Psychodynamic Treatment for Borderline Personality Disorder and Mood Disorders: A mentalizing perspective

Patrick Luyten and Peter Fonagy

Patrick Luyten, Faculty of Psychology and Educational Sciences, University of Leuven, Leuven, Belgium. E-mail: patrick.luyten@ppw.kuleuven.be

Peter Fonagy, Research Department of Clinical, Educational and Health Psychology, University College London, London UK. E-mail: p.fonagy@ucl.ac.uk.

Tel: +44 20 7679 5690

Correspondence to Professor Fonagy

Abstract

Borderline personality disorder (BPD) and mood disorders are highly comorbid, and both disorders share important developmental pathways and underlying neurobiological features. This chapter reviews evidence for the overlap between BPD and mood disorders and presents an attachment and mentalizing approach to the conceptualization and treatment of patients with depression with and without marked BPD features. We propose that patients with BPD and mood disorders can be situated on a continuum, with four related features distinguishing individuals with depression with versus without marked BPD features: (a) the nature of their depressive experiences, (b) the nature of their mentalizing impairments, (c) the presence of insecure, but organized, attachment in response to stress and arousal versus disorganized attachment and (c) problems with epistemic trust versus epistemic hypervigilance. We outline the therapeutic implications of these views, arguing that treatments that combine a mental representation and mental process (i.e., mentalizing) focus may be most appropriate for patients with mood problems without marked BPD features. Yet, for patients with more marked BPD features these treatments may be iatrogenic, as these patients may have serious problems in establishing a therapeutic alliance and lack the reflective capacities needed for such treatments. For these patients, a mental process approach that focuses on restoring the capacity for mentalizing might be more appropriate. Preliminary empirical evidence supporting these assumptions is presented.

Keywords: attachment, mentalizing, social cognition, early adversity, psychodynamic, stress

Introduction

Considering comorbidity between depression and BPD (BPD) is important both from a research and a clinical perspective. Studies not only suggest that depression and BPD are highly comorbid, but also that comorbidity with BPD features may influence the clinical course as well as treatment response in depression in negative ways [1, 2]. Similarly, depression or dysphoria is a core feature of BPD, although studies suggest that depression in BPD has a different character than in MDD [3, 4]. As we will argue in this chapter, differences in the phenomenology of depression in BPD have often been neglected, despite the fact that they have very important implications for treatment and point to substantial differences in the development and course of these disorders.

From a mentalizing perspective, we believe that (brief) focused treatments that are effective in more high-functioning patients suffering from depression are likely to be less effective with depressed patients with (marked) BPD features if the treatment model is not adapted to the specific characteristics of these patients. Patients with BPD suffer from marked impairments in their mentalizing capacities – that is, in their capacity to understand the self and others in terms of intentional mental states, such as feelings, desires, wishes, values and goals. Particularly in severely disturbed BPD patients, treatments that strongly rely on reflective capacities might actually become iatrogenic [5, 6]. We argue that the reasons for this lie in differences in the attachment history and impairments in mentalizing, and related epistemic hypervigilance [7], in patients with (severe) BPD features versus those without. These differences are presumed to have a negative impact on the treatment of these patients, as they (a) impede the development of a therapeutic alliance, a key predictor of therapeutic outcome in evidence-based treatments for depression, regardless of the type of treatment [8], and (b) are negatively related to the patient's ability to benefit from both brief and longer-term supportive and particularly expressive (i.e., insight-oriented) treatments [9]. As we will

see, although it is not yet clear whether depression and BPD are part of a spectrum of affective disorders, we consider it helpful from a treatment perspective to think of depressed patients as situated on a continuum ranging from depressed patients without BPD features to depressed patients with marked BPD features, necessitating a different treatment approach depending on their position on this continuum. Briefly, depressed patients without marked BPD features may benefit from a *mental representations* approach [10], i.e., an approach that focuses on distortions in the content and/or developmental level of mental representations (cognitive affective schemas or internal working models of self and others). Yet, the more patients move to the borderline spectrum, the less likely they become to benefit from this approach, to the point that such an approach may become iatrogenic. Such patients may benefit more from *a mental process* or *mentalizing* approach, where the focus is on distortions in processes related to the meta-cognitive ability to reflect on the self and others [11, 10].

In this chapter, we first review, with an attachment/mentalizing focus in mind, relevant empirical research concerning comorbidity between BPD and depression, and similarities and differences in the etiology of these disorders. Next, we describe a mentalization-based spectrum of interventions for depressed patients with varying levels of BPD comorbidity, with different weight given to mental representation and mental process models depending on the severity of BPD comorbidity. We also provide preliminary evidence supporting the effectiveness of mentalization-based treatments in depression.

Comorbidity between BPD and mood disorders

Depression is a highly prevalent disorder, with population-based studies suggesting a lifetime prevalence for unipolar depression of 15%, and up to 25% in women [12-14]. Depression is expected to be the second most serious disorder with respect to the global

disease burden by the year 2020 [15]. Studies suggest that unipolar depression has a relapse rate of 20–30% within 3 years following a first episode, and 70-80% within 3 years in subjects who have had three or more depressive episodes [16]. The probability of at least one further episode of depression after a first episode is estimated to be almost 90% [17] and the average depressed patient will experience four episodes during their lifetime, each approximately 20 weeks in duration [18]. A notable illustration of the long-term negative impact of mood disorders is given by the finding that children of parents with mood disorders are themselves at higher risk of developing psychopathology in later life [19]; both internalizing and externalizing disorders are more common in the children of parents with mood disorders [20].

