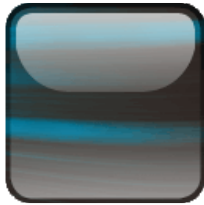


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Mentalization-based Treatment for Borderline Personality Disorder: A Practical Guide

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Assessment of interpersonal and relational world

Chapter: Assessment of interpersonal and relational world

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It is important to assess the predominant style and quality of relationships a patient develops using a time frame of at least 5 years. Many patients show a distinct pattern and the therapist needs to identify this early in the assessment process. We have already discussed in Chapter 5 the importance of assessing mentalizing capacity within the context of current relationship styles. Here we discuss how the pattern of relationships will not only inform the types of interventions used but also indicate the form of the relationship which is likely to develop between the patient, the therapist and the treatment team. Remember, characteristics of previous and current relationships should correlate with your assessment of mentalizing ability. If you find a discrepancy during assessment between the pattern of relationships and your assessment of mentalizing you should probe more carefully.

Once a pattern is identified you should point out to the patient that perhaps this will be repeated within the treatment itself—‘You sound like you have found that all your relationships become problematic after a few months and you begin to feel unwanted. Perhaps we are going to have to look out for that in our relationship when we begin treatment’. This is a typical ‘transference tracer’ (see [link]) and is a very common form of intervention in MBT.

Patterns of relationships

For practical purposes we have defined two types of distinct relationship patterns commonly identified in patients with BPD. The first is the centralized pattern and the second is the distributed type. Inevitably, dividing patterns of relationships into two distinct categories is not only embarrassingly schematic but also grossly over-simplified. Nonetheless the aim is to help the therapist to orientate himself to the experience of the patient and to help him choose appropriate interventions. In order to define the centralized and distributed relationship we assume that there is a normal pattern but again we are being schematic.

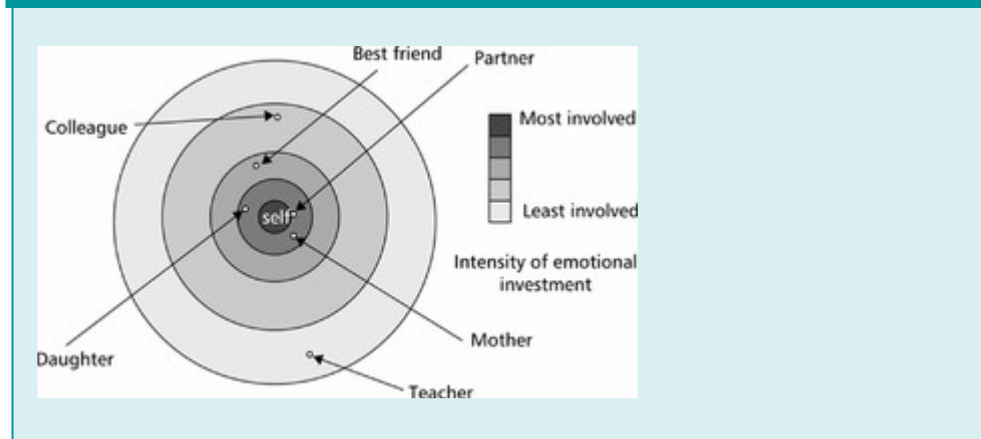
Normal

A ‘normal’ pattern of relationships shows selectivity, flexibility and stability over time.

Individuals form a variety of relationships ranging from intimate to distant which together form part of a coherent interpersonal world. The relationships may vary over time and move from intimacy to greater distance or from distance to closeness according to circumstance or choice but a sense of constancy is portrayed. The core self is never threatened. This pattern is represented diagrammatically in Box 6.2.

Assessment of interpersonal and relational world

Box 6.2 The hierarchy of relationship involvement—normal



A normal pattern correlates with secure attachment and is marked by a relatively good capacity to mentalize and to generate coherent narratives of even turbulent interpersonal episodes. Individuals value attachment relationships, coherently integrate memories into a meaningful narrative

Box 6.1 Interpersonal/relational representations—normal

Balanced—selective
Flexible—reversible
Stable—consistent over time
Developmental—change over time

and regard them as formative over time. They anticipate influencing others and being changed by them. They remain organized when under stress, show stability in emotional response and communicate negative emotions constructively. This perfect pattern is of course rare! In essence these individuals allow others with whom they have a highly invested relationship to have their own mind.

Remember, these characteristics of previous and current relationships should correlate with a robust ability to mentalize. If you find a discrepancy during assessment between the pattern of relationships and your assessment of mentalization you should probe more carefully.

