The role of attachment epistemic trust and resilience in personality disorder; a trans theoretical reformulation

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The things I feel proud of
(just showing off, you don’t need to listen!)
Some of the Mentalizing Mafia

- **UCL/AFC/Tavistock**
  - Prof George Gergely
  - Professor Pasco Fearon
  - Professor Mary Target
  - Prof Anthony Bateman
- **University of Leuven**
  - Dr Patrick Luyten
- **University of Leuven & UCL/AFC**
  - Dr Liz Allison
  - Professor Alessandra Lemma
  - Professor Eia Asen
  - Dr Trudie Rossouw
  - Dr Dickon Bevington
Some more mafiosi (The USA branch)

- Menninger Clinic/Baylor Medical College/U Laval/Harvard
  - Dr Jon Allen
  - Dr Lane Strathearn
  - Dr Karin Ensink
  - Dr Read Montague
  - Yale Child Study Centre
    - Prof Linda Mayes
    - Dr Carla Sharp
    - Dr Efrain Bleiberg
    - Professor Lois Choi-Kain
    - Dr Elisabeth Newlin
    - Helena Rutherford

Dr Lane Strathearn
And European recruits to the ‘Family’

- Dawn Bales
- Dr Mirjam Kalland
- Professor Finn Skårderud
- Professor Sigmund Karterud

Cindy Decoste
Catherine Freeman
Ulla Kahn
Ilan Diamant
Morten Kjolbe
Benedicte Lowyck
Tobi Nolte
Marjukka Pajulo

Svenja Taubner
Bart Vandeneede
Annelies Verheught-Pleiter
Rudi Vermote
Joleien Zevalkink
Bjorn Philips
Peter Fuggle

And Nicolas Lorenzini, Chloe Campbell, Liz Allison and Rose Palmer for help with the preparation of this presentation.
A working definition of mentalization

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

Washes brains whiter!

But hurry! Only 2,000 copies left!

Longer than all previous versions!

Bottom line: The mentalization based approach to treatment is quite effective in treating BPD
Articles Published Citing Papers About Mentalizing or Mentalization
Google Ngram of “mentalization”

Google’s Ngram Viewer shows the percentage a word is present in a corpus of **5.2 million books** published from the years 1500 to 2008.
indispensable requisite to the decline of cerebral metamorphosis.

As to the more intimate nature of the metamorphosis incident to cerebration, but little is known with certainty. Hammond has conducted a series of careful urinal analyses, for the purpose of ascertaining the changes in the composition of the urine incident to increased mentalization. From these experiments he is led to draw the following conclusions:

(1.) That increased mental exertion augments the quantity of urine.

(2.) That, by its influence, the urea, chlorine, and phosphoric and sulphuric acids are increased in quantity.

(3.) That the uric acid, on the contrary, is very materially reduced in amount.

(4.) That diminished intellectual exertion produces effects directly contrary to all the above.

More recently, Byasson has demonstrated that the mental expenditure is in inverse ratio to physical activity. Furthermore, that the addition of phosphates of potassium in the form of phosphates of potassium is a very powerful agent in increasing mental activity. Ever since these facts were discovered by Roux and Blum, the medical profession has been impressed with the idea that the power of the mind is dependent upon the action of the nerves and that the glands which secrete the same are influenced by the action of the mind.

For a more detailed account of these experiments than is admissible in a work of this character, see my monograph on "Brain Exhaustion," D. Appleton & Co., New York.
Mentalization: The Movie
(In Inside Our – an E-Motion Picture from Pixar)
Implicit-
Automatic-
Non-conscious-
Immediate.

Explicit-
Controlled
Conscious
Reflective

Mental
interior
cue
focused

Mental
exterior
cue
focused

Cognitive
agent:attitude
propositions

Affective
self:affect state
propositions

Imitative
frontoparietal
mirror neurone
system

Belief-desire
MPFC/ACC
inhibitory
system

Impulsive, quick assumptions
about others’ thoughts and feelings
not reflected on or tested, cruelty
lateral temporal cortex (LTC) and the dorsal anterior cingulate cortex (dACC)

Laters and medial prefrontal cortex (MPFC) or tested, cruelty
lateral temporal cortex (LTC) and the dorsal anterior cingulate cortex (dACC)

Recruits lateral fronto-temporal
flyer-vigilant, judging
by appearance.
Evidence for attitudes and other
internal states has to come from
outside

Associated with several areas
of prefrontal cortex
Associated with inferior prefrontal
gyrus

Unnatural certainty about ideas
Associated with several areas
of prefrontal cortex

Unintolerant of alternative ways
of seeing things.

Belief-desire
MPFC/ACC
inhibitory
system

Lack of conviction about own ideas
Lack of conviction about own ideas

Rigid assertion of self, controlling
others’ thoughts and feelings.
Rigid assertion of self, controlling
others’ thoughts and feelings.

Hyper-vigilant, judging
by appearance.
Evidence for attitudes and other
internal states has to come from
outside

Fears ‘disappearing’

Hypersensitive to others’
moods, what others say.

Rigorous assertion of self, controlling
others’ thoughts and feelings.

Prementalizing Modes of Subjectivity

**Psychic equivalence:**
- Mind-world *isomorphism*; mental reality = outer reality; internal has power of external
- **Intolerance** of alternative perspectives → concrete understanding
- Reflects domination of self:affect state thinking with *limited internal focus*

**Pretend mode:**
- Ideas form no bridge between inner and outer reality; mental world *decoupled* from external reality
- “dissociation” of thought, hyper-mentalizing or pseudo-mentalizing
- Reflects explicit mentalizing being dominated by *implicit, inadequate internal focus*, poor belief-desire reasoning and vulnerability to fusion with others

**Teleological stance:**
- A focus on understanding actions in terms of their *physical* as opposed to mental *constraints*
- Cannot accept anything other than a modification in the realm of the *physical* as a true index of the intentions of the other.
- Extreme *exterior focus*, momentary *loss of controlled* mentalizing
- **Misuse** of mentalization for teleological ends (harming others) becomes possible because of lack of *implicit as well as explicit* mentalizing
The development of the ‘mentalizing self’

- The capacity to mentalize emerges through interaction with the caregiver:
- The quality of the attachment relationship

 ➤ If the parent is:
  - Able to reflect on infant’s intentions accurately
  - Does not overwhelm the infant

 ➤ Then this:
  - Assists in developing affect regulation
  - Helps develop child’s sense of a mind and of a reflective self
Mentalization: The basics

- Attachment and mentalization are **loosely coupled** systems existing in a state of partial exclusivity.

- Mentalization has its **roots in** the sense of being understood by an attachment figure,
  - it can be more **challenging to maintain** mentalization **in the context of** an attachment relationship (e.g. the relationship with the therapist) (Gunderson, 1996).

