
  - the variability between treatments (0–1%),
  - evidence-based treatments versus placebo (0–4%),
  - the alliance (5%) (Duncan, 2010; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007).
- When we ignore the effect of the individual therapist, we erroneously attribute the effectiveness—or lack thereof—to the specific treatment (Bo, Sharp, Luyten, Kongerslev, & Fonagy, 2022).
- Average recovery rate for more effective therapists 2x less effective group (Schiefele et al., 2017)
- What are the factors?
  - Self-doubt, humility, modesty (Heinonen & Nissen-Lie, 2020)
  - Rogerian qualities (empathy, warmth, positive regard, clear and positive communication, ability to handle criticism)

Lesson 4

Factors outside the therapy room explain the largest proportion of variance in psychotherapy outcomes

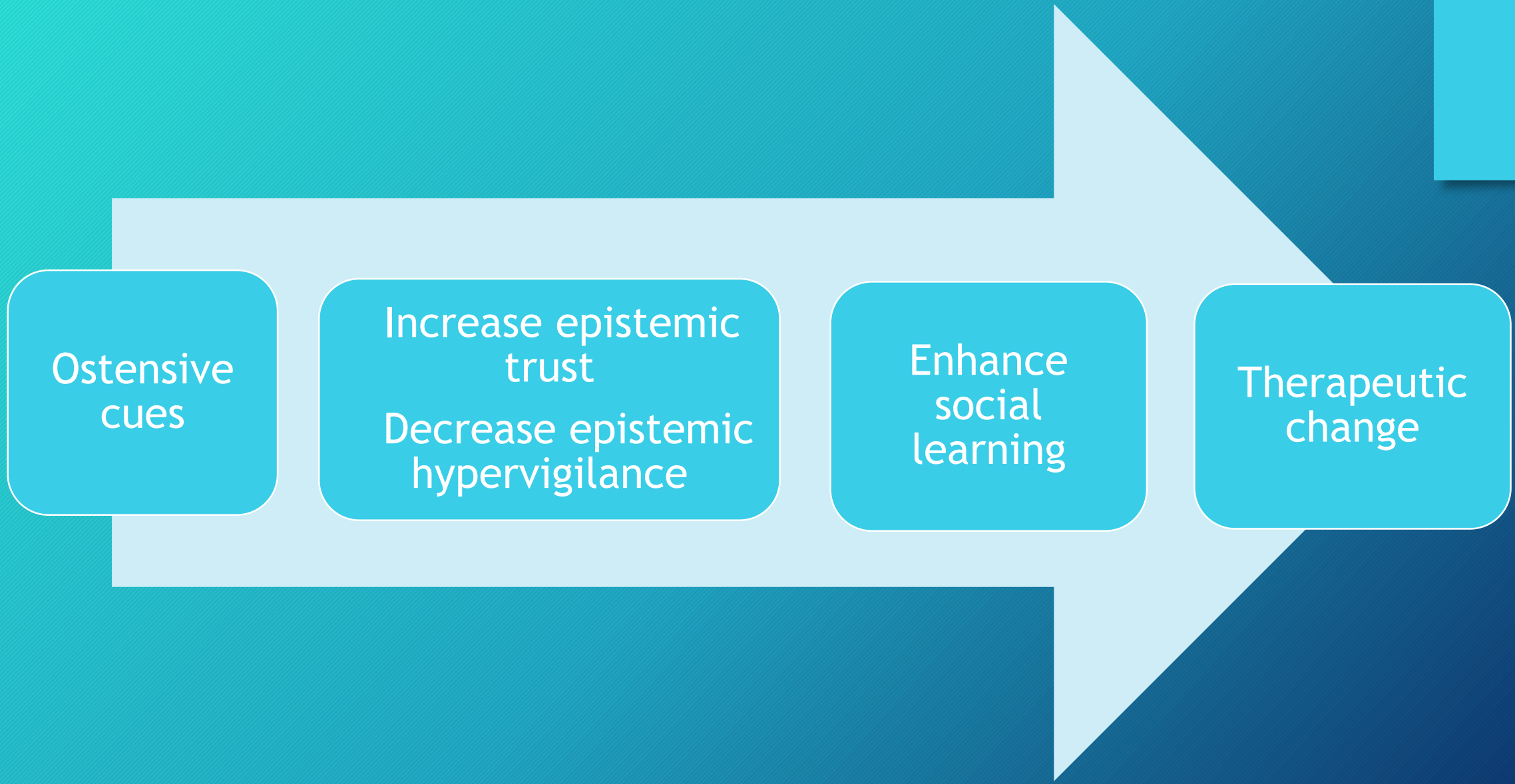
Therapists factors

- 86% of variance in outcomes to extra-therapeutic factors (Wampold & Imel, 2015)
- Whether a person in in therapy or not explains only 14% of outcomes (Wampold & Imel, 2015; Bo et al., 2020).
- What are those factors?
  - Work
  - Love
  - Other factors in the environment

Taken together, what we need is a therapy approach that:

- Treats common factor in psychopathology
- Treats common factor in personality pathology
- Represents the common factors across therapies that account for improvement in outcomes
- Enhances “getting a life” and activating the natural salutogenic effects of social support and relationships

The transdiagnostic mechanism of change in MBT


Ostensive cues
Increase epistemic trust
Decrease epistemic hypervigilance
Enhance social learning
Therapeutic change

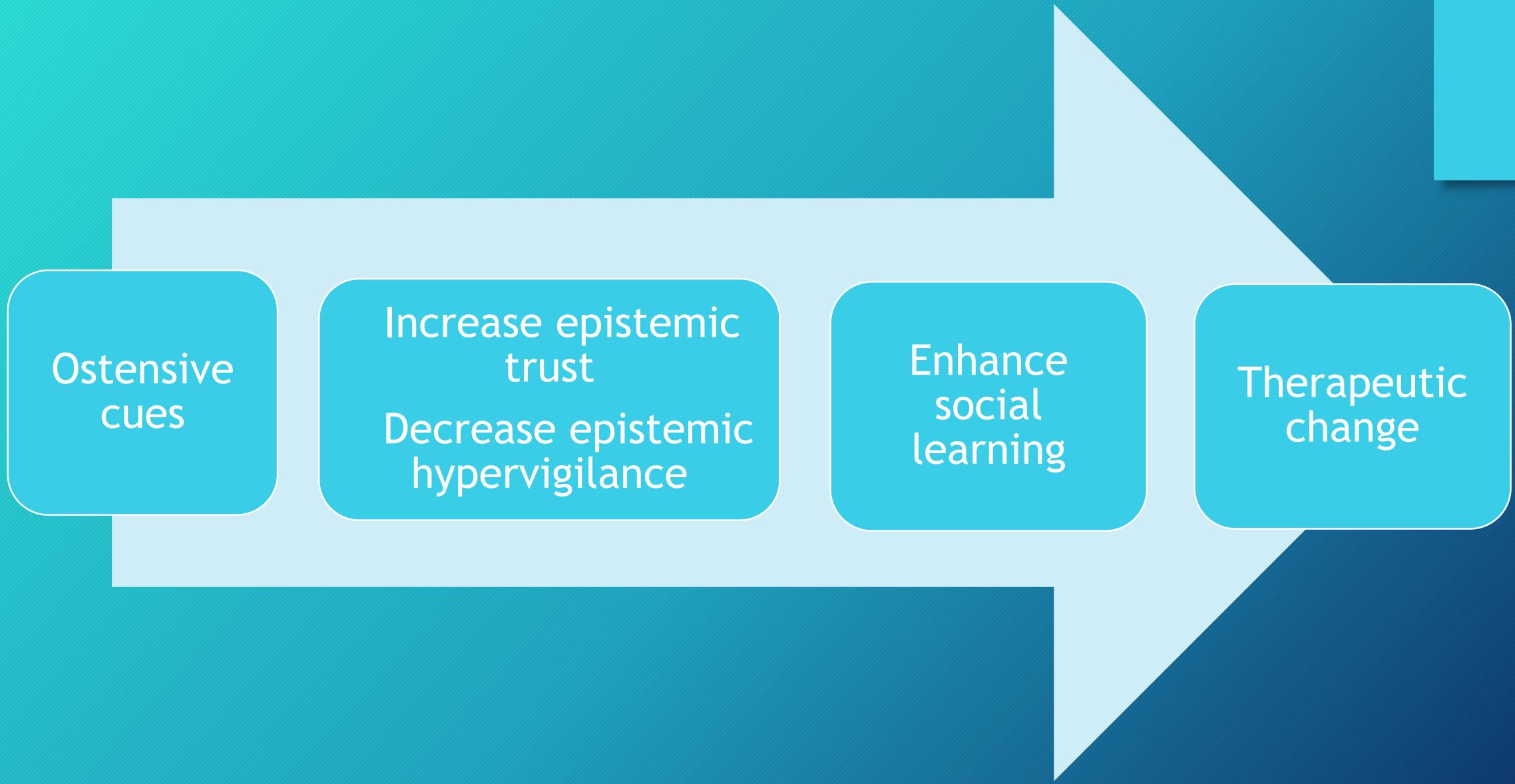
- Put your mind on the table
- Intention for communicating info
- My mind is different from yours
- Both minds are equally important
- Signals gap in understanding
- Collaborative learning opportunity

Ostensive cues

Decrease epistemic hypervigilance

Enhance social learning

Therapeutic change


Ostensive cues
Increase epistemic trust
Decrease epistemic hypervigilance
Enhance social learning
Therapeutic change

- The capacity to identify knowledge conveyed by others as personally relevant and generalizable to other contexts
- The feeling of being understood
- Knowledge worth knowing is conveyed

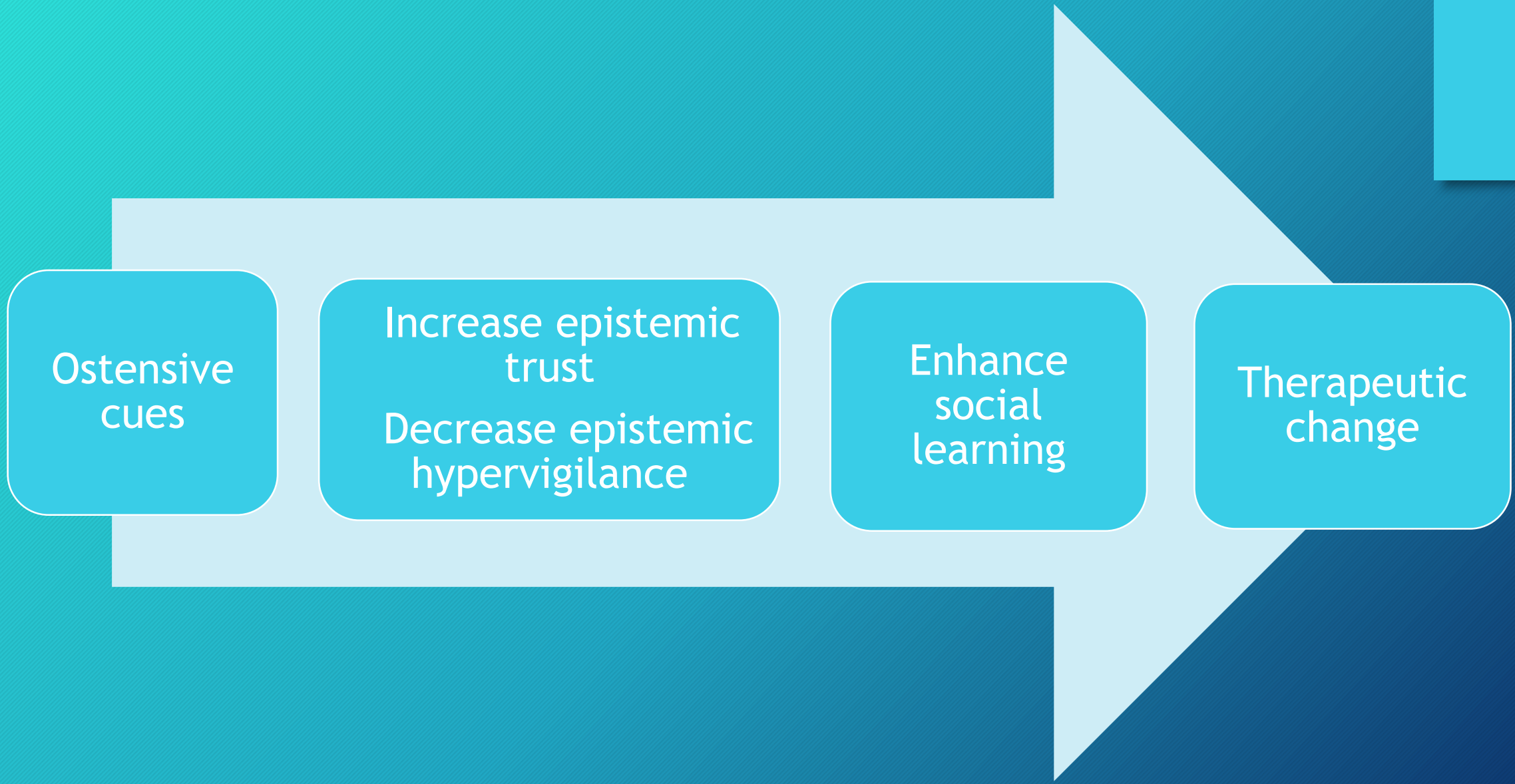
Ostensive cues

Increase epi… trust

Decrease epister…ic hypervigilance

…ce social learning

Therapeutic change


Ostensive cues
Increase epistemic trust
Decrease epistemic hypervigilance
Enhance social learning
Therapeutic change

Ostensive cues

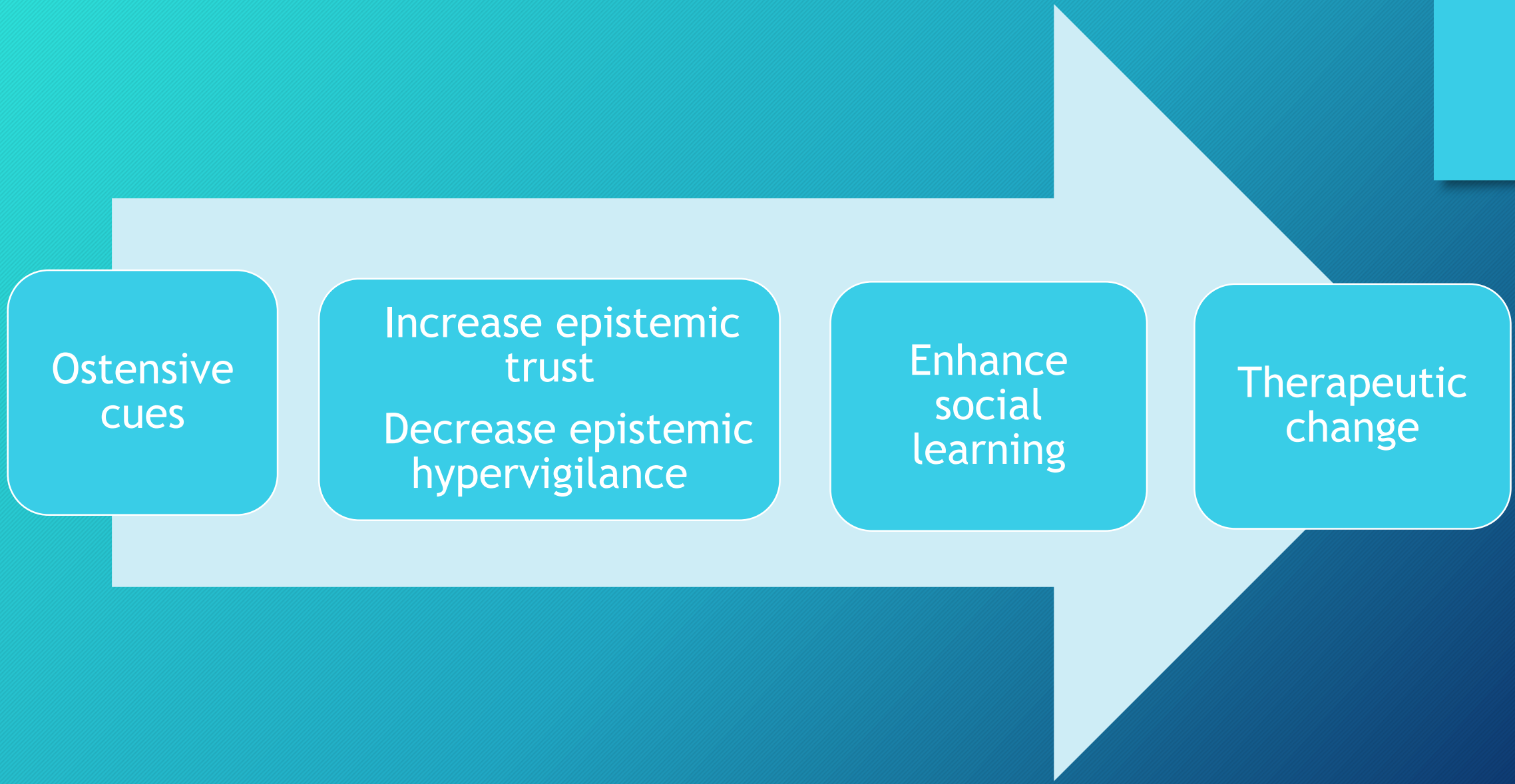
Increase epistemic trust

Decrease epistemic hypervigilance

Enha… soci… learning

…herapeutic change

- Now the social context is activated and can do its work
- Generalization into the world
- Feedback from enriched social connections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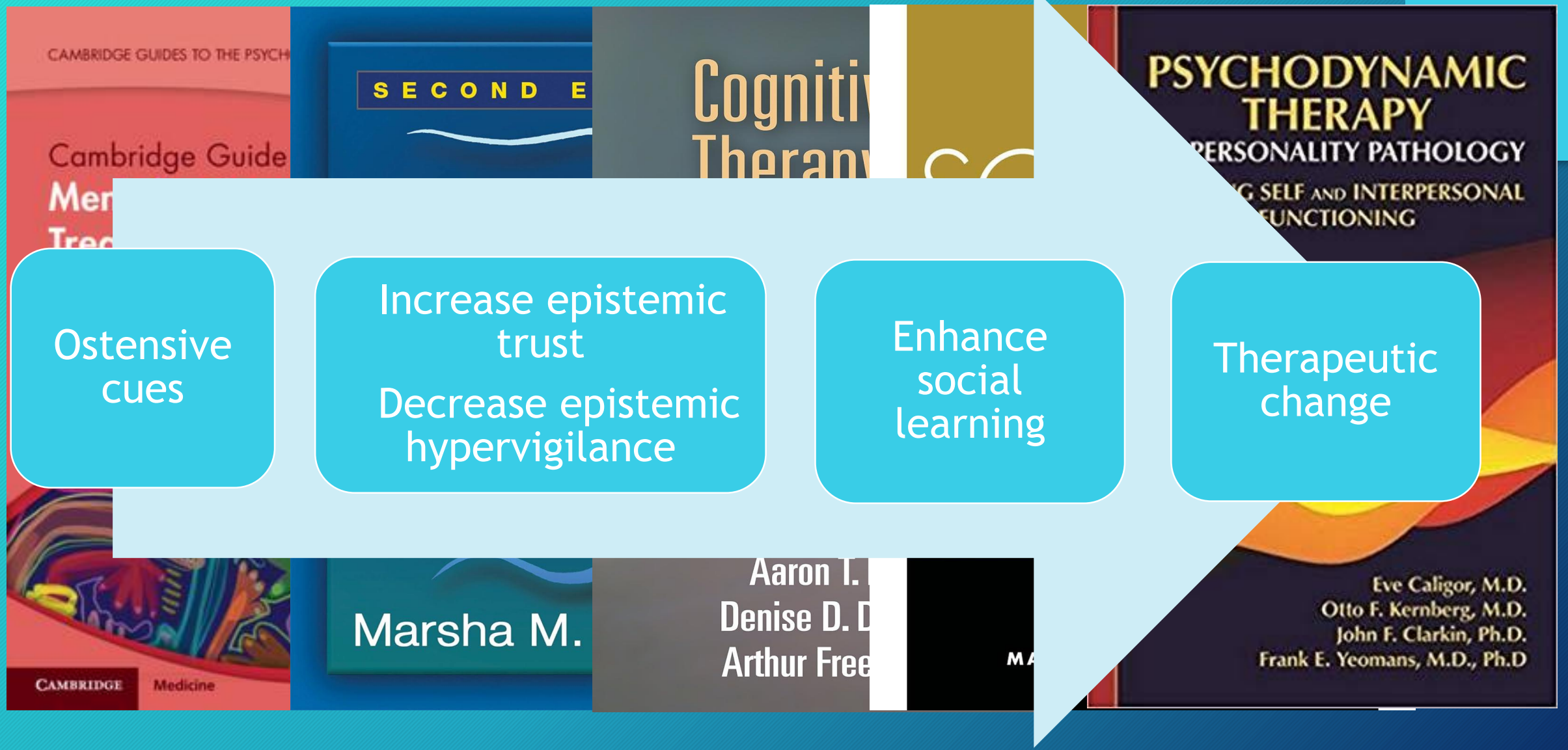


Ostensive cues

Increase epistemic trust

Decrease epistemic hypervigilance

Enhance social learning

Therapeutic change

Break

Agenda

09:00-10.30: Mentalizing: A common factor across disorders and modalities

10.30-11:00: Break

11:00-13:00: Mentalizing: Its importance in working with adolescents

13:00-14:00: Lunch

14:00-16:00: Distilled components

Mentalizing:

Its importance in working with adolescents

Treatment should target common core

AMPD as a developmentally sensitive approach to PD

Sharp & Wall, 2021, *Annual Review of Clin Psych*

Henry

- 15-year-old white male
- Identifies as pansexual
- Lives with his adopted mother, stepfather, and 5-year-old brother
- Referred after a suicide attempt that led to an acute inpatient hospital stay
- Break-up with his girlfriend
- Intense anger outbursts; otherwise feeling “dead inside”
- Reported that he has no friends and feels utterly alone
- “Black sheep” of his family because he ruins everything
- Diagnoses: depression, general anxiety, insomnia, ODD and ADHD
- Considering homeschooling.

Sharp, C., Cano, K., Bo, S., & Hutsebaut, J. (2022)

Henry: early years

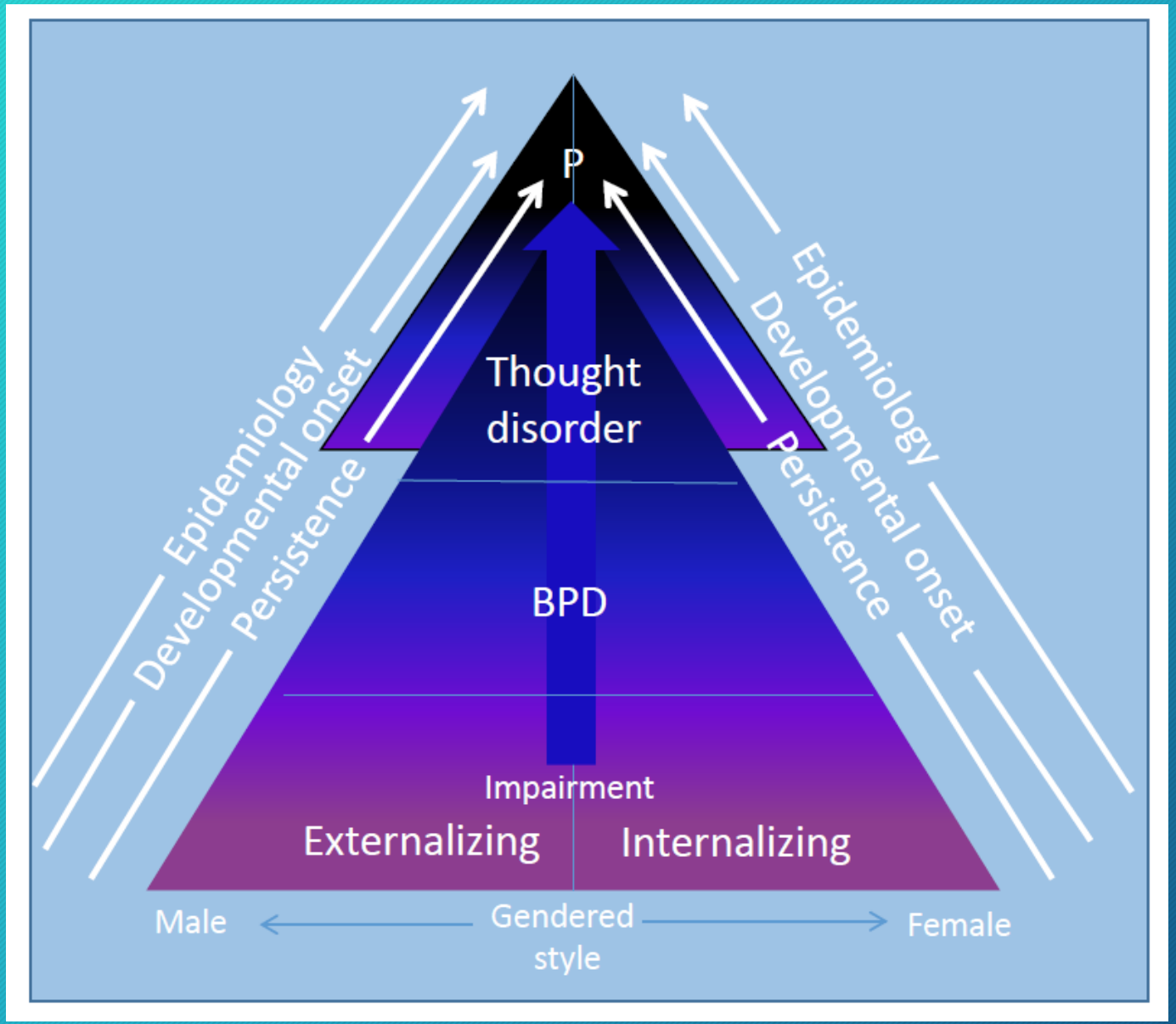
- Baby: Fussy and not easily soothed.
- Toddler: sensitive; frequent tantrums.
- Preschool: active and energetic.

Henry: elementary school years

- Elementary school: symptoms of hyperactivity and anxiety; diagnosed with ADHD at age 6.
- Difficulty making friends and was often seen playing alone at recess.
- When he did make friends, anxious to impress them; feelings would get hurt easily if friends chose to play with someone else.
- 3rd grade (age 9) school avoidance; somatic symptoms - diagnosis of school refusal and generalized anxiety.

Henry: aging into adolescence

- Middle school (6th grade; age 12) defiant; detentions for misbehavior
- Temper outbursts and irritability - oppositional defiant disorder (ODD).
- Henry reported that at that time he felt sad much of the time; diagnosed with depression.
- At 13, feelings of sadness increased shortly after his only friend moved away.
- Cutting himself nine or ten times during the 8th grade (age 14): when his feelings were “dead”, and he wanted to “turn them back on”; to distract himself from bullying due to sexual preferences).
- Mood stabilizer
- After Henry does not respond to mood stabilizers, he is sent to a PD expert who diagnoses BPD



Sharp & Wall (2017) *Current Dir Psychology*
Sharp, et al. (2018) *Psych Clin North America*

How does this map onto the AMPD?

Personality-psychopathology spectrum approach

Criterion A Level of Personality Function (0-4) Maladaptive self and interpersonal function	Criterion B Maladaptive trait function 5 trait domains 25 trait facets *The Big Five	Borderline personality disorder
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (at least one must be risk taking, impulsivity, hostility
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

Temperament-personality

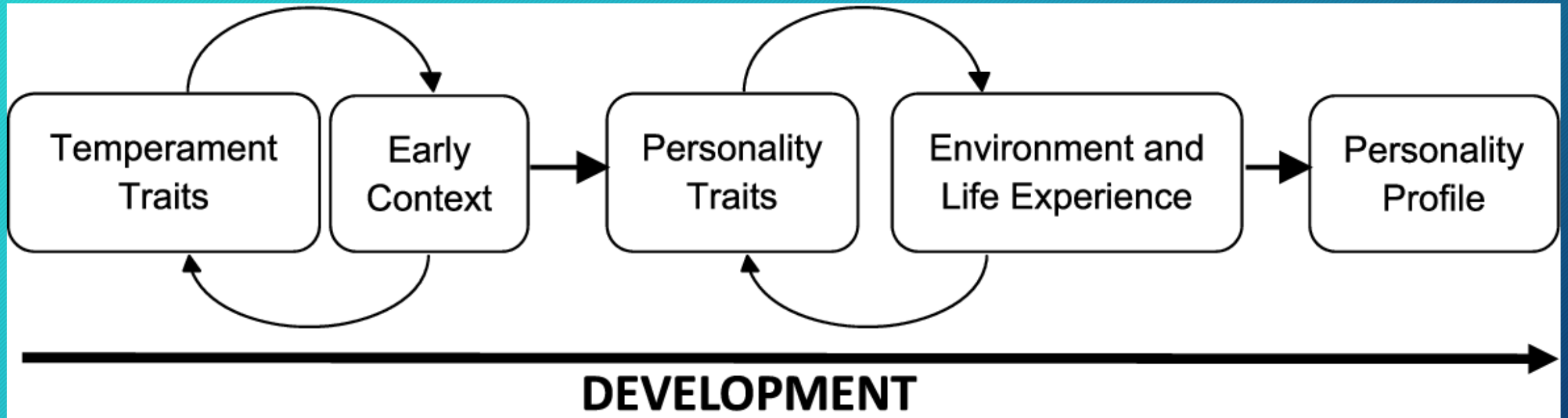
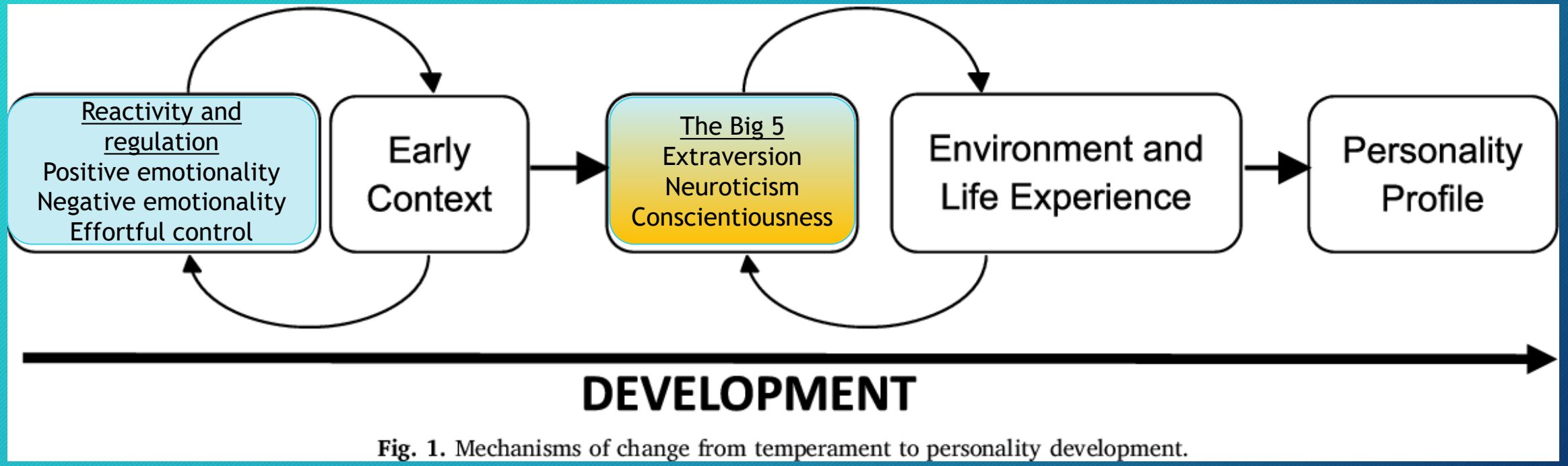


Fig. 1. Mechanisms of change from temperament to personality development.

