Interventions related to specific forms of Psychopathology:

Normality, Neurotic, Borderline versus Psychosis:

a structural perspective and what kind of interventions are needed

Psychopathology

General remarks

Psychopathology

- **Different forms of mental functioning. In it self NOT pathological**

- **Not mentalized**: process disorders
  - Paranoid/ schizoid position
  - Psychotic mental states

- **Mentalized**: representational disorders
  - Depressive position
  - Neurotic mental states

Psychopathology

Different forms of pathology

- **In it self anaclytical/introjective are ways of organizing information: NOT pathological**

- **Anaclytical:** relatedness
  - Preoccupied att. Style
  - Attachment
- **Both sides are there**: balance between relatedness and autonomy
  - Safe att. Style
  - Attachment and Separation
- **Introjective:** autonomy
  - Avoidant att. Style
  - Separation

Psychopathology

- **Severity of the pathology:**

  Always related to the quality of interpersonal functioning
  - **Self agency, Identity**
  - **Empathy, intimacy**

- Self object differentiation
- Quality of attachment and primary relations
- There is a continuity between normality and pathology

Organization of the Personality

Kernberg

- Healthy : **no inpairment** of interpersonal functioning and self agency
- Neurotic P.O.: **mild** impairment
- Borderline P.O.: **moderate** till **severe** impairment
- Psychotic P.O.: **severe** impairment

- Manifest itself within the dominant object relational dyad or inner working model
- The way the organism is organising his interpersonal experiences

Healthy

- Interpersonal functioning is not impaired
- Adequate ego and superego functioning
- Conflicts are primarely intrapsychic and not interfering with interpersonal functioning
- They are able to contain ambivalencies
- Stable object relations at the level of take and give
- Good object constancy
- Stable self image

High Level

- Suffering from inner conflicts
- Conflicts are primarely intrapsychic but interfering with interpersonal functioning
- Their superego is severe and punishing
- They should repress some of their drives to safe guard the identity of their Ego
- Are able for having stable object relations at the level of take and give,
- they can contain ambivalencies
- Good object constancy
- Stable self image

Middle

- Suffering from inner conflicts and deficits
- Are able to have a form of relationship
- Integration of superego and regulation of the Ego is failing
- Superego is sadistic and cruel
- Weak object constancy
- There is some capacity to contain conflicts and ambivalences
- Defense is failing

Low

- Suffering from deficits, development is stagnating
- Problems with bounderies
- Failing object constancy
- Sadistic superego and problems with guiltfeelings
- Splitting, Ego diffusion, failing ego identity
- Impulsive
- Problems with creating and having relations and a job

Structural Personality Organization

Kernberg (1984)

	Neurotic	Borderline	Psychotic
Identity	integrated	diffuus	fragmentated
Defense	mature	archaic	archaic
Reality Testing	in tact	in tact in a way	absent

KERNBERG'S SCHEME OF PERSONALITY DISORDERS.

Mild severity

Neurotic Personality Organization:

Obsessive-compulsive | **Depressive-masochistic** | **Hysterical**

Predominance *of conflict*. Defense:

Repression

"High" *borderline personality organization*

Avoidant | **Dependent**

Histrionic

Narcissistic

Both *conflict* and *deficit*.

Both *repression* and *splitting*

`Low" *borderline organization*

Paranoid

Malignant narcissism

SCHIZOID | **BORDERLINE**

Schizotypal | **Antisocial**

Predominance *of deficit* Defense:

Splitting

Psychotic Personality Organization

Atypical psychoses

Extreme severity

Introversion ←----------→ ***Extraversion***

Ego identity

- S/O Differentiation
- Mature Object Relations
- Mature Defenses
- Reactive Agression

- internal structure
- autonomous

Identity diffusion

- Fusion
- Primitive Object Relations
- Archaic Defense
- Primitive Agression

- external regulated
- dependent

Weak internal versus Strong internal structure

- Archaic defenses
- Panic
- Regression of the ego
- No ambivalencies
- Deficits
- Acting out
- Structuring

↓

"Borderline"

- Mature defenses
- Neurotic anxieties (signal)
- regression in favour of the ego
- Ambivalent
- Conflict
- Containing
- Rerstructuring

↓

"Neurotic"

Structural Interview

Quality of the inner structure

Kernberg´s Structural Interview

- Symptoms
- Personality organisation
- Identity
- Reality testing
- Present and the past
- The last question

- Always the cycle of confrontation and interpretation

1. Clarification of the Symptoms

- ***"I would like to hear from you " :***

- *What is the reason for coming*
- *What is in fact the problem*
- *What are you expecting from treatment*
- *And what did you already done on it*

2. Personality organisation

- *"Now you have told me about your problems, I would like to hear some more about yourself as a person. Can you give me an impression about your live your works, family friends, your sexual live sports hobbies and so on "*

This question helps to explore the functioning of the patiënt.

3. Identity

- *"Can you describe me the personality of the person who is the most important one in your life, in such a way that is gives me a vivid impression of what kind of a person he/she is? "*

- When somebody is able to do this it means that he is able to create a mental representation, and his identity is quite wel defined.
- When he is not succeeding you can ask him to describe someone else..

3. Identity

The next question will be:

- *" Can you describe yourself as a unique person so that it gives me a clear picture of the person you are"*

Compare this with your own imression.

Again the cycle → confrontation→interpretation.
It gives you an idea about reality testing and defensive mechanisms

4. Realitytesting

- *"Now I would like to discuss with you something that struch me during this interview, something that was strange to me (strange behavior, emotion or idea)"*

- With this question you are testing if the patient is able to have a feeling for what it is normal criterium for reality
- Is the patient able to replace him/herself in your position or can he accept a bit your evaluation.
- The psychotic patient cannot the borderline can.

5. present and the past

- With Neurotic patients you are exploring the relation between his complaints and the past.
- With borderline patients you are focusing upon the present, the past is only coming in in general terms.
- With borderlines always ask for antisocial things.

6. Last Question.

Testing of the realitytesting and objectrelation in the contact, by the following questions:

- *"What should I have asked you what I did not asked you? "*
  This question is testing the motivation to go on with the process you are in.