- BPD associated with **hyperactive attachment systems** as a result of their **history** and/or **biological** predisposition

- But without **activation** of the attachment system in **therapy** borderline PD patients will never learn to **function** psychologically **in** the context of **interpersonal relationships**.
Failure of Mentalization

Excessive demand for excellence
Becoming adult
Rejection
Current ‘insurmountable’ life challenges
CSA
History of physical maltreatment
Adverse parenting

Activation of attachment system
Disruption of mentalization
Stress reaction (fight/flight)

Genetic & early environmental influence

The Disorganised Self

INSIDE-OUT thinking
(Psychic Equivalence)
or excessive certainty

ELEPHANT-IN-THE-ROOM thinking
(Pretend Mode or excessive uncertainty)

QUICK FIX thinking
(Teleological Mode)
The mentalizing model of BPD

**Distal factors**
- Constitutional Factors
  - Early caregiving context
  - Stress/arousal

**Proximal factors**
- Proximal factors
  - Hyper-sensitivity to mental states
  - Impairments in integration of cognition & affect
  - Low threshold for attachment activation & deactivation of MZ

**Attachment Disruptions**
- Poor self-other differentiation

**BPD: Core features**
- Dysfunctional relationships
- Affect dysregulation
- Impulsivity
- Pre-mentalizing social cognition (PE, PRT, TEO)
- Identity diffusion
- Dissociation
- Feelings of inner pain & emptiness
Treatment vectors in re-establishing mentalizing in borderline personality disorder

- Implicit-Automatic
- Explicit-Controlled

- Mental interior focused
- Mental exterior focused

- Cognitive agent: attitude propositions
- Affective self: affect state propositions

- Imitative frontoparietal mirror neurone system
- Belief-desire MPFC/ACC inhibitory system

- Impression driven Appearance
- Certainty of cognition
- Sensitivity to others

- Cognitive agent: attitude propositions
- Affective self: affect state propositions

- MPFC/ACC inhibitory system
The MBT technique

- Simple **sound-bite** interventions
- **Affect focused** (love, desire, hurt, catastrophe, excitement)
- Focus on patients **mind** (not on behaviour)
- Relate to **current** event or activity – mental reality (evidence based or in working memory)
- Use of **therapist’s mind** as model – ‘marking’ as making clear in patient’s situation the therapist would feel (¿disclosure)
- **Identify non-mentalizing** and recover it on the many occasions when apparently lost
Clinical summary of intervention

- Focus is on a **break in mentalizing** – psychic equivalence, pretend, teleological
- **Rewind** to moment before the break in subjective continuity
- Explore current **emotional context** in session by identifying the momentary affective state between patient and therapist
- Identify **therapist’s contribution** to the break in mentalizing (humility)
- Seek to **mentalize** the experience in the context of the therapeutic **relationship**
So what should the therapist aim do?

- In MBT, the mind of the patient becomes the focus of treatment.
- Help the patient learn about the complexities of his thoughts and feelings about himself and others, how that relates to his responses, and how ‘errors’ in understanding himself and others lead to actions.
- It is not for the therapist to ‘tell’ the patient about how he feels, what he thinks, how he should behave, what the underlying reasons are, conscious or unconscious, for his difficulties.
  - any therapy approach to BPD which moves towards ‘knowing’ how a patient ‘is’, how he should behave and think, and ‘why he is like he is’, could be harmful.
- We recommend an inquisitive or ‘not-knowing’ stance. Conveys a sense that mental states are opaque.
So what is MBT?

- **Stimulate a patient’s attachment** and involvement with treatment **whilst helping him maintain mentalization.**
  - Treatment must enhance the patient’s mentalizing capacities without generating iatrogenic effects as it stimulates the attachment system.

- **Other approaches to BPD** include important components facilitating mentalization, discussed in slightly different language eg ‘mindfulness’, ‘validation’, ‘self-states’ etc.
  - aspects of DBT
  - Ryle’s cognitive analytic therapy
  - Hobson’s conversational model as applied by Stevenson & Meares

- **MBT is unique in placing mentalization at the epicentre of therapeutic change.**
## Contrary Moves within a session

<table>
<thead>
<tr>
<th>Patient/Therapist</th>
<th>Therapist/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing</td>
<td>Unknowing</td>
</tr>
<tr>
<td>Self- reflection</td>
<td>Other reflection</td>
</tr>
<tr>
<td>Emotional distance</td>
<td>Emotional closeness</td>
</tr>
<tr>
<td>Certainty</td>
<td>Doubt</td>
</tr>
</tbody>
</table>
State of the Art: MBT as Long Term therapy

Mentalization Based Intensive Outpatient Treatment: Who needs MBT?

Bateman & Fonagy  BJPsych, 2013

One Axis II Diagnosis

Two Axis II Diagnoses

Three Axis II Diagnoses

Four Axis II Diagnoses

Baseline 6 months 12 months 18 months

Linear Prediction of Recovery

SCM  MBT
State of the Art: MBT Derivatives

Mentalization Based Object Relations Therapy for Depression (DIT)  
Lemma, Target, Luyten, Fonagy et al.  
Psychiatry, 2012
I will not leave to the last slide what I want to say because I will run out of time.
Plan of talk

- Some **recent findings** in relation to mentalizing, attachment and trauma
- The notion of **epistemic trust**
- The structure of psychopathology and the notion of high general distress in psychopathology: ‘P’score
- The nature of **resilience** as higher order cognition and
- **PD** as the **absence** of resilience
- High ‘P’ scores linking to PD because of limitation of higher order cognitive function (HOC)
- Speculation on how **psychological therapies** work to deal with the vulnerability of resilience
  - Ostensive cues
  - Mentalizing
  - Social learning
A historical overview of shifting frames

Changing one’s favourite instinct:

- Up to age 40: The psychosexual AND aggression instinct – Freud and classical psychoanalysis

- Age 40-60: The instinct for attachment – Bowlby, Ainsworth and early infant researchers
  - Attachment theory extended to mentalizing can encompass:
    - Sexuality – failure of early mirroring
    - Aggression – failure of affect regulation and impact awareness

- Age 60 to †: The instinct for communication – Tomasello, Gergely, and modern developmental research
  - Communication defines attachment relationships
    - Secure attachment ensures capacity to learn from experience
Let the boy dream Ivan, He is a born dilettante!

You will never amount to anything if you hold a ball like that!

I want to write my PhD on the “Use of low signal-to-noise ratio stimuli for highlighting the functional differences between the two cerebral hemispheres”.