Anaya & Perez-Edgar (2019)

Temperament-personality



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Personality-psychopathology spectrum approach

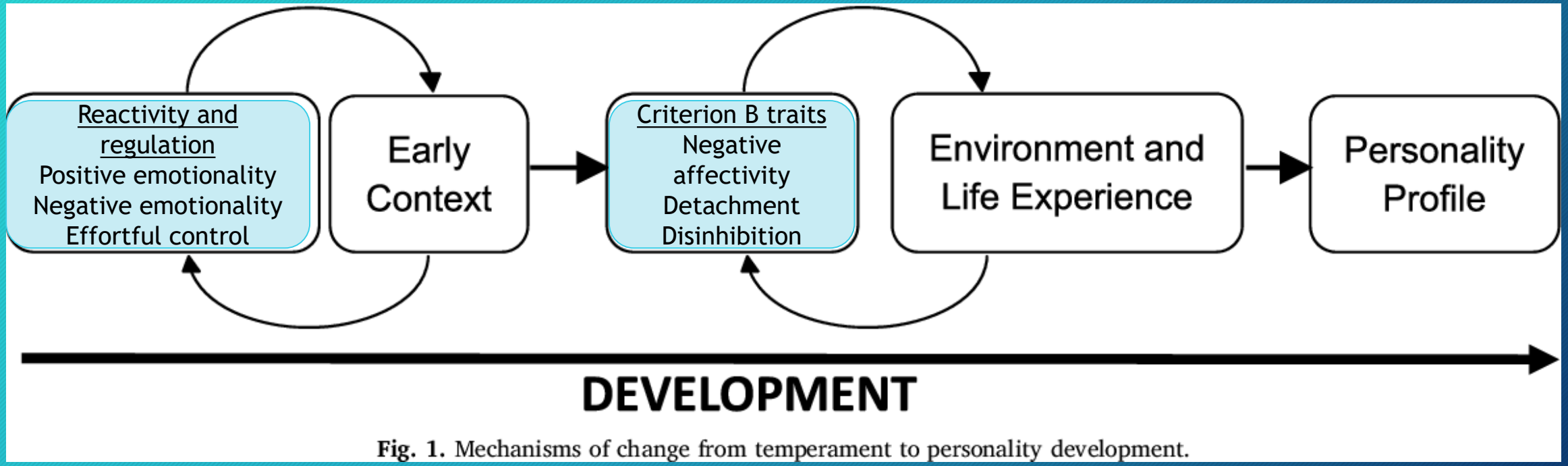

Fig. 1. Mechanisms of change from temperament to personality development.

DeClercq et al. (2009)
Shiner & Tackett (2014)
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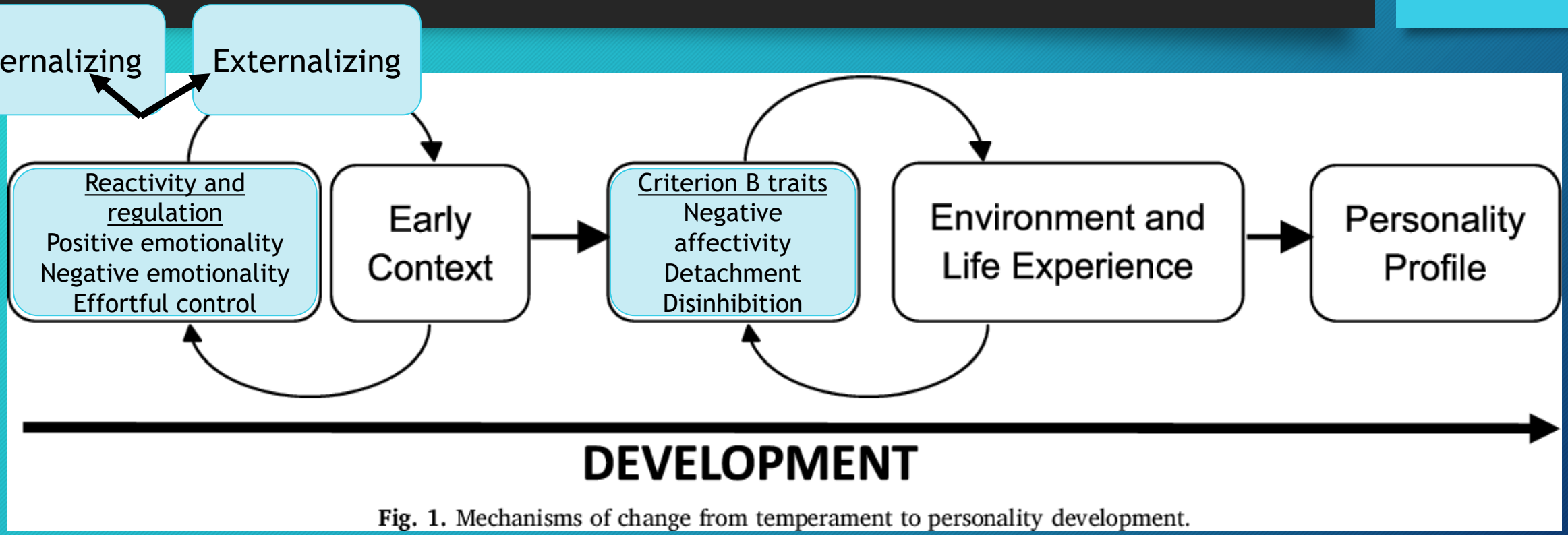
Personality-psychopathology spectrum approach



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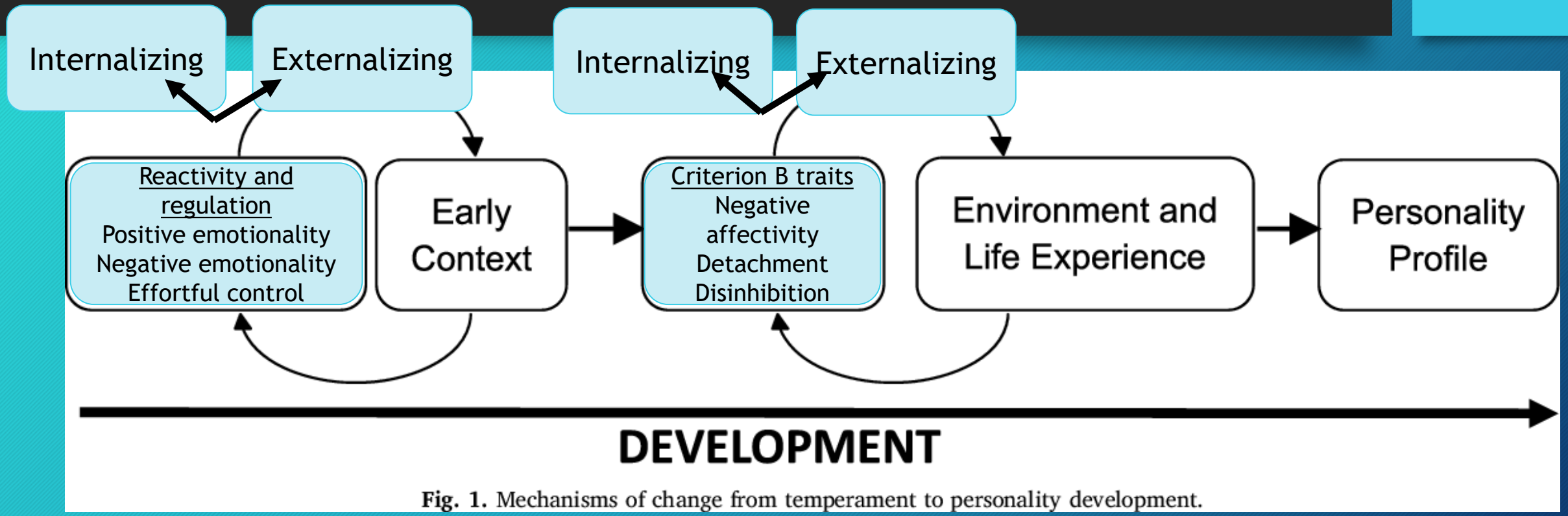

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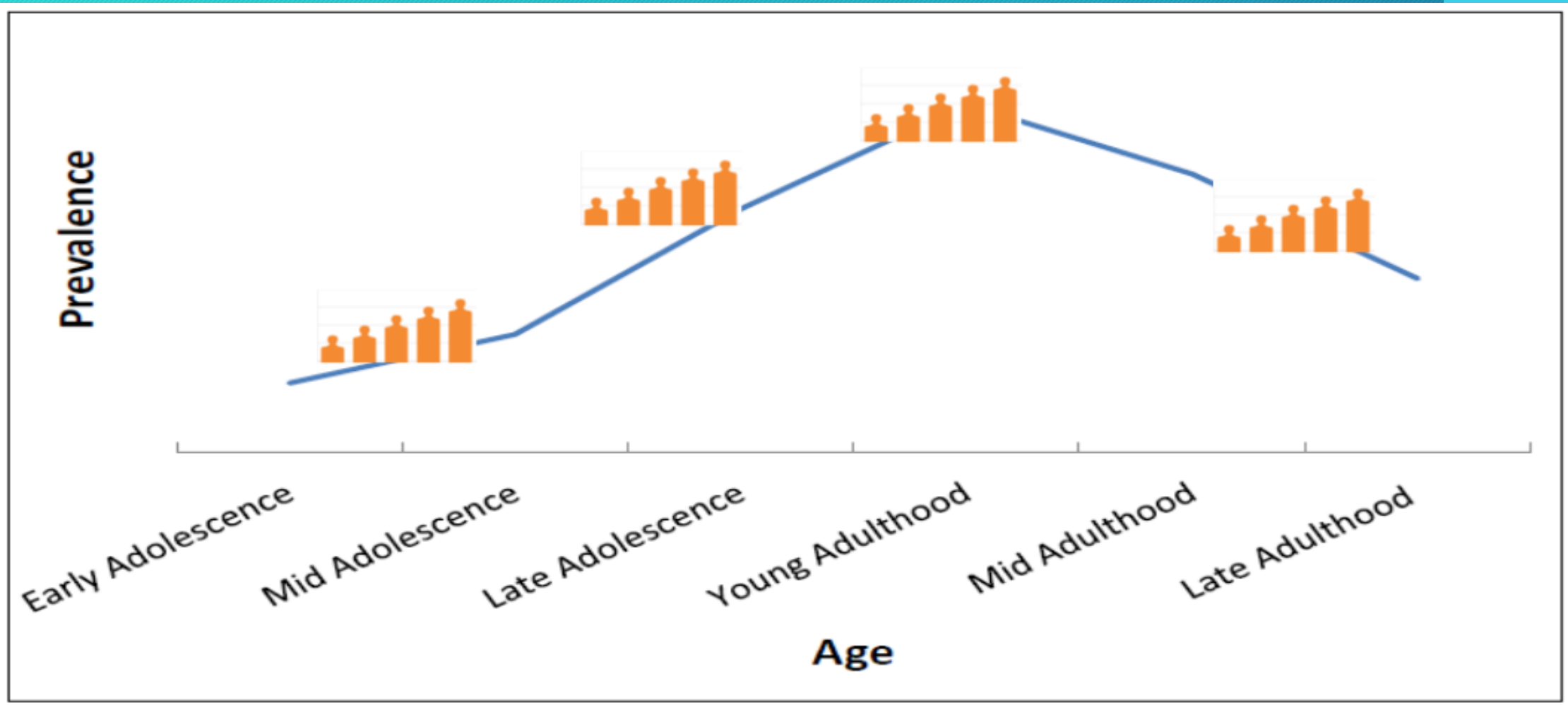


Rank order stability coefficients 0.5 - 0.7

Traits are descriptive, but they do not explain

What happens in adolescence that did not happen before?

We become a person! (identity) (integrated sense of self)

Development of maladaptive self and interpersonal function

Criterion A Level of Personality Function (0-4) Maladaptive self and interpersonal function	Criterion B Maladaptive trait function 5 trait domains 25 trait facets *The Big Five	Borderline personality disorder
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (at least one must be risk taking, impulsivity, hostility
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

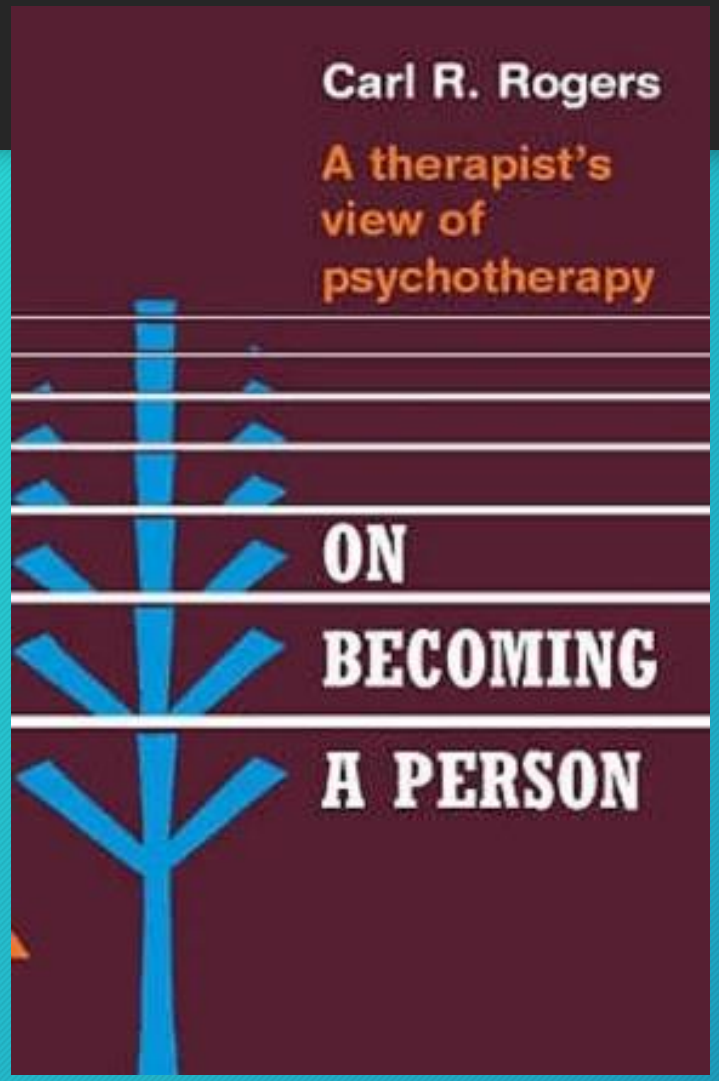
LPF score of 0:
Healthy personality functioning

Identity	Self-direction	Empathy	Intimacy
Ongoing awareness of unique self; boundaries	Reasonable goals; realistic assessment of capacities	Can understand others' experiences and motivations	Maintains multiple satisfying, enduring relationships
Consistent, self-regulated positive self-esteem; accurate self-appraisal	Appropriate standards of behavior; fulfilment in multiple realms	Comprehends and appreciates others' perspectives	Desires and engages in number of caring, close, reciprocal relationships
Experience, tolerates, regulates range of emotions	Can reflect on and construct meaning of internal experience	Ware of effect of own actions on others	Strives for cooperation and mutual benefit; flexibly responds to others

Personality originally defined: intrapsychic system needed to understand and manage the self

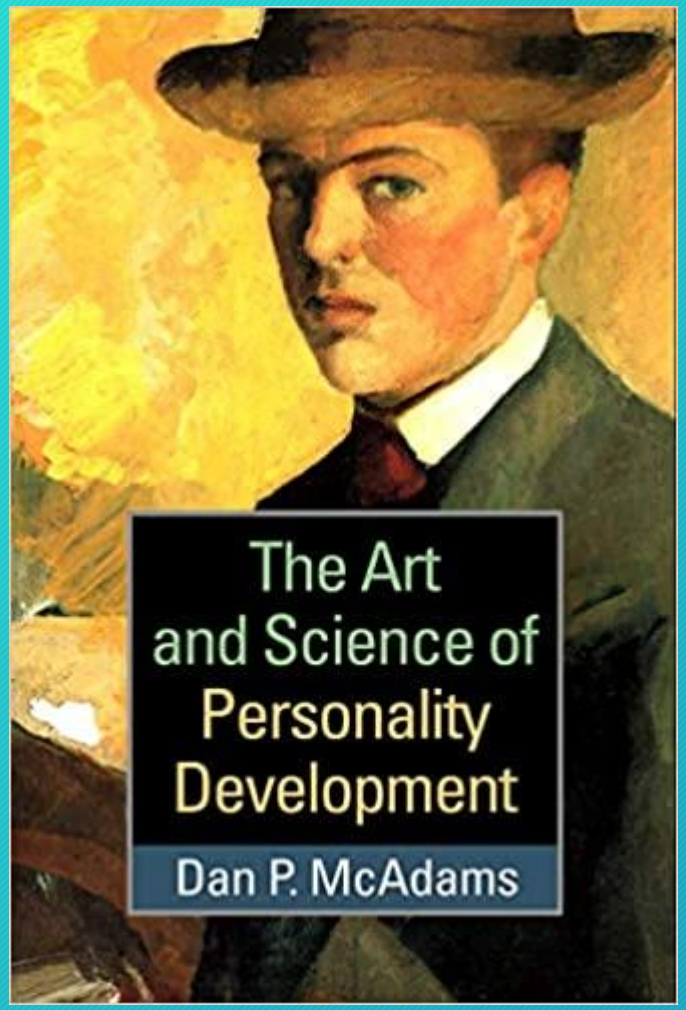
- William James (1892/1963)
  - "I": an intuitive, emotionally experienced sense of self (self as subject)
  - "Me": a result of self-reflective process leading to an integrated awareness and knowledge about oneself (self as object)
- Freud (1923):
  - Ego = "Ich" = "I"
  - Id = "Es" = "it"
- Mead (1934):
  - the social world (an audience, real or imagined) facilitates self-regulation, invoking the idea that humans can look upon themselves from the outside in to regulate the self

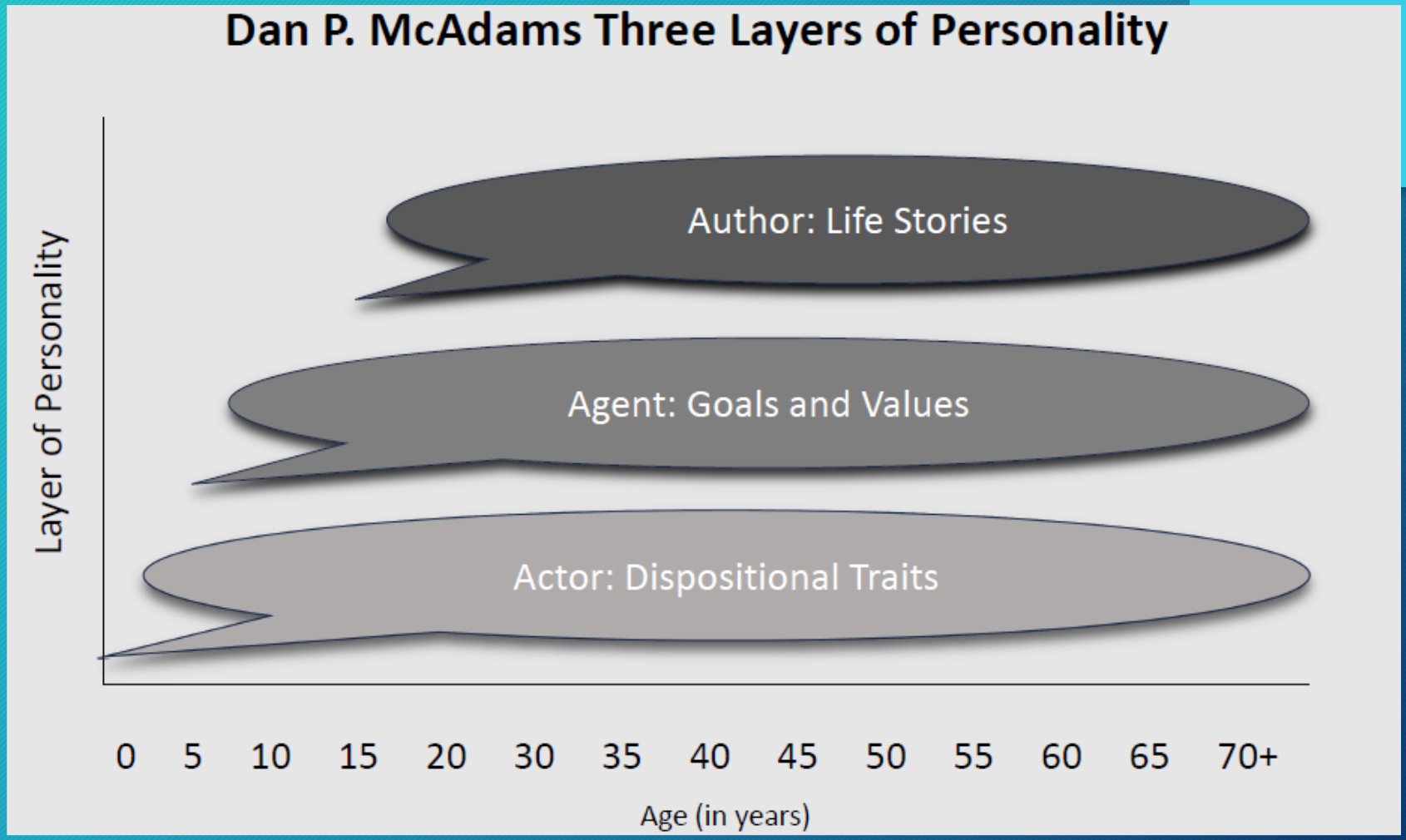
Sharp & Wall, 2021, *Annual Review of Clin Psych*



- "**a person** is a fluid process, not a fixed and static entity; a flowing river of change, not a block of solid material; a continually changing constellation of potentialities, not a fixed quantity of traits."

- "It seems that gradually, painfully, the individual explores what is behind the masks he presents to the world, and even behind the masks with which he has been deceiving himself. Thus on an increasing degree he becomes himself — not a façade of conformity to others, not a cynical denial of all feeling, not a front of intellectual rationality, but a living, breathing, feeling, fluctuating process — in short, he **becomes a person.**"

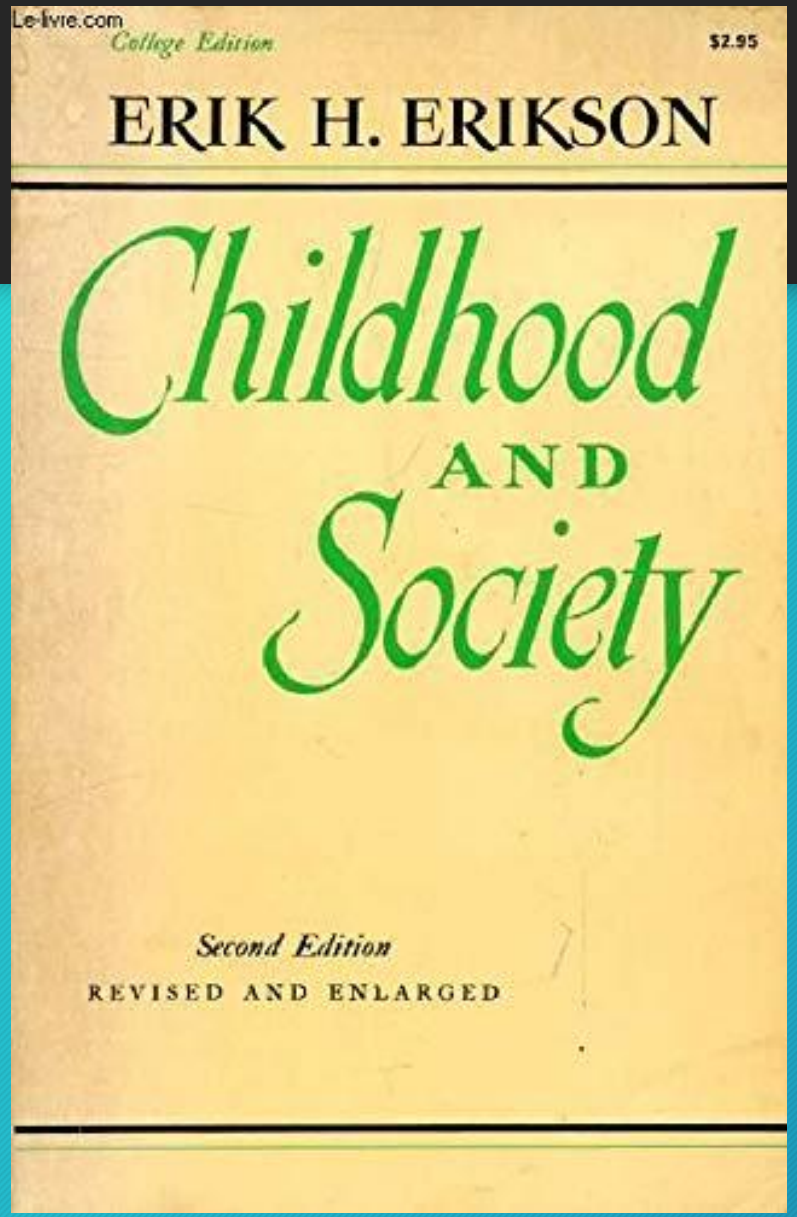




McAdams (2015)

The self is representational

- Psychologically, the self is a fiction (Hallford & Mellor, 2017)
- David Hume (1738/1969): the perception of a self arises as a result of meaningful associations between each impression or experience in consciousness and is not grounded in any “real” or “actual” self.
- It is through constructing memories that self-continuity emerges (Locke, 1694/1970)
- Temporal coherence: is the ability to accurately perceive the order in which experiences have occurred over the lifetime to date.
- Causal coherence refers to the perception that experiences are meaningfully associated and that events have causal connections with self-identity.
- Thematic coherence is the ability to draw out similarities between episodes in life, and identify overarching themes that act as integrated interpretations of these events or circumstances.
- Awareness of stories that one has developed and how conscious one is of drawing on these stories to understand the kind of person one is. It is this metacognitive awareness that brings cohesion and meaning to events irrespective of the content.



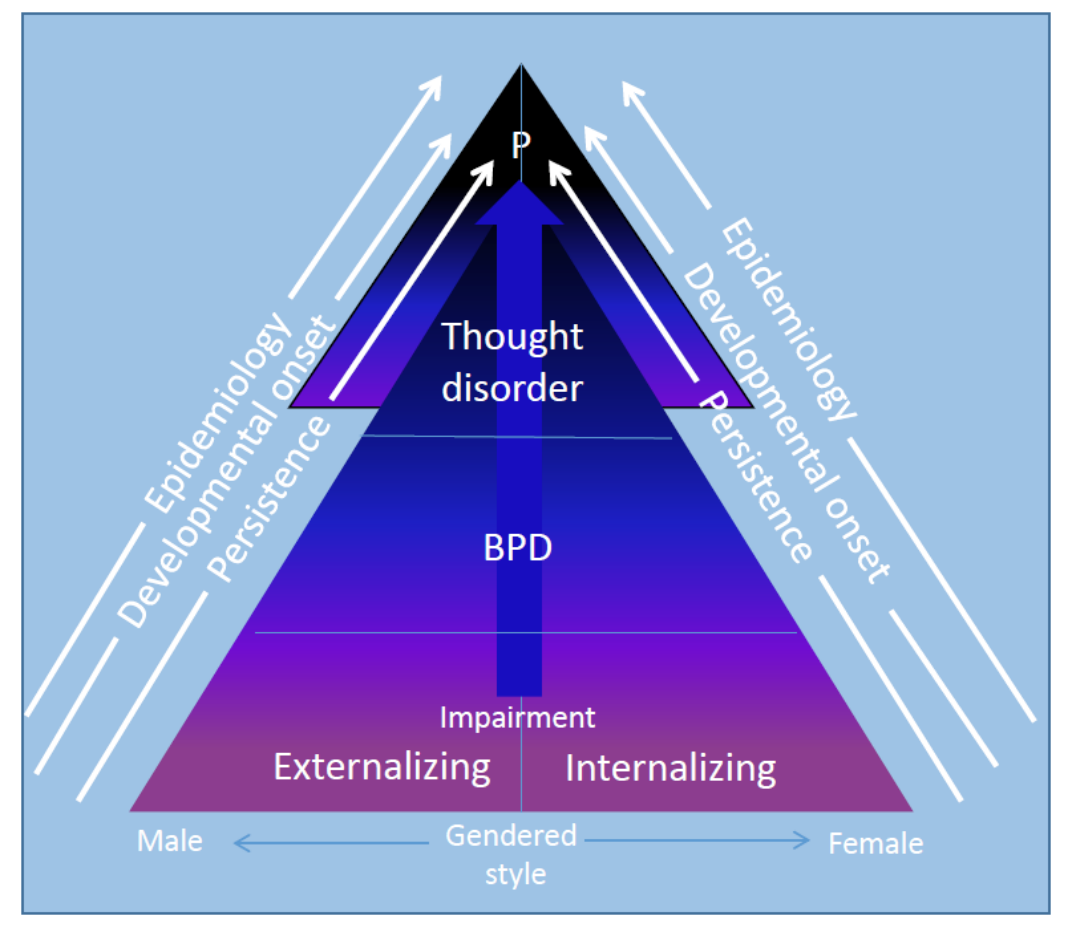
- defines ego identity as “the accrued confidence that one's ability to maintain inner sameness and continuity is matched by the sameness and continuity of one's meaning for others.”

Summary

- Humans contribute to an active and continuous process of reflection and interpretation of themselves and others.
- The capacity for this reflective process onsets in adult form in adolescence and facilitates consolidation of identity and adult role function (love and work).
- If disrupted, personality pathology (Criterion A dysfunction) ensues.
- Criterion A can account for the onset of personality disorder in adolescence, while Criterion B provides a useful descriptive account of continuous aspects of personality function over time.
- While Criterion B maladaptive traits provide important descriptive nuance to manifestations of personality pathology, maladaptive Criterion A function is conditional to the diagnosis of personality disorder.

Sharp & Wall, 2021, *Annual Review of Clin Psych*

Thinking about Henry…..