- *"How did you liked our interview ?"*
- *"What kind of an impression you think I have about you? "*
- *"What kind of an impression do you have about me ?"*

Borderline Personality Organization

High and middle levelers

Personality Organization Point of View : Levels of Organization

A mixed Categorical and Dimensional System

1-Normal flexibility and adaptation

2-Neurotic level of personality organization

3-Borderline level of personality organization:

- High level borderline
- Low level borderline

4-Psychotic level of personality organization

Borderline Personality Organization

Basic Characteristics

- Identity Diffusion vs. integrated view of self and others (internal sense of continuity)
  - No integrated concept of self
  - No integrated concept of significant others
- Primitive Defenses
- Variable Reality Testing

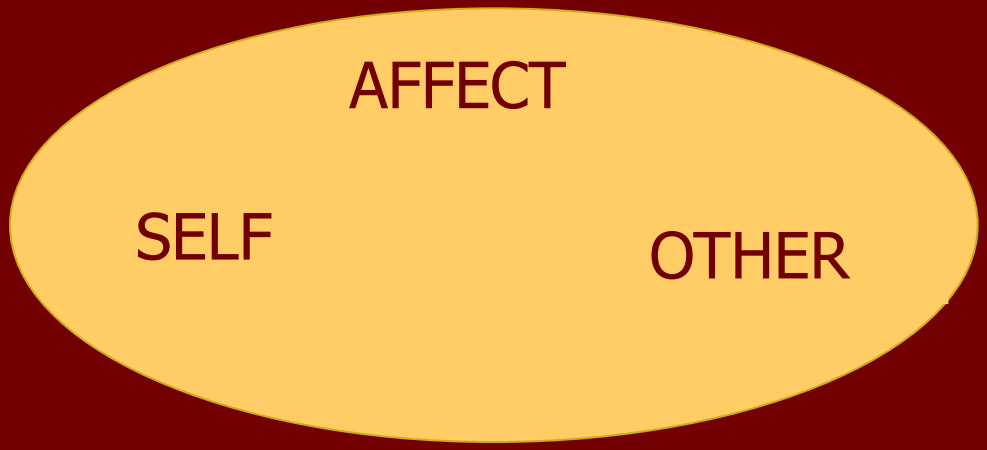
Transference Focused Psychotherapy

Object relational approach: High levelers

TFP

- Primary drives are experienced in relation to a specific object
- They express themselves in a longing to relatedness versus in a longing for autonomy
- The fundamental building stones of the psychic structure are "dyads"
- Those "dyads" are representations more than objective realities

Inner Dyad



DYAD

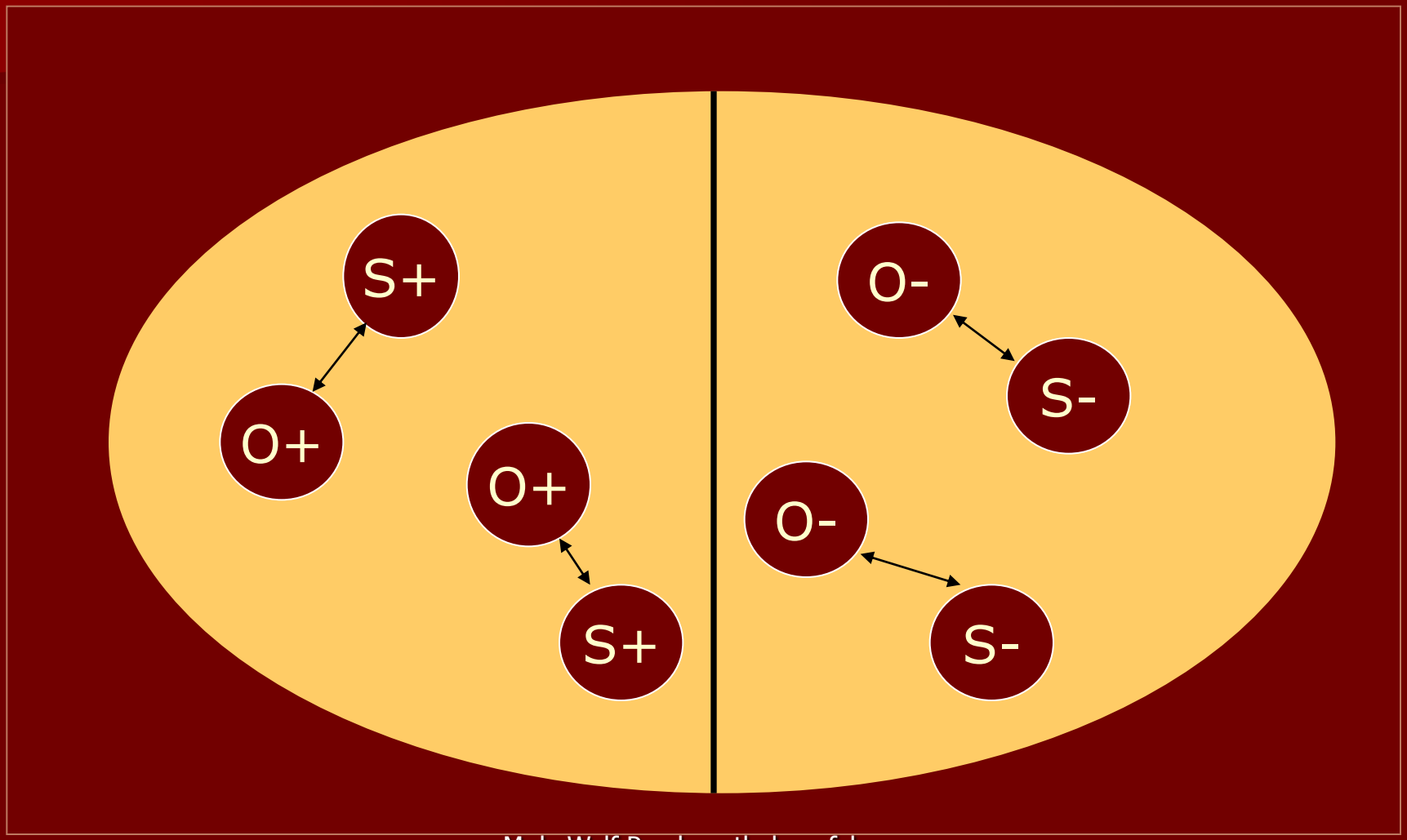
THE DEVELOPMENT OF PSYCHOLOGICAL STRUCTURE IN THE INTERNAL WORLD

THE PERSISTENCE OF THE SPLIT STRUCTURE

Borderline pathology develops when:

1. Under the stress of maltreatment or aggressive constitutional loading, the negative experiences outweigh the positive experiences.
2. The negative experiences remain isolated and split off from the positive experiences, preventing integration and leading to the fixation of the originally normal developmental split. This perpetuates perceiving self and others in extreme, absolute terms.