You look smug now but you will lose your hair just like Dad.
Replication and progress: Measuring mentalizing and trauma in the family system
Measuring Mentalization in children: CRFS

• Child Reflective Functioning Scale
  – Adapted from the Adult Reflective Function Scale (Fonagy et al., 1998)
  – For use with the Child Attachment Interview
    • General Reflective Function (α= .94) and two subscales:
      – Child Reflective Function regarding Self
      – Child Reflective Function regarding Other
  – It correlates significantly with age ($r = .28, p<0.01$)

Mentalization in abused children

Abused children (n=46)

- \( t_{93} = 4.51^{**} \)
- \( g = .94 \)
- 95% CI: 0.65 – 1.67

Controls (n=48)

- \( t_{93} = 3.84^{**} \)
- \( g = .79 \)
- 95% CI: 0.56 – 1.76

- \( t_{93} = 4.44^{**} \)
- \( g = .92 \)
- 95% CI: 0.63 – 1.65

RF General

- \( t_{93} = 4.44^{**} \)
- \( g = .92 \)
- 95% CI: 0.63 – 1.65

RF Self

- \( t_{93} = 4.51^{**} \)
- \( g = .94 \)
- 95% CI: 0.65 – 1.67

RF Other

- \( t_{93} = 3.84^{**} \)
- \( g = .79 \)
- 95% CI: 0.56 – 1.76

Intrafamilial abuse

- \( t_{93} = 2.13^{*} \)
- \( g = .62 \)
- 95% CI: 0.05 – 1.64

Extrafamilial abuse

- \( t_{93} = 2.06^{*} \)
- \( g = .60 \)
- 95% CI: 0.02 – 1.98

- \( t_{93} = 1.99^{*} \)
- \( g = .58 \)
- 95% CI: -0.01 – 1.55
Sexual abuse associated to various outcomes:

MANOVA comparing **abused (n=174)** vs. **not abused** children (n=194)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>F</th>
<th>Cohen’s d</th>
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<tbody>
<tr>
<td>Maternal RF</td>
<td>12.88*</td>
<td>.56</td>
</tr>
<tr>
<td>Child RF</td>
<td>23.40*</td>
<td>.75</td>
</tr>
<tr>
<td>Child dissociation</td>
<td>34.42*</td>
<td>.90</td>
</tr>
<tr>
<td>Child depression</td>
<td>22.42*</td>
<td>.71</td>
</tr>
<tr>
<td>Child eternalising problems</td>
<td>32.85*</td>
<td>.89</td>
</tr>
<tr>
<td>Child sexualising behaviour</td>
<td>9.21*</td>
<td>.46</td>
</tr>
</tbody>
</table>

* p<0.05  
** p<0.001

CFI > .95; TLI > .95; RMSEA < .01; SRMR < .01; controlling for child’s age and maternal education

Ensink *et al* (manuscript in preparation)
Mentalization of parental trauma
Implications for intergenerational transmission of attachment

- 20-month **longitudinal design**
  - N=157 mother-infant dyads; mothers aged 28.77, SD=5.57
- Administered **AAI to expecting mothers** who experienced trauma
  - **General** Reflective Function (RF-G)
  - **Reflective Function specific to Trauma** (RF-T)
- Babies were evaluated by **SSP at 17 months** of age

The number of traumatic events suffered by mothers had an effect on
- mothers RF-T
- infant disorganisation

Berthelot, Ensink, Bernazzani, Normandin, Luyten & Fonagy, 2015
Mentalization of parental trauma
Implications for intergenerational transmission of attachment

- Prediction of infant attachment disorganisation is twice as powerful (22% vs 41% of variance explained) when maternal RF-T is added to a model containing maternal unresolved trauma as only predictor.
  - Unresolved trauma: $\beta=2.54^{**};$ RF-T: $\beta=-1.50^*$,
- Maternal RF-G is not a significant predictor of infant’s disorganised attachment

Berthelot, Ensink, Bernazzani, Normandin, Luyten & Fonagy, 2015
Measuring parental RF using the Squiggle

- Initially developed by Winnicott (1971)
  - Adapted by Ensink, Normandin & Fonagy (2000)
- Mother needs to **direct** the creation of 6 sequenced **drawings** to produce a story
- Mother is **free to comment and ask questions** to the child
- It poses challenges faced by mothers in everyday interaction with their children:

  - Provide **structure**
  - Consider the **child’s interests** and reactions
  - Allows for a **playful interaction**
Measuring parental RF using the Squiggle

Those subscales loaded onto 3 distinct factors:

**Reflective orientation (α=.87)**
- **Interest in** the subjective experience of the child
- Affective communication
- Capacity to **play**

**Affectionate support of agency (α=.85)**
- **Support of** investment/agency of the child
- Expression of affection

**Negativity (α=.74)**
- Aggressive control
- **Hostility**

* The items Withdrawal/Disengagement did not load on any factor
Measuring parental RF using the Squiggle
Relationships with child sexual abuse and psychopathology

N= 157 mother infant dyads
• 88 girls
• 70 boys
89 children experienced sexual abuse
• 54 girls
• 35 boys

Mothers of sexually abused children in comparison with not abused:
• Showed less reflective orientation ($t_{156} = 2.826, p = 0.005$)
• Less affectionate support of agency ($t_{156} = 2.668, p = 0.009$)
• No differences regarding negativity ($t_{156} = -0.622, p = 0.535$)

**Correlations with PDI**
Reflective orientation .45***
Affectionate support of agency .30**
Negativity -.40**

Reflective orientation
• Externalising problems ($r= -.18^*$)
• Delinquency ($r= -.14^{+}$)
• Aggression ($r= -.16^*$)
• Dissociation ($r= -.14^{+}$)
• Teacher reported (TR) internalising ($r= -.29^*$)
• TR externalising ($r=-.36^*$)
• TR social problems ($r= -.39^{**}$)
• TR attention problems ($r= -.35^{**}$)
• TR delinquency ($r= -.39^{**}$)
• TR aggression ($r= -.39^{**}$)

Affectionate support of agency
• Internalising ($r= -.15^+$)
• Externalising ($r= -.19^*$)
• Attention problems ($r= -.16^*$)
• Delinquency ($r= -.17^*$)
• Aggression ($r= -.19^*$)
• Dissociation ($r= -.19^*$)

Negativity
• Externalising ($r= .15^+$)
• TR delinquency ($r= .23^{+}$)

*p<.05**
**p<.01
* p<.08
Normal variation in early parental sensitivity:
Predicts child structural brain development (total N = 191 dyads, 50% girls)

Maternal Sensitivity

- Predicts larger grey matter volume
  - $\beta = 0.13, p = 0.0.3$
- Predicts total brain volume (trend)
  - $\beta = 0.13, p = 0.0.3$