Sharp & Wall (2017) *Current Dir Psychology*
Sharp, et al. (2018) *Psych Clin North America*
Sharp (2020) *Psychopathology*
Sharp, Kerr & Chanen (2021) *APA textbook*

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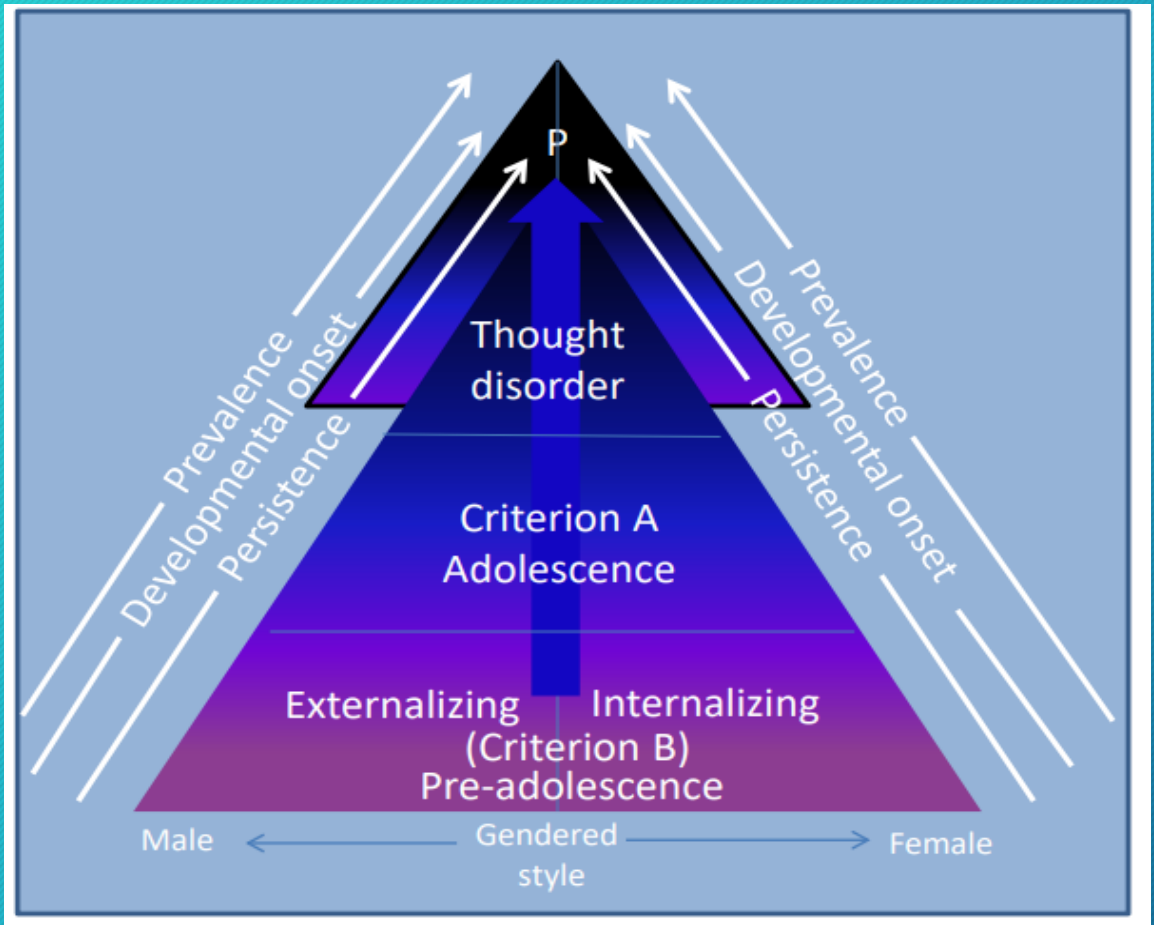
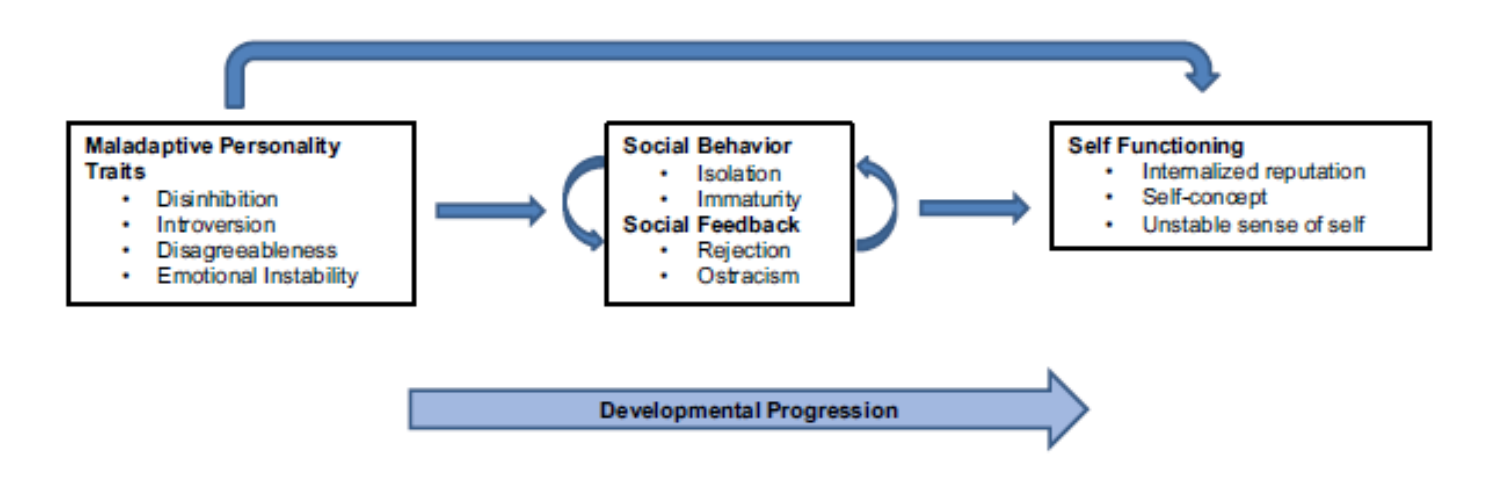


Sharp & Wall (2017) *Current Dir Psychology*
Sharp, et al. (2018) *Psych Clin North America*
Sharp (2020) *Psychopathology*
Sharp, Kerr & Chanen (2021) *APA textbook*

Empirical support

1. Traits affect social functioning which affects self-functioning

- N = 157 (134 community; 23 clinical); 63.1% female
- Baseline age 10.80 (SD = 1.43): DIPSI
- Wave 2 one year later (age 11.66; SD = 1.41): CBCL interpersonal problems
- Fifth wage age 20.97 (SD = 1.64): 14-day diary study of self-function:
  - "Today I had the feeling that I knew who I was and what I wanted to reach for"



Vanwoerden et al., 2021, *Ch Psych Hum Dev*

2. Identity diffusion increases in adolescence and tracks with personality pathology

- N = 2,381 recruited from 11 schools
- Age 12-18 (m = 14.92; SD = 1.94; 46% male)

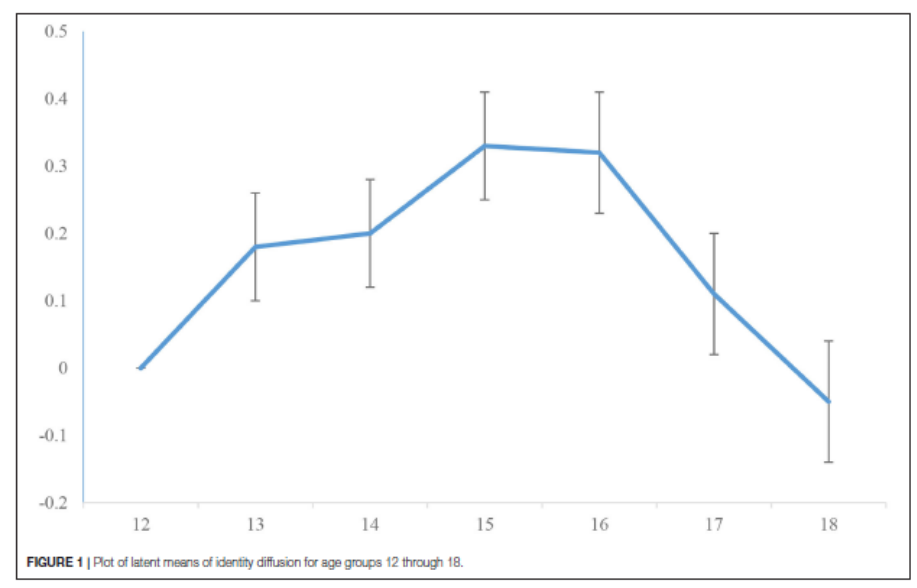


FIGURE 1 | Plot of latent means of identity diffusion for age groups 12 through 18.

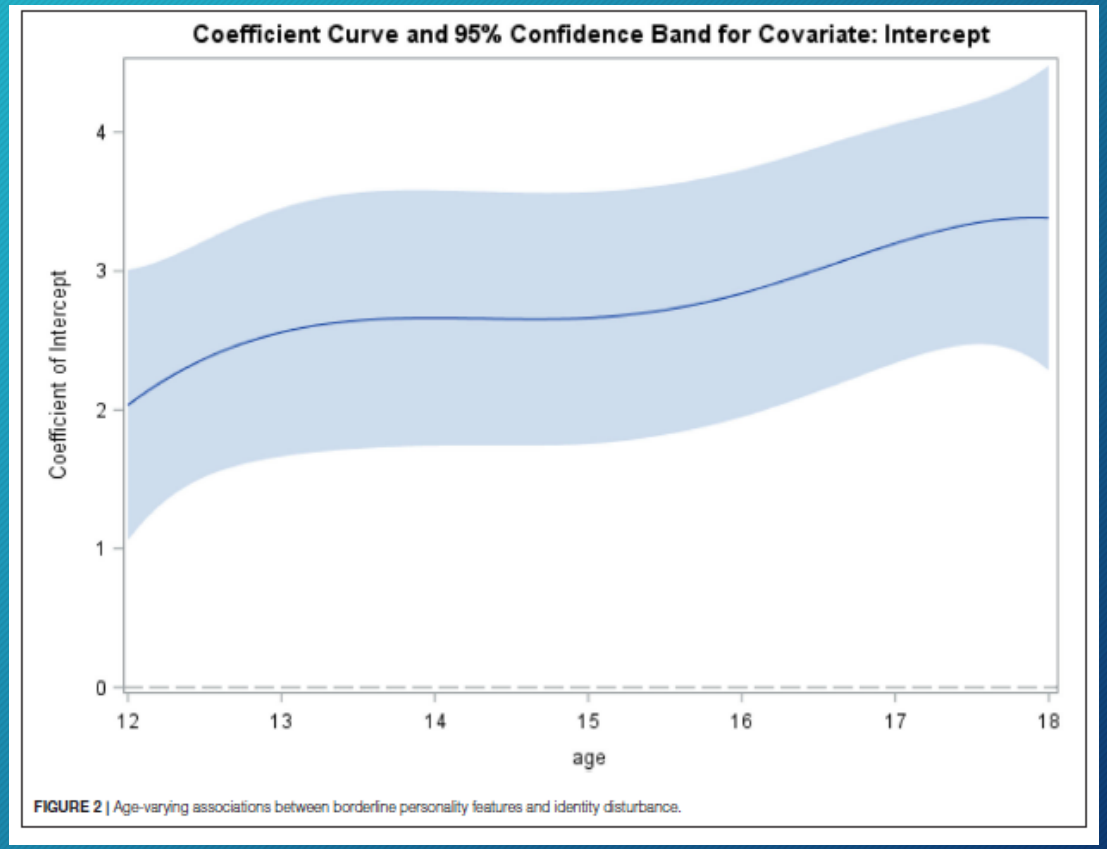


FIGURE 2 | Age-varying associations between borderline personality features and identity disturbance.

Sharp et al.., 2021, *Frontiers Psychiatry*

3. Maladaptive identity increments general functioning in predicting personality pathology

		b	SE	β	t	p	Adj. R^2	△ Adj. R^2
Step 1[a]	Age	.01	.44	.00	.01	.99	10.1%	
	Gender	10.03	1.53	.33	6.56	<.001		
Step 2[b]	Age	-.24	.25	-.03	-.95	.35	72.6%	62.5%***
	Gender	4.95	.90	.16	5.49	<.001		
	YSR total problems	.32	.02	.68	19.24	<.001		
	SDQ peer problems	.80	.25	.10	3.15	<.001		
	Life satisfaction	-.52	.14	-.14	-3.78	<.001		
	Academic motivation	.08	.14	.02	.56	.58		
Step 3[c]	Age	.02	.22	.00	.11	.91	79.7%	7.1%***
	Gender	4.61	.78	.15	5.92	<.001		
	YSR total problems	.20	.02	.42	10.73	<.001		
	SDQ peer problems	.51	.22	.06	2.33	.02		
	Life Satisfaction	-.30	.12	-.08	-2.48	.01		
	Academic motivation	-.05	.12	-.01	-.44	.66		
	AIDA maladaptive identity	.44	.04	.41	11.25	<.001		

Sharp et al., 2022, *PDTRT*

4. Maladaptive identity increments general psychiatric severity predicting personality pathology

Table 3. Hierarchical regression models testing the incremental validity of LoPF maladaptive self- and interpersonal functioning.

Variable		b	*SE*	β	*t*	*p*	Tol.	VIF	Adj. R^2	Δ Adj. R^2
DV = Maladaptive Personality Traits (PID-5-BF Total Score)										
Step 1 [a]	Age	−0.04	0.03	−0.07	−1.08	0.28	1.00	1.00	−0.1%	
	Gender	−0.05	0.07	−0.05	−0.71	0.48	1.00	1.00		
Step 2 [b]	Age	−0.03	0.02	−0.06	−1.41	0.16	1.00	1.00	51.0%	51.1%
	Gender	0.02	0.05	0.02	0.37	0.71	0.99	1.01		
	BPM Total Problems	0.05	0.003	0.72	16.36	<0.001	0.99	1.01		
Step 3 [c]	Age	−0.03	0.02	−0.05	−1.33	0.18	1.00	1.01	57.8%	6.8%
	Gender	0.04	0.05	0.04	0.93	0.35	0.98	1.02		
	BPM Total Problems	0.04	0.004	0.50	9.56	<0.001	0.60	1.68		
	LoPF Maladaptive Self and Interpersonal	0.004	0.001	0.34	6.47	<0.001	0.59	1.69		
DV = Borderline Personality Features (BPFSC-11 Total Score)										
Step 1 [d]	Age	0.45	0.37	0.06	1.21	0.23	0.99	1.01	3.7%	
	Gender	−3.24	0.82	−0.20	−3.97	<0.001	0.99	1.01		
Step 2 [e]	Age	−0.003	0.25	<0.001	−0.013	0.99	0.99	1.02	56.6%	52.9%
	Gender	−2.16	0.55	−0.13	−3.93	<0.001	0.98	1.02		
	BPM Total Problems	0.81	0.04	0.73	21.45	<0.001	0.99	1.01		
Step 3 [f]	Age	0.01	0.24	0.001	0.03	0.98	0.99	1.02	58.4%	1.8%
	Gender	−1.97	0.54	−0.12	−3.64	<0.001	0.98	1.02		
	BPM Total Problems	0.72	0.04	0.65	16.56	<0.001	0.72	1.39		
	LoPF Maladaptive Self and Interpersonal	0.02	0.01	0.16	4.15	<0.001	0.72	1.39		

Sharp et al., 2023, *Children*

5. Narrative identity associates with personality pathology in adolescents

- N = 70 inpatient adolescents (age 15.37; SD = 1.37; 80% female)
- Methods: AIDA, BPFSC, and CAI coded for narrative coherence (Baerger & McAdams, 1999) on scale from 0=3 with 3 indicating higher coherence
  - Orientation: degree to which the narrative provides the reader with sufficient background information to understand the story
  - Structure: extent to which the narrative flows logically from one point to the next
  - Affect: extent to which the narrative uses emotional language to make an evaluative point
  - Integration: extent to which the narrator relates the episode being described to whom he or she is as a person or why this story is being told
- Results
  - AIDA and BPFSC: $r = .72$, $p < .001$
  - Narrative coherence and BPFSC: $r = -.27$, $p < .05$
  - Regression: Only identity diffusion ($B = .68$, $p = .001$) and not narrative coherence ($B = .15$, $p = .082$) remained significantly associated with borderline features when both entered into regression with BPFSC as dependent variable

Lind et al., 2018, *PD TRT*

6. Narrative identity associates with attachment security and mentalizing

- Same sample
- Attachment coherence scale of the CAI (9-point scale); RFQY; narrative coherence coded in the same way.

Table 2. Correlations between main study variables.

	M	*SD*	1	2	3	4	5	6	7	8
1. Narrative coherence[a]	1.69	.57	—	.45**	.03	.27*	−.37**	.01	—	−.14
2. Attachment coherence[b]	5.11	1.65	—	—	.16	.09	−.23	.10	—	.08
3. Reflective function Scale A	4.63	.55	—	—	—	.16	−.03	−.08	.03	.07
4. Reflective function Scale B	4.29	.41	—	—	—	—	.40**	.02	.21	−.01
5. Externalizing	58.57	11.83	—	—	—	—	—	.27*	−.02	.17
6. Internalizing	67.60	12.47	—	—	—	—	—	—	−.12	.10
7. CAI word count	4542.53	1986.35	—	—	—	—	—	—	—	−.28*
8. Participant age	15.37	1.37	—	—	—	—	—	—	—	—

Lind et al., 2018, *JPD*

7. Agentic aspects of narrative identity particularly important for personality functioning

Correlations Between Main Study Variables

Variable	1	2	3	4	5	6	7
1. BPD	—	.69***	−.14	−.38***	−.24**	.02	.05
2. Emotion dysregulation	—	—	−.08	−.20*	−.20*	−.02	.01
3. Mentalizing	—	—	—	.24*	.25*	−.04	−.01
4. Agency	—	—	—	—	.58***	−.07	.08
5. Communion	—	—	—	—	—	−.05	.05
6. Agency: Future wishes	—	—	—	—	—	—	−.57***
7. Communion: Future wishes	—	—	—	—	—	—	—

Hierarchical Regression Model Examining Variance in BPD When Accounting for Age, Gender, Emotion Dysregulation, and Narrative Identity Themes

Dependent variable	Predictor variable	Step 1 *SE*	Step 1 β	Step 2 *SE*	Step 2 β	Step 3 *SE*	Step 3 β
BPD features	Age	1.093	.044	.815	.092	.777	.127
	Gender	3.836	−.133	2.856	−.108	2.658	−.113
	Emotion dysregulation			.045	.670***	.043	.614***
	Agency					1.759	−.279**
	Communion					1.803	−.029
F		.680		22.660***		18.529***	
Adj. *R*2		−.008		.442		.517	
*R*2 Change		.017		.446***		.084**	

Lind et al., 2021, *JPA*

8. Assessment of Identity Development in Adolescence (AIDA)

Study 1
2,119 young adults

Bifactor fit indices:
$x^2(1268) = 3716.32$; CFI = .95; RMSEA = .03; SRMR = .02

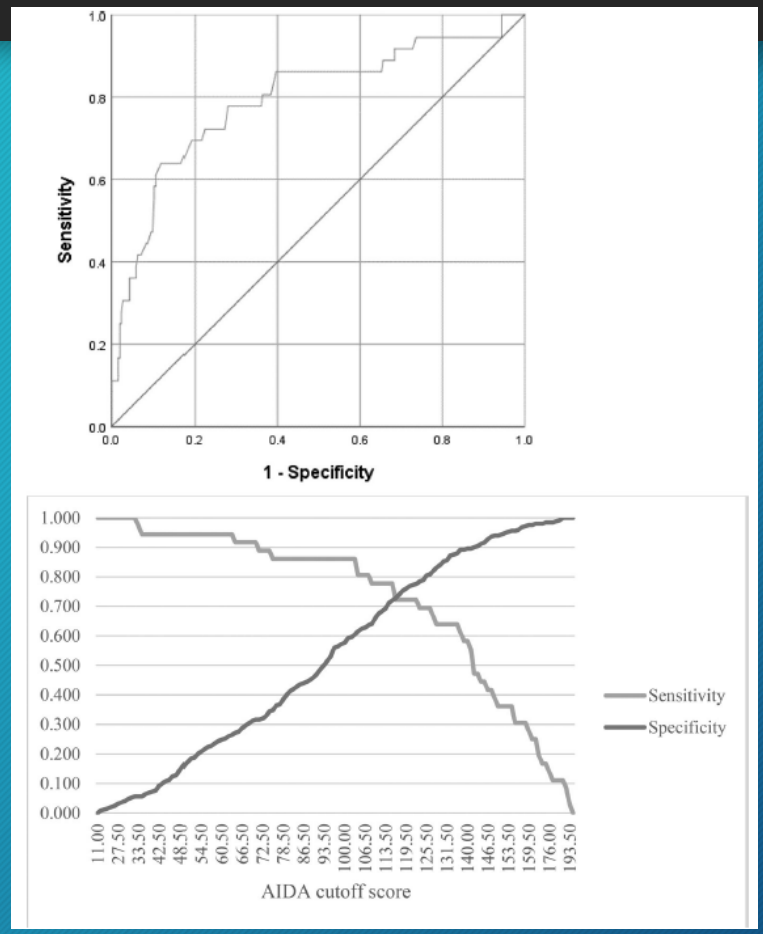
Gender invariance:

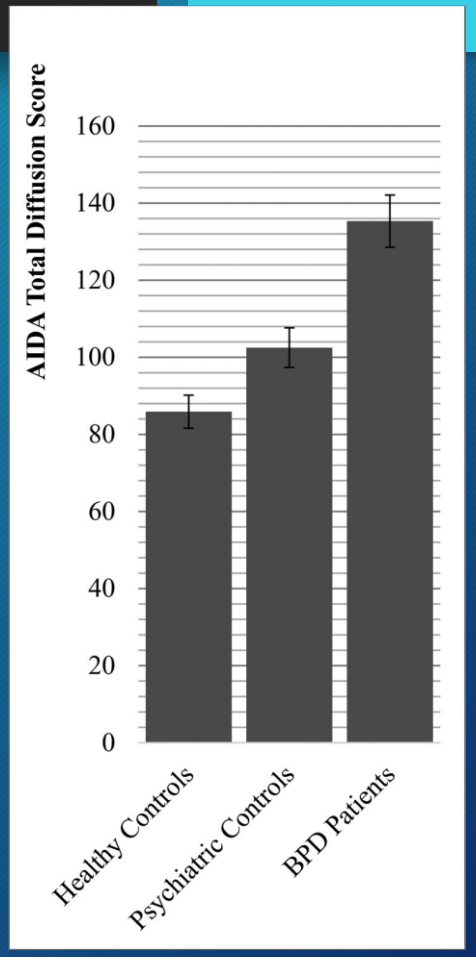
Table 2. Measurement invariance analysis results.

Model	χ^2(df)	CFI	RMSEA	SRMR	ΔCFI	ΔRMSEA
1. Configural	5230.43 (2536)	0.95	0.03	0.02	–	–
2. Metric	5790.044 (2893)	0.94	0.03	0.03	0.004	0.001
3. Scalar	6025.43 (2944)	0.94	0.03	0.03	0.004	0.001

CFI: Comparative Fit Index; RMSEA: Root Mean Square Error of Approximation; SRMR: Standardized Root Mean Squared Residual.

Study 2
122 inpatient adolescents (n = 36 with BPD)
164 community-based





Sharp et al., 2022, *JPA*

9. Levels of Personality Functioning Questionnaire 12-18

Study 1
N = 453; age 10–18; 57% female
Community sample

Bifactor fit indices:
x^2 (4,456) = 8,440.94, $p < .001$; RMSEA = .04; CFI = .89; TLI = .89; SRMR = .07.

OmegaH .90 (90% variance attributed to individual differences in general factor)
Omega .97

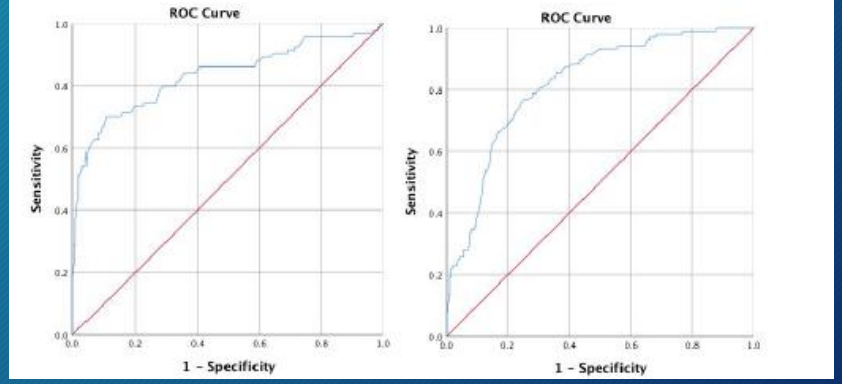
Kerr et al., 2022, *Assessment*

Table 2. Study 2 Pearson's Correlations Among Continuous Variables (Control Sample on Top, Clinical Sample on Bottom).

		1	2	3	4	5	6	7	8	9	10	11
1	LoPF-Q 12-18	1	.84**	.81**	.66**	.71**	.45**	.62**	.47**	.55**	.62**	−.35**
2	AIDA diffusion	.95**	1	.97**	.68**	.57**	.41**	.44**	.33**	.46**	.54**	−.48**
3	AIDA diff. (no LoPF)	.91**	.98**	1	.71**	.59**	.45**	.43**	.33**	.47**	.56**	−.40**
4	BPFSC-11 Total	.62**	.63**	.62**	1	.67**	.57**	.46**	.35**	.52**	.60**	−.13*
5	PID-5-BF Average	.73**	.69**	.67**	.70**	1	.76**	.75**	.62**	.80**	.83**	−.20**
6	Negative affect	.67**	.67**	.67**	.75**	.84**	1	.40**	.27**	.49**	.56**	−.03
7	Detachment	.53**	.50**	.48**	.54**	.74**	.60**	1	.47**	.47**	.56**	−.18**
8	Antagonism	.38**	.33**	.30**	.30**	.56**	.22**	.29**	1	.38**	.34**	−.10
9	Disinhibition	.54**	.51**	.50**	.58**	.84**	.65**	.48**	.47**	1	.62**	−.26**
10	Psychoticism	.64**	.58**	.56**	.48**	.83**	.62**	.48**	.34**	.62**	1	−.20**
11	Age	.18	.12	.09	.28**	.27**	.28*	.22*	.21*	.19*	.14	1

Study 2
community sample (*n* = 298; age 10–18; 54.4% female)
clinical sample (*n* = 94; age 11–18; 58.5% female)

Study 2 ROC curve for the sample (left) and for the BPFSC-11 clinical cut-off (right)



10. Awareness of Narrative Identity Questionnaire (ANIQ)

ANIQ

Everyone has memories about the experiences they have had over their lifetime. Sometimes these memories can be used to create stories about our lives. The following statements refer to how you might use your memories to understand the kind of person that you have been, the person you are, and the person you expect to become. **You can respond to the statements on a scale from 0 (*completely disagree*) to 10 (*completely agree*),** with a higher score indicating stronger agreement. Please try to answer the questions broadly, and in relation to how you generally use your personal memories, rather than trying to relate them to specific circumstances or experiences.

1.	My memories are like stories that help me understand my identity.	
2.	I use my stories about my life to work out the kind of person I am.	
3.	The experiences from my past make the story of who I am.	
4.	My sense of self is embedded in memories of my life.	
5.	When I think over my life, I can observe how there is a story that tells me who I am.	
6.	I can put the events of my life in order of when they occurred.	
7.	Knowing the order in which my life events occurred is easy for me.	
8.	When I'm thinking back over experiences I have had, I know when they occurred in my life.	

- ANIQ shows good internal consistency
- 3 factors instead of 4 (causal coherence does not appear to form its own factor)
- Temporal coherence associated with personality pathology.
- Temporal coherence independent from identity diffusion.
- Self-report offers a viable alternative to coding

Balzen et al., 2023, JPA

11. Identity diffusion increases levels of personality pathology, which heightens suicide severity levels

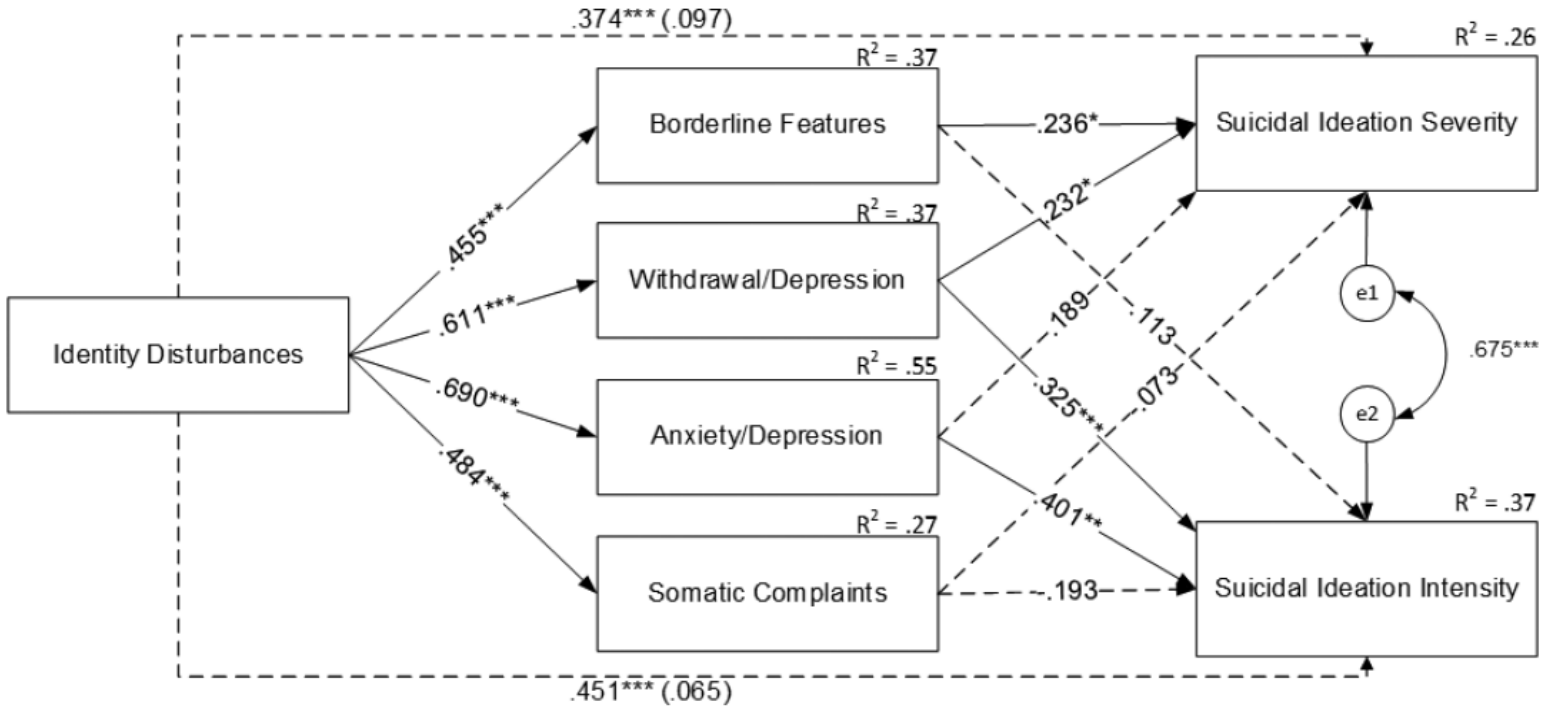


FIGURE 2. Structural model of relations between identity disturbances, borderline features, internalizing disorders, and suicidality in inpatient adolescents (controlling for gender).