Splitted: all good-all bad



The Evolution of Treatment

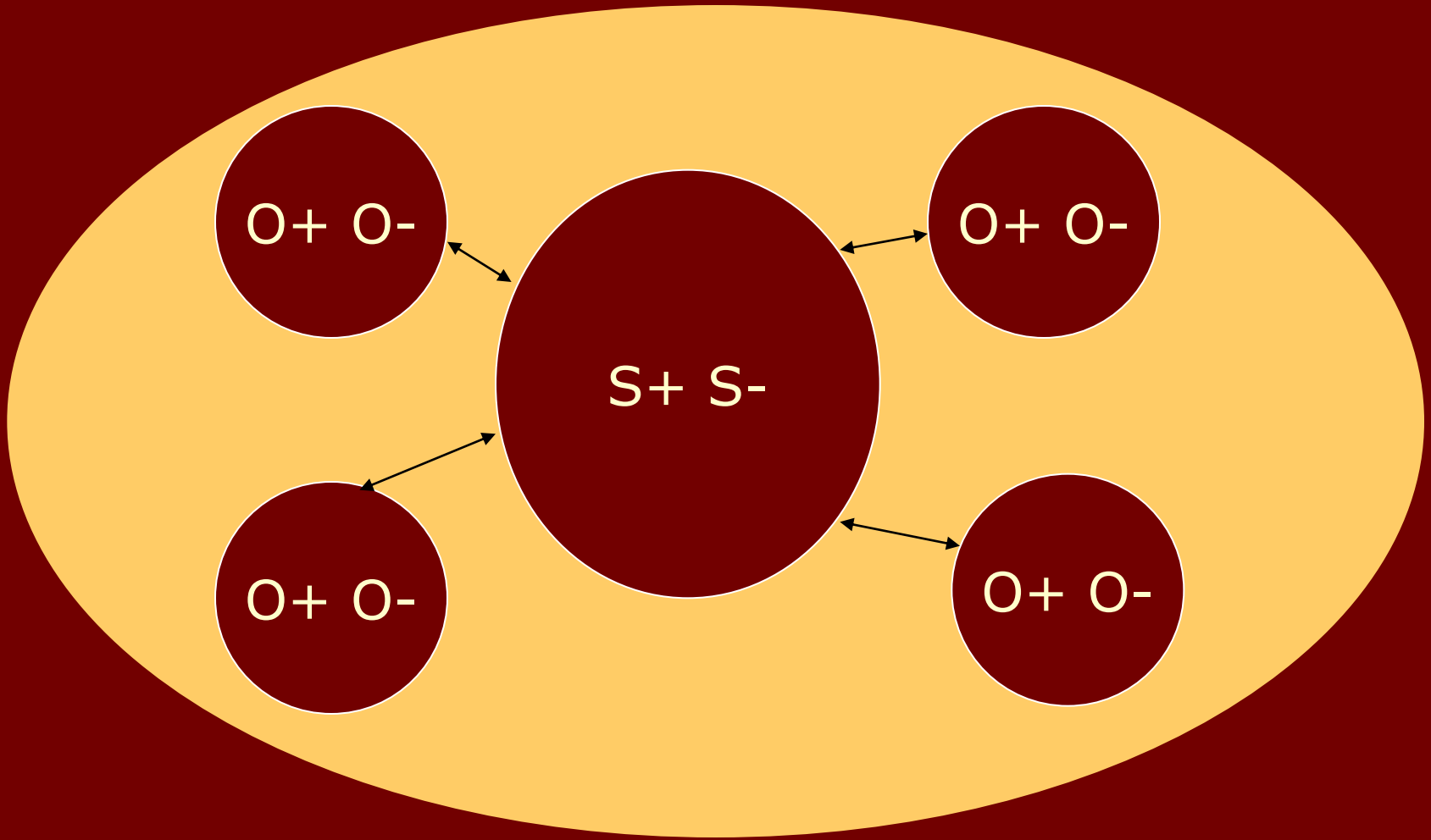
From Splitting to Integration;

- From the projection of negative motivations to the capacity to take responsibility for one's thoughts, feelings, actions and integrate them.