Paternal sensitivity shows similar predictions, but nonsignificant

Normal variation in early parental sensitivity:

Parental sensitivity (both mother and father)

Brain structure measures

- Parental sensitivity
- Total brain volume (volume z score)
- White matter (volume z score)
- Gray matter (volume z score)
- Right hemisphere cluster (thickness mm)
- Left hemisphere cluster (thickness mm)

Controlling for:
- Child gender
- Child age
- Parental education
- Child behavioural and emotional problems

Left hemisphere cluster: precentral, postcentral and caudal middle frontal gyrus

Right hemisphere cluster: precentral, caudal middle frontal, and rostral middle frontal gyrus
Validation of the RFQ
Study 2: Replication of study 1 with a different sample

Same factor model was replicated in this study
$\chi^2/df = 1.59; \text{RMSEA} = .04 (CI .03-.05); \text{CFI} = .95, \text{NNFI} = .92$

<table>
<thead>
<tr>
<th>Measure</th>
<th>Clinical features</th>
<th>RFQ_C</th>
<th>RFQ_U</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHI</td>
<td>Self Harm</td>
<td>-.17</td>
<td>.33**</td>
</tr>
<tr>
<td>IPO</td>
<td>Primitive Defence mechanisms</td>
<td>-.36**</td>
<td>.52**</td>
</tr>
<tr>
<td>IPO</td>
<td>Identity Diffusion</td>
<td>-.41**</td>
<td>.57**</td>
</tr>
<tr>
<td>IPO</td>
<td>Impairments in Reality Testing</td>
<td>-.24**</td>
<td>.54**</td>
</tr>
<tr>
<td>IPO</td>
<td>Total</td>
<td>-.40**</td>
<td>.59**</td>
</tr>
<tr>
<td>DID</td>
<td>Severing of depression</td>
<td>-.09</td>
<td>.40**</td>
</tr>
<tr>
<td>DID</td>
<td>Psychosocial Impairment</td>
<td>-.13</td>
<td>.36**</td>
</tr>
<tr>
<td>DID</td>
<td>Quality of Life</td>
<td>-.08</td>
<td>-.26**</td>
</tr>
<tr>
<td>STAXI</td>
<td>State Anger</td>
<td>-.16*</td>
<td>.35**</td>
</tr>
<tr>
<td>STAXI</td>
<td>Trait Anger</td>
<td>-.36**</td>
<td>.37**</td>
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<tr>
<td>STAXI</td>
<td>Anger In</td>
<td>-.13</td>
<td>.28**</td>
</tr>
<tr>
<td>STAXI</td>
<td>Anger Out</td>
<td>-.20*</td>
<td>.17**</td>
</tr>
<tr>
<td>STAXI</td>
<td>Anger Control</td>
<td>.32**</td>
<td>-.36**</td>
</tr>
<tr>
<td>SCL</td>
<td>Symptomatic Distress</td>
<td>-.17*</td>
<td>.45**</td>
</tr>
<tr>
<td>IPP</td>
<td>Interpersonal Problems</td>
<td>-.16*</td>
<td>.32**</td>
</tr>
</tbody>
</table>

RFQ_C $t=5.98, p<.001$
RFQ_U $t=-14.61, p<.001$

129 PD patients
281 healthy controls

* $p<.05$, ** $p<.01$, *** $p<.001$
Validation of the RFQ
Study 3: The relationship between RFQ, PRFQ and offspring attachment

129 healthy controls
Summary of findings

- **Mentalizing of sexually abused** children is reduced both in relation to self and others associated especially with **intra-familiar** abuse.
- **Dissociation** following abuse linked to **RF**.
- Parental capacity to **mentalize traumatic experience** rather than general mentalizing capacity determines the impact on the child’s attachment.
- **Mothers** of sexually abused children are no more negative but are **less reflective** and **less affectionate** and these mediate symptomatic expression.
- **RF** can be measured in simple questionnaire as appropriate certainty (and uncertainty) about mental states and most RF findings can be replicated.
The journey from attachment to family systems
BPD and disorganised attachment

• A **disorganised** attachment pattern is **noticeable** in the **unstable relationships** BPD patients usually have. Holmes, 2004; De Zulueta, 2006; Barone, 2003

• Zero order **partial correlations** between BPD and **disorganised attachment** in clinical population: 0.44 for **adolescents** and 0.48 for **adults** ($p \leq 0.001$). Westen et al., 2006

• In a sample of **140 BPD** subjects, **40%** presented **disorganised attachment**. Barone, Fossatu & Gulducci, 2011

• In a review of **13 studies**, the percentage of BPD patients presenting disorganised attachment has been estimated between **32.2% and 89%**. This percentage raised to **100% among** BPD patients with history of **trauma**. Agrawal et al., 2004

• Among these studies, **earlier** ones show **stronger correlations** between BPD and disorganisation (around **0.8**). **Subsequent** studies showed a somewhat weaker association (**0.5-0.6**). Levy, 2005
Criticisms of attachment theory

From psychoanalysis: “mechanistic”
“reductionistic”
“no real metapsychology”
“broad classifications that lose the subtlety and detail of the original material”

From anthropology: “culturally blind”
“socially oblivious”
“misses different family configurations, e.g., alloparenting”
“empirically based on WEIRD people”

*WEIRD: Western, Educated, Industrialised, Rich & Democratic*

Fonagy & Target, 2007; Röttger-Rössler, 2014; Otto, 2011
Attachment not universal: Historically childhood is a state of enduring murderous abuse and brutality

(Ariès, 1973; Stone, 1977)

**Infanticide** in 19th C Milan was 30-40% (Marten, 2010)

**Women** living in extremely deprived conditions in **Brazilian ghettos**, allowing the **death** of their **infants** with apparently **little sorrow**, but become **loving** mothers to **subsequent** children or to children who they previously gave up on as hopeless cases, but appear to go on to survive

Different **social environment** are likely to **trigger** different **attachment styles** as more adaptive
Attachment is **one, very important**, form of content learnt from the social environment

Limited evidence for the link between childrearing environments and later outcomes and a fluctuating significance of infant attachment style across life.

While genetic factors are negligible during infancy, in adolescence they predict **38% and 35%** of security and insecurity respectively (Fearon et al., 2013)

Continuity of attachment from infancy to adulthood is moderated by the presence of the OXTR G/G phenotype (Raby et al., 2013)
Rethinking the centrality of attachment in developmental psychopathology

PDs are enduring behaviors; their features include an intrapersonal component (dysregulation of arousal, impulse, and affect), an interpersonal component (dysfunctional relationship patterns), and a social component (which creates conflicts with others and with social institutions). Attachment theory accounts for these four characteristics of PDs and provides an ideal standpoint to understand these disorders, integrating psychological, psychiatric, genetic, developmental, neuroscientific, and clinical perspectives.