Centralized

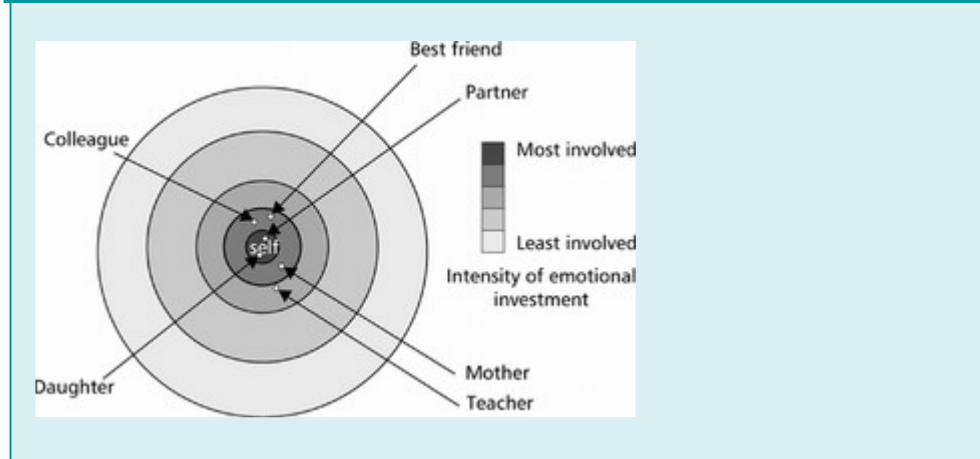
Patients demonstrating a centralized pattern of relationships describe unstable and inflexible interactions (see Box 6.3). Their representation of the other person's mental state is closely linked to their representation of self. This does not mean that the thoughts and feelings of self and other are identical but rather that they are highly contingent on each other. Change in the other person is anticipated in response to change in the feelings of the self and if it does not occur or the other indicates independence of mind, panic and confusion occurs. The key to defining this type of relationship organization is finding that relationships fluctuate between being close and over-involved and being remote and denigrated. The patient is self-focused. Emotions surrounding relationships are powerful, fluctuating and compelling. People quickly become 'best friends', 'lovers', 'enemies' and 'betrayers'. The dialogue contains statements like 'I cannot live without him' or 'she betrayed me', and 'he is out of my life forever'. Interactions swing wildly from intimacy to distance or become turbulent following apparently small slights. The other person is often experienced as being unreliable or inconsistent and failing to demonstrate love adequately. Experience of disloyalty and abandonment is common and the quality of the relationship is often represented in a schematic way, especially when the core self is threatened. Descriptions become polarized with blame apportioned liberally. Not surprisingly the strength of emotion surrounding this pattern of relationship leads to impulsivity and suicide attempts or self-harm, often in the context of emotional turmoil. This pattern is represented diagrammatically in Box 6.4.

Box 6.3 Interpersonal/relational representations in BPD

- ◆ Centralized
 - Unstable
 - Self-focused
 - Inflexible
- ◆ Distributed
 - Stable
 - Distancing
 - Inflexible

Assessment of interpersonal and relational world

Box 6.4 The hierarchy of relationship involvement—centralized—unstable



The centralized pattern of relationships links with insecure attachment. On numerous measures of adult attachment, patients with BPD are identified as insecure, preoccupied and fearful in their relationships. They have a specific type of disorganized, anxious, preoccupied attachment focused around an approach avoidance dilemma where the attachment figure is simultaneously perceived as a source of threat and a secure base. Gunderson carefully described typical patterns of borderline dysfunction in terms of exaggerated reactions of the insecurely attached infant, for example, clinging, fearfulness about dependency needs, terror of abandonment, constant monitoring of the proximity of the caregiver and deep ambivalence and fearfulness of close relationships. This is the centralized borderline patient.

The centralized borderline patient will not be able to maintain mentalizing normally in the context of attachment relationships. Separation of minds becomes impossible and this leads to confusion of what is within and what is without, whose feeling is whose, and what is self and what is other. The hyper-responsiveness of the attachment system, perhaps related to traumatic or other early experiences or genetic predisposition, has an unusually negative impact upon mentalizing. So, once again, your assessment of the relationship pattern should correlate with your assessment of mentalization. More specifically, capacity for mentalization may be reasonable outside close interpersonal interactions but once embroiled within a relationship the patient's capacity is likely to be significantly diminished.