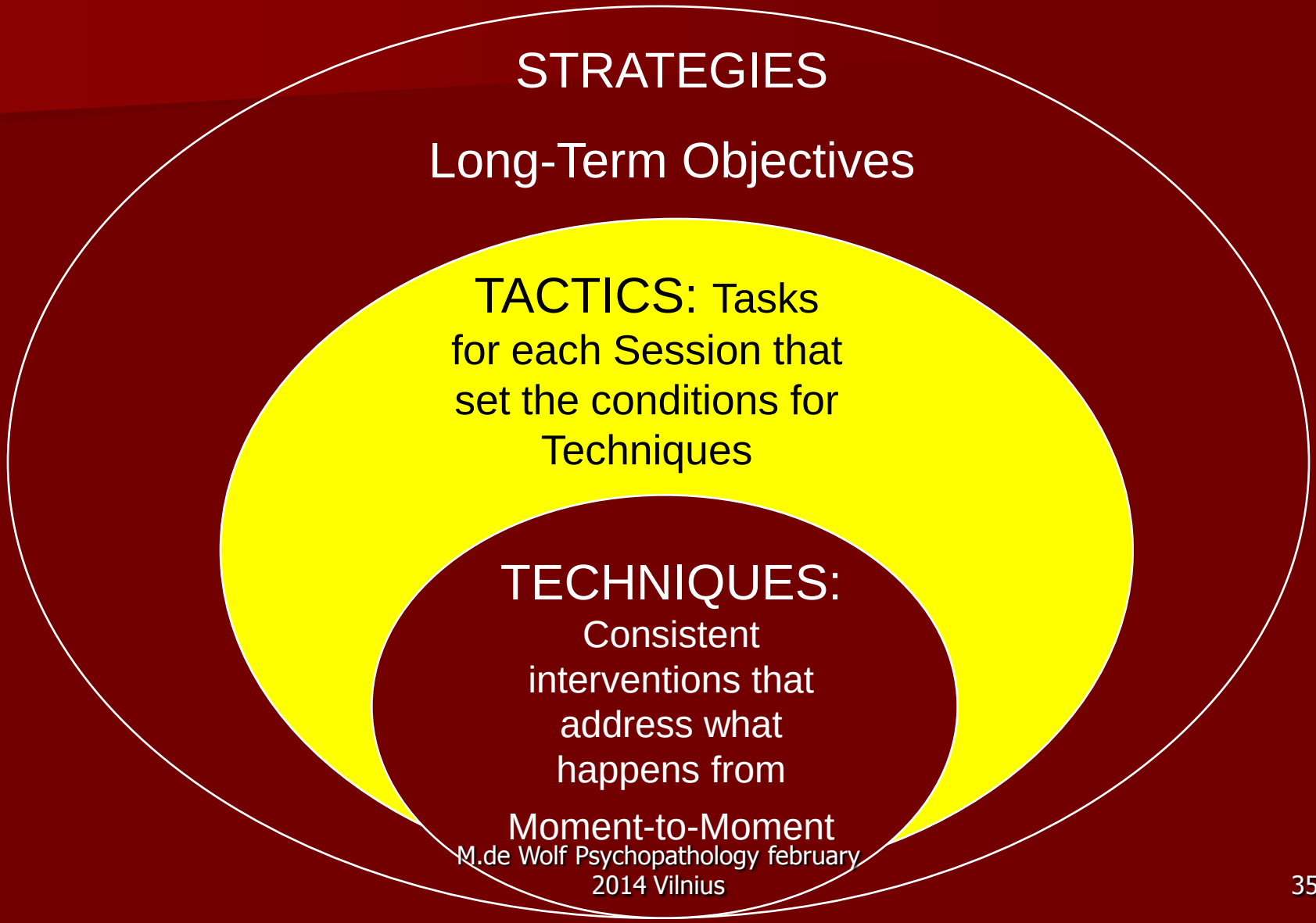
  (In older psychoanalytic terminology, to move from the Paranoid-schizoid position to the Depressive position)

- How does focusing on the transference facilitate this change?

Normal: Integration-Ambivalency



The Relationship of Strategies, Tactics and Techniques



TFP Treatment Strategies

Treatment Strategies → long term objectives

- The idea that integration of the patient's self representations and object representations will result in personality change

THE STRATEGIES OF TFP - I

STRATEGY 1: Defining the dominant object relations

Step 1: Experiencing and tolerating the confusion of the patient's inner world as it unfolds in the transference

Step 2: Identifying the dominant object relations

Step 3: Naming the actors as they are played out

Step 4: Attending to the patient's reaction

THE STRATEGIES OF TFP - II

STRATEGY 2: Observing and interpreting patient role reversals (the patient identifies with the entire relationship/dyad – not just with one side of it)

STRATEGY 3: Observing and interpreting linkages between object relation dyads which defend against each other, with the goal of integrating the paranoid and idealized segments of experience. This resolves identity diffusion: The warded off dyad

STRATEGY 4: Working through the patient's capacity to experience a relationship differently in the transference, and reviewing the patient's other significant relationships in light of this change.

TFP Techniques

1. Clarification → exploration
2. Confrontation → incongruenties
3. Interpretation → the meaning of the conflict
4. Analysis of transference/Counter transference
5. Management of technical neutrality

Techniques

- The interpretative process:
  - Consists of clarifying, confronting, and interpreting
  - Is a means of enhancing mentalization
- Conducting transference analysis (systematic analysis of distortions in the relationship)
- Managing technical neutrality (attitude of concerned objectivity; not drawn into patient's problems)
- Utilizing countertransference awareness

TFP Channels of Communication

- The verbal content of the discourse of the patient *(what he is saying)*
- The patients nonverbal communication *(how they say something; body language)*
- The therapists countertransference → determined by:

1. *Pt's transference to the therapist*
2. *Pt's objective reality*
3. *The therapists own dipositions*
4. *The reality of the therapists life*

Clarification

- This technique is requesting clarification, not offering clarification
- Provides material for interpretation by clarifying
  - The patient's perception of self in the moment
  - The patient's perception of the other/the therapist
- This technique sheds light on the patient's internal world and helps to elaborate distortions (i.e., enhances mentalization)

Confrontation

- This technique is not a hostile challenge, but rather an honest inquiry into an apparent contradiction in the patient's communication
- It is an invitation for the patient to reflect
- It is assumed that the different elements of the contradiction represent aspects of the self that are split off from one another

The Focus of Interpretation

- Because of the predominance of splitting-based defensive operations (rather then repression-based defenses) in BPD patients:

1. Interpretation focuses on mutually dissociated aspects of experience that are accessible to consciousness, though at different times (rather than repressed material)
2. As treatment progresses, dissociative defenses give way to repressive defenses, when interpretations can shift to focus on repressed mental contents

TFP Techniques

Different levels of interpretation:

- **from the surface to the depth**

1. Interpret that acting out or primitive defenses are serving to avoid awareness of inner experiences/ avoid integration
2. Interpret the dominant object relational dyad and the role reversals
3. Interpret the dominant object relational dyad and the warded off dyad

Steps of Interpretation

- Understand/Identify self state in the moment
- Understand patient's experience of the therapist in the moment
- Consider therapist's experience of the moment, and that it may be different from the patient's
- Contrast the immediate experience of self and of therapist with that at other times (address splits)
- Consider reasons for splits
- Put the above in the context of other relations

Technical Neutrality

- A therapist who intervenes from a position of technical neutrality avoids siding with any of the forces involved in the patient's conflicts
- Neutrality means maintaining the position of an observer in relation to the patient and his difficulties
- When working from a position of technical neutrality the therapist is aligned with the patient's "observing ego"

Why Neutrality?