OK! ATTACHMENT IS NOT EVERYTHING!
‘The universal socialization task for cultures regarding attachment concerns the learning of trust, not ensuring the “secure” attachment of an individual child to a single caregiver in a dyadic relationship. The question that is important for many, if not most, parents and communities is not, “Is [this individual] child ‘securely attached?’”, but rather, “How can I ensure that my child knows whom to trust and how to share appropriate social connections to others? How can I be sure my child is with others and situations where he or she will be safe.”

Thomas S. Weisner, 2014
Attachment and modern evolutionary theory

- Attachment theory, as originally conceived by Bowlby, was an approach that sought to locate child emotional development in a way that made sense in evolutionary terms.

- In line with a social-cultural perspective:
  - Particular attachment styles are themselves one piece of social communication that the familial context is promoting about the most effective way to function in the prevailing culture.
  - Attachment is part of a social signaling system telling the child to prioritize developing capacities particular patterns of behavior.
  - BPD entails triggering particular style of adaptation to ensure survival, albeit one that causes pain to the person and is challenging to the immediately surrounding environment.
  - For example, sexual risk taking behavior in adolescents with a childhood history of neglect is a way of ensuring that they will contribute to the gene-pool.

- Clinical implication:
  - Hard to change because genes communicate this adaptation is most likely to ensure survival (of the genome)
Mentalizing, attachment and the family

- Lower levels of mentalizing, greater aggressiveness and higher sensitivity to perceived threats are adaptive responses to certain cultural environments
  - hypersensitivity to issues of shame and honour
  - lack of faith in the support of external authorities and institutions
  - families are charged with psychologically enculturating their children to maximise likelihood of survival.

- Social learning from the immediate family and culture can help us account for the relationship between individual behaviours – adolescent male gun crime, for example – and the culture that engenders it.

- Mentalizing intervention to succeed needs to occur in the context of the family, and enhance the quality of mentalizing within the family system
The journey from attachment to communication
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge
- The challenge of discerning epistemic trustworthiness and the need for EPISTEMIC VIGILANCE!
- The pedagogic stance is triggered by ostensive communicative cues (E.G. turn-taking contingent reactivity, eye contact)
- Ostensive cues have in common
  - Person recognized as a self
  - Paid special attention to (noticed as an agent)
Innate Sensitivity to Contingency
Triggering the Pedagogical Stance

- **Ostensive cues function to trigger epistemic trust:**
  - Opening channel to receive knowledge about social and personally relevant world (CULTURE)
  - Going beyond the specific experience and acquire knowledge relevant in many settings
  - Triggers opening of an evolutionarily protected epistemic channel for knowledge acquisition

- **Mimicry** may be protected by human evolution because it generates epistemic trust
  - Social smile (recognition of self) increases imitation because smile generates epistemic trust and opens channel to receive knowledge
Experimental illustration of ostensive cues

Gergely, Egyed et al. (2013)

Subjects: 4 groups of 18-month-olds
Stimuli: Two unfamiliar objects
1: Baseline – control group
No object-directed attitude demonstration

Simple Object Request by Experimenter A

Subjects: n= 20 Age: 18-month-olds
Ostensive Communicative Demonstration

Requester: OTHER person (Condition 1)
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization
Non-Ostensive (Non-Communicative) Demonstration

Requester: OTHER person (Condition 2)
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization

Percent Giving Positive Object

71

40
Condition 4: Non-Ostensive (Non-Communicative)

Demonstration Requester: **SAME** person
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization

Non-Ostensive Expression - Person-Specific Attribution

Egyed et al., in prep.
Social Cues that Create Epistemic Trust

- **Attachment to** person who responded **sensitively** in early development is **special condition** for generating epistemic trust → **cognitive** advantage of security → including neural development (Van Ijzendoorn et al.)

- Generally any **communication** marked by **recognition** of the listener as **intentional agent** will increase **epistemic trust and** likelihood of **communication** being **coded** as
  - Relevant
  - Generalizable
  - To be retained in **memory as relevant**

- **OSTENSIVE CUES TRIGGER EPISTEMIC TRUST WHICH TRIGGERS A SPECIAL KIND OF ATTENTION TO KNOWLEDGE RELEVANT TO ME**
Transdiagnostic structure of mental disorder
Life-course structure to psychopathology

Need for longitudinal research designs

• **Extant research** on structure of psychopathology focuses on individuals who report **symptoms within** a specified **period**
  - Biggest puzzle is why people change clinical presentations over time (adolescent conduct problem adult depression)

• **Mixing single-episode**, one-off cases **with recurrent** and chronic cases which differ in:
  • extent of their **comorbid** conditions
  • the **severity** of their conditions
  • **etiology** of their conditions.

• Some individuals more **prone to persistent psychopathology**.
Caspi et al., 2013 The p Factor One General Psychopathology Factor in the Structure of Psychiatric Disorders? Clinical Psychological Science.
Bi-factor model with the item-loadings


Community-based sample aged 11-14 years (N= 23,477)
Logistic regression predicting future caseness

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Chi-square</th>
<th>Odds-ratio</th>
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<tbody>
<tr>
<td><strong>2-factor model</strong></td>
<td></td>
<td></td>
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<tr>
<td>Internalising</td>
<td>.49***</td>
<td>76.4</td>
<td>1.80</td>
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<td>689.64</td>
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<td>413.74</td>
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</tr>
<tr>
<td>P-Factor</td>
<td>2.33***</td>
<td>479.01</td>
<td>10.30</td>
</tr>
</tbody>
</table>

N=10,270
BPD loads on internalizing and externalizing and shows invariance across gender (Sharp et al., 2014)

The scalar model did not result in a significantly worse fit than the configural model: robust $\chi^2_{\text{diff}}(6, N = 434) = 12.51$, $p > .05$, CFI = .95, TLI = .93, RMSEA = .05 (90% CI: .03-.07).
BPD as the ‘g/P-factor’ of personality pathology (Sharp et al 2015)

- Evaluated a **bifactor model** of PD pathology in which a **general (g) factor** and several **specific (s) factors** of personality pathology account for the covariance among PD criteria.

- **966 inpatients** were interviewed for 6 DSM–IV PDs using **SCID-II**.