N = 96
Inpatient adolescents

Sekowski et al., 2021, *JPD*

12. Identity disturbance is a central symptom across age groups

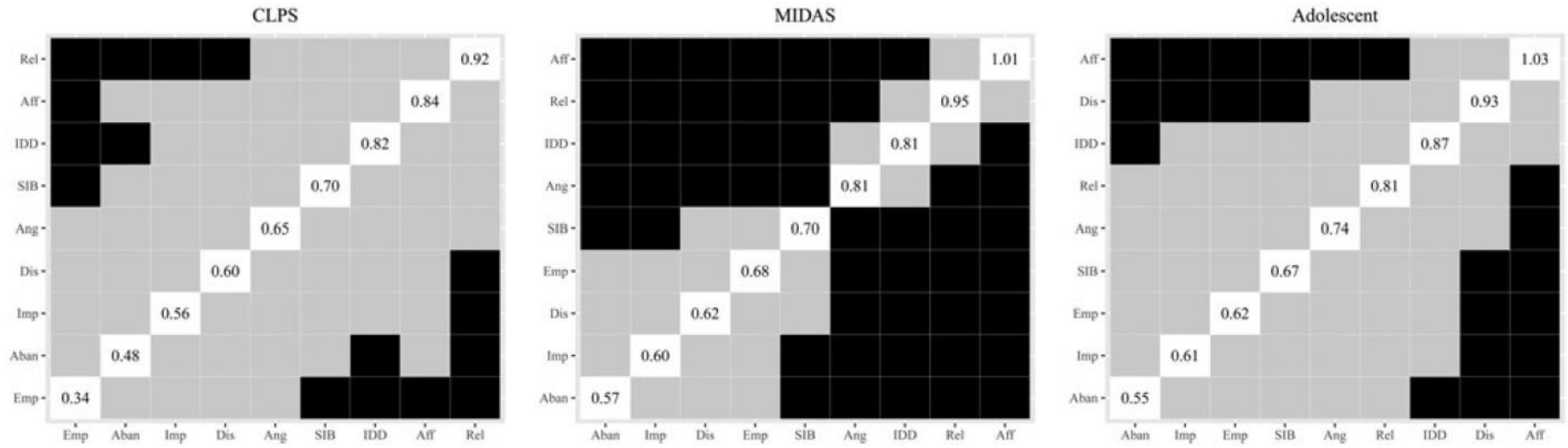


Fig. 2. Expected influence centrality difference tests based on nanoparametric bootstrapping within each of the three samples. Black cell indicates a significant difference between the associated centrality estimates. The diagonal of each plot displays the observed expected influence for each of the nodes. Ang, intense anger; Aff, affective instability; Emp, feelings of emptiness; IDD, identify disturbance; Dis, stress-related paranoia or dissociation; Abn, efforts to avoid abandonment; SIB, suicidal or self-injurious; Imp, self-damaging impulsivity; Rel, unstable relationships.

Peters et al. (2022), *Psych Medicine*

Review Article

Psychopathology

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Adolescent Personality Pathology and the Alternative Model for Personality Disorders: Self Development as Nexus

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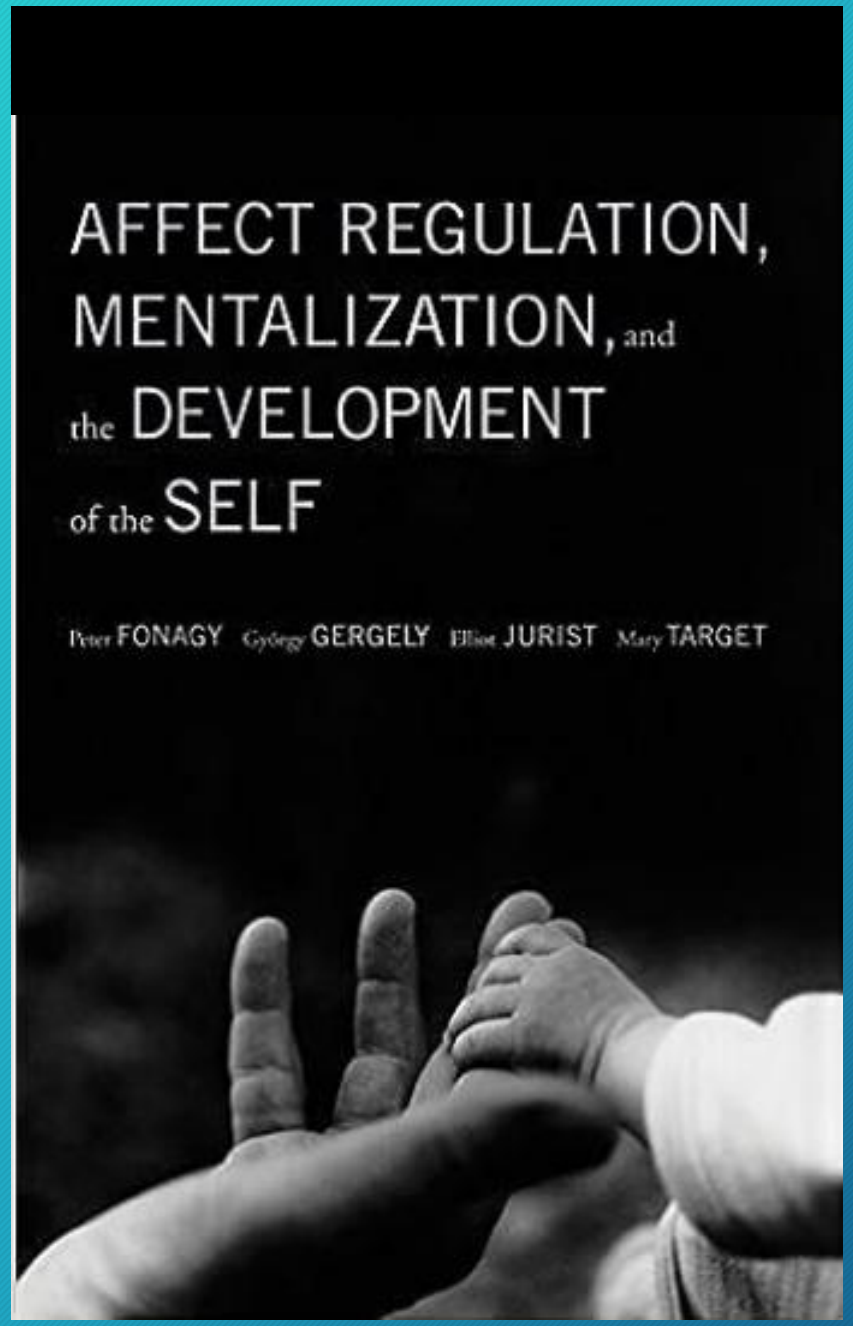
Nature and Assessment of Personality Pathology and Diagnosis

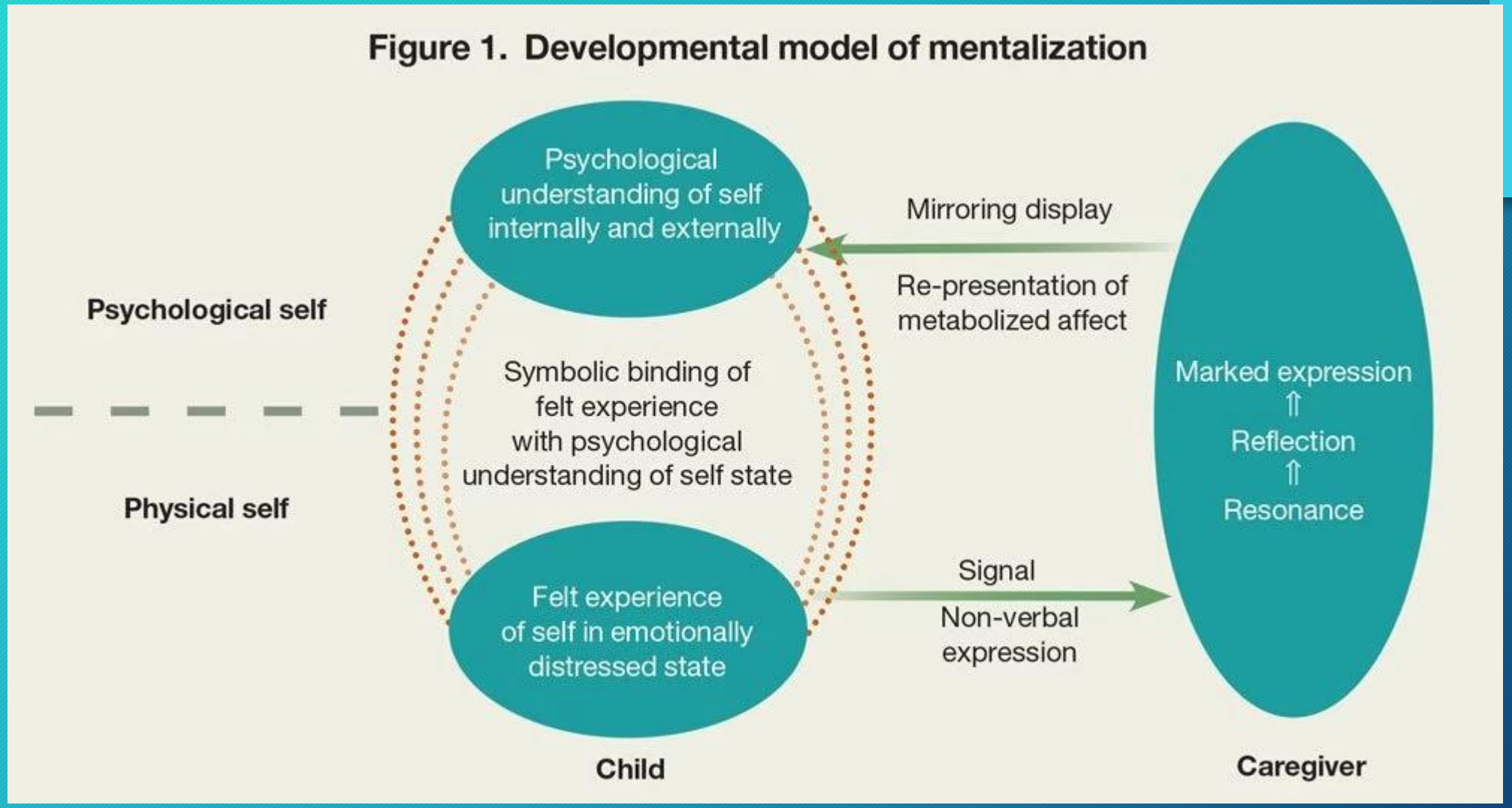
Carla Sharp, Ph.D., and John Oldham, M.D., M.S.

This article demonstrates the contribution of Otto Kernberg's object relations theory of personality pathology to the current understanding of the nature and assessment of personality pathology and diagnosis. The article introduces recent advances in psychiatric nosology and presents differing views on the meaning of the general severity criterion common to all personality pathology (i.e., level of personality functioning as described in criterion A of the Alternative DSM-5 Model for Personality Disorders). Next, the significance of Kernberg's theory to recent nosological advances is discussed, with a focus on two important features: first, a definition of personality that goes beyond signs and symptoms to include structural motivational components, in the domains of self- and interpersonal functioning, that are common to all personality manifestations and that fulfill an intrapsychic, organizing function; second, identity formation and consolidation as the ultimate end point of healthy personality functioning. That these cornerstone features of Kernberg's theory, articulated more than 50 years ago, align with the most up-to-date conceptualization of personality pathology confirms that Kernberg's theory represents an idea whose time has finally come.

Am J Psychother in Advance
(doi: 10.1176/appi.psychotherapy.20220016)

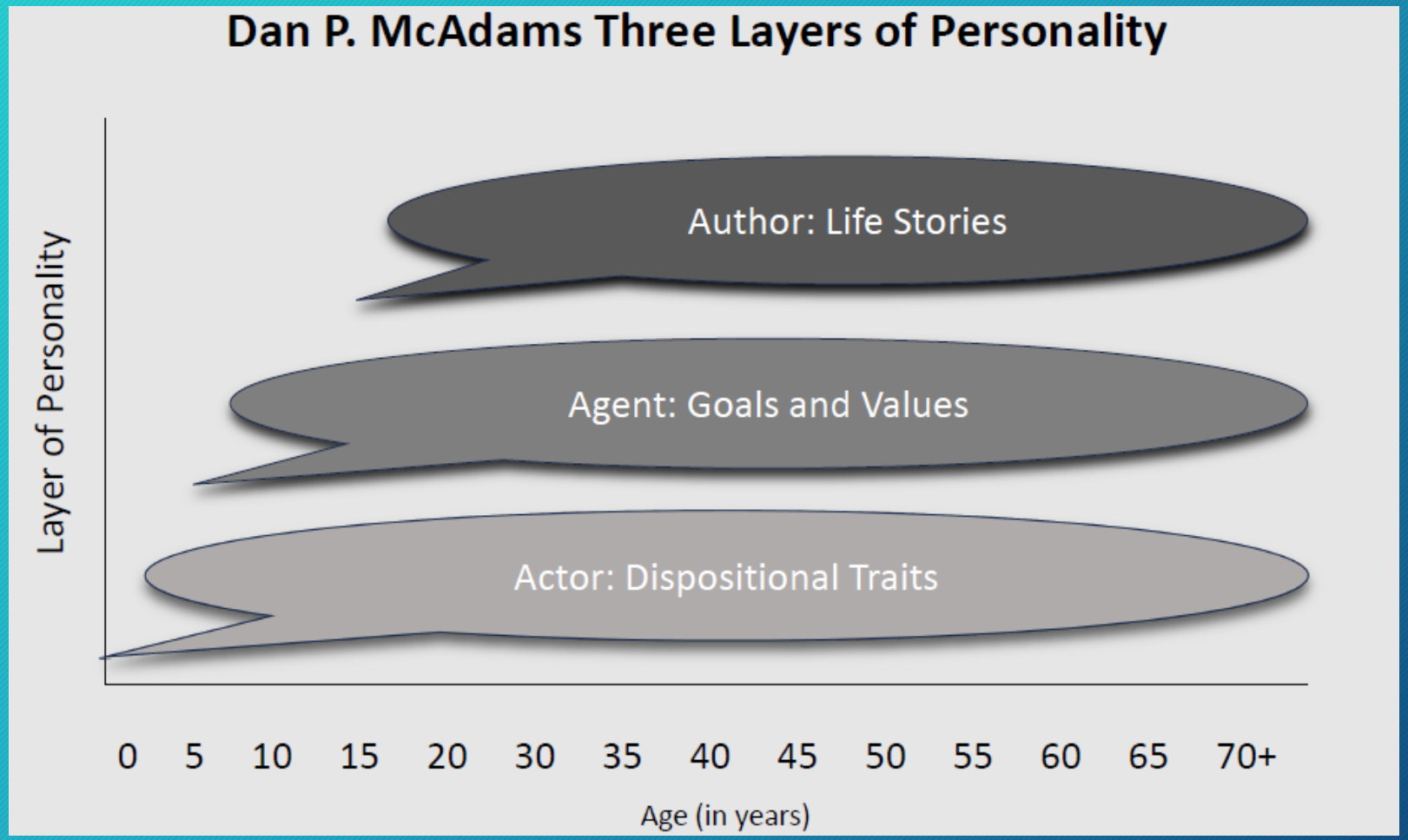
How do we become a person?


AFFECT REGULATION,
MENTALIZATION, and
the DEVELOPMENT
of the SELF
Peter FONAGY György GERGELY Elliot JURIST Mary TARGET



Fonagy et al. 2002
Choi-Kain & Unruh, 2016

MENTALIZING CAPACITY



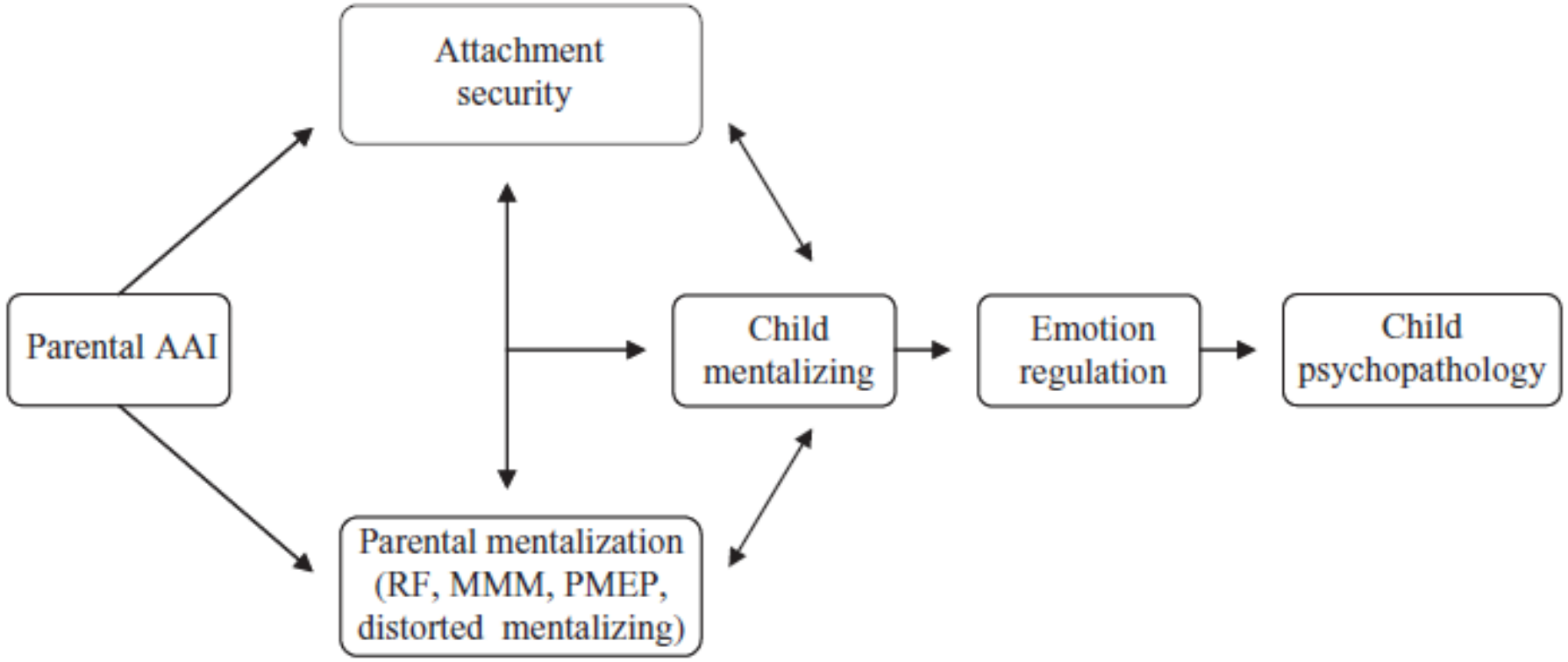
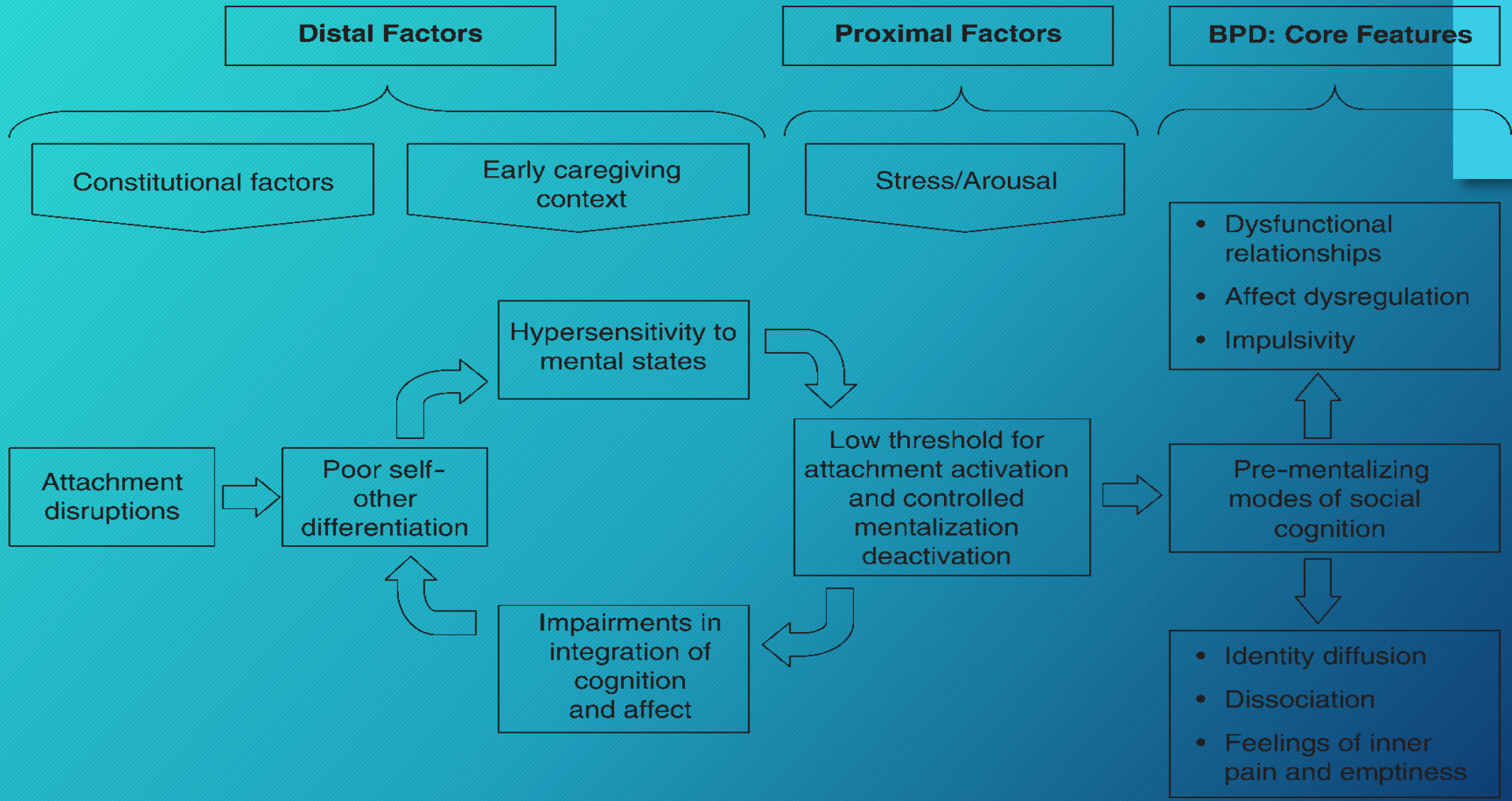


Figure 1. Testable Model of Factors that Relate to Parental Mentalization and Suggested Pathway for the Development of Psychopathology through Mentalization.

Sharp & Fonagy, 2008, *Social Development*

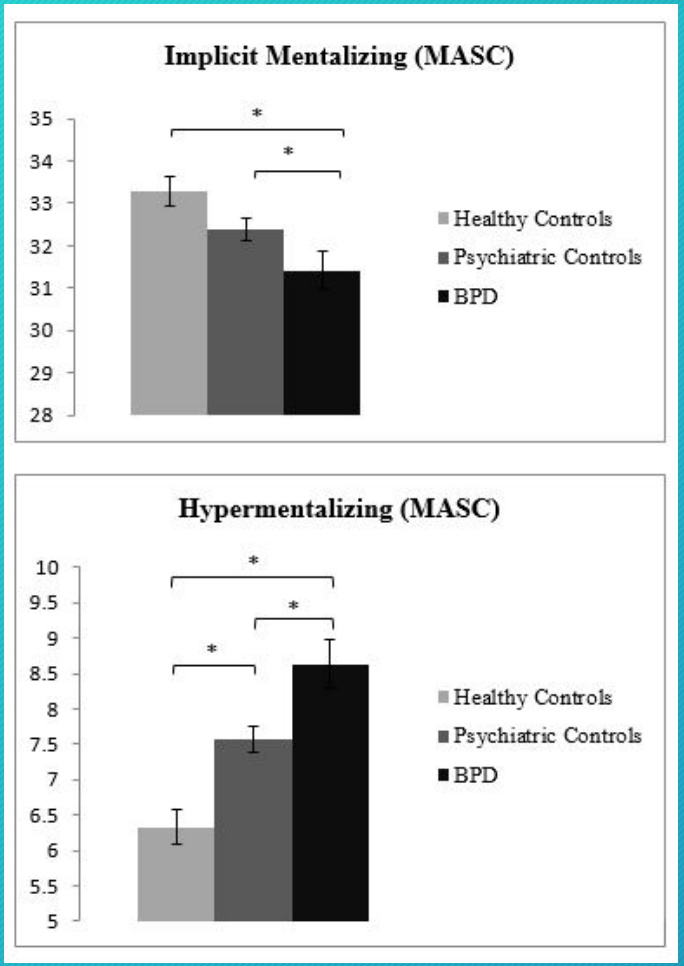


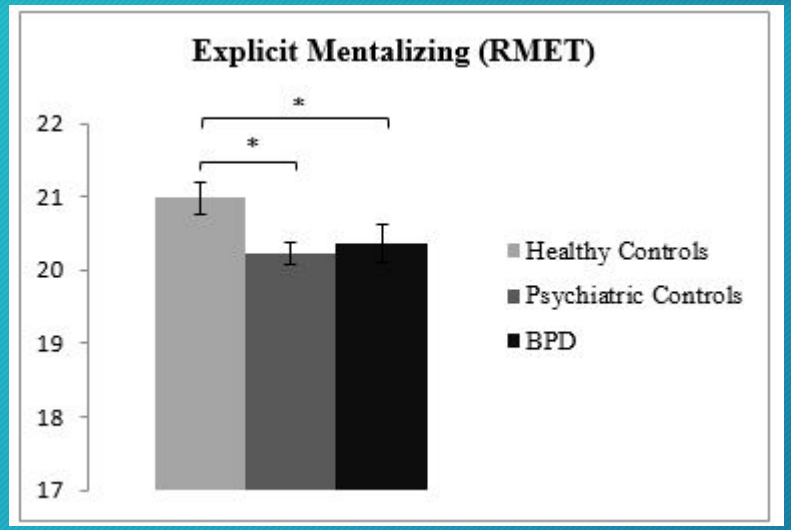
Fonagy & Luyten, 2009

Attachment is an important context for the development of mentalizing capacity

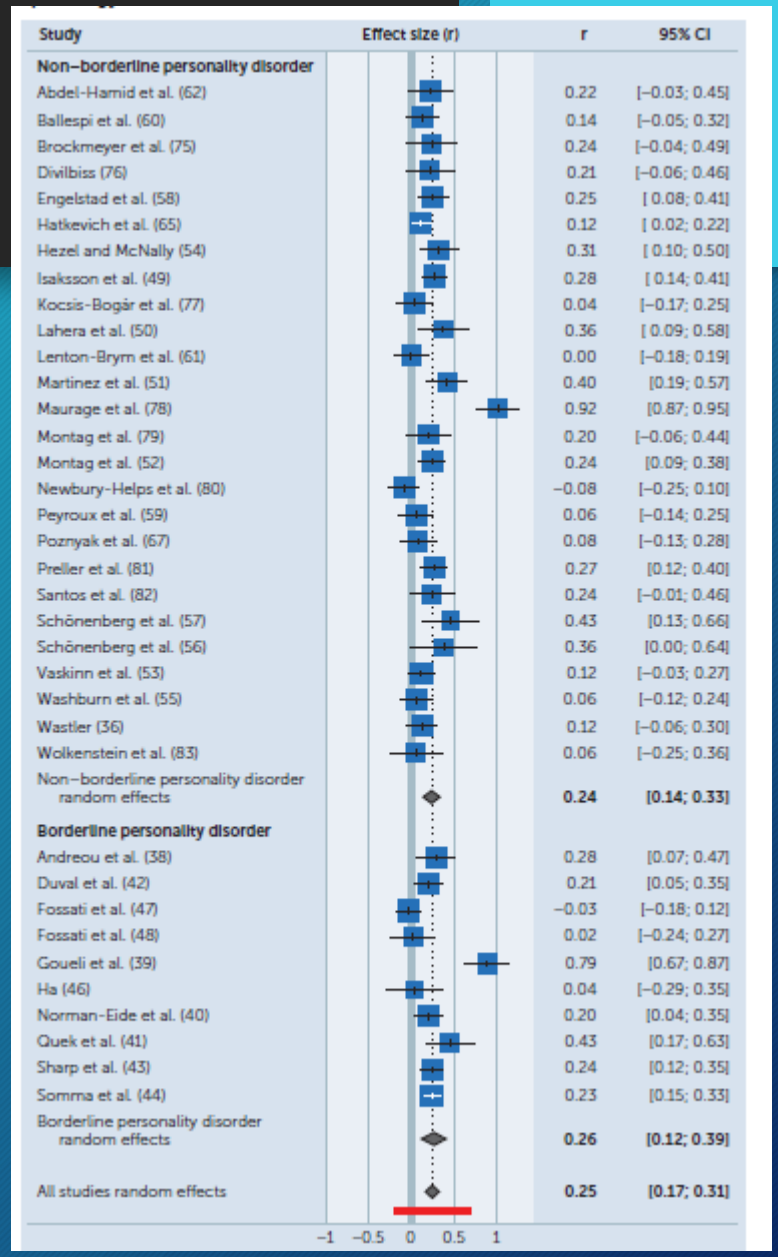
- Family conflict → belief that interpersonal needs are not being met → borderline features (Kalpakci, Venta, & Sharp, 2014)
- Attachment security → capacity to mentalize the self → mindread others (Vanwoerden, Kalpakci, & Sharp, 2015)
- Insecure attachment → mentalizing impairment → peer problems (Venta & Sharp, 2015).
- Attachment insecurity → hypermentalizing → borderline features (hypermz washes out the correlated effects of emotion dysregulation) (Sharp et al., 2015)
- Problems of inadequate parent-child boundaries associated with borderline features in adolescents (Vanwoerden, Kalpakci, & Sharp, 2017)
- Reduced maternal availability and dependability associated with borderline features in adolescence are associated with (Ball, Venta, & Sharp, 2018)