- Encourages redirection of patient's conflicts into the therapy
- Allows therapist to diagnose internal object relations dominant at any given moment
- Strengthens patient's observing ego
- Interpretations presented from a position of neutrality facilitate integration of split off internal object representations

Containment of countertransference

The therapist "metabolizes" the patient's projections in the countertransference

- Allows patient to him internally
- Tolerates his emotional experience without turning to action
- Reflects upon what the patient has stimulated in him and what this might say about the object relation enacted in the transference

Treatment Tactics

Treatment tactics → tasks the therapist attends to in every session

- Contract setting
- The priority theme to address
- Maintaining an appropriate balance between expanding incompatible views of reality between patient and therapist
- Analyzing transference pos/neg aspects
- Regulating the intensity of affective involvement

The Tactics

- Set Contract
  - To protect the survival of patient, therapist and treatment
  - To eliminate secondary gain of illness
- Maintain the frame and boundaries of treatment to control acting out
- Select the focus of attention and intervention
  - Attend to what is affectively dominant
  - Attend to what is in the transference
  - Attend to the general priorities of treatment
- Maintain common perceptions of reality
- Analyze both positive and negative transferences
- Regulate the intensity of affective involvement

Thematic Priority - I

- **Obstacles to Transference Exploration – Resistances to explore**
  - suicide or homicide threats
  - Threats to treatment continuity (inc. financial probs, plans to move, requests to meet less often)
  - dishonesty or deliberate withholding in sessions (e.g., lying to the therapist, refusing to discuss certain subjects, silences occupying most of the sessions)
  - contract breaches (e.g., failure to act on other parts of treatment such as AA, failure to take prescribed meds)
  - in-session acting out (e.g., abusing office furnishings, refusing to leave at the end of the session, shouting)
  - narcissistic resistances
  - non-lethal between-session acting out
  - non-affective or trivial themes

Channels of Communication

Countertransference

- The more primitive the pathology the more communication by ***belly talk***
- ***Concordant*** countertransference → empathy; the therapist learns what the patient feels by identification
- ***Complementary*** countertransference → identification with the patient's split-off part

TFP Purpose

- **Treatment Purpose**

1. integration of the patient's self representations and object representations.
2. Internalizing the contract and the dialogue with the therapist by the patient.
3. Interpreting the dominant dyad and the underlying conflict between love and hate.

Course of the treatment

- **The beginning** involves assessment, history sessions and setting the contract.
- **The early treatment phase**:

1. testing the frame;
2. containing the impulses and the affect storms;
3. reducing secondary gain;
4. increasing the capacity of maintaining the relationship with the therapist; getting attached.

Course of the treatment

The middle phase

- Decreasing of the acting out, increasing focus on the interaction between therapist and patient
- The repetitive analysis of the dominant object relational dyad in the transference (the here and now of the session)
- Growing towards integration

Course of the treatment

Advanced phase and termination:

- Growing integration of self and object representations
- Splitting is diminishing, more mature forms of resistance
- Temporarily episodes of regression
- Resolution of symptoms; personality change
- Separation issues are raising

Course of the treatment

- **From acting out and paranoid/schizoid position and paranoid transference**

1. *Towards learning to contain emotions and feelings, to learning to reflect upon (thinking and talking)*
2. *Towards more integration of self and object representations*

- **To the depressive Position and depressive transference**
- Progression goes not linear but by affect storms (integration goes with anxiety)

TFP summary 1

Different routes to symptom change

- DBT→ skill training to help patients to regulate emotions and to reduce symptoms
- TFP → self control by integrating S/O representations as they are activated in the relation with the therapist

TFP summary 2

- **TFP** is an effective way of treatment for borderline patients.
- Reflective functioning, secure attachment and attachment coherence is increased after treatment.
- Suicidality, aggression and impulsivity are significantly decreased

TFP summary 3

1. It is about interpreting conflicting mental representations
2. It is focusing on transference and defense
3. It takes the lack of S/O differentiation as a defensive structure
4. Holding is limited because of the differentiation between crisis management and psychotherapy

Mentalisation Based Treatment

Facilitating the mentalizing ability and creating mental representations:

Middle & Low levelers

Mentalization Based Treatment

Development by intersubjectivity

- In the beginning the Self is a somatic Self
- At the end there will be a psychological Self
- **From Soma to Psyche**
- **From outside to inside**

Mentalization Based Treatment

- Insight as a result of change and not a condition to change.
- It is about facilitating a developmental process which was inhibited or blocked.
- It is about mirroring and containing instead of interpreting

MBT

The Target is Developing a Mind or a Psychological Self by mentalization

- Using the Social Biofeedback theory of parental mirroring
- Facilitate the Integration of Equivalent and Pretend Mode → Reflective Mode

Developing the Interpersonal Interpretive Function; IWM; Dominant Dyade; Schema.