- Confirmatory analysis **replicated DSM-IV PDs**, with high factor correlations.
### P factor in PDs: the DSM factor structure

**Sharp et al., 2015 Journal of abnormal psychology**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Factor Score</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD</td>
<td>.78</td>
<td>Avoids abandonment, Interpersonal instability, Identity disturbance, Self-harming impulsivity, Suicidality, Affective instability, Emptiness, Intense anger, Transient dissociation</td>
</tr>
<tr>
<td>AVPD</td>
<td>.76</td>
<td>Avoids social work, Socially inhibited, Views of self as inept, No risks or new activities</td>
</tr>
<tr>
<td>OCPD</td>
<td>.41</td>
<td>Orderly, Perfectionistic, Reluctance to delegate, Miserly, Rigidity</td>
</tr>
<tr>
<td>SZTPD</td>
<td>.60</td>
<td>Ideas of reference, Odd beliefs, Odd behaviour/appearance, Odd affect, Odd behaviour/appearance, Odd affect, Odd behaviour/appearance</td>
</tr>
<tr>
<td>NPD</td>
<td>.72</td>
<td>Grandiose, Preoccupied with fantasies, Lacks empathy, Lacks close friends, Envious</td>
</tr>
<tr>
<td>ASPD</td>
<td>.92</td>
<td>Failure to conform, Deceitfulness, Impulsivity, Irritable, aggressive, Disregard for safety, Irresponsible, Lacks remorse</td>
</tr>
</tbody>
</table>

**UNACCEPTABLE MODEL FIT**

Comparative Fit Index (CFI) < 95
Tucker-Lewis Index (TLI) < 95

Sharp et al., 2015 *Journal of abnormal psychology*
### P factor in PDs: the DSM factor structure

N=966 inpatients

<table>
<thead>
<tr>
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<td>BPD</td>
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</tr>
<tr>
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<td>.31</td>
<td>.04</td>
<td>.16</td>
<td>.56</td>
<td>-</td>
</tr>
</tbody>
</table>

In spite of internal coherence at a criterion level, DSM personality disorders, within individuals, are not neatly separable. They are not discrete phenomena.
P factor in PDS: does EFA replicate the DSM factor structure?

Excellent model fit:

\[ \chi^2(897) = 1110.58, \ p < .001 \]
\[ \text{RMSEA} = .02 \ [ .01, .02 ], \ p = 1 \]
\[ \text{CFI} = .97 \]
\[ \text{TLI} = .97 \]

Factor 1:
- Avoids abandonment
- Interpersonal instability
- Identity disturbance
- Self-harming impulsivity
- Suicidality
- Affective instability
- Emptiness
- Intense anger
- Transient dissociation

Factor 2:
- Avoids social work
- Must be liked
- Restraint in intimacy
- Preoccupied with rejection
- Socially inhibited
- Views of self as inept
- No risks or new activities

Factor 3:
- Orderly
- Perfectionistic
- Workaholic
- Moral inflexibility
- Reluctance to delegate
- Miserly
- Rigidity

Factor 4:
- Ideas of reference
- Odd beliefs
- Odd perceptions
- Odd thinking/speech
- Suspicious
- Constricted affect
- Odd behaviour/appearance
- Lacks close friends
- Social anxiety

Factor 5:
- Grandiose
- Preoccupied with fantasies
- Believes s/he is special
- Needs admiration
- Entitlement
- Exploitative
- Lacks empathy
- Envious
- Irresponsible

Factor 6:
- Failure to conform
- Deceitfulness
- Impulsivity
- Irritable, aggressive
- Disregard for safety
- Arrogant
- Lacks remorse

N=966 inpatients

Sharp et al., 2015 Journal of abnormal psychology
P factor in PDs: Exploratory bifactor model

Excellent model fit:
\[ \chi^2(897) = 1030.09, \ p < .001 \]
RMSEA = .02 [.01, .02], \( p = 1 \)
CFI = .98
TLI = .97

Only factor loadings >|30| are shown

Sharp et al., 2015 Journal of abnormal psychology
Impairment

Externalizing

Internalizing

Gendered Style

Male

Female

Ungendered chronic
Psychotic conditions

Partially gendered
Personality disorder

Gendered
‘Neurotic’ conditions

The ‘P’ Factor (Caspi et al., 2013)

‘Neurotic’ conditions
Personality disorder
Persistent psychological distress and the lack of epistemic trust
Understanding the ‘P’ or ‘g’ factor as an absence of expected resilience
From disease- to health-oriented research: A paradigm shift
Formerly: Investigating the mechanisms that lead to stress-related illness
Now: Investigating the mechanisms that protect against illness
Basic assumption of resilience research: Resilience is **not** simply due to an absence of disease processes but reflects the work of **active adaptation** mechanisms with a biological basis (Kalisch et al)
Active refers to any resource demanding process and may apply to cognitive as well as behavioral processes (Kalisch et al., in press)
Resilience has been conceptualised variously as a...
The ability of a system to resist dynamically a perturbation or adverse condition that challenges the integrity of its normal operation and to preserve function as a result in reference to some initial design or normative functional standards.
Bringing order to the conceptual chaos

Factors
- eg social support
- social status
- personality
- life history
- coping style
- genetic background
- brain function

Mediating mechanisms
- psychological
- or biological

Outcome

May overlap conceptually and/or interact statistically
The role of systemic factors

Factors

Systemic factors
- Eg quality of family, school or community

Individual factors
- Eg social support
  - social status
  - personality
  - life history
  - coping style
  - genetic background
  - brain function

Mediating mechanisms

Outcome

Resilience

Psychological or biological
What is it that patients with BPD lack?

- Individuals with intense persistent distress (high ‘P’ scorers) are by definition **not** resilient:
  - They are **oversensitive** to possibly difficult social interactions (they **cannot interpret the reasons for other’s actions** reliably)
  - **Cannot set aside** (put out of their mind) potentially **upsetting memories** of experiences leaving them vulnerable to emotional storms
How appraisal shapes our experience

Not Enough

Except our experience is social: not with physical objects but with people
The type, quality and extent of emotional reactions (including stress reactions) are **not** determined by simple fixed stimulus-response relationships…

The process underlying **resilience** is driven by **top-down cognition**
Appraisal (higher order cognition) theory

- Stimulus
- Mental representation
- Higher order cognition
- Emotional response

...but by context-dependent evaluation of motivational relevance
• Brains can **preserve** core aspects of the functional architecture of **information processing** that sustains higher order cognition **in spite** of substantial **structural damage** (Rudrauf, 2014, *Advances in Neuroscience*).

• Full **AD** diagnosed postmortem in 25%-67% of elderly with **no** prior cognitive **impairment** (Dubois et al., 2012).