Mentalizing is an important correlate of maladaptive personality function

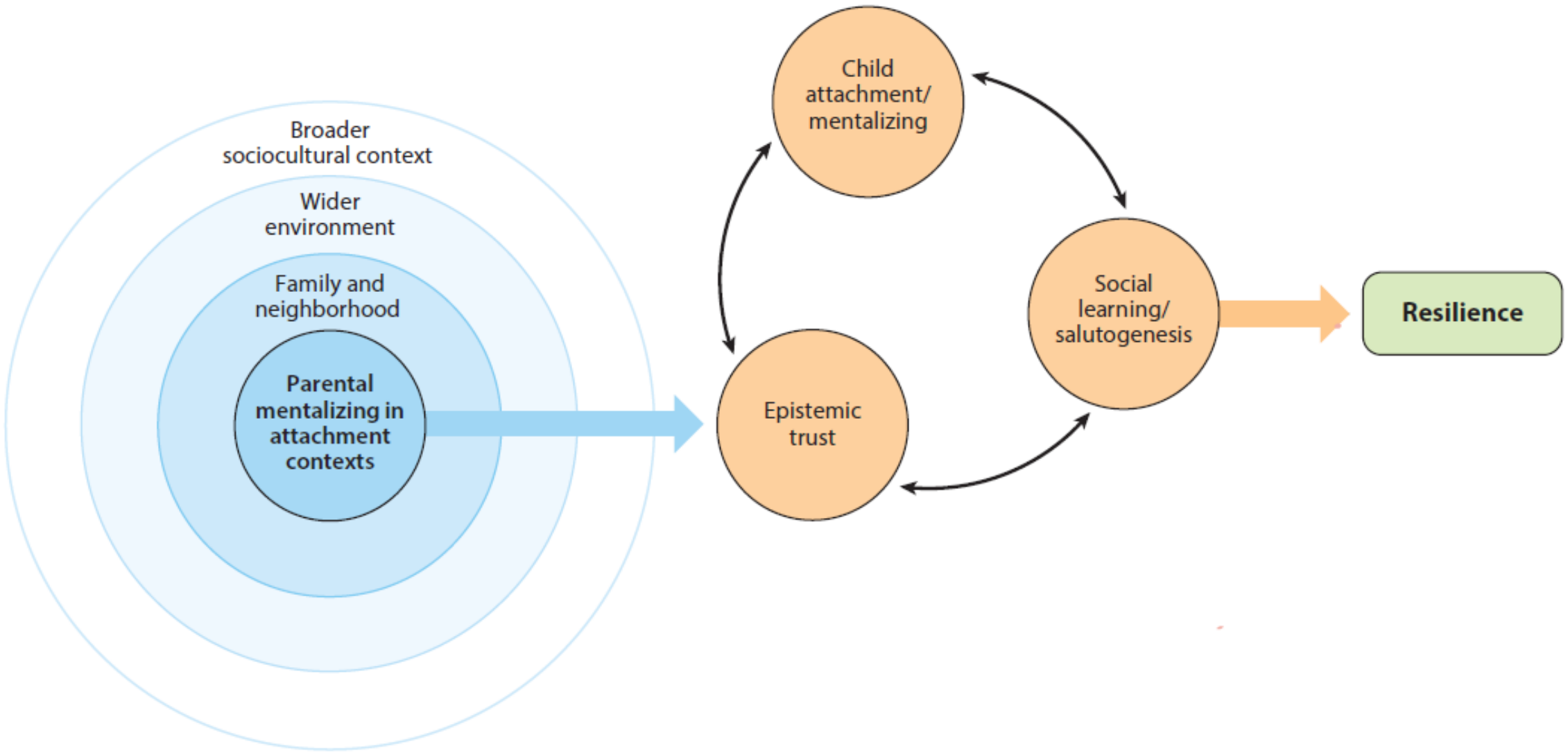




Penner et al., 2019, *JPD*



McLaren et al., 2022, *AJP*



Luyten & Fonagy, 2020, *ARCP*

1. Epistemic trust (parent and peer trust) associated with personality pathology in adolescents

Table 2 Regression beta weights

Variable	BPFS-C	BPFS-P	CIBPD (dimensional)	CIBPD (categorical) [a]
IPPA-M	−.19***	−.11*	−.21***	−.05***
Age	−.10	−.05	−.08	−.13
Gender	−.08	−.04	−.19**	1.00***
CBCL	.06	.67***	.15**	.06**
IPPA-F	−.12*	−.10*	−.11	−.03*
Age	−.08	−.04	−.06	−.11
Gender	−.10	−.04	−.20***	.97***
CBCL	.04	−.10*	.14*	.02*

IPPA-M Inventory of Parent and Peer Attachment, Mother Trust Subscale, *IPPA-P* Inventory of Parent and Peer Attachment, Father Trust Subscale, *BPFS-C* Borderline Personality Features Scale, Child Report, *BPFS-P* Borderline Personality Features Scale, Parent Report, *CIBPD* Child Interview for DSM-IV Borderline Personality Disorder, *CBCL* Childhood Behavioral Checklist

[a]Binary logistic regression beta weights

*$p < .05$; **$p < .01$; ***$p < .001$

Orme et al., 2022, *BPD/ED*

2. Epistemic trust (emotional, reliability, honesty) associated with personality pathology in adolescents

TABLE 1. Scores on main study measures across groups

	BPD (*n* = 83, 18.7%)		Non-BPD Psychiatric (*n* = 197, 44.2%)		Healthy Controls (*n* = 165, 37.1%)	
	M	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
Honesty (CGTB)	22.47	(5.93)	23.35	(5.55)	24.34	(4.53)
Emotional Trust (CGTB)	25.05	(5.73)	26.36	(5.53)	28.10	(4.92)
Reliability (CGTB)	28.61	(5.55)	28.53	(5.36)	30.29	(4.47)
Borderline Features (BPFS)	79.41	(13.12)	65.35	(12.75)	55.60	(14.40)
Internalizing (YSR)	29.46	(11.35)	23.09	(11.74)	14.15	(10.26)
Externalizing (YSR)	26.28	(10.94)	17.45	(9.96)	9.49	(7.52)
Age	14.92	(1.29)	14.98	(1.48)	15.42	(1.23)

Note. CGTB = Rotenberg Children's Generalized Trust Beliefs Scale; YSR = Youth Self Report; BPFS = Borderline Personality Features Scale (Child Self Report)

TABLE 3. Hierarchical regression model evaluating whether there is a unique association of borderline features with each form of interpersonal trust

	b	*SE*	β	*t*	*p*	R^2 (%)	Adj. R^2 (%)
DV = Emotional Trust (CGTB)							
Step 1						8.7[a]	7.8
Gender	-.53	.56	-.05	-.95	.34		
Age	.45	.19	.12	2.42	.02		
Internalizing problems (YSR)	-.09	.03	-.21	-3.78	<.001		
Externalizing problems (YSR)	-.05	.03	-.10	-1.79	.07		
Step 2						10.3[b]	9.2
Gender	-.68	.56	-.06	-1.22	.22		
Age	.48	.19	.12	2.59	.01		
Internalizing problems (YSR)	-.06	.03	-.13	-2.05	.04		
Externalizing problems (YSR)	-.01	.03	-.02	-.30	.77		
Borderline features (BPFS)	-.07	.03	-.19	2.67	.01		
DV = Reliability (CGTB)							
Step 1						8.4[c]	7.5
Gender	-.94	.53	-.08	-1.77	.08		
Age	.63	.18	.17	3.50	.001		
Internalizing problems (YSR)	-.05	.02	-.11	-1.90	.06		
Externalizing problems (YSR)	-.07	.03	-.16	-2.83	.01		
Step 2						9.4[d]	8.3
Gender	-1.06	.53	-.10	-1.99	.048		
Age	.65	.18	.17	3.63	<.001		
Internalizing problems (YSR)	-.02	.03	-.04	-.63	.53		
Externalizing problems (YSR)	-.04	.03	-.09	-1.45	.15		
Borderline features (BPFS)	-.05	.02	-.16	-2.18	.03		
DV = Honesty (CGTB)							
Step 1						8.7[e]	7.8
Gender	-.06	.55	-.01	-.11	.92		
Age	.58	.19	.15	3.14	.002		
Internalizing problems (YSR)	-.06	.03	-.15	-2.60	.01		
Externalizing Problems (YSR)	-.06	.03	-.13	-2.22	.03		

3. Epistemic trust (behavioral economic game) associated with personality pathology in adolescents

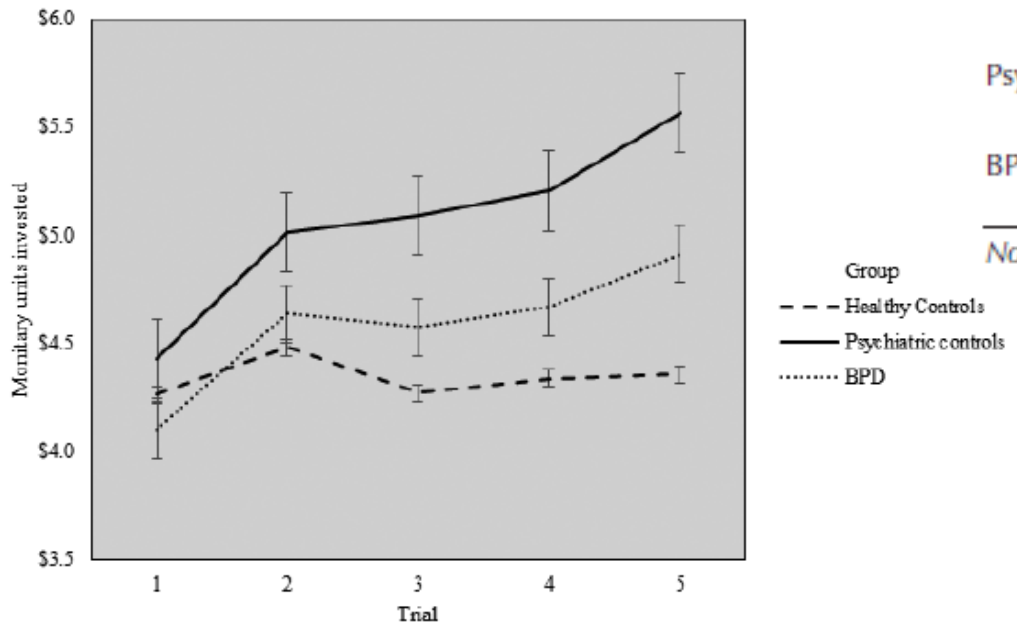


FIGURE 1. Average monetary units invested across trials of the trust and lottery games by each group.

TABLE 2. Correlations (Pearson's *r*) with Rotenberg's Trust Belief Scale for Each Group and Significance Tests for Differences Between Correlations (*z*)

	Trust game		Lottery game	
Sample	*r*(*p*)	*z*(*p*)	*r*(*p*)	*z*(*p*)
Healthy controls	.17 (.09)	PC: 1.78 (<.05)* BPD: 1.13 (.31)	.10 (.29)	PC: 1.69 (<.05)* BPD: 1.31 (.10)
Psychiatric controls	−.05 (.30)	HC: 1.78 (<.05)* BPD: 0.25 (.40)	−.11 (.26)	HC: 1.69 (<.05)* BPD: 0 (.50)
BPD	−.01 (.87)	HC: 1.13 (.31) PC: 0.25 (.40)	−.11 (.45)	HC: 1.31 (.10) PC: 0 (.50)

Note. *Statistic is significant at a $p < .05$ level.

126 healthy controls
59 inpatients with BPD
137 inpatients without BPD

Graves et al., 2021, *ScJChAdPsych*

AMPD-defined personality disorder

1. Parental closeness associates with identity diffusion; identity diffusion partly accounts for the relationship between parental closeness and personality pathology

TABLE 1 Bivariate correlations between main study variables.

	1	2	3	4	5	6
1. Closeness—mom	-					
2. Closeness—dad	0.56**	-				
3. Identity diffusion	−0.23*	−0.32**	-			
4. BPD features	−0.18*	−0.25**	0.73**	-		
5. Age	−0.07	−0.11	0.09	0.17	-	
6. Gender (female)	0.02	0.004	−0.10	−0.14	0.25**	-
Mean (SD)	138.88 (45.27)	129.58 (45.01)	110.13 (41.45)	68.53 (14.66)	15.35 (1.43)	-
% Female	-	-	-	-	-	72.2
N	131	130	109	126	131	131

*$p \leq 0.05$, **$p < 0.01$.

TABLE 2 Mediation analyses.

Path	*B*	*SE*	*t*	*P*	LLCI	ULCI
IV: Closeness—Mother[a]						
a	−0.22	0.09	−2.49	0.014*	−0.39	−0.04
b	0.26	0.02	10.64	0.000**	0.21	0.31
c	0.00	0.02	0.07	0.943	−0.04	0.05
c'	−0.06	0.03			−0.11	−0.01
IV: Closeness—Father[b]						
a	−0.31	0.09	−3.45	0.001**	−0.48	−0.13
b	0.26	0.03	10.28	0.000**	0.21	0.31
c	−0.02	0.02	−0.66	0.513	−0.06	0.03
c'	−0.08	0.02			−0.13	−0.03

[a]$n = 108$; [b]$n = 107$. Values are unstandardized path coefficients from models including gender as a covariate. *$p < 0.05$, **$p < 0.01$.

131 inpatient adolescents (*Mage* = 15.35, 70.2% female)

Cervantes et al., 2023, *Front Psych*

2. Emotional abuse → reduced reflective function → identity diffusion

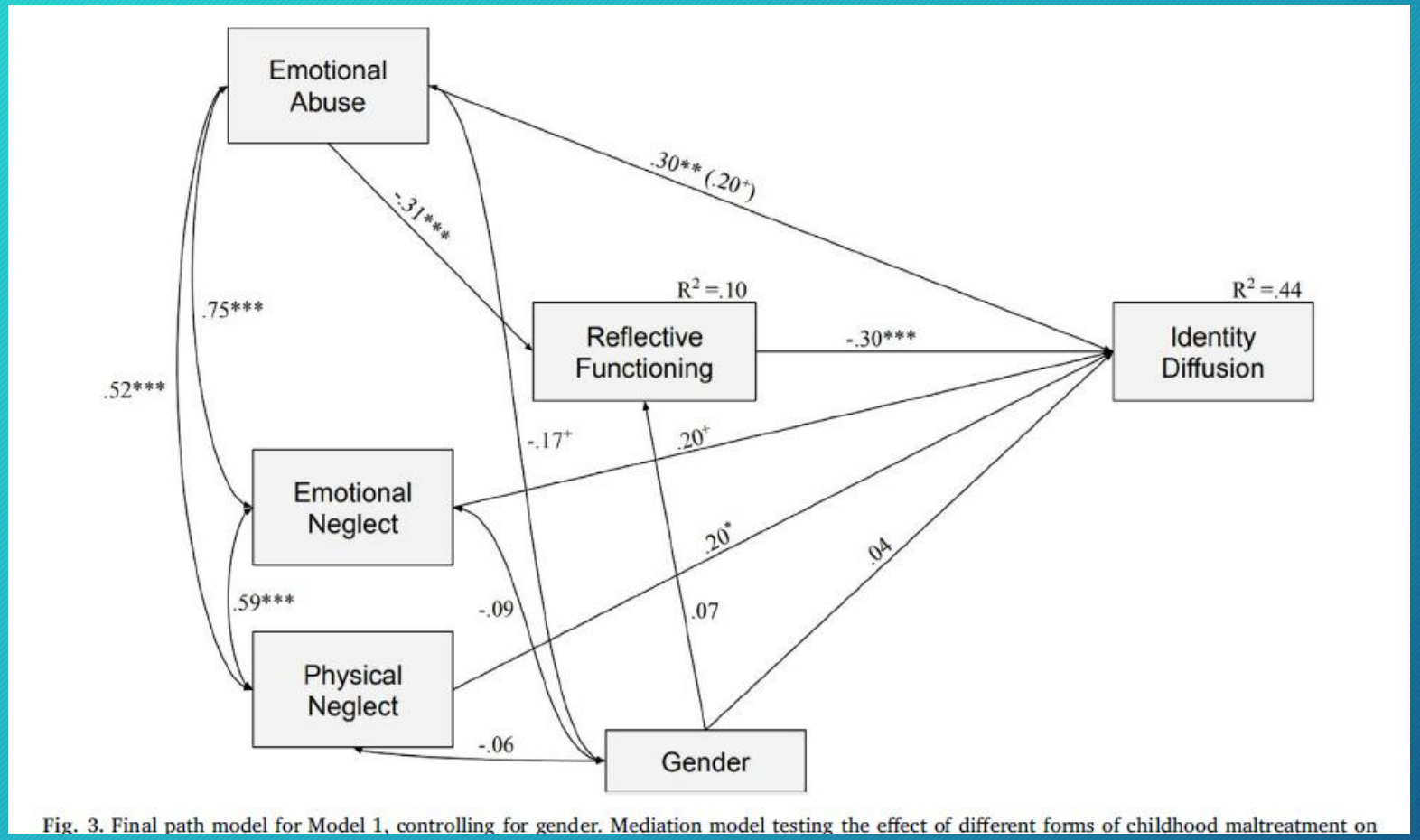


Fig. 3. Final path model for Model 1, controlling for gender. Mediation model testing the effect of different forms of childhood maltreatment on

N = 104
Inpatient adolescents

Penner et al., 2019, *JoAdol*

Clinical implications

Assessment

- We must assess for personality functioning over and above internalizing and externalizing pathology - is personality binding into a unidimensional severity continuum?
- Assessment of Criterion A is conditional.
- Assessment of Criterion B is optional, and can be helpful.
- Assessing self-function is essential – is the construction of a healthy sense of self scaffolded?
- Assessing family functioning is essential.
- Assessment of mentalizing capacity essential.

Intervention

- Interventions that scaffold self and interpersonal functioning
- DBT if mindful of Criterion A (and not just emotion dysregulation – Criterion B)
- Mentalization-based therapy for Adolescents (Rossouw & Fonagy; and others)
- Generalist approaches

Lunch

Agenda

09:00-10.30: Mentalizing: A common factor across disorders and modalities

10.30-11:00: Break

11:00-13:00: Mentalizing: Its importance in working with adolescents

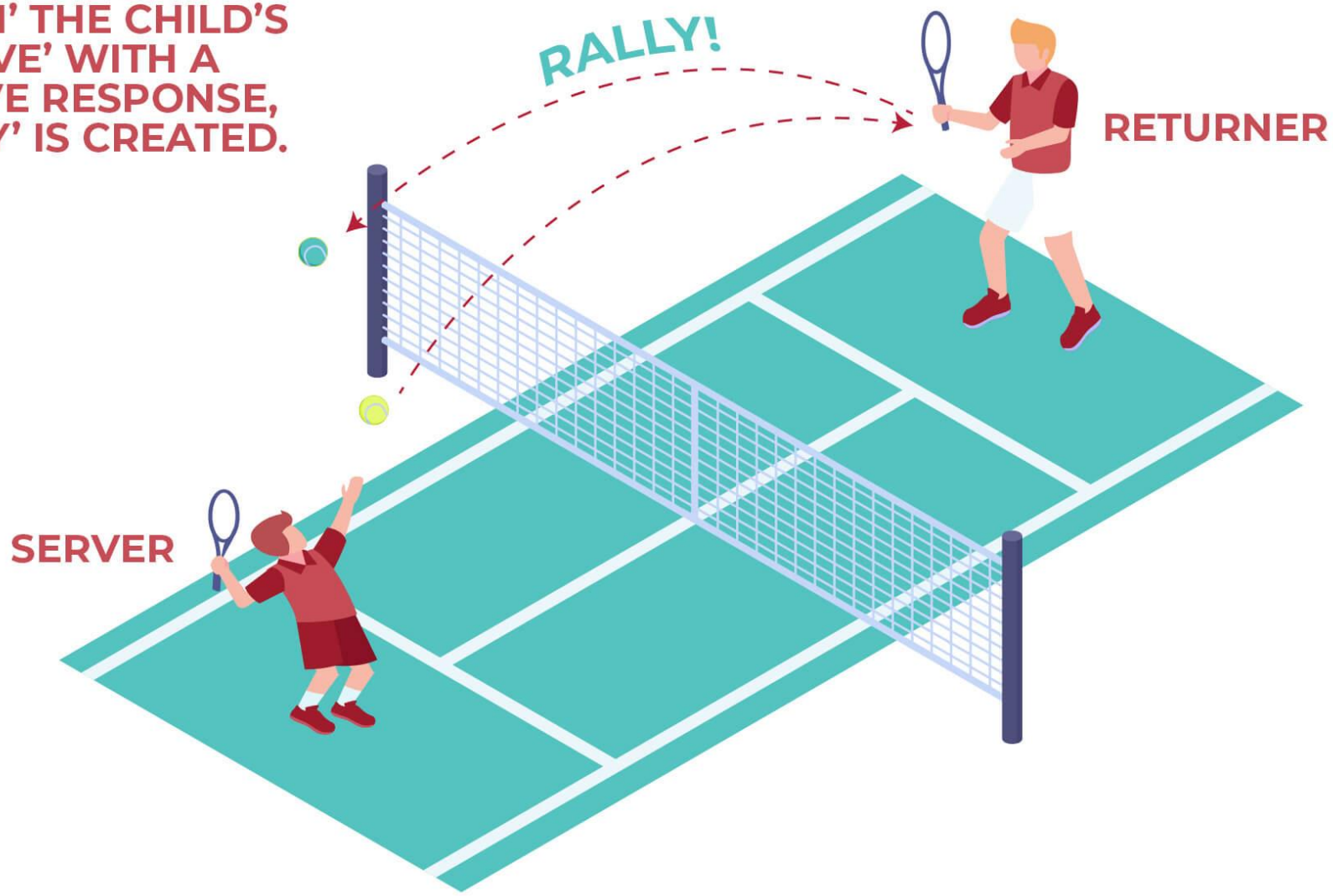
13:00-14:00: Lunch

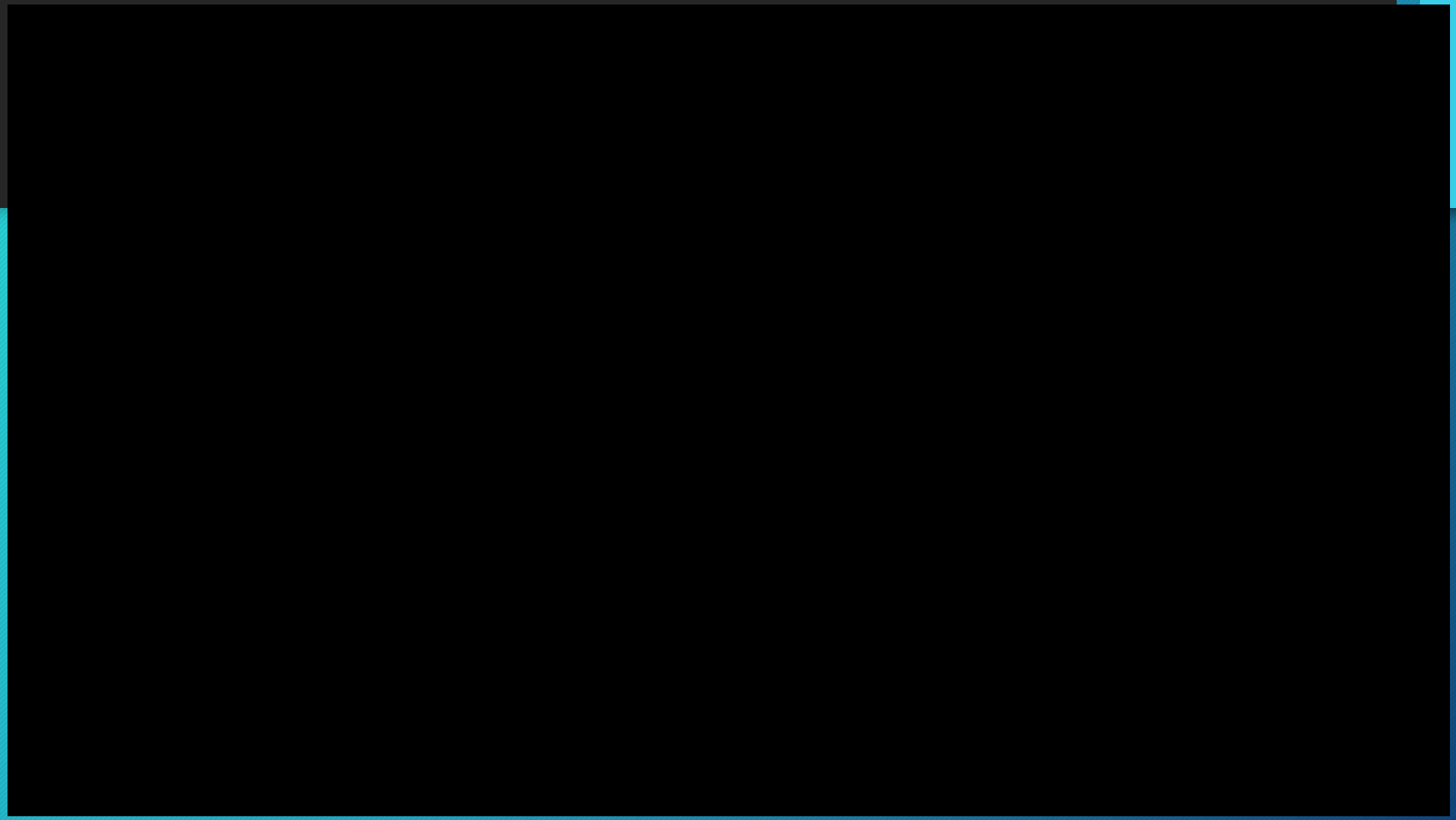
14:00-16:00: Distilled components

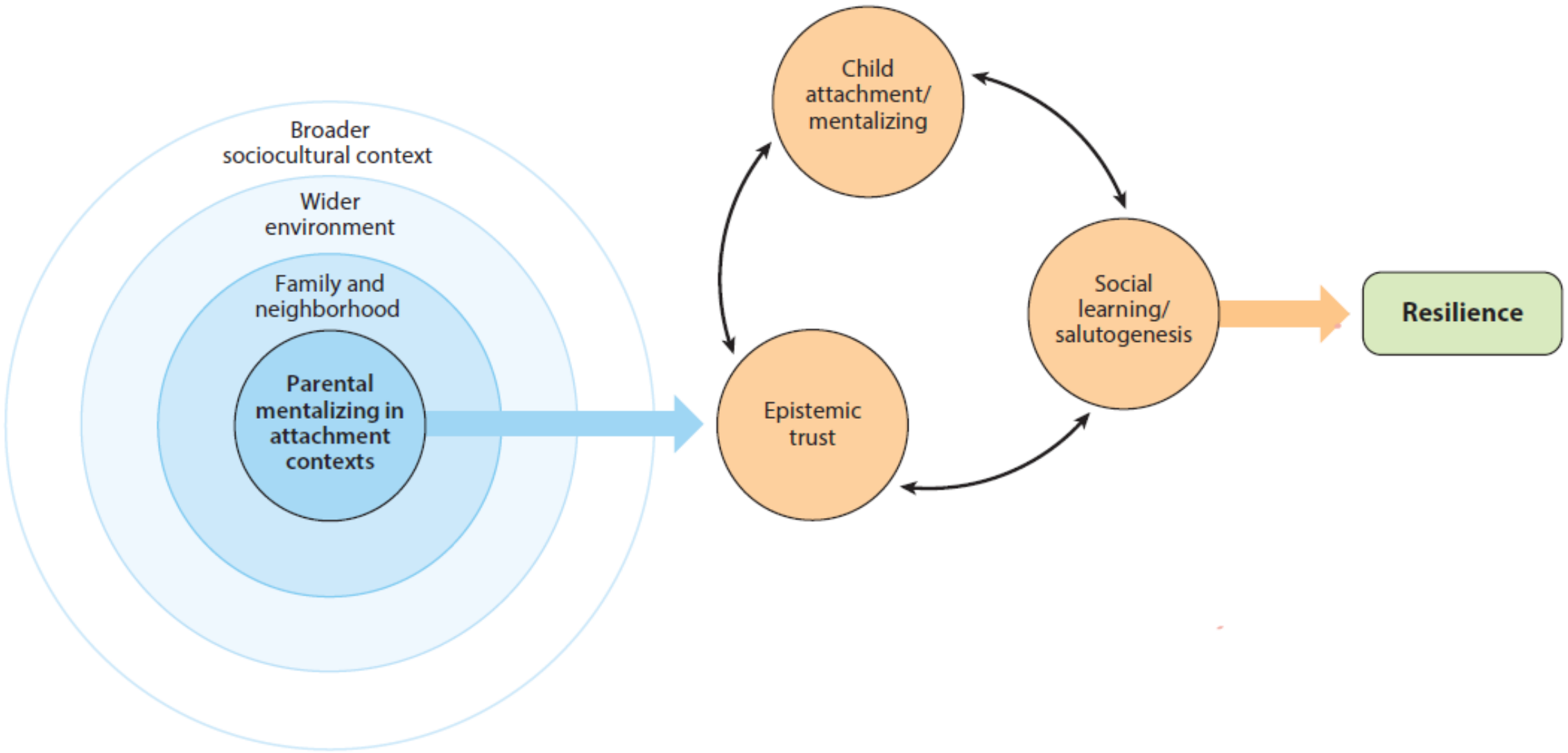
Distilled components


CAMBRIDGE GUIDES TO THE PSYCH
Cambridge Guide
Mentalization-
Treatment (MB
Anthony Bateman | Peter Fonagy |
Patrick Luyten | Martin Debbané
CAMBRIDGE
Medicine
SECOND E
DBT Sk
Trainin
Manua
Marsha M.
Cognitiv
Therapy
Persona
Disorde
THIRD EDIT
edite
Aaron T.
Denise D. D
Arthur Free
SCH
THE
A PRACTI
MARJO
PSYCHODYNAMIC
THERAPY
FOR PERSONALITY PATHOLOGY
TREATING SELF AND INTERPERSONAL
FUNCTIONING
Video
Illustrated
Eve Caligor, M.D.
Otto F. Kernberg, M.D.
John F. Clarkin, Ph.D.
Frank E. Yeomans, M.D., Ph.D

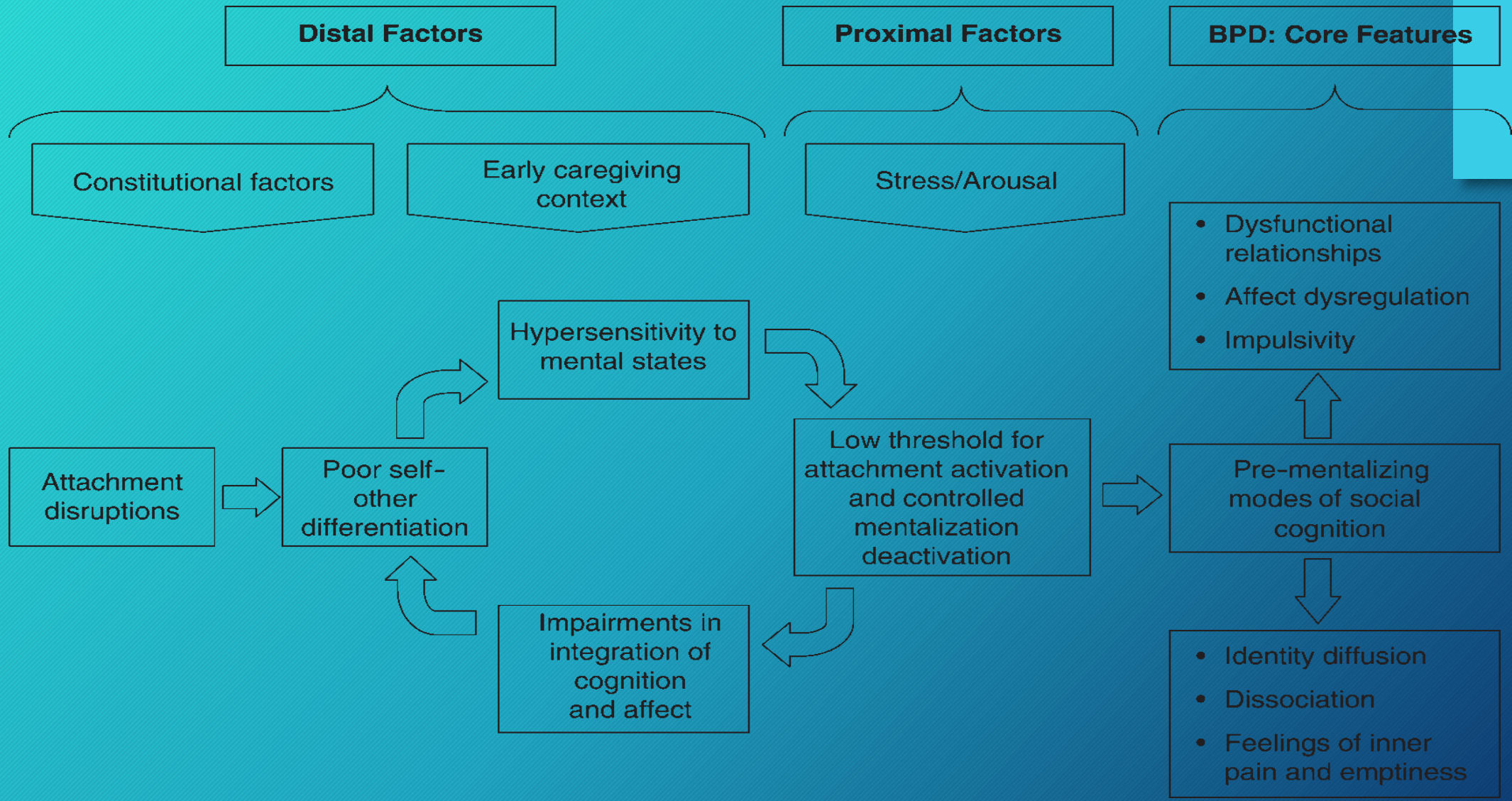
WHEN ADULTS ‘RETURN’ THE CHILD’S ‘SERVE’ WITH A POSITIVE RESPONSE, A ‘RALLY’ IS CREATED.