Practice point

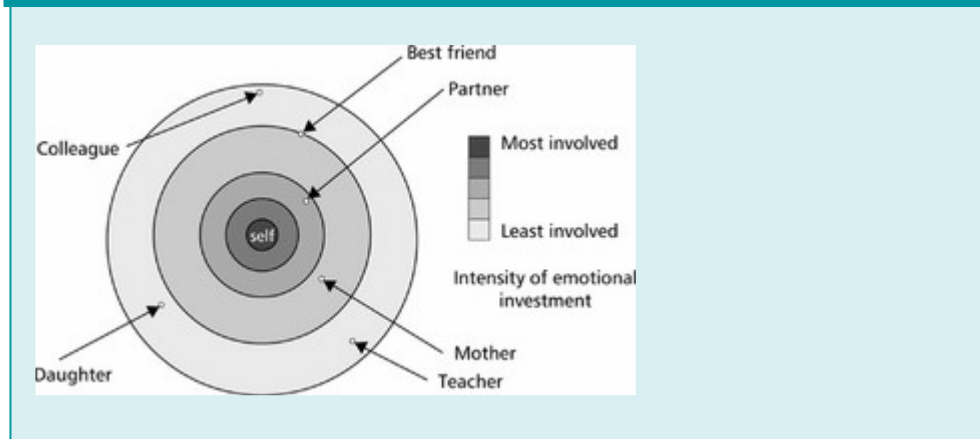
As soon as you stimulate the attachment relationship in treatment the patient's mental capacities will rapidly decrease, making it difficult for him to understand complex interventions. Under these circumstances you must alter your interventions, making them simple and understandable, to ensure that the patient does not become over-aroused which will further reduce his capacities (see [\[link\]](#)).

Distributed

In contrast to the instability of centralized relationships the distributed pattern demonstrates fragile stability (see Box 6.3). This is linked to a detached attachment pattern. People are distanced; there is little flexibility in the system with no one being allowed to become close. A clear separation of one's own mind and the other's mind is maintained. Intimacy is dangerous—as one patient said 'I don't do relationships anymore. That way I feel OK'.

Patients may present at assessment with pseudo-mentalization (see [\[link\]](#)) and can rapidly engage in conversation with the therapist using pretend mode (see [\[link\]](#)). They give plausible explanations for their problems and the insight-oriented therapist may be left wondering what more he can offer. The picture of isolation and distancing may have emerged over time because repeated attempts to have relationships have resulted in failure. Eventually patients give up and, in despair, retreat from emotions and interactions with others just as they may have done from their family. This is represented diagrammatically in Box 6.5.

Box 6.5 The hierarchy of relationship involvement—distributed—relatively stable



Nonetheless they can find this 'dissociated' state painful and at times attempt to remedy the situation by seeking out others only to find that this leaves them feeling inadequate and foolish once again. Disappointed, they seek help but either leave quickly when they realize that treatment means having an emotional involvement or alternatively maintain treatment but hold the therapist and others at a distance.

In general these patients have decoupled their capacity to deal with their own or others' mental states comprehensively, particularly in an attachment context, but this leaves them isolated and alone. Beginning relationships or starting treatment becomes a way of placing aspects of themselves outside. This stabilizes their fragile sense of self and once the externalization is achieved, the patient has no interest in the relationship with the therapist and may in fact wish to repudiate it totally. At these moments the therapist may feel abandoned and some instances of boundary violations may be related to the therapist's difficulty in coping with the implicit rejection which the patient's wish to distance themselves from a disowned part of their mind entails.

Practice point

Dynamic therapists tend to interpret what they believe is the representation of a self-object dyad which is being enacted within the therapeutic encounter but we recommend that this is not done at this point. Remember that when the patient rejects some aspect of treatment it may be because they fear that the externalized aspects are being forced back into them. Focusing the patient's attention at these moments on the

relationship may be felt by them as undermining their attempts at separating from the disowned part of themselves and consequently can be counterproductive, leading the patient to prematurely terminate the treatment. It is better to gradually ease the patient towards exploring the relationship by placing yourself within the relationship in an overt way—‘I think that I must be doing something that makes you nervous. Can you identify what it is?’ (see Chapter 8 for fuller discussion).

Why assess the pattern of relationship?

There are two main reasons for assessing the pattern of the relationship. First, it indicates the relational contexts in which problems in mentalizing will occur and need to be addressed. Second, it enables the therapist to position himself in relation to the patient. In the centralized patient the therapist needs to maintain a careful balance between closeness and distance. When the patient pushes the therapist away the therapist needs to push back into the relationship. When the patient becomes entangled emotionally with the therapist, appropriate distancing is necessary. The danger for the therapist is of becoming too involved or too distant and oscillating between the two poles.

In the distributed patient the therapist must try gently to bring the patient closer into contact with his emotions especially in relation to the patient/therapist interaction. The danger for the therapist is of becoming too distant, allowing the patient to remain detached through intellectualisation or stimulating ‘pretend mode’ through rational, emotionless, exploration of relationships.