• **“Higher-order cognition” unites** in a functionally integrated **subjective frame**
  • **executive** functions
  • **attention,**
  • **self-awareness**
Positive appraisal style theory of resilience (PASTOR)

Factors | Mechanism | Outcome
---|---|---

Kalish et al, 2014
Positive appraisal style theory of resilience (PASTOR)

- Mildly aversive situations
  - Do not necessarily or automatically generate stress response
- Dominant role of memory content
- Undemanding neuro-cognitive processes

Amygdala: deactivation
Prefrontal cortex
Dorsomedial deactivation
Ventromedial activation

Kalish et al, 2014
Positive appraisal style theory of resilience (PASTOR)

Process Class 2(PC$_2$)

Reappraisal attenuate *ongoing* stress responses by appropriately adjusting negative and/or generating complementary positive appraisals

- Strongly aversive situations
  - The stress response is essentially unavoidable
  - Situation automatically classified as negative
- Implies changes in the meaning of the stimuli
- Cognitive reappraisal in terms of intentional mental states

Hippocampus: activation
Ventromedial prefrontal cortex: activation of mesocortical dopamine system

Kalish et al, 2014
M₁

1. Positive appraisal
2. Positive reappraisal
3. Interference inhibition

Resilience

Process Class 3(PC₃)

Implies the inhibition of conflictive negative appraisals and interfering emotional reactions to information processing

- Strongly aversive situations
  - Situation automatically classified as negative
  - Inhibition allows for reappraisal to consolidate
- Not sufficient for reappraisal. Protects the acquisition of new appraisals
- Might be a trait-like capacity that remains malleable

Kalish et al, 2014

Ventromedial prefrontal cortex: activation of efferents towards…
Amygdalar interneurons: deactivation
‘P’ Factor

Resilience
‘P’ Factor

Resilience

Normal/neurotic
‘P’ Factor

Resilience

BPD
Can we draw these constructs into a unifying conceptualisation?
Can we draw these constructs into a unifying conceptualisation?
The current bio-psycho-social MZ model of BPD as an absence of resistance to social stress

- The ‘P’ factor of general vulnerability to psychopathology is actually an indication of the absence of resilience (psychological equivalent of immune system response, Higgitt & Fonagy, 1992)
  - The nature of the stressor (abuse, bullying, neglect, maltreatment or everyday social stress) is not relevant
  - Most toxic stressors attack the mechanisms of resilience

- While patients with limited comorbidity problems (regardless of severity) have high resilience (unlikely to be effected by subsequent stressors) those with BPD have low resilience and are likely to succumb to psychosocial stress
The current bio-psycho-social MZ model of BPD as an absence of resistance to social stress

- ‘P’ and ‘R’ are inversely related because they are identical at the level of mechanisms
  - Low ‘R’ reflects an adaptation consequent on serial communication problems in development combined with genetic vulnerability characterized by epistemic hypervigilance which prevents or undermines a reappraisal process and results in apparent rigidity (imperviousness to social influence)
  - The failure to engage in meaningful reappraisal creates a general vulnerability to psychosocial stress (low ‘R’) which yields to the high prediction of future psychopathology from ‘P’
  - Increasing mentalizing increases epistemic trust which in turn generates resilience through improved capacity for appraising and re-appraising stressful events
Being mentalized in the context of an attachment relationship

EPISTEMIC TRUST

Ability to form and learn from social connections
Ability to reappraise via mentalizing where necessary to repair, preserve, develop and increase these connections throughout life.
Implications for understanding and treating BPD
The nature of psychopathology in PD

- Social adversity (most deeply trauma following neglect) is the destruction of trust in social knowledge of all kinds → rigidity, being hard to reach

- Cannot change because cannot accept new information as relevant (to generalize) to other social contexts

- Personality disorder is not disorder of personality but inaccessibility to cultural communication relevant to self from social context
  - Partner
  - Therapist
  - Teacher


Epistemic Mistrust
Judgment bias for approachability and trustworthiness of faces.

Nicol et al., 2013 Plos One

P<.001

NS

BPD
Control

Direction of bias
Epistemic mistrust not believing what one is told

- It is the consequence of high levels of epistemic vigilance (the over-interpretation of motives and a possible consequence of hyper-mentalization, Sharp et al., 2011)
- The recipient of a communication assumes that the communicator’s intentions are other than those declared and therefore not treating the communication deferentially
- Mostly it consists of misattribution of intention and seeing the reason’s for someone’s actions as malevolent and to be treated with epistemic hyper vigilance
- Most important consequence is that the regular process of modifying stable beliefs about the world (oneself in relation to others) remains closed
I hear you
but I'm not listening
Implications: The nature of psychopathology

- Epistemic mistrust which can follow perceived experiences of maltreatment or abuse leads to **epistemic hunger** combined with mistrust
- Therapists ignore this knowledge at their peril
- Personality disorder is a **failure of communication**
  - It is not a failure of the individual but a **failure of learning relationships** (patient is ‘hard to reach’)
  - It is associated with an **unbearable sense of isolation** in the patient generated by epistemic mistrust
  - Our inability to communicate with patient causes **frustration in us** and a tendency to **blame the victim**
  - We feel they are not listening but actually it is that they find it **hard to trust** the truth of what they hear
Openness to the (social) environment is usually adaptive...
Openness to the (social) environment is usually adaptive...
Openness to the (social) environment is usually adaptive...
...but so is hypervigilance under certain circumstances
Epistemic hypervigilance

High ‘P’ factor/
absence of
expected resilience

Epistemic trust

Resilience/
low ‘P’ factor
Building a social network in adolescence
When the capacity to form bonds of trust is shaky and tends to break down...
...we lose our safety net
Reconceptualising BPD: understanding not in terms of disease mechanisms...
...but as an absence of expected resilience or lack of epistemic trust...
...which may once have been adaptive
Implications for understanding how treatment ‘works’
How can we overcome the therapeutic impasse?

You’re not listening to me! If you’re still not better, you have only yourself to blame!
How can we overcome the therapeutic impasse?

I feel so alone. I can hear the things you’re saying perfectly well. I just don’t know if I can take the risk of believing them.
Evidence based or promising treatments

DBT  MBT
Psychotherapy for BPD

- A range of structured treatment programmes for BPD shown to be effective in studies
  - DBT
  - TFP
  - SFT
  - CBT
  - SPT
  - DDP
  - CAT
  - GPM
  - CMT
  - MBT

- But do they work for the reasons the developers suggest?
What happens when you ask a room of psychotherapists whose approach is the most effective?

What can be done to end this unseemly behaviour?
Can we do any better than agreeing with the Do Do Bird?

“Everybody has won, and all must have prizes.”
The DoDo bird sounds like a pigeon

If we can’t do better than say everything works than my career as a treatment developer is over and I might as well turn into a DoDo bird!
Oh dear! Better come up with an answer quick!
The paradigmatic common factor is…

“Can we pull a rabbit out of a hat here?”
All together now… mentalizing!!!