Luyten & Fonagy, 2020, *ARCP*



Fonagy & Luyten, 2009

Prementalizing Modes of Subjectivity

Psychic equivalence:

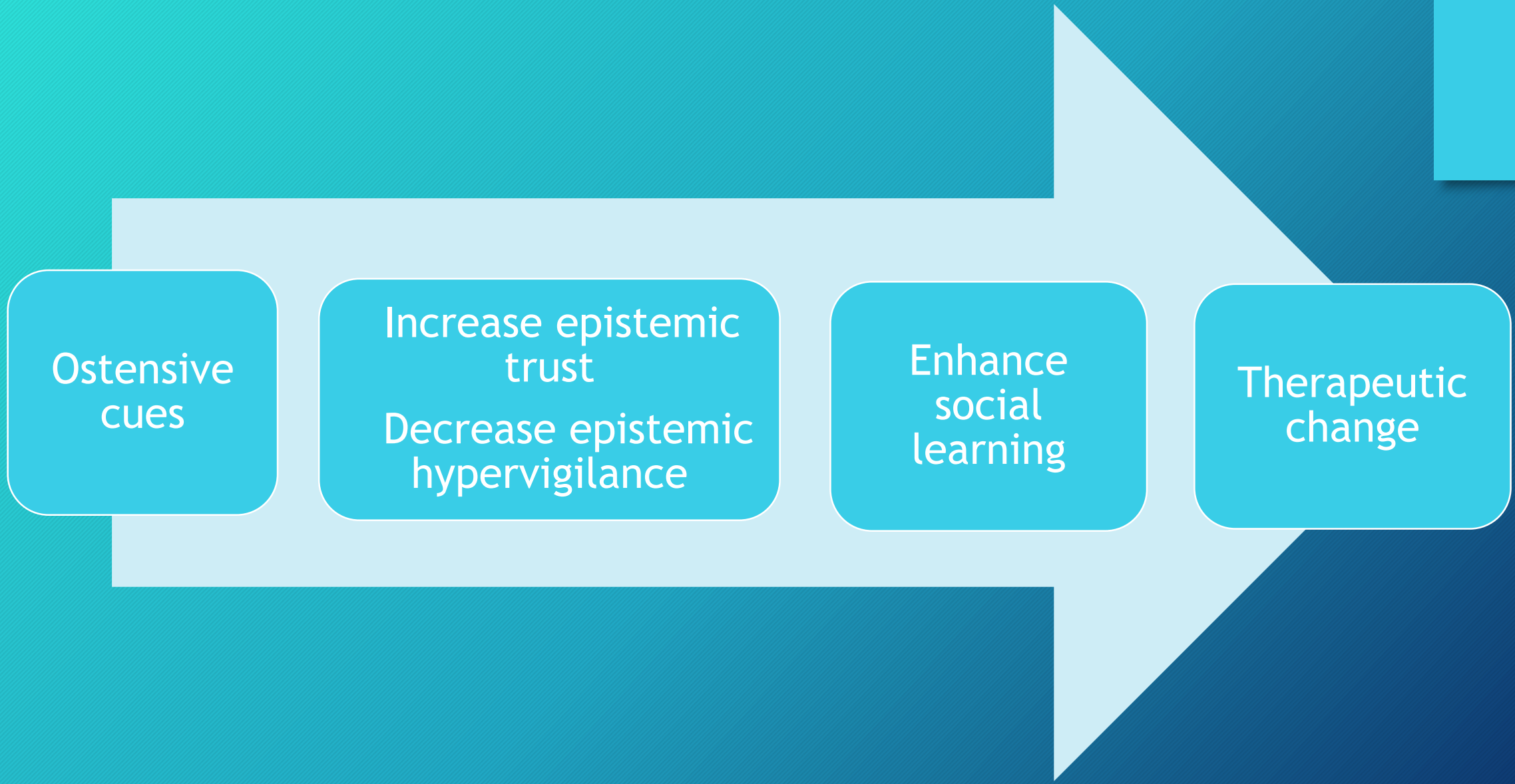
- Because I think it, it is true.
- What is in my mind, is out there in nature.
- My perspective reflects reality.

Pretend mode:

- Using mental state words, but lacks coherence and authenticity.
- Fake it, till it's real
- Because I act like it, it's true

Teleological stance:

- A focus on understanding actions in terms of their physical as opposed to mental constraints
- Cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Absent mind; quick fix thinking
- Only with physical evidence will I believe it.


Ostensive cues
Increase epistemic trust
Decrease epistemic hypervigilance
Enhance social learning
Therapeutic change

Stretch out the serve and return →meaning-making

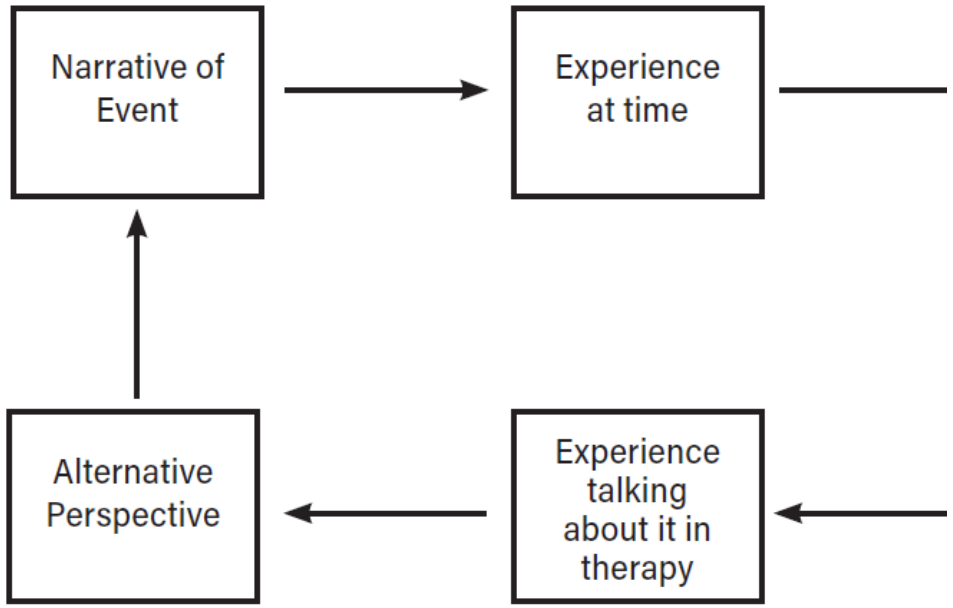
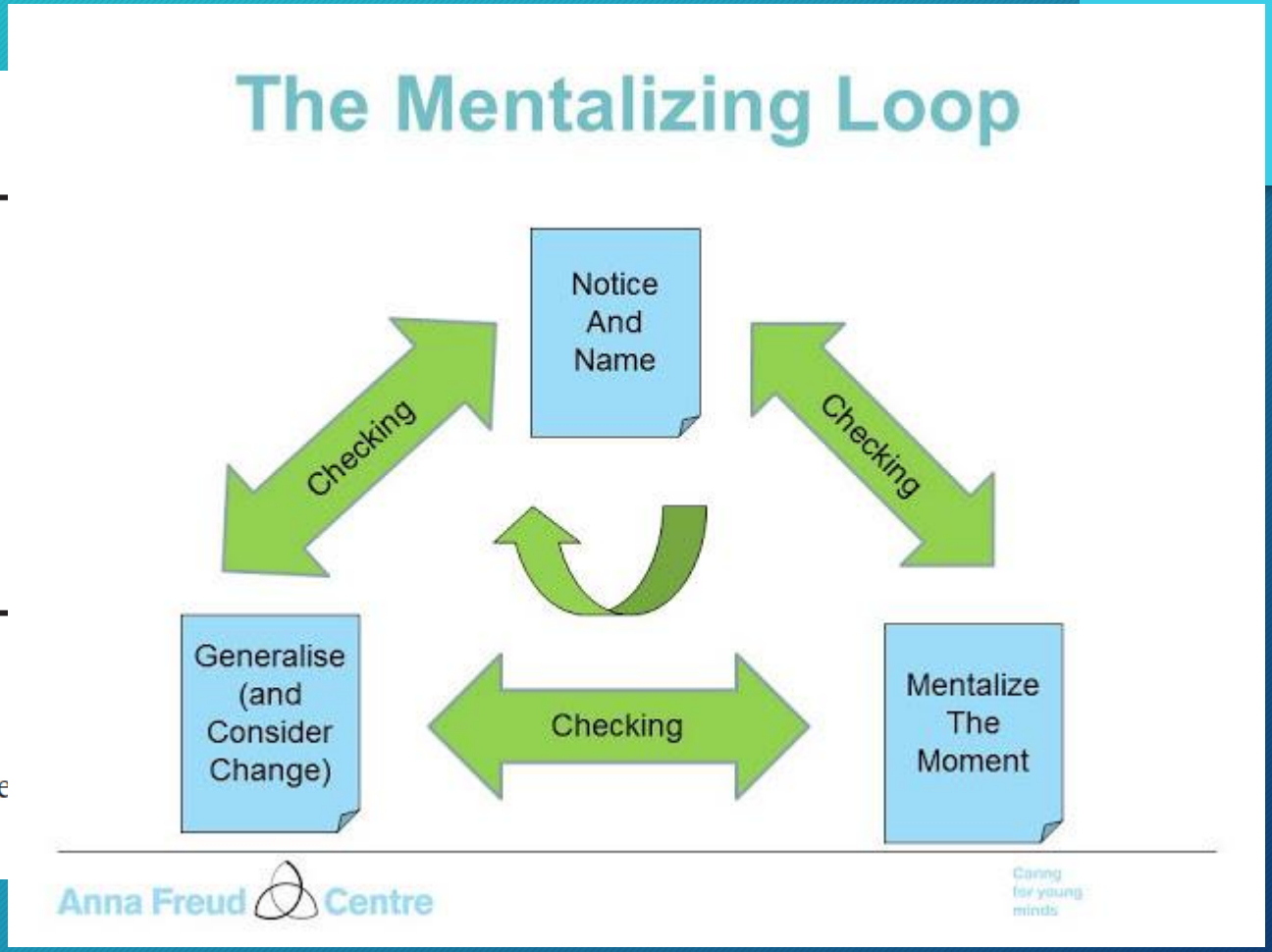


FIGURE 7.1. The mentalizing process to "stretch" out the se
enhances reflective capacity.



But how?

Caregiver mentalizing/parental RF

- All MBTs promote mentalizing as a primary target of intervention.
- Aim is to help parent restore mentalizing especially during moments of high arousal.
- Validation, clarification, exploration, challenge, mentalizing the relationship.
- Maintain mentalizing (not-knowing) stance.
- MBT family/parenting interventions – preschoolers and adolescents:
  - Minding the Baby (Ordway et al., 2014)
  - Reflective Parenting (Etezady & Davis, 2012)
  - Mothering from Inside Out (Suchman et al., 2016)
  - MBT-A for personality disorders (Rossouw & Fonagy, 2012)
  - MBT-A for conduct disorders (Taubner & Thorsten- Christian Gablonski, 2019).
- MBT family/parenting interventions – middle childhood
  - Midley et al. (in press) review

Limitations

- Acceptance of MBT has been slower than that of cognitive-behavior approaches
- Construct described as obscure (Choi-Kain & Gunderson, 2008).
- Too abstract and relying too heavily on expert supervisors that can translate dense psychodynamically-based theory into practice (Hutsebaut, et al., 2012).
- MBT manuals suggest openness, high cognitive flexibility, intellectual humility, low rigidity, adaptability, and high tolerance of uncertainty as key ingredients of the mentalizing stance, but granular-level guidance is not provided to achieve these.

Gaps in mentalizing theory and practice

- Affective components of mz theory and practice well-articulated; while concept of epistemic trust (learning from others) has been introduced, learning components are not well articulated.
- Limited behavioral operationalization.
- Theory and tools are representational and focus on the quality of the narrative
  - Adult Reflective Functioning Scale (Fonagy et al., 1998)
  - Parent Development Interview (Slade et al., 2004)
  - In session RF scale
  - Client Attachment Coding System (Talkia & Miller-Bottome, 2014)
  - MBT Adherence and Competence Scale (Karterud, 2015)
  - Therapist Mental Activity Scale (Ensink et al., 2013)
  - Revisesd MIO/PE Adherence Scale (Suchman et al., 2010)
  - Attachment patterns in therapy (Suchman et al., 2010)
- Need for an approach that is informed by learning and that breaks down mentalizing in observable, granular-level actions.
- → MECHANISMS OF CHANGE

LITERATURE REVIEW

CLINICAL PSYCHOLOGY SCIENCE AND PRACTICE WILEY

Learning to mentalize: A mediational approach for caregivers and therapists

Carla Sharp[1,2] | **Cilly Shohet**[3] | **Deborah Givon**[3] | **Francesca Penner**[1] | **Lochner Marais**[2] | **Peter Fonagy**[4]

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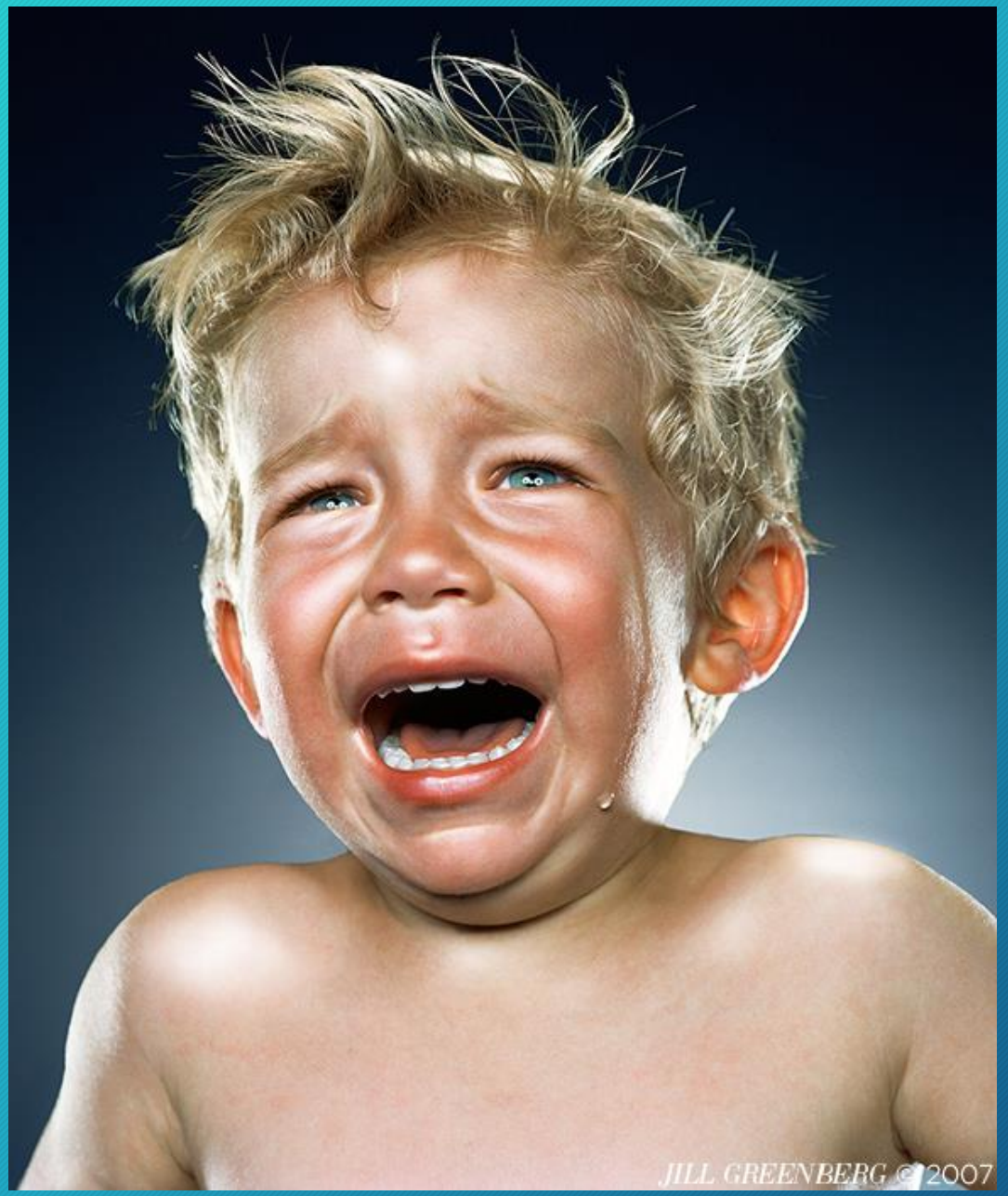
Funding information
Eunice Kennedy Shriver National Institute of Child Health and Human Development, Grant/Award Number: 1R01HD081985 (PI: Sharp)

Abstract

Mentalization-based therapies (MBTs) are rigorous, theoretically grounded, and evidence-based interventions. However, dissemination of this psychodynamic informed intervention lags behind that of more skills-based therapies due to a lack of concrete operationalization of its key components. In this proof-of-concept article, we describe how the learning (mediational) components of an educational intervention, the mediational intervention for sensitizing caregivers, can operationalize key components of MBTs in behaviorally anchored ways. We suggest that the process of the recovery of mentalizing can be operationalized through five learning components: focusing, affecting, expanding, rewarding, and regulating. In operationalizing the process of rebuilding mentalizing using these observable, behaviorally anchored concepts focusing on creating epistemic trust, we hope to increase the accessibility of MBTs to a wider audience.

KEYWORDS

caregivers, mediational intervention, mentalization-based therapy, mentalizing, psychotherapy


JILL GREENBERG © 2007

MISC (Klein, 1996)

The objective:

More **I**ntelligent and **S**ocial (**S**ensitive) **C**hildren

The process:

Mediational **I**ntervention for **S**ensitizing **C**aregivers
(Including parents and teachers, and therapists)

Mediation

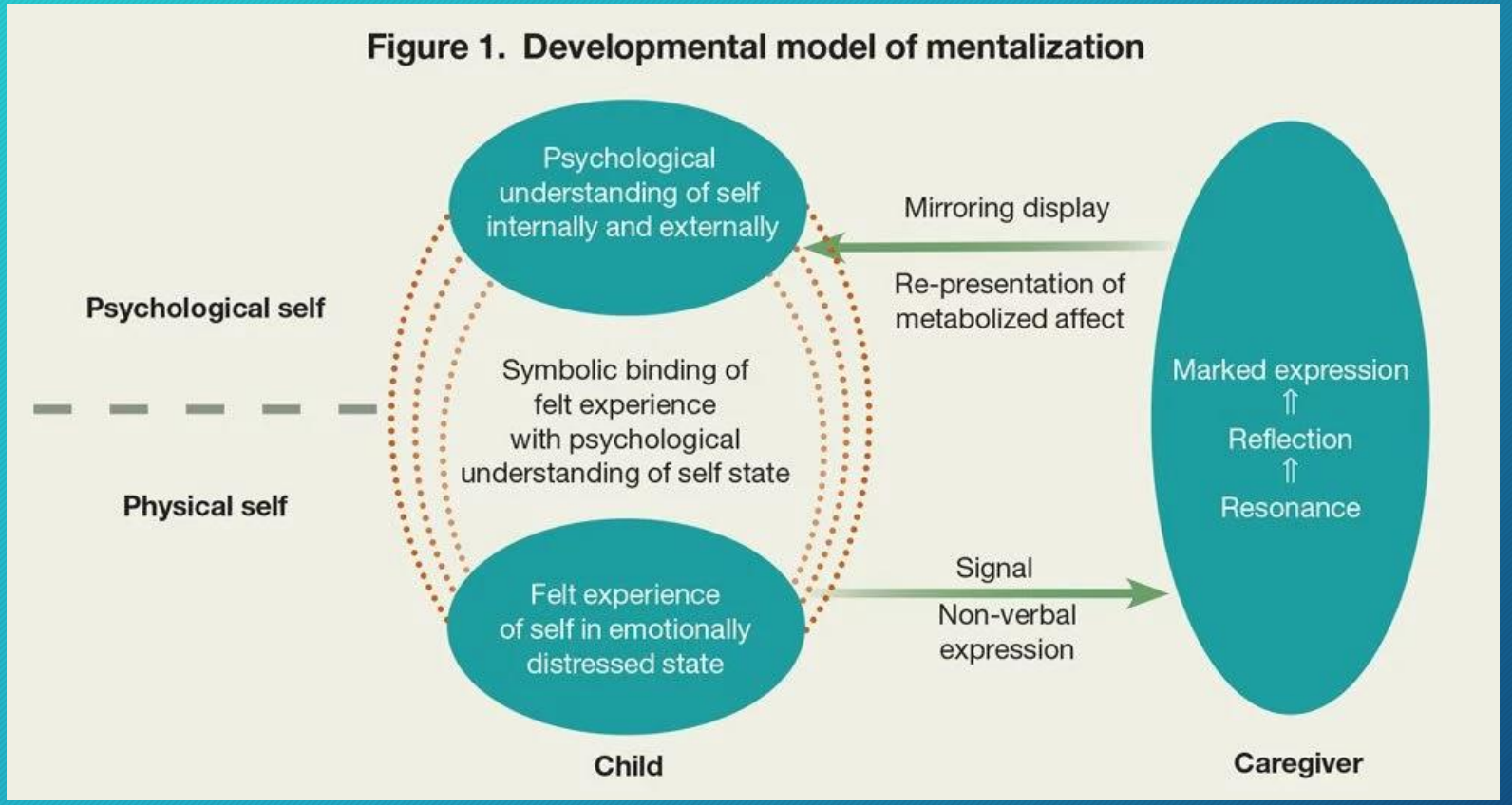
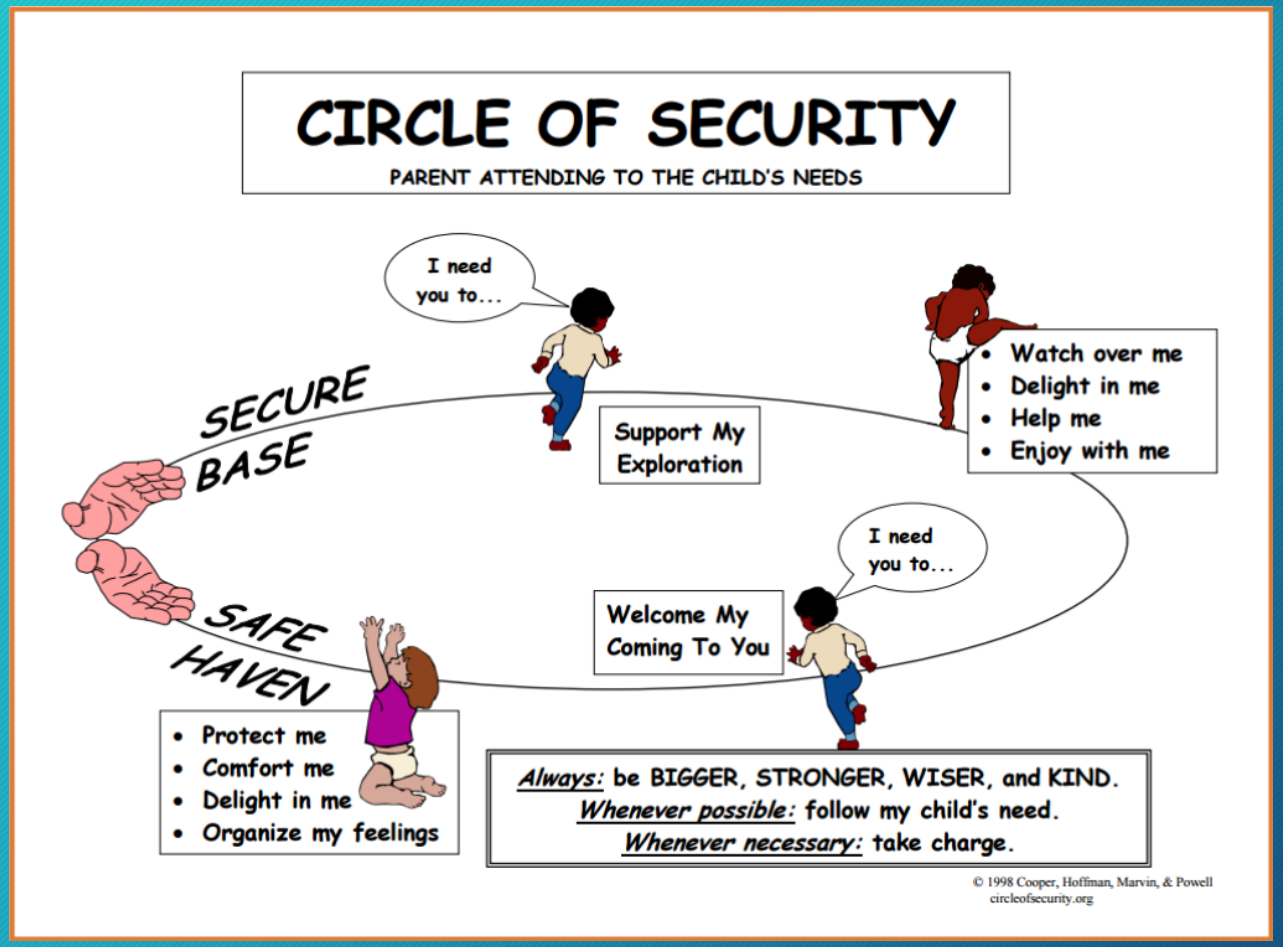


Figure 1. Developmental model of mentalization
Psychological understanding of self internally and externally
Mirroring display
Re-presentation of metabolized affect
Psychological self
Symbolic binding of felt experience with psychological understanding of self state
Marked expression
⇑
Reflection
⇑
Resonance
Physical self
Signal
Non-verbal expression
Felt experience of self in emotionally distressed state
Child
Caregiver

Attachment-based interventions



It's worthwhile to act / I can do
I'm with you / I'm safe
I love you / I'm loved

Basic Messages

Affect

Mutual Attention
Mutual engagement

Empathy
Smiles
Eye Contact
Turn-Taking
Verbal expressions
Physical Closeness
Sharing of Joy
Sensitivity
Containment
Responsiveness

Synchrony

Roots of Emotional Development

Pnina Klein (1996, p. 5)

"In a way, one can say that the affectionate bond between a child and her caregiver opens the gate to the child's mental development, but does not, in itself, determine what will pass through the gate."

Regulating
Rewarding
Expanding
Meaning
Focusing

It's worthwhile to act / I can do
I'm with you / I'm safe
I love you / I'm loved

Basic Elements Of Mediation

Basic Messages

Affect

Mutual Attention
Mutual engagement

Empathy
Smiles
Eye Contact
Turn-Taking
Verbal expressions
Physical Closeness
Sharing of Joy
Sensitivity
Containment
Responsiveness

Synchrony

Roots of Emotional Development

Cognitive (learning/mediational) components

- Focusing (intentionality and reciprocity): any adult act or sequence of acts that appears to be directed towards achieving a change in the child's perception, or response
- Affecting (provision of meaning): the adult names, describes and gives meaning (without interpretation) to the child's experience
- Expanding: An adult's behaviour directed toward the broadening of the child's cognitive and emotional awareness, beyond that which is necessary to satisfy the immediate need that triggered the interaction. Beyond the concrete here and now.
- Rewarding: Any verbal or nonverbal behaviour of an adult that expresses satisfaction with a child's behaviour or identifies specific components of the child's behaviour that the adult considers successful.
- Regulating: The caregiver brings to the child's awareness the possibility of "thinking" before doing, of planning steps of behavior towards attaining a goal.