MBT

- **Mentalization**

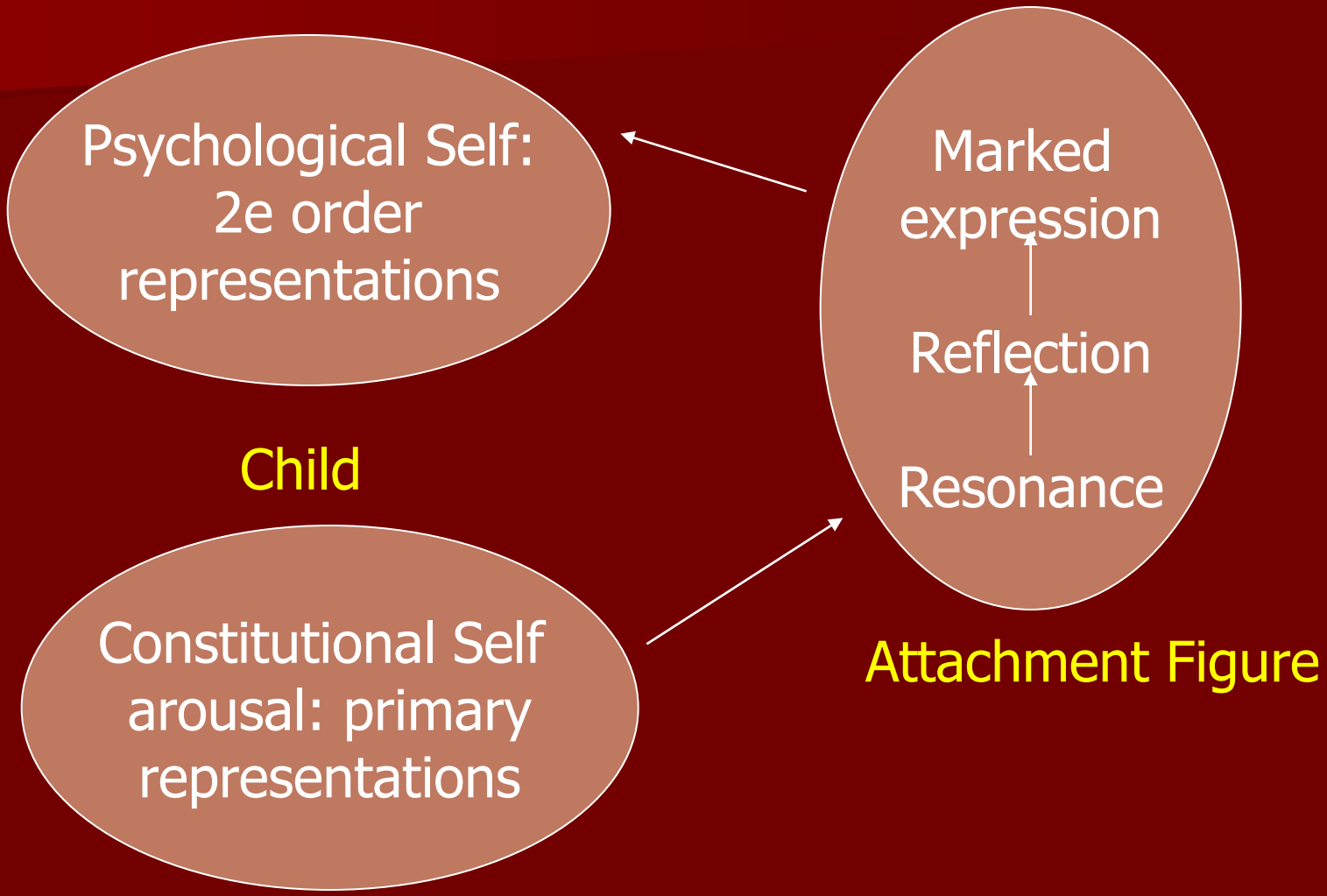
1. Develops in the relationship → intersubjective
2. Thoughts and Feelings are seen as representations rather than of reality itself
3. Behavior is seen as intentional
4. There is some psychological mindedness
5. Internal Working Model/ Interpersonal Interpretive Function
6. Regulating attention and emotion
7. Gives sense of continuity, control and agency

MBT

- **Self Development**

1. The agentive, mentalizing, psychological sense of self is rooted in the attribution of mental states
2. This emerges in the interaction with the caregiver, by mirroring in the context of an attachment relationship
3. This capacity can be inhibited by trauma and inaccurate mirroring

Social biofeedbacktheory: parental mirroring



*Fonagy, Gergely, Jurist, Target, 2002

Developmental proces by mirroring

Mental processing: *(conflicting) mental representations*

The parental object tries to understand the affective state and intentions of the child, is mirroring it to the child.He feels recognized and seen by the parental object and learns to understand himself and put himself into words

Result:

The birth in himself of a mental representation of the self and other

Developmental proces by mirroring

Mental processing disorder: *Mentalizing deficit*

The parental object is reacting from his/her own affective state so the child is unable to recognize himself in the eyes of the parental object and will not learn to understand himself or to put himself into words

Result :

Developing in the self an introjected self of the parental object (alien self), this means there is no development of an inner representation of the self and the other

Non adequate mirroring

1 Accurate resonance but not marked

- Not clear what is from me and what from the other
- No containment
- Projective identification as a defense
- Predisposition to equivalent mode; controlling, manipulation, internalizing pathology

RELATEDNESS as a defensive structure

Non adequate mirroring

2. **Resonance is not congruent**

- Not related to the primary experience
- Creation of False Self/ Alien Self
- Predisposition to pretend mode; no contact, disconnecting himself, externalizing pathology

AUTONOMY as a defensive structure

MBT

- **Mentalization**

The psychic reality of the child consists of two different modes:

- **Equivalent mode**: internal = external; too realistic, concreteness fusion
- **Pretend mode**: internal separated from the external; too unrealistic, meaninglessness dissociation, pseudo mentalization

Teleological mode

- Primacy of the physical
- Experience is only felt valid when its consequencies are apparent to all
- Affection is only real when accompanied by physical expression
- Automutulation or suicidality as the only route to the patient experiencing a sense of being cared for
- May lead to misuse of mentalization in the sense of manipulating and controling the other

MBT

- **Reflective Mode**

1. Capacity to mentalize
2. Integration of equivalent and pretend mode
3. Internal and External reality are connected, not dissociated but differentiated

MBT

Result

1. The person is able to understand himself and the other in psychological terms
2. He develops an Inner Working Model or Interpersonal Interpretive Mechanisms by which he organizes, anticipates and is selecting his world.
3. He becomes intentional

Failure of Mentalization

- Pretend Mode: **Pseudo Mentalization**
- Equivalent Mode: **Concrete Understanding**
- Teleological Mode: **Misuse of Mentalization**