Mentalize!
How do you think your audience might be feeling right now?

- Bored
- Sleepy

Is it time for coffee yet?

Fonagy should write a new talk
Psychotherapists listening to an account of mentalizing as the effective component of all therapies
Time for a change?

What?? You didn’t like the mentalizing rabbit???
The theory of epistemic trust as the underlying structure of psychopathology implies a new psychotherapeutic driving force: (re)opening epistemic trust to allow for social (re)learning

A three-stage process of change

Re-emergence of epistemic trust

Mentalizing

Attachment

Social environment
Three stages of a cumulative process that makes psychotherapy effective

Communication System 1
Content

Communication System 2
Epistemic trust in psychotherapy

Communication System 1
Generalisation of epistemic trust

Opening to social learning

Increased interest in the therapist’s mind and their use of thoughts and feelings

Re-emergence of robust mentalizing

Benign social environment
Role of Mentalizing in Learning in Therapy

All evidence based models present models of mind, disorder and change that are accurate, helpful to patients and increase capacity for understanding but need to get over epistemic hypervigilance (‘not true’, ‘not relevant to me’)

- Mentalizing interventions demand collaboration (working together)
  - Seeing from other’s perspective
  - Treating the other as a person
  - Recognizing them as an agent
  - Assuming they have things to teach you – since mental states are opaque
  - Responding contingently to a patient

Mentalizing is the catalyst to activate effective ingredient of therapy
Communication System 1: The teaching and learning of content

- The first stage of any effective treatment involves the transmission of **substantive content** to the patient:
  - Their psychopathological **state**
  - **Coherent and credible** for the patient to accept
  - Personally **relevant**
  - Patient recognised as an **agentive self**

- Besides the content, this stage is a subtle and **rich** process of **ostensive cueing**.
  - Therapist **must mentalize** the patient to find and transmit content that is **personally relevant** to them

The content provides valuable ways for the **patient** to understand (mentalize) **themselves** and their **reaction to others**

The process of transmission involves the patient **recognising the truth and relevance** of the content: **relaxation of epistemic mistrust**
Communication System 2: The re-emerging of robust mentalizing

- **Constant mentalization of the patient by the therapist**
  - Recognising the patient as an **agentiveness of patient’s self**
  - Marking the patients **experiences** acknowledging the **patient’s emotional state**
  - Use **ostensive cues** to denote:
    - **Personal relevance** of the transmission
    - **Generalisable** social value of the transmission

- **By mentalizing the patient effectively, the therapist models mentalization:**
  - Open and **trustworthy environment**
  - Low arousal

This must be understood as a complex, **non-linear progression**

A **virtuous cycle** is put in motion:

- Improving **mentalizing is not the main goal** of therapy, but it enables the patient to **learn from** their **wider social context**
Why patients with high capacity for mentalizing improve more in psychotherapy?

Mentalizing moderates the impact of therapeutic communication because ostensive cues of the therapist are frequently erroneously interpreted by a poorly mentalizing individual and epistemic trust is not established.

With improved mentalizing the communication of the therapist is appreciated and accurately interpreted as to be trusted and has the intended influence on the patient.
The mentalizing stance in therapy
(Bateman & Fonagy, 2006)

- The **mentalizing stance entails epistemic trust**
  - Nonjudgmental **inquisitiveness**, curiosity, open-mindedness, uncertainty, **not-knowing**, and interest in understanding better (Allen et al., 2008, p. 183).
  - **Benevolence**, acceptance, respect, and **compassion** are implicit in the mentalizing stance (Allen, 2013a; Allen et al., 2008).

- Moreover, fostering epistemic trust entails **transparency** on the part of the **therapist**.
  - “The patient has to find himself in the mind of the therapist and, equally, the therapist has to understand himself in the mind of the patient if the two together are to develop a mentalizing process. Both have to experience a mind being changed by a mind” (Bateman & Fonagy, 2006, p. 93).
Mentalizing, epistemic trust and psychotherapy
(Fonagy, Luyten & Allison, 2015)

- The very experience of having our subjectivity understood—of being mentalized—is a necessary trigger for us to be able to receive and learn form the social knowledge that has the potential to change our perception of ourselves and our social world.

- The gift of a mentalizing process in psychotherapy is to open up or restoring the patient’s openness to broader social influence, which is a precondition for social learning and healthy development at any age (Allen & Fonagy, 2014; Fonagy & Allison, 2014).

- The greatest benefit from a therapeutic relationship comes from generalizing epistemic trust beyond therapy such that the patient can continue to learn and grow from other relationships.
**Communication System 3:**
The re-emergence of social learning beyond therapy

- Therapist responds sensitively
- Patient retreats from epistemic isolation
- Patient begins exercising their mentalizing skills
- Generalisation to wider social context
- Emotional reaction to social context

**Key Outcomes:**
- Improved epistemic trust
- Robust mentalizing
- Less rigidity in social interactions
- Accumulation of benign social experience
- Growing robustness of mentalizing capacity

**Generalisation of social learning is highly contingent on the environment being largely benign**

**THE SOCIO-ECONOMIC ENVIRONMENT DOES BUFFER THE INDIVIDUAL PSYCHE**
The general increase in Epistemic Trust

- Therapy is not just about the **what** but the **how** of learning:
  - Opening the person’s mind via establishing epistemic trust (collaboration) so he/she can once again trust the social world by changing expectations
  - It is **not just what is taught** in therapy that teaches, but the evolutionary **capacity for learning from social situation** is rekindled
  - Therapy interventions are effective because they open the person to **social learning experience** which feeds back in a virtuous cycle
Communication System III: Beyond therapy

- Enhanced mentalizing achieves improved social relationships
- Improved epistemic trust/abandonment of rigidity enables learning from experience
- But change is probably due to how a person uses their social environment, not to what happens in therapy
- Benefit remains contingent on what is accessible to patients in their particular social world
- We predict that psychotherapy is more likely to succeed if the individual's social environment at the time of treatment is by and large benign
Expanding to cover the need for supporting the therapists and consultation
Epistemic hypervigilance

ADAPTATION = adaptation to a particular social context

Epistemic trust
Traditional therapeutic model

Patient and therapist are isolated in a room
Traditional therapeutic model

But the reality is that the therapist becomes part of the patient’s dysfunctional social system → systemic intervention may be required to address this
The therapist requires their own system of support relationships with other clinicians in order to scaffold their capacity to mentalize and facilitate epistemic trust.
From individual to systemic approach: AMBIT

Epistemic hypervigilance

Epistemic trust
From individual to systemic approach: AMBIT

ADAPTATION = adaptation to a particular social context

Epistemic trust
Thank you for bearing with my meanderings!

And once again the slides:
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