Regulating
Rewarding
Expanding
Meaning
Focusing

It's worthwhile to act / I can do
I'm with you / I'm safe
I love you / I'm loved

Basic Elements Of Mediation

Basic Messages

Affect

Mutual Attention
Mutual engagement

Empathy
Smiles
Eye Contact
Turn-Taking
Verbal expressions
Physical Closeness
Sharing of Joy
Sensitivity
Containment
Responsiveness

Synchrony

Roots of Emotional Development

MISC

NEEDS

- To have Successful Experiences & to complete tasks
- To search Meaning & Excitement
- To Seek Information Beyond Sensory To Explore, To Ask To Seek Adult Help
- To Seek Clarity of Perception
- To Think Before Doing To Organize & plan

Basic Elements Of Mediation

- Regulating
- Rewarding
- Expanding
- Meaning
- Focusing

Basic Messages

- It's worthwhile to act / I can do
- I'm with you / I'm safe
- I love you / I'm loved

Roots of Emotional Development

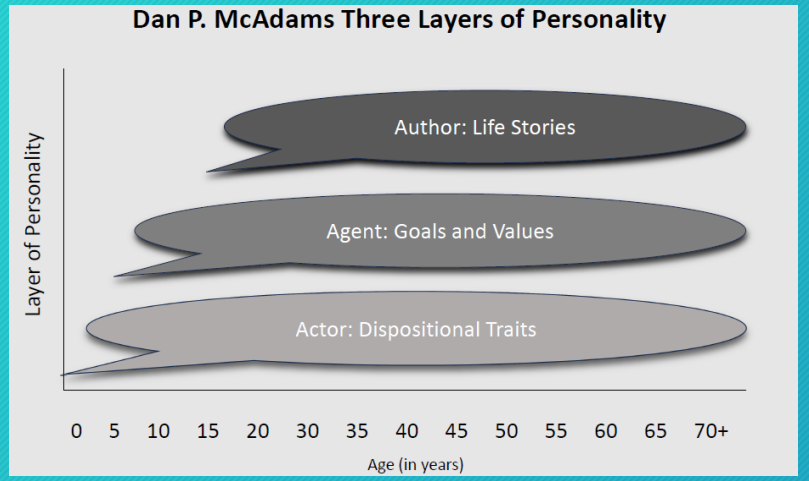
Affect

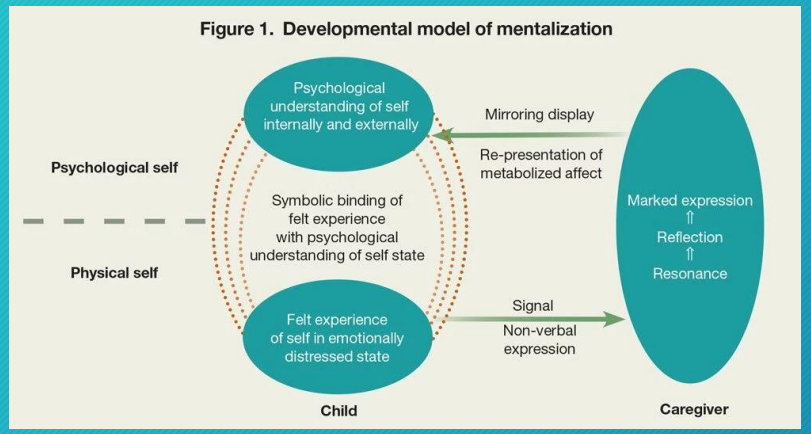
Mutual Attention Mutual engagement

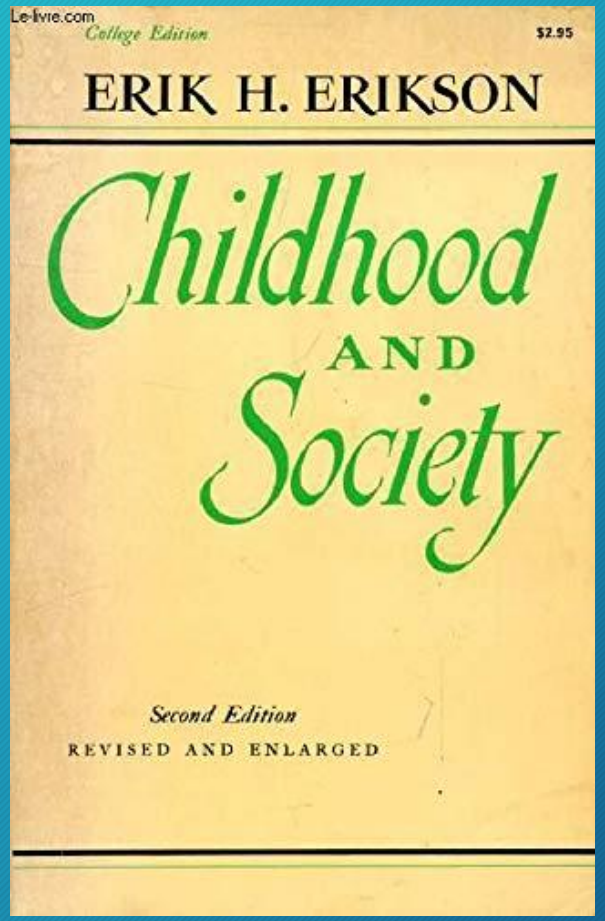
- Empathy
- Smiles
- Eye Contact
- Turn-Taking
- Verbal expressions
- Physical Closeness
- Sharing of Joy
- Sensitivity
- Containment
- Responsiveness

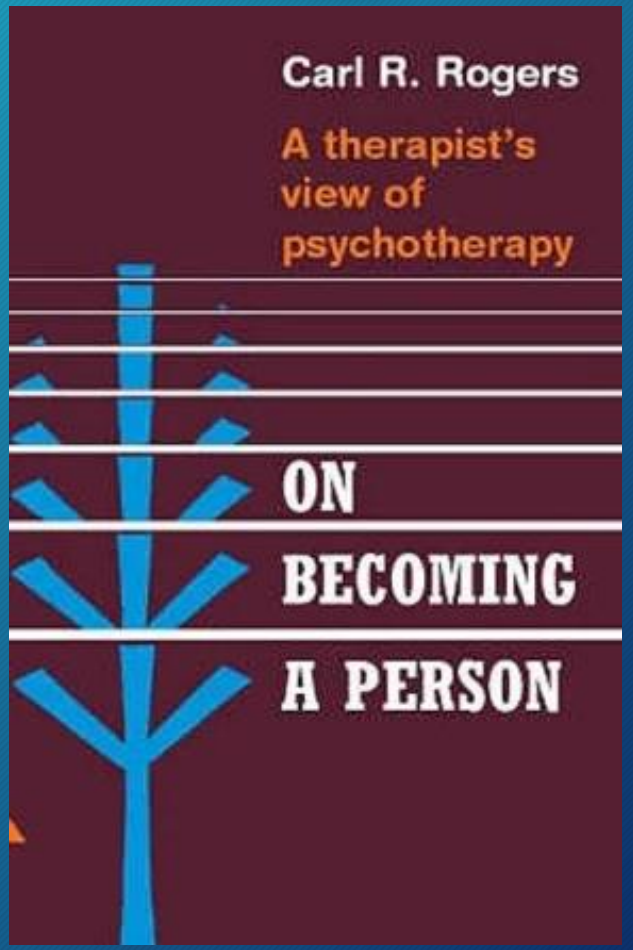
Synchrony

The agentic self









Caregiver-child example: non-MISC

A mother, arriving tired at home after work, finds her 8-year daughter had not completed her homework as previously agreed upon. The mother puts down her bag, sighs, and looks at her daughter, who is sitting in front of the television watching a favorite show. “What?” says her daughter. Mom responds by saying “You know what.” Her daughter appears baffled. Mom sighs again and reminds her daughter in a somewhat exasperated tone that they agreed at school drop-off that the daughter would complete her homework at after-school care. Her daughter explains that she forgot and mom says “Well, that’s not good enough. Go sit down now and do your homework while I start dinner. No buts! Now! Go sit down.” The daughter becomes distressed and says that she wants to finish her show. Mom becomes more exasperated and says “I don’t want to be saddled with your homework after dinner. Do it now! Or no more television for you for the rest of the week.” By now, the daughter is crying and runs off to her room.

How would you change it into a MISC interaction?

Caregiver-child example: MISC

A mother, arriving tired at home after a full day of work, finds that her 8-year-old daughter had not completed her homework as previously agreed upon. She finds her daughter sitting on the couch watching a favorite TV show. She quietly sits down next to her daughter, takes the remote control, and says: "Sarah, can I pause your show for a moment, as I have something important to talk you about?" (*Focusing*). Her daughter says "Yes" and turns to her mom. Her mom, making eye contact, says "I can see you are busy watching your favorite show, but I realize that your homework is still not done and I've been looking forward to reviewing it with you (*Focusing/Affecting*). What about we look at it together to see what still needs to be done and then we can decide how to fit it all in around dinner?" (*Regulating*). Sarah agrees (partly because her show has not been completely switched off and she is agreeing to come up with a plan to get the homework done and not necessarily having to do the homework right now). "Ah!" says her mom (*Affecting*). "Look at this!" (*Focusing*). Your teacher has asked you to do more exercises in fractions (*Affecting—providing meaning*). What do you think about that?" Sarah then says that it's easy to do that. Her mom says "You want to show me how you do it?" (*Focusing*). By now, Sarah is excited about showing her mom how fractions work, and she begins to work on her homework. After the first problem is completed, her mom says "Excellent work—I like how you first think through the problem and then write down your answer" (*Reward with explanation*). Sarah smiles and starts on the next problem. Her mom then says: "It's close to dinner time; do you want to continue on with the fractions while I make dinner and then watch your show after dinner? Or do you want to wait until after dinner to do your homework?" (*Regulating*). Because Sarah is excited by the positive feedback and the thought of completing her homework, she elects to carry on with her homework while her mom cooks dinner.

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Routledge
Taylor & Francis Group

Mediational Intervention for Sensitizing Caregivers to Improve Mental Health Outcomes in Orphaned and Vulnerable Children

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[a]University of Houston; [b]University of the Free State; [c]Bar-Ilan University; [d]Michigan State University

ABSTRACT

Objective: There is an urgent need to equip community-based careworkers with the skills to address the mental health needs of orphans and vulnerable children (OVC) as an essential response to shortages in human resources for mental health in Sub-Saharan Africa. We conducted a quasi-experimental feasibility trial in South Africa to adapt and evaluate an established year-long semi-structured, manualized video-feedback caregiver intervention (the Mediational Intervention for Sensitizing Caregivers; MISC) for community-based organizations (CBOs).

Methods: Following a year-long iterative cross-cultural adaptation of MISC, we recruited 88 OVC (ages 7–11; 45.5% girls) and their CBO careworkers ($N = 18$; 94.4% female). Two CBOs (45 children; 9 CBO careworkers) received 12 months of MISC, and two CBOs (43 children; 9 CBO careworkers) received treatment as usual. Child mental health and quality of caregiving were assessed at 6 months into the intervention and at completion through multi-informant questionnaires and video-recordings of careworker-child interactions. Qualitative interviews were conducted to evaluate feasibility and acceptability.

Results: MISC-CBO was acceptable and feasible in terms of attendance and post-intervention interviews. MISC improved child mental health, as well as the quality of careworker caregiving in terms of interactive effects for affective and cognitive (Expanding) components of MISC, and main effects for the cognitive components of Rewarding and Provision of meaning. MISC components did not mediate the effects of the intervention.

Conclusions: The current study shows that laypersons with no tertiary education and virtually no prior training who undergo MISC training can improve caregiving quality and the mental health of OVCs.

The setting

- Globally 16 million orphans and vulnerable children (OVC)
- South Africa: 1.9-3.7 million OVC.
- Attachment disruption.
- High mental health needs.
- Community-based organizations as strategic point of intervention.
- Lack of training and resources.

Two CBO careworkers with an orphan at a CBO in Mangaung

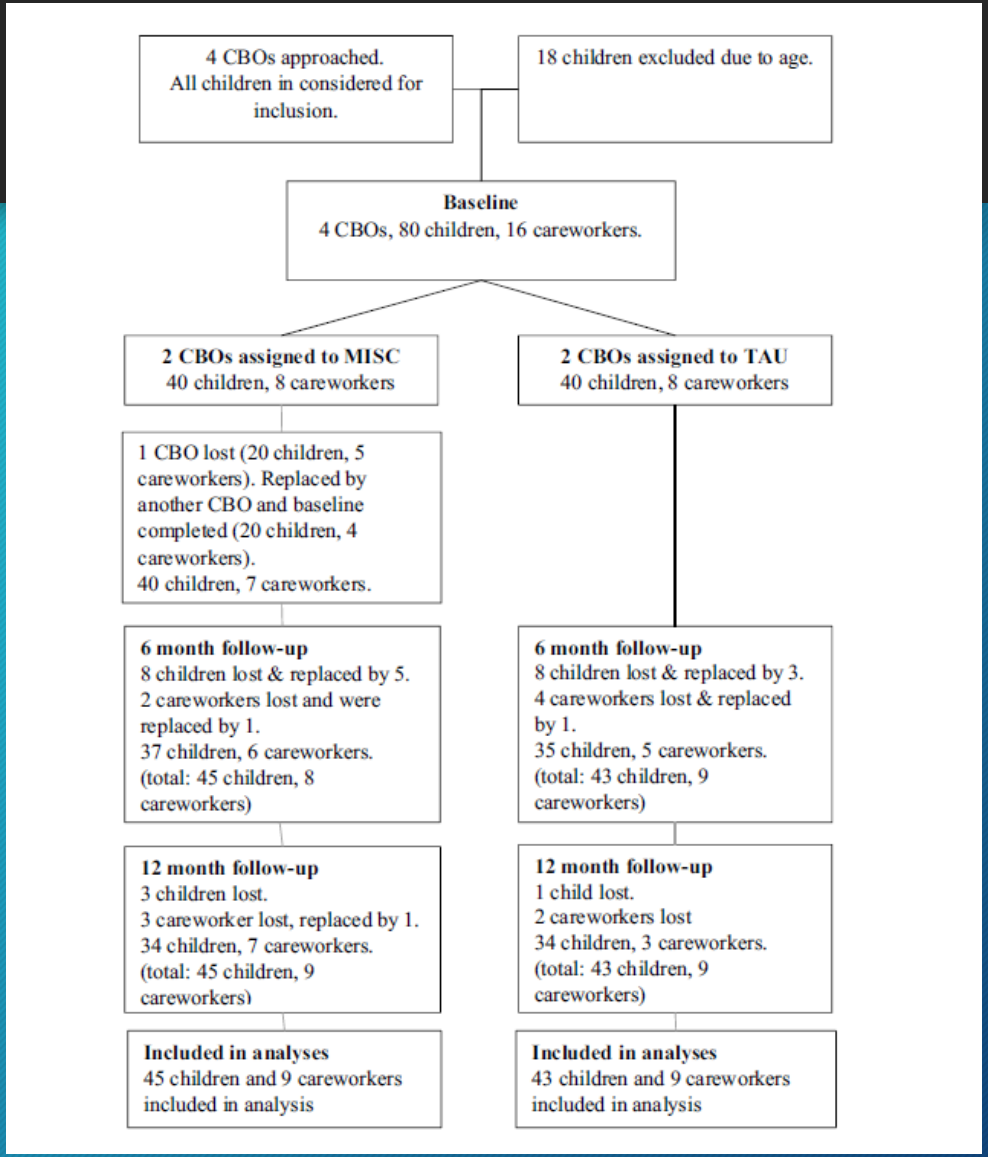
Intervention needed

- Designed for low resource settings.
- Developmentally transportable.
- Culturally transportable.
- Must address both cognitive developmental and mental health needs.
- An intervention that transcends culture, setting and stage to tap into the basic mechanism that sustains meaningful relationships

Study phases

1)Feasibility and acceptability

2)Implementation and outcome assessment



Feasibility and acceptability

- Careworkers understood MISC components
  - “I feel that I truly now know how to reward and touch. I make sure that the children do not get bored during our interactions. I give them affect. I also use eye contact to see if they understand”.
  - “With the MISC training, I know I have to be sensitive in how I do things with the children. I have to do things intentionally. If I want to make a child focus, I need to do this intentionally”
  - “It taught me being in the children’s shoes or a person who can act on behalf of a child”
  - “We are now more aware of the children’s emotions. The children feel more welcome at the center”.
- MISC was deemed feasible with regard to several characteristics.
  - “It was easy because MISC was part of our daily work”
  - “So we didn’t have extra costs as an organization to say we’re gonna spend over, on this. We did not need anything extra for the MISC”
  - “And even these videos, you get scared you understand . . . but as time went on, I ended up seeing myself being okay feeling free to act naturally”
- Functions of the MISC trainer
  - “The trainer let you talk when there was a problem, or if you did not quite understand”
  - “I would ask, may I please speak about something that challenges me in this and that. She was able to listen attentively”
  - “When we talked I would be free. She supported me and cared”

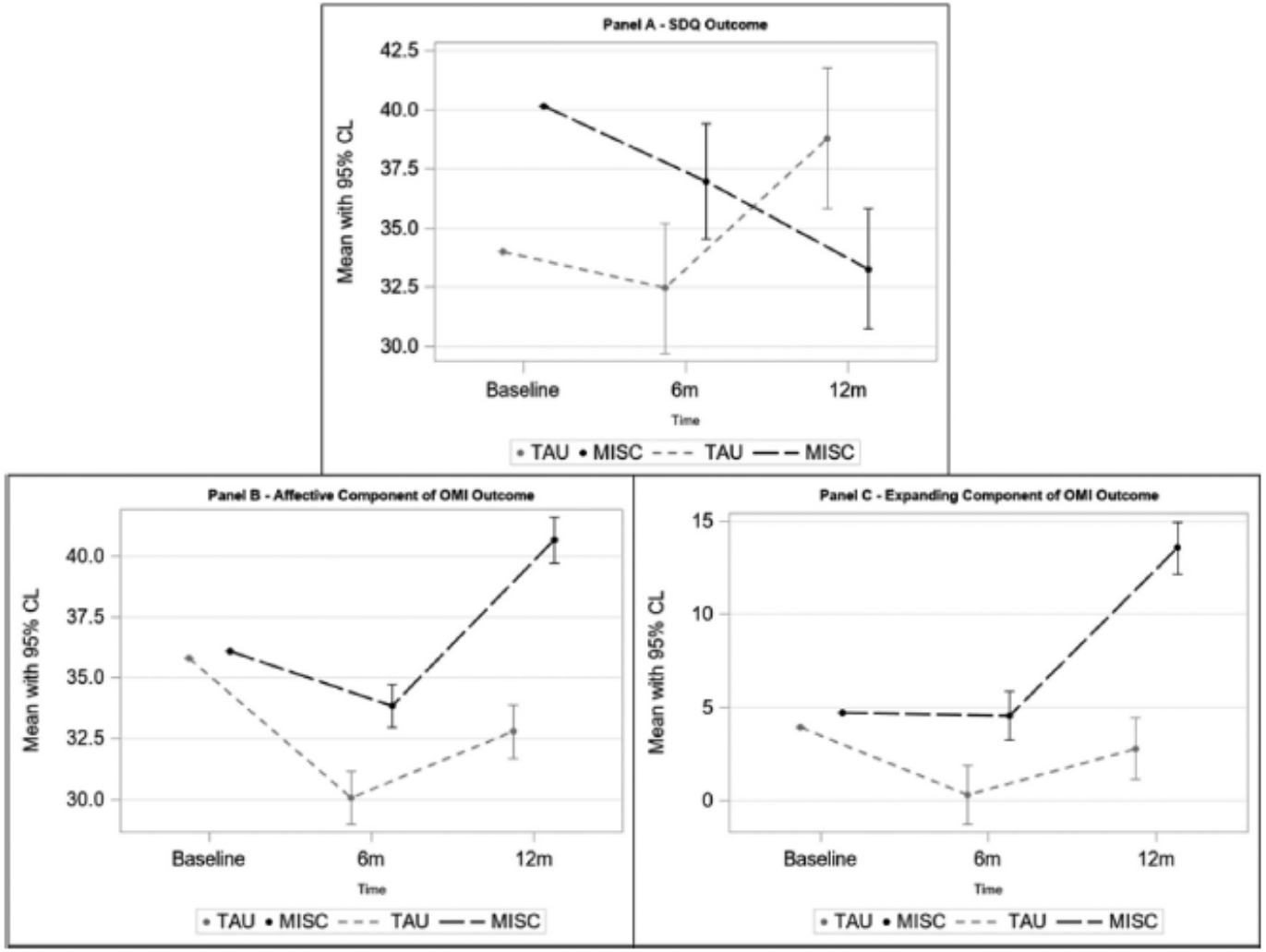


Figure 3. Effect of MISC vs. TAU on child mental health and caregiving quality. Panels A through C represent line plots depicting interactions of MISC and post-baseline timepoints for (A) SDQ outcome, (B) Affective components of OMI outcome, and (C) Expanding component of OMI outcome. Please note that the 6 m and 12 m means are adjusted (conditional on covariates in the estimated models) while the baseline mean is unadjusted. Error bars for the baseline means are therefore not included as they inaccurately present variability in the data due to their unadjusted nature.

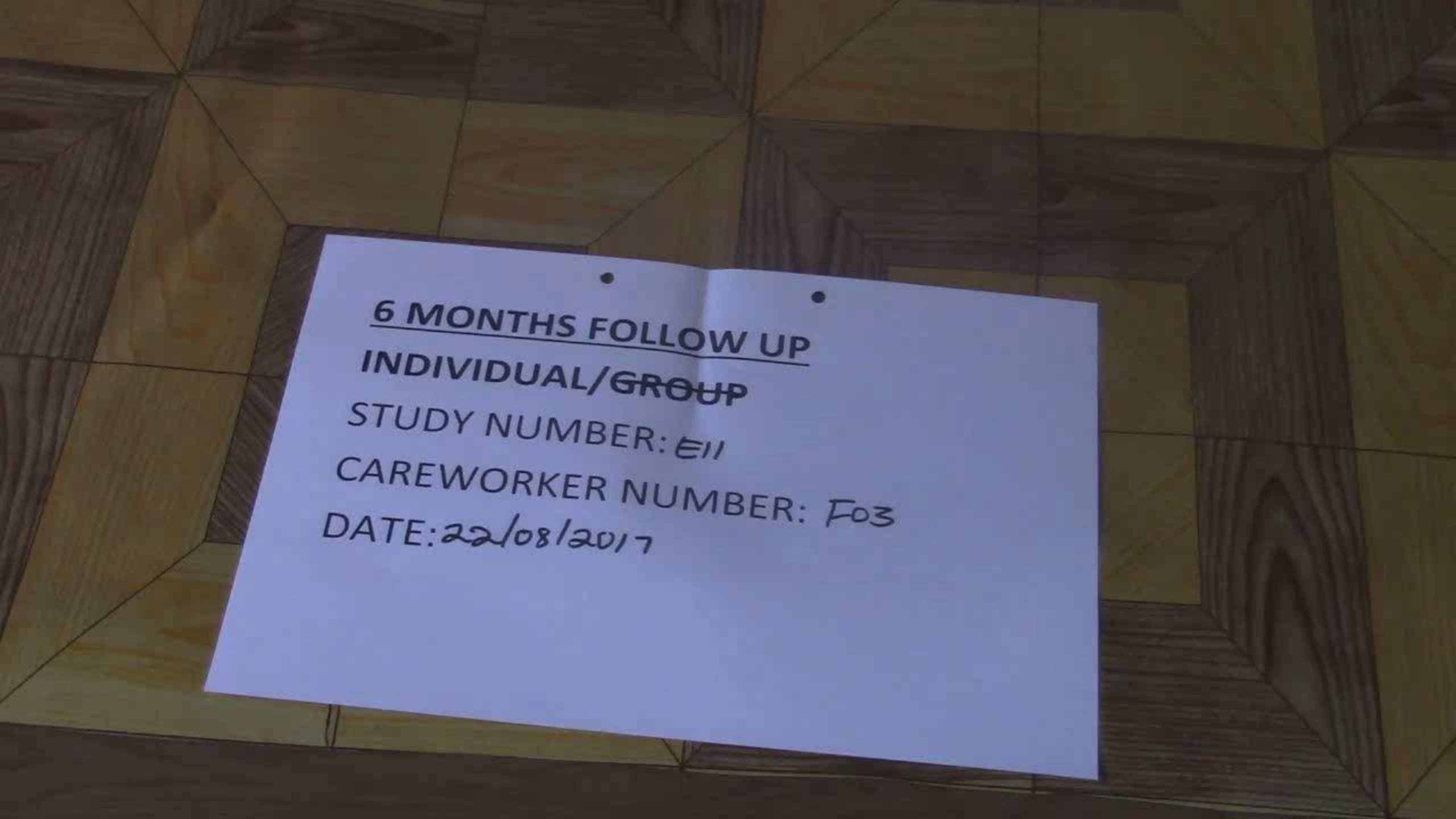
BASELINE

INDIVIDUAL/~~GROUP~~

STUDY NUMBER: E11

CAREWORKER NUMBER: F03

DATE: 15/05/2017


6 MONTHS FOLLOW UP
INDIVIDUAL/~~GROUP~~
STUDY NUMBER: E11
CAREWORKER NUMBER: F03
DATE: 22/08/2017

1 YEAR FOLLOW-UP

INDIVIDUAL/~~GROUP~~

STUDY NUMBER: E11

CAREWORKER NUMBER: F03

DATE: 07/05/2018

Emotional components

ID:

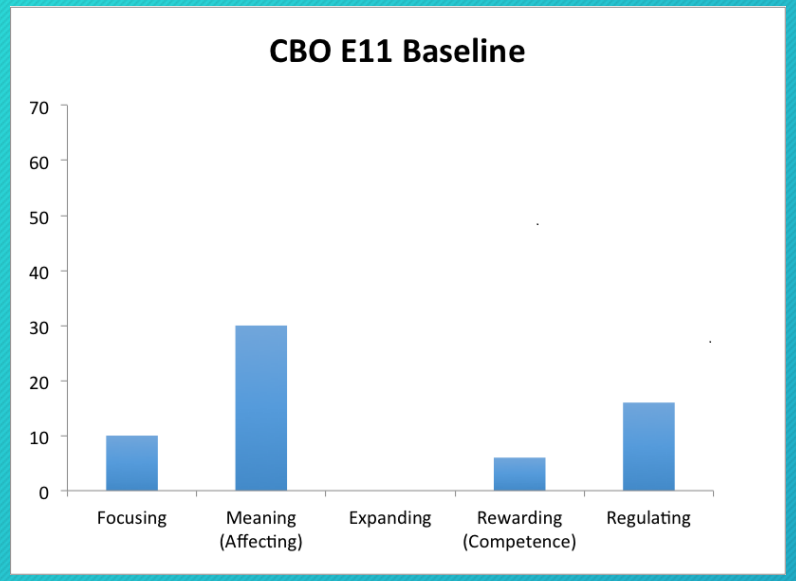
COMPONENT	SCORE
Smiles (1-5)	
Physical closeness (1-5)	
Touch (1-5)	
Eye contact (1-5)	
Turn taking (1-5)	
Verbal expressions (1-5)	
Sharing of joy (1- absent, 2-present)	
Mutual attention (1-5)	
Mutual engagement (1-5)	
Sensitivity and responsiveness (1-3)	
Empathy (1-5)	
Containment (1- absent, 2-present)	
Synchrony (1-5)	
Validation (paraphrasing) (1- absent, 2-present)	
Adult's affect (1-5)	
Child's affect (1-5)	
Dyad's affect (1-5)	
SUM	
# SCORED	
AVERAGE	

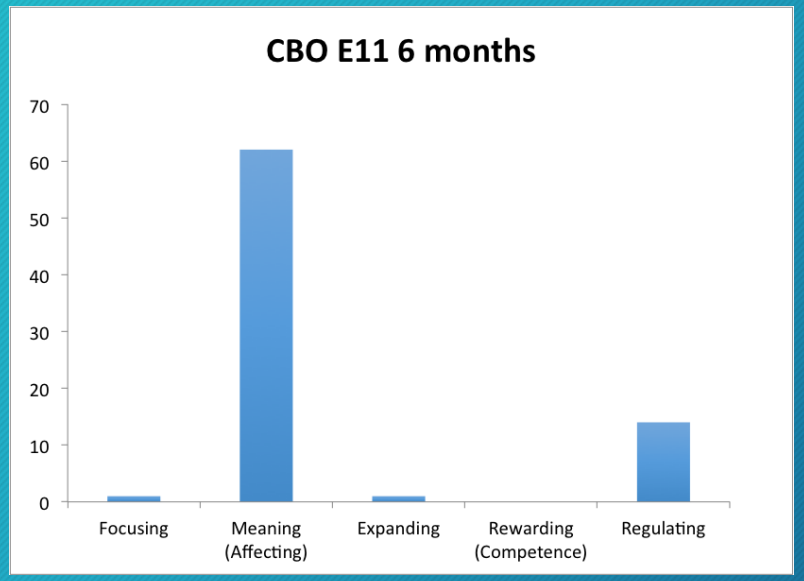
Cognitive components

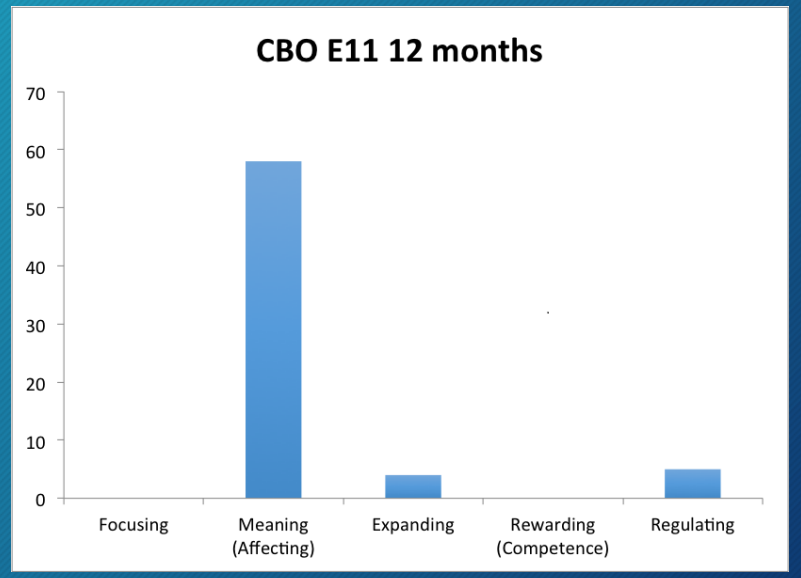
		Provision		Request		
		Initiation (PI)	Response (PR)	Initiation (RI)	Response (RR)	
Focusing (intentionality & reciprocity)						
Verbal	F1					
Nonverbal	F2					
Combined (F1 +F2)	F3					
Misses	MF					
Meaning (Affecting)						
Verbal	A1					
Nonverbal	A2					
Combined (A1 + A2)	A3					
Misses	MA					
Expanding						
Content of specific experience	E1					
Clarifying processes	E2					
Cause and effect	E3					
Comparison	E4					
General rules	E5					
Other	E6					
Misses	ME					

		Provision		Request		
		Initiation (PI)	Response (PR)	Initiation (RI)	Response (RR)	
Rewarding (competence)						
With no explanation	C1					
With explanation	C2					
Modification of situation to allow success	C3					
Misses	MC					
Regulating Behavior						
In relation to time or space	R1					
Sequencing of steps	R2					
Matching ability to task requirements	R3					
Other	R4					
Demonstration	R5					
Instructions	R6					
Misses	MR					

Observing Mediational Interaction (OMI)