Pseudo Mentalization

Pretend Mode

- **Intrusive:**

1. They know for sure what people are feeling or thinking.
2. Opaqueness of minds is not respected

- **Overactive**

1. Idealization of insight for its own sake
2. Thought about others felt by them as obscure and confusing

- **Destructively inaccurate**

1. Cast in terms of accusations
2. Denying someone's real feelings, replacing them with a false construction

Concrete understanding

Equivalent mode

- Lack of attention to feelings thoughts of others
- Massive generalizations/prejudice
- Circulair explanations
- Influence of situational/physical factors
- Style of blaming and fault finding
- Inflexible and rigid sticking to the first reasonable account of behaviour available
- Absense of reflection and questioning
- Black and white reasoning

Misuse of mentalization

Teleological Mode

- Using mentalization to control the behaviour of others / manipulative
- Often in a manner that is detrimental to those "mentalized"
- Inducing guilt, anxiety and shame
- Use knowledge of others feelings in a sadistic way
- Physical threats, shouting, abusive language
- Humiliating or threatening humiliation for example by suicidal threats

Hierarchy of relationship

Normal

- Safe attached
- Selectivity; balanced
- Stable and consistent
- Developed over time
- Reflective mode
- Able to modulate and calm down painful affects

Hierarchy of relationship

Centralized

- Preoccupied attached
- Unstable
- Self directed/ looking for intimacy
- Rigid not flexible
- Equivalent mode
- Underregulation of the affects

Hierarchy of relationship

Distributed

- Avoidant attached
- Fragile stability
- At a distance
- Rigid
- Pretend mode
- Overregulation of the affects

Mentalizing: Therapeutic stand

1. Not knowing stand
2. Clarification and Exploration instead of Interpretation
3. Support, reassurance and Empathy
4. Working In the transference instead of working through the transference.
5. Mentalizing the transference
6. Reparation is an important type of intervention
7. Developing alternative explanations
8. Stop, stand, rewind and explore

Interventions

In General

During non mentalizing interactions

- Simple and short
- Focused on affect
- Focused on the patients mind not on the behaviour
- Relate to current activity or event
- Focused at the near-conscious or conscious

Interventions

Clinical Pathway

- Identify the affect and not simply the behaviour
- Explore the emotional context
- Define the current interpersonal context outside
- Examine the broad interpersonal theme in treatment
- Explore the specific (transference) context

From up till down the emotional intensity is growing

Interventions

Spectrum

- Reassurance, support and empathy
- Clarification, challenge and elaboration
- Basic mentalizing
- Interpretive mentalizing
- Mentalizing the transference
- Non-mentalizing interpretations (use with care)

Reassurance, support and empathy

- Reflective listening and accurate empathy
- Non-judgmental
- Open questioning
- Encouraging and stimulating exploration
- Check your understanding

Clarification and Affect elaboration

- Explore and reconstruct the event
- Make behaviour explicit
- Trace action to feeling
- Try to elicit feeling states
- What need to happen for the patient to feel differently
- Stop, stand, rewind and explore

Basic mentalization

Stop and Stand

- To reinstate mentalization when it fails
- An interruption to insists the patient to focus on the moment of rupture
- Identify affect attached to action
- Focus on the here and now

Basic mentalization

Stop listen and look

- Stop and investigate
- Let the interaction slowly unfold, control it
- Highlight who feels what
- Identify how each aspect is understood from multiple perspectives
- Challenge reactive "fillers"
- Identify how messages feel and are understood, what reactions occur

Basic mentalization

Stop rewind and explore

- In case of loosing control and the danger of self destruction
- Let us go back and see what happened just then
- At first you seemed to understand what was going on …..but then?
- Let us try to trace exactly how that came about
- Hang on before we move off, let us just rewind and see if we can understand something in all this

Interpretive mentalizing

- Connect different explanations with each other
- Defining repetiting patterns of behaviour, by connecting behaviour to affects
- Defining transference tracers as a possibility not as a fact

Mentalizing the Transference

- Focusing on the here and now of the relation between patient and therapist
- Validate the transference feeling
- Explore the transference
- Accept enactments
- Offer alternative perspectives to the patient
- The proces is more important then the content

Spectrum of interventions

- **Reassurance, support and empathy**
  - I realisme that you feel hurt
- **Clarification and elabortion**
  - I realisme that you feel hurt and I ask myself how it happens
- **Basic mentalization**
  - I realisme that you feel hurt , that should make it difficult for you to talk today with me

Spectrum of interventions

- **Interpretative mentalization**
  - I see you feel hurt and that reminds me that you are reacting in the same way when someone is not doing exactly what you want him to do.
- **Mentalization in the transference**
  - I see you feel hurt and than you do not know if you want to be here. I think that only by feeling a hurt victim you can have the experience that you own my attention.

Summary MBT: Borderlines have no Mind

1. It is not about mental representations but about the mentalizing process itself
2. It is about creating mental representations
3. It is not about interpreting but about constructing/exploration of the mental state
4. It is not about conflicts but about deficits or inhibitions
5. **Developmental** instead of **conflictual** approach

Psychotic Personality Organization

Low levelers

Psychotic Personality Organisation

Neurosis

- conflict between Ego and Id, there is repression → there are symptoms when repression is not adequate. Distorsion and avoiding but not denial of reality. Reality is dominant

The Narcisistic Neurosis

- Conflict between Ego and Superego

Psychosis

- Disturbance between Ego and reality, denial or disavowal, withdrawing from reality, Realitytesting is lost, the Id is dominant. Reality is denied and reconstructed and by that the person is trying to replace reality by the reconstruction

Psychotic Personality Organisation

Disavowal

- Differs from repression. It is about two different things which excludes each other.
- The object of disavowal is,in a way known
- Disavowal is also called "foreclosure", it is equal to repudiation
- Disavowal provokes splitting

- **Partial: in perversions or fetisjism**
- **Total: in psychosis**

Psychotic Personality Organisation

- The step from somatic to psychological self is not made because of a complexity of factors including genetic dispositions
- Patients are functioning on a teleological level
- There is no symbolisation, and by that no mentalizing ability
- Functioning on the level of "thing" representations instead of "word" representations, connected with "day rests"