Current and past relationships

Establishing the pattern of relationships requires the therapist to elicit the details of all important present and past relationships but with an emphasis on current and recent involvement with others (see Box 6.6).

Box 6.6 Identify all important current and past relationships

- ◆ Characterize each relationship according to
 - Form
 - Process
 - Change
 - Behaviour
- ◆ Explore how relationships relate to problems; for example, suicide attempts, self-harm, drug misuse
- ◆ Link past to current relationships (BUT eschew causality) where similarities exist—‘that sounds just like you felt with your present partner’
- ◆ Identify priorities/hierarchy for intervention

Each notable relationship should be explored from beginning to end, its trajectory charted and its effect on the patient’s emotional state identified. In particular the interaction between relationships and suicide attempts, self-harm and impulsive behaviour should be explored. Insist on discussing the quality of interaction, obvious moments of change in the relationship and characteristic interactions. The information will be important as you seek to understand the experience of the patient. Do not simply seek out negative and problematic areas of relationships but give equal importance to aspects that give the patient security, pleasure and moments of happiness. Few relationships are solely negative.

An important aspect of all psychotherapy is to help patients develop a narrative of themselves in relation to others in terms of past experience and current understanding. You should make obvious links between past and current relationships—‘that sounds just like how you felt with your present partner’—but in doing this it is important to eschew causality. MBT does not seek to explain present problems as repetitions of the past, and attempting to offer such explanations early in treatment is likely to make the patient feel that their current difficulties lack substance. Mentalizing is not explanation and insight but a capacity to make and break story lines according to new experience and reflection. Rigid adherence to a narrative is anti-mentalizing as it disallows construction

and re-construction of an autobiographical story and prevents re-appraisal within a new context.

As part of the assessment the therapist should elicit a detailed account of at least one, and preferably three or more, important current interpersonal interactions in which the attachment relationship has been emotionally activated; for example, an argument with a partner (see Box 6.7).

Box 6.7 Assess current emotional interactions

- ◆ Identify common communication difficulties
- ◆ Explore any open conflict associated with affect storm—outcome
- ◆ Characterize ambiguous, indirect non-verbal communication
- ◆ Delineate incorrect assumptions; that is, that one has communicated or that one has understood
- ◆ Identify silent closing off communication and repetitive statements—‘I know that I am no good’
- ◆ Identify faulty communication by listening for the assumptions that the patient makes about other’s thoughts or feelings including in therapy dialogue

The patient needs to begin to grasp the idea that interpersonal events are complex, cannot easily be explained and are too easily dismissed as a way of managing disturbing and destabilizing feelings. All too often patients fail to mentalize events even after an emotional storm has passed, preferring to forget about them or to pretend that they did not happen. (see Box 6.8).

Box 6.8 Common assessment questions

◆ Questions

- Looking back, can you think a bit about what made her behave like that?
- How do you explain his action?
- Is that something that has happened before?
- Is there any other explanation?
- What do other people think about it?

◆ Probes

- I can see that you must have wanted to end the relationship but somehow you stuck it out. Tell me what made you carry on.
- You must have been so excited when the relationship started and felt so let down when he was unreliable. How did you manage those feelings?

MBT requires the patient to focus carefully on their internal experience and state of mind at the time. But importantly MBT also asks the patient to focus on the other person's mind. This means that the therapist has to identify misunderstandings in relationships, define ambiguous, indirect non-verbal communication and delineate incorrect assumptions—'What was it that made you behave like that at that moment? Why do you think that he said that? How do you explain his behaviour towards you'. When we talk to people we assume that they have understood what we are saying and why we are saying it. In fact their perceptions of our motivations may differ from our own and so the interaction gradually becomes distorted. The vulnerable mentalizing capacity of the borderline patient makes this a common event. If it occurs during the assessment the therapist should alight on it and identify the process leading to progressive confusion.

Patients may use silence, closing off communications and repetitive statements—'I know that I am no good'; 'it is all my fault'. The therapist should ensure that if closure statements occur during the assessment they highlight the effect these have on further consideration of the topic. If at all possible identify flawed communication by listening for the

assumptions that the patient makes about others' thoughts or feelings including your own. Many patients will insist that you do not understand because you have not experienced what they have—'how can you understand? You weren't abused like I was'—and yet they have no way of knowing whether you have or have not experienced similar events or feelings. This is not a cue to tell them about yourself but is a moment to challenge their assumptions about you and to question whether they make similar assumptions about others and act on those assumptions (see stop and stand, [\[link\]](#)).