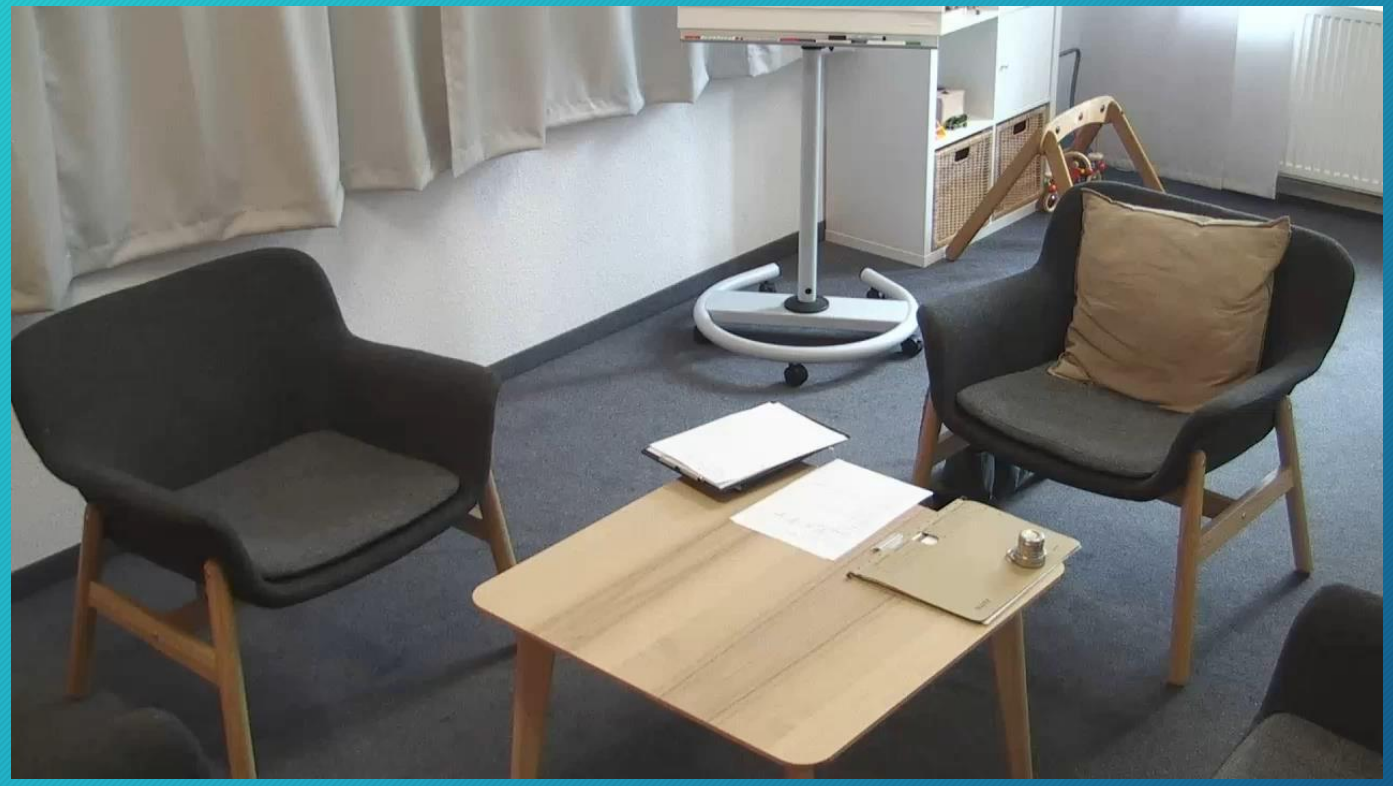






Training the trainer – caseworkers MISC-IPV

Training the trainer - psychotherapy



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CLINICAL CASE REPORT

WILEY

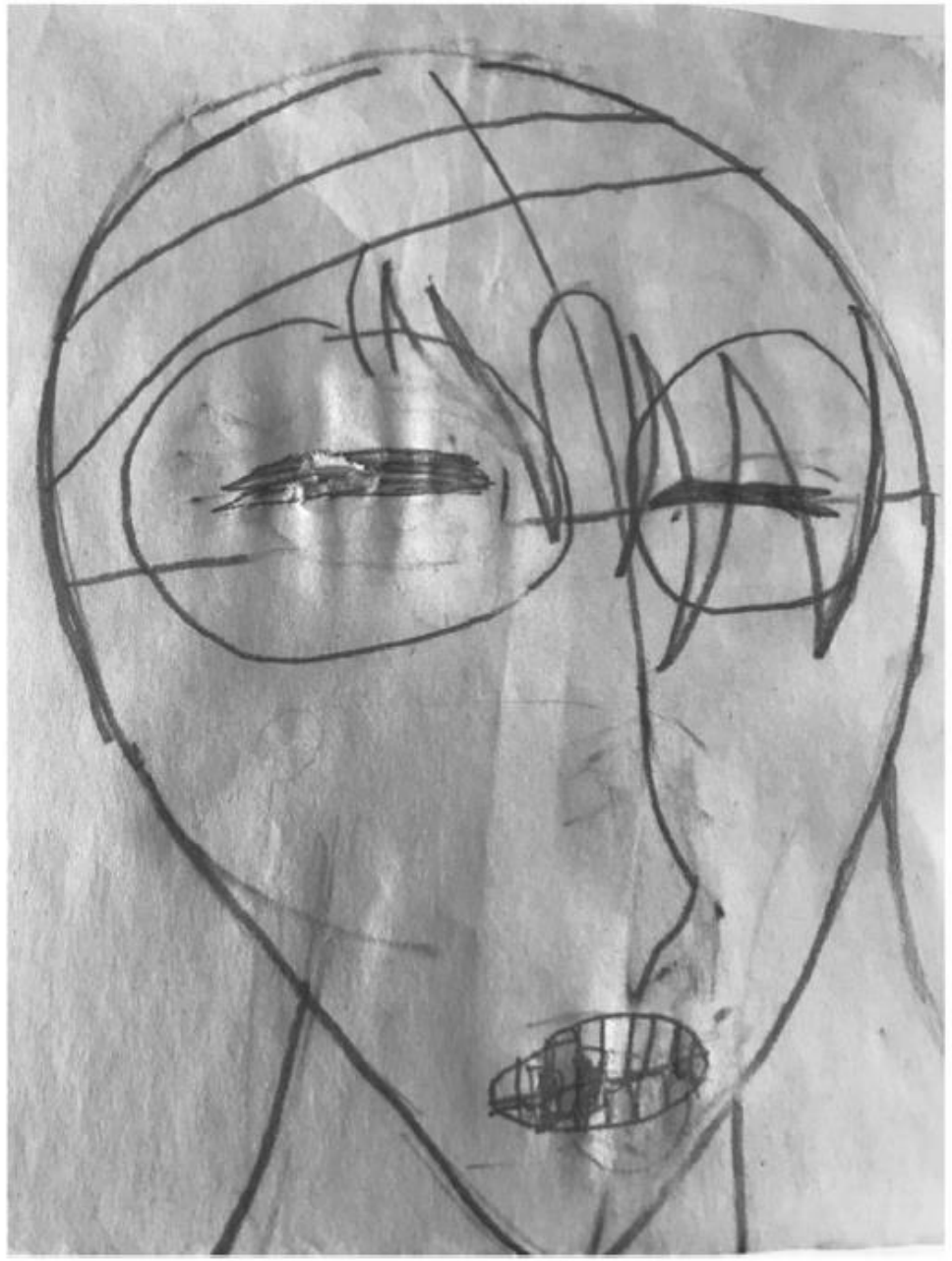
Enhancing the capacity for optimal social and personality function through the mediational intervention for sensitizing caregivers: A case illustration

Carla Sharp[1,2]

Presenting problem

The school teacher reported that the only way Sara stands out from the other children is her “very big emotions,” and that Sara is more sensitive than other children. Thus, if she ever gets teased, even gently, she will retreat. Sara also reported that sometimes she feels like she wants to die; this appeared to be isolated to incidents of bullying at school (e.g., another student saying, “you don't belong here,”“you're not like the others,”“you have different color skin”).

Sara reported that she went to her mother when she felt sad; Sara said that her mother was good at making her feel better and reassured her that she was “great in her own way.” While discussing difficulties, Sara became withdrawn and quiet; she turned to her sketch book during this time and drew what she said was a zombie. Furthermore, during a structured interview about her family (discussed below), Sara became so with-drawn that the assessor took a break from the interview to allow Sara to see her mother; Sara climbed straight into her mother's lap and curled up, hugging her.



Mentalization-based formulation

Sara's problems are best understood as avoidance of real-time emotions in an attempt to manage intense feelings of rejection in her family despite significant efforts on the part of the family to include her. Repeated inability to remain in contact with subjective experiences of anger, disappointment and rejection, combined with emotions to cover or distract her from her painful loneliness are exacerbated by her mother's reciprocal avoidance strategies characterized by pseudomentalizing (trying to sound empathic but not really feeling it), and/or engagement in these emotions in an overcontrolled fashion; in addition to her father and siblings' concrete avoidance of all interaction with her. Together, these maladaptive family mentalizing processes failed to provide the necessary scaffolding for creating an environment where Sara can practice the "serve-and-return" impeding her ability to connect with attachment figures in her family, and leading to significant social isolation outside the home.

Aging into adolescence, it was essential to find ways of scaffolding the serve-and-return between Sara and her family to provide an optimal "laboratory" for interrupting her social isolation, and learning adaptive self and interpersonal function—in MISC terms: to build interaction literacy in service of building a functional personality structure.

The first video

- *Therapist*: So where is Sara sitting in the car?
- *Gillian:* She is behind me…. I know… it's terrible – but there wasn't really another interaction that was easy to video; and I'm seldom alone with her so this was the best I could do.
- *Therapist*: So are you able to see her face in the rearview mirror?
- *Gillian*: No because I'm keeping my eye mostly on the road.
- *Therapist*: Can she see a bit of your face in the rearview mirror?
- *Gillian*: I'm not sure….
- *Therapist*: So I'm wondering what the effect of it may be when you are not able to see each others' faces?
- *Gillian*: Hmmm….yes…. I guess we miss a lot.
- *Therapist*: Like a lot of information gets lost?
- *Gillian:* Yes – I guess it's not the best way to talk about things.
- *Therapist*: What would work better? And is that even feasible? Things sound pretty hectic with all three the children's schedules.
- *Gillian*: But I guess for this to work we need to have a better interaction where we can see what is happening.
- *Therapist*: Yes, I would say try to get a video where we can see you both in the same frame, your faces visible so we can read your emotions and not just hear your voices.

The second video

- *Therapist*: Can I pause the video for a moment? I would like us to focus here for a moment (*focusing*). What is going on there with Sara? (*request for meaning*).
- *Gillian*: She is folding the paper but she is doing it wrong.
- *Therapist*: Look at her face (*focusing*). What do you think she is thinking here? (*request for meaning*).
- *Gillian*: Well she is looking at what her sister is doing because she is doing it wrong.
- *Therapist*: I'm trying to think what she might be feeling in that moment (*request for meaning*).
- *Gillian*: She looks a bit sheepish. Is she feeling ashamed? Her sister always gets everything perfect and she does everything wrong.
- *Therapist*: I don't know… well let's see what happens next.

The second video

At this point Sara gets up and turns up the music, which had been playing in the background. She moves almost out of the frame of the video and begins dancing and laughing. Gillian looks annoyed and a bit embarrassed and the other children look confused.

- *Gillian*: Yes… this happens a lot. We cannot finish anything. She just starts dancing and loses interest.
- *Therapist:* So what do you think that was all about? (*request for meaning*)
- *Gillian*: I don't know…. She struggled with the task and then just sort of gave up?
- *Therapist*: Let's rewind again. I want to look at her face again. (Therapist rewinds.) Look there (*focusing*)…
- Gillian: Look! She is looking at me for a split second. Almost as if asking for help.
- Therapist: Oh wow – yes – well spotted! (*rewardin*g).
- *Gillian*: I did not notice that before. I guess if I saw it I could have helped her with the folding. I can see it in the video now, but in the moment I did not.
- *Therapist:* That's tough though because you are with all three of them while doing your craft yourself. What are your options? (*request for regulation*)
- *Gillian*: True – but I think I miss things with her and then she just avoids the task and us and does something different.

The third video

- *Gillian:* Come sit closer (*affective component*). Tell me what's up (*focusing/request for meaning*).
- *Sara* (moves closer to her mom on the bed). I don't want to go to bed.
- *Gillian*: So what is that about? (*request for meaning*).
- *Sara*: Just don't wanna go.
- At this point Sara's younger brother comes into the room and says that he needs to brush his teeth.
- *Gillian*: Peter, you go ahead and brush your teeth. I'll be here a little while longer with Sara. (Gillian turns to Sara making eye contact – *affective component*). Sorry…. You said you just don't want to go to bed? (*request for meaning*).
- *Sara*: I can't fall asleep.
- *Gillian*: Hmmm… that's tough, right? What happens when you try? (*request for expansion*).
- *Sara*: My thoughts just keep going.
- *Gillian*: Oh boy… ok… that *is* tough! How to get one's thoughts to stop?… that is tricky (*request for expansion*).
- *Sara*: I could try to count sheep (giggles).
- *Gillian*: Certainly… what else (*request for regulation*).
- *Sara*: Maybe think of something nice like the beach…perhaps I can call you if it does not work?
- *Gillian*: I like how you are coming up with a whole bunch of things! (*rewarding*). You certainly can call me – you think it would help knowing that you can? (*request for expansion*)
- *Sara:* Yes.

Reflection

- Value of MISC is in breaking down interactions into granular-level observable interactions (“the next action”).
- It offers MBT a critical set of specific methods to optimize communication between the therapist and client (and caregiver and child) in the interest of establishing the therapeutic situation as a learning experience that requires the generation of epistemic trust. MISC is implicitly focused on establishing the communicator (caregiver) as reputable and obliges the communicator to regard the interaction partner as a similarly valid, competent, and interesting agent, which opens a collaborative teaching–learning relationship between the two parties (Sharp et al., 2020).
- Its components slow down the interaction so that the “next action” can be contemplated and its impact on self and other reflectively considered, thereby scaffolding the development of a representational (psychological) self in service of optimal personality development. Optimal personality development, in turn, facilitates the individual's capacity for making use of the social environment beyond the attachment dyad for further social learning and connectedness.

Therapy session – early

- Client: I'm just so frustrated! I'm not sure how to deal with this anymore. It is driving me nuts and I'm about to just give up! It's always the same. I can't take it anymore. I'm just…
- Therapist: Hang on there, Sara. Can you slow down for a moment? I can see this is really important for you, but I have trouble keeping up. (*Focusing*)
- Client: OK. Sorry. I was going too fast. Let me walk you through it again. As I said, Jack phoned me yesterday. I've told him a million times not to do that to me. Like that time last week…
- Therapist: Hang on a second (*Focusing*). Let me get a clear picture in my mind. You were home and Jack called? (*Request for meaning*).
- Client: Yes, he called.
- Therapist: And something he said made you feel frustrated? (*Request for meaning*)
- Client: Yes, he said he can't see me on Saturday. We've planned this for weeks and now I'm so angry because he always does this to me and I'm sick of it.
- Therapist: Let's just stay for a moment with the phone call—I'm still trying to get a clear picture in my mind—is that alright? (*Focusing*). Sounds like you planned something important for Saturday night and Jack cancelled on you? (*Request for meaning*).

Therapy session – when more regulated

- Therapist: So if I get his right, you planned a party to introduce Jack to your friends. This is the fourth time you've tried to do this and he keeps cancelling on you (*Provision of meaning*).
- Client: Yes!
- Therapist: I can totally see how this might be frustrating (*Rewarding and Provision of meaning*). I would be frustrated too (*Expansion*). But I'm also thinking if I were in your situation, I might have felt a bit hurt? (*Request for expansion*).
- Client: I do actually.
- Therapist: And what do you think that might be about? (*Request for expa*nsion)
- Client: It's like he doesn't want to acknowledge me in public as his girlfriend.
- Therapist: Do you think that is what he might be thinking? (*Request for expansion*)
- Client: Yes…
- Therapist: Is that something he said in the past? (*Request for expansion*)
- Client: No, he has not said that in so many words… but I know it's true!
- Therapist: Can you tell me more about that… you sound very certain of it? (*Request for expansion*).

Therapy session - later

“Wow, Sara, you worked hard today in making sense of all this” (*Rewarding*) or “So let me get this straight—what sometimes happen is that you think Jack is thinking some things, but that you don’t always know for sure, and that those are the times you need to slow down and investigate first… is that right?” (*Regulating*).

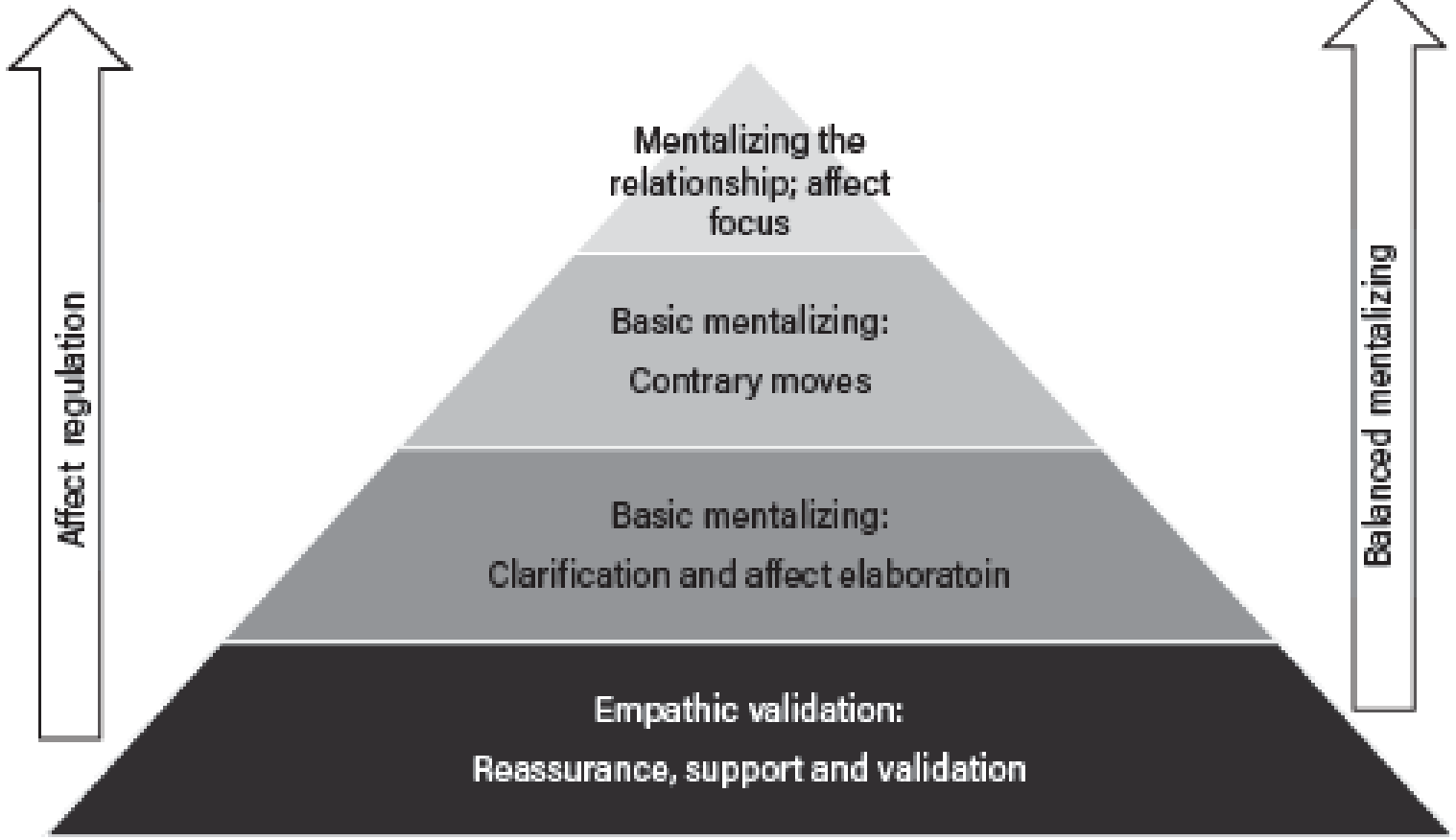


FIGURE 8.1. The affect pyramid depicting a spectrum of mentalizing intervention associated with the client's capacity to regulate affect and to mentalize.

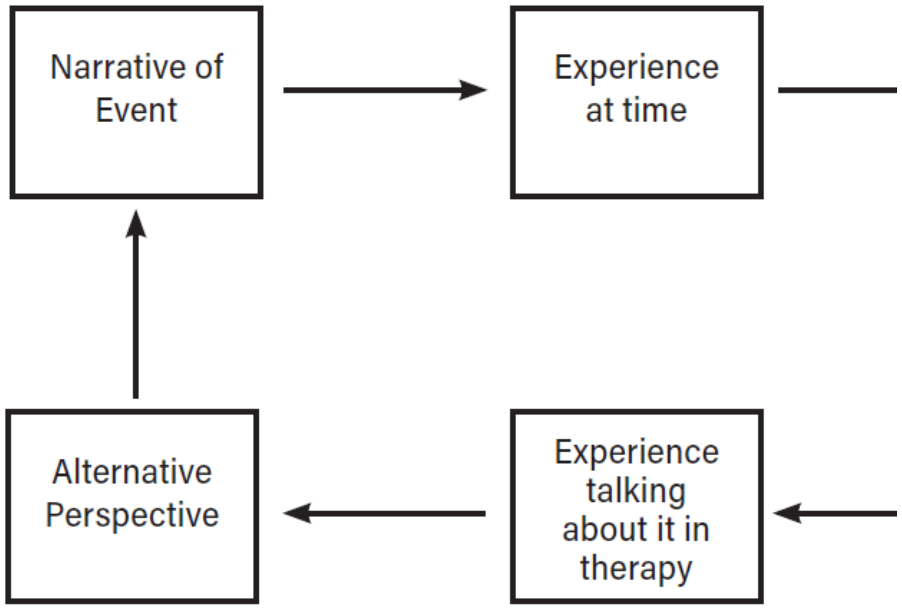
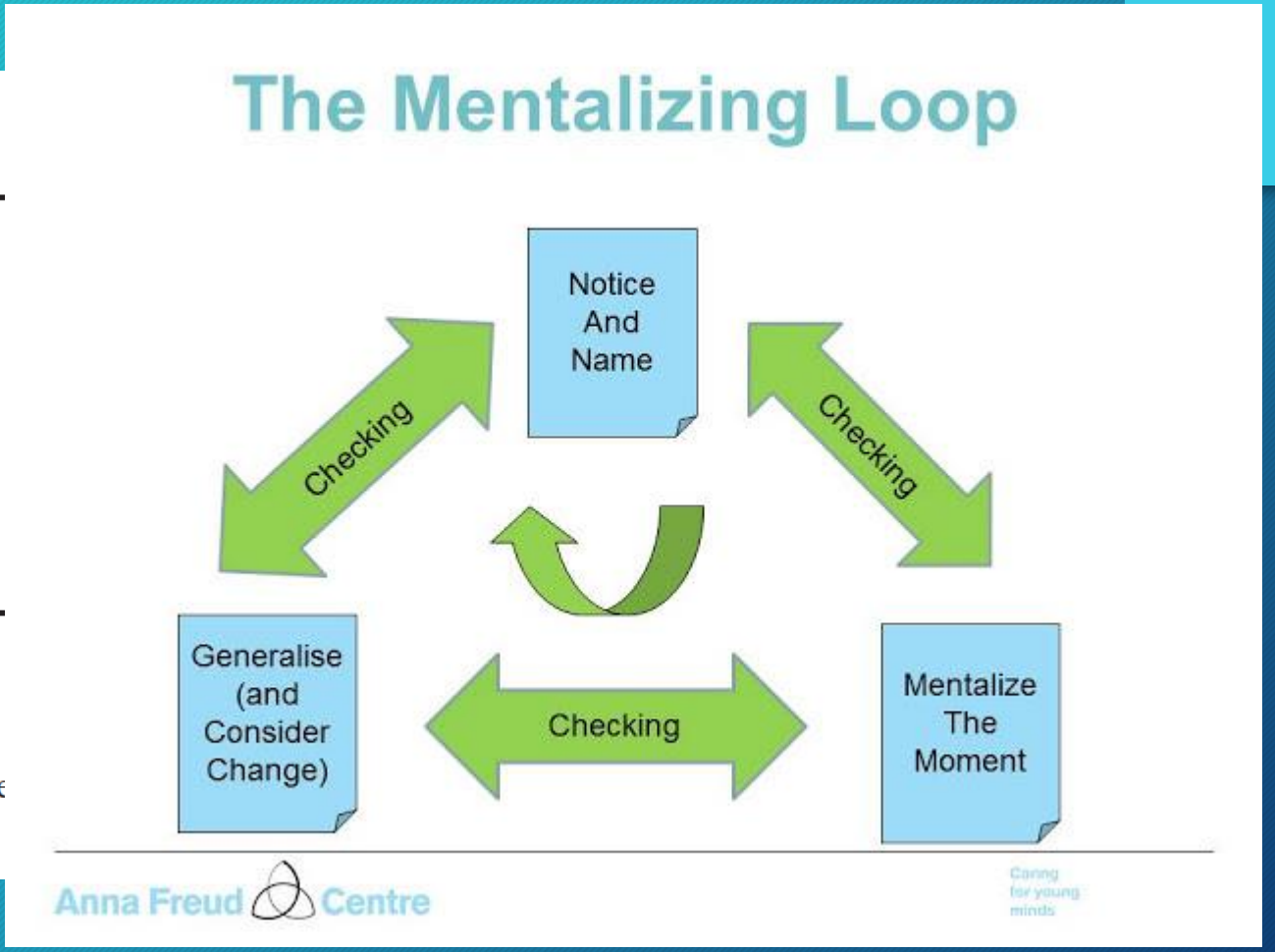
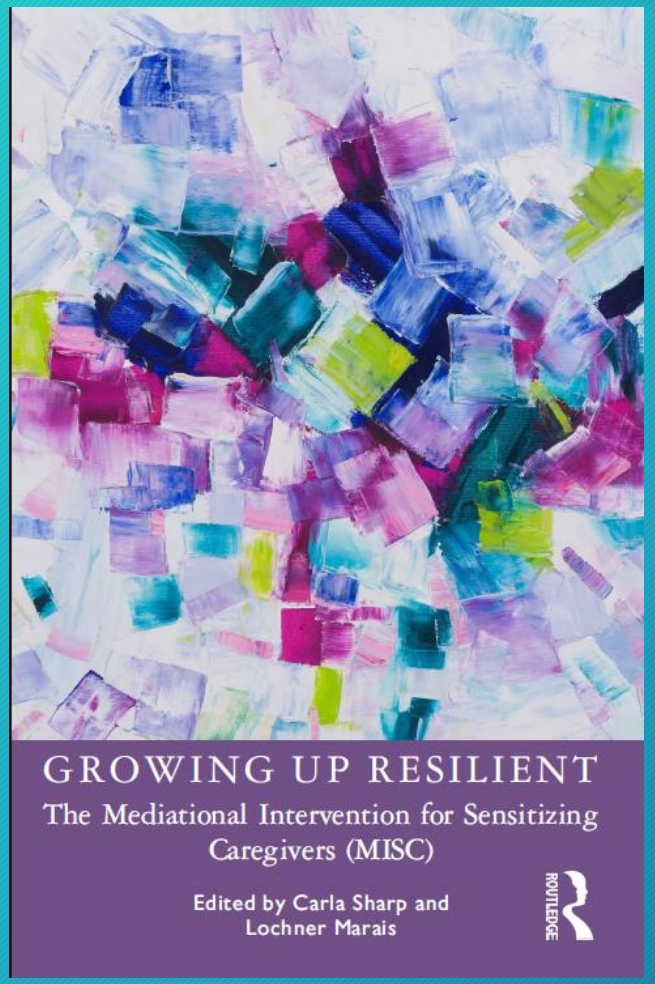


FIGURE 7.1. The mentalizing process to "stretch" out the enhances reflective capacity.



Cheat sheet



- Focusing
- Request/give meaning
- Expanding
- Regulating
- Rewarding

Clip 5 MBT-A

Clip 6 MBT-A

Clip 2 DBT

Clip 3 DBT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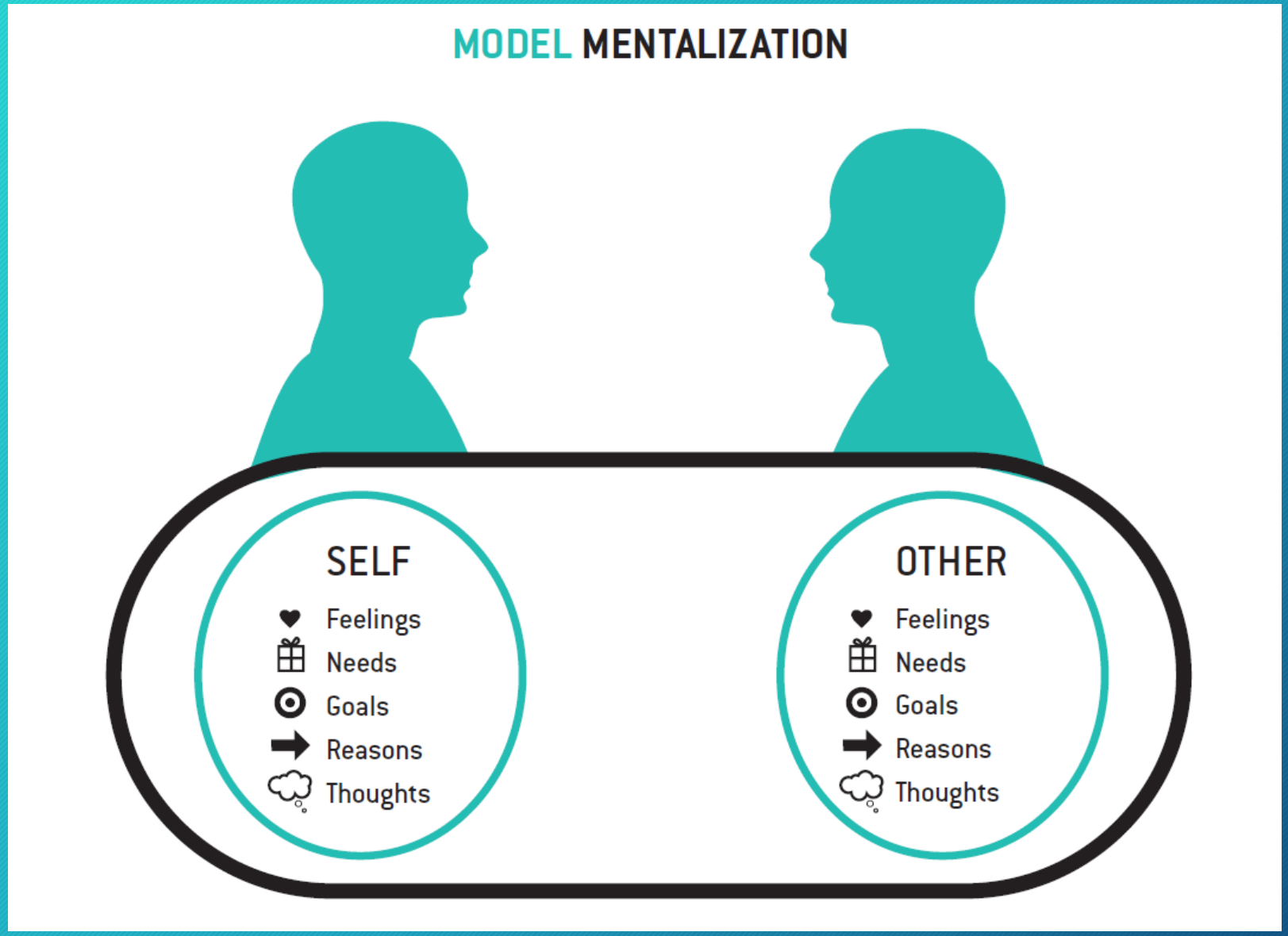

Center for Mentalization, Denmark

Thank you!

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