Teleological mode

- Primacy of the physical
- Experience is only felt valid when its consequencies are apparent to all
- Affection is only real when accompanied by physical expression
- Automutulation or suicidality as the only route to the patient experiencing a sense of being cared for
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- Using mentalization to control the behaviour of others / manipulative
- Often in a manner that is detrimental to those who are "mentalized"
- Inducing guilt, anxiety and shame
- Use knowledge of others feelings in a sadistic way
- Physical threats, shouting, abusive language
- Humiliating or threatening humiliation for example by suicidal threats

Psychotic Personality Organisation

- Functional psychotic illnesses
  - Schizophrenia
  - Major affective disorders
  - Paranoid psychosis
- Psychotic development secondary to an acute or chronic organic brain syndrome

Psychotic Personality Organisation

- Severe inpairment of interpersonal functioning and self agency:
  - Intimacy, empathy
  - Identity and agency
  - More fusion than self object differentiation

Psychotic Personality Organisation

- Blurring of the bounderies
  - Between Self and Object
  - Of the Ego

- Lack of self - object differentiation
- More fragmentation than diffusion
- Impaired reality testing

Exploration

- Sensorium, then memory and intelligence
- Before focusing on reality testing
- Major psychotic symptoms in behavior, affect, thought content and organization, hallucinations

- Confirming loss of reality testing by clarification and confrontation,
- After that reality distorsion is no longer challenged, on the contrary: empathize maximally

Confrontation

- When delusional or hallucinatory phenomena are potentially present: reality testing should include a confrontation not only with:
  - External Reality

  but also with
  - Psychotic Reality

- You once told me that sometimes you have the feeling being Jesus Christ. But that of course you are aware that you are not really Jesus Christ. Could it be that, deep down, you are really cinvinced that you are Jesus Christ but afraid that this conviction will be interpreted as "crazy" by me or by others

Interpretation

- When the exploration of inappropriate behavior, affect or thought content does not clarify the issue of reality and when there is no indication for hallucinations or delusions

- Then you can make use of the interpretation in the here and now of primitive defense mechanisms
  - BPO: increasing of reality testing
  - PPO: decrase of reality testing

Low levellers

- Suffering from deficits, development is stagnated
- Severe Problems with bounderies. No difference with what is from inside and what from outside
- No difference between reality and phantasy
- Failing object constancy
- Sadistic superego and problems with guiltfeelings
- Splitting, Ego fragmentation, failing Ego identity
- Impulsive
- Problems with creating and having relations and a job

Psychotic Functioning

- Disorganized thinking, speech and behavior
- Inappropriate affect, depression, anxieties, phobias, sleeping problems, somatic concern
- Violent behavior and suicidal attempts
- Poor insight, no mentalising ability

(PDM 2006)

Psychotic Functioning

Affective States:

- Feelings of being empty, numb and detached from emotions and other people
- Difficulties in expresing or identifying feelings
- Intense feelings of anxiety, nervousness, or wishes to withdraw into sleep or isolation
- Intense anger in response to percieved threats from others
- Suspicious
- Urgent neediness and fears of being left alone, accomponied by anxiety and intense urges to cling to anyone available

(PDM 2006)

Psychotic Functioning

Cognitive Patterns

- Unable to focus, overwhelmed by pressing thoughts
- A sense of being transparant, vulnerable and easy invaded, being an open book
- Special feelings related to mindreading, mind control or power of prophecy
- Ideas of reference
- Shame deep sadness and jealousy in a momentary but intolerable way intense

(PDM 2006)

Psychotic – Non Psychotic Personalities

- **It is about different persons but it also can be about different aspects in one person**

- Predominance of destructive feelings
- Hatred of internal and external reality and of all those processes that make one aware of those realities
- Dread or immanent annihilation
- Tendency to sudden and premature formation of object relations, especially transferences "whose thinness is in marked contrast with the tenacity with which they are maintained

(Bion 1957)

Psychotic character

Personality Organization

- Disturbed relation with reality, illusions and bizarre deviations in social manners
- Disturbed feeling of reality, depersonalization, when reality testing is intact.
- Infantile object relations
- Pervasiveness of primitive ego defenses
- Vulnerability to micropsychotic episodes that are time limited and reversible

- **Not always a break down into overt psychosis**

(Frosch 1960; 1964; 1970)

Psychotic core

- A central psychic structure developed during infancy and childhood
- Filled with hatred for self and others
- Vulnerable to autistic regression

- Hereditary and constitutional factors: excessive anxiety. Potential for abnormal thinking, impaired visual-proprioceptive integration
- Environmental factors: problematic object relations, problems with differentiations and ego skills
- Intrapsychic factors: fantasizing

(Volkan 1994)

Psychotic Anxieties

- All internal objects including the good ones will be destroyed
- The mental capacity for synthesis and symbolization will be destroyed

  (M.Klein)

- Unthinkable anxieties: breaking through when maternal care is failing
  1. Going to pieces
  2. Falling forever
  3. Having no relation to the body
  4. Having no focus

  (Winnicott)

Technique

- Focusing on building a relationship
- Therapist should maintain a flexible stance regarding the mode and content of the treatment
- Finding the optimal balance between distance and intimacy
- Creating a holding environment
- Serving as a container
- Being an auxiliary ego/superego
- Being genuine, open and tranparant
- It is about stabilizing,stopping regression: cooling down instead from heatening up, calming down the patient

  (Gabbard 2005)

Technique, interventions

- No (thus postponing) interpretations,
  - start at the surface
  - Offering Reassurance
  - Clarification: making reconstructions, trace action to feelings and thoughts
  - Support: spell out the emotional impact of his doing on others
  - Empathy

  Untill the therapeutic relation is solid enough

Reassurance, support and empathy

- Reflective listening and accurate empathy
- Non-judgmental
- Open questioning
- Encouraging and stimulating exploration
- Check your understanding

Clarification and Affect elaboration

- Explore and reconstruct the event
- Make behaviour explicit
- Trace action to feeling
- Try to elicit feeling states
- What need to happen for the patient to feel differently
- Stop, stand, rewind and explore

Keep in Mind

- Offering insight can provoke regression and fragmentation
- Focuse more on cognitions than on affects
- Offering psycho-education

The End

- Thank you for listening
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