Studies have shown that currently used pharmaceutical and psychotherapeutic treatments have limited efficacy for a considerable proportion of depressed individuals, with only around 50% of depressed patients responding to these treatments [21-23]. As a consequence, treatment guidelines have emphasized the need for a long-term approach in depression management, stressing continuation and treatment maintenance, and with a focus on relapse prevention [21].

One reason for the relatively limited response of many depressed patients in current evidence-based treatments [e.g. 24] may lie in the high comorbidity between MDD and BPD [25-27, 22]. Lower response rates in depressed patients with BPD have often been reported [28, 29]. For instance, in a large study of 276 patients with MDD, randomized to interpersonal psychotherapy or pharmacotherapy, higher levels of personality pathology and the presence of borderline personality disorder in particular were associated with a longer time to remission [2]. However, some higher quality studies tend not to show an influence of BPD comorbidity [30]. This may be the case for at least two reasons. First, patients with marked BPD features (e.g., high levels of parasuicidal behavior and impulsivity) might

simply be excluded, particularly in high quality studies. Westen and colleagues, for instance, found a high correlation between the number of exclusion criteria (as an indicator of the quality of the study) and treatment outcome in studies of depression and anxiety [31]. Second, therapists who are closely supervised and monitored, as is typically the case in high-quality studies, might be more likely to tailor their treatment and interventions. Hilsenroth and colleagues, for instance, showed that short-term psychodynamic psychotherapy was equally effective for depressed patients with and without comorbid borderline pathology. Yet in patients with comorbid BPD features, therapists used more structuring techniques than in patients without comorbid borderline pathology. These included providing structure at the start of therapy, suggesting specific activities between sessions, maintaining an active focus on treatment topics, more supportive interventions and more interventions aimed at examining relational patterns [29]. These adaptations in techniques are, in our opinion, not coincidental, as there is emerging consensus that a more active, structured and coherent treatment approach may be a common factor explaining the effectiveness of evidence-based treatments of BPD [32]. As outlined in detail in this chapter, a more active interpersonal, supportive and structured approach is central to MBT.

The relationship between BPD and depression

The precise nature of the relationship between depression and BPD is elusive. This should come as no surprise, as depression refers to (a) a psychobiological response to loss and defeat, (b) a symptom, and (c) a disorder [23]. BPD, in turn, has not quite shed its historic definitional challenge of being an "adjective in search of a noun" [33]. As is well known, BPD has been conceptualized as (a) a level of functioning [34, 35] encompassing a wide variety of personality disorders, (b) a disorder with substantial overlap/comorbidity with other disorders such as substance abuse disorder, posttraumatic stress disorder (PTSD) and

mood disorders [36, 37], (c) part of a spectrum of affective disorders (including bipolar disorder) – given its high comorbidity with mood disorders [38] – congruent with models of BPD that emphasize affect dysregulation, and depression in particular, as a key feature of BPD [39], yet, BPD has also been hypothesized to be part of (d) a spectrum of psychotic disorders [40] and (e) PTSD [41].

A focus on descriptive diagnostic criteria and features alone may not shed further light on these issues [42], as disturbed mood is essential to BPD and, conversely, disturbed interpersonal relationships have been implicated as a cause, concomitant and consequence of depression [22]. This is also shown by rather unproductive attempts to decrease the comorbidity between BPD and mood disorders by replacing the word "depression" in the DSM-III-R criteria with the word "dysphoria". While these efforts to distinguish phenomenologically between feelings of depression in MDD and BPD are, as we explain in more detail below, legitimate, they are unlikely to resolve matters, as studies suggest that BPD is most distinctly characterized by *affective dysregulation* or *affective instability* rather than dysphoria [36]. If the core problem of BPD includes instability of affect states, then studies investigating longitudinal relationships between MDD and BPD, although informative, will similarly be limited in their ability to shed light on the relationship between mood problems and BPD.

From our attachment theory and mentalizing perspective, the possibility of untangling the Gordian knot of the relationship between depression and BPD lies in analyzing the differences in the developmental pathways involved in patients with depression with and without BPD features. Developmental factors moderate differences in symptomatology, phenomenology, prognosis, and treatment response. Also congruent with this emphasis on developmental continuities is a dimensional approach to pathology intrinsic to the NIMH's Research Domain Criteria (RDoC) initiative [43]. Our focus is on the role of the behavioral

and neurobiological aspects of attachment and mentalizing (social cognition) in generating the developmental pathways that are implicated in mood disorders and BPD. Given this focus, differences between mood disorders and BPD are unlikely to be categorical, but the differences in developmental behavioral paths and underlying neurobiology are sufficient to warrant separate consideration, particularly as they have important but specific treatment implications.

The mentalizing approach to BPD and mood disorders

Similarities between BPD and mood disorders

BPD and depression are not only highly comorbid at the symptomatic and syndrome levels; there is also increasing evidence for shared underlying psychosocial and neurobiological mechanisms. From the mentalizing perspective, findings concerning the powerful ties between disruptions in (a) mentalizing and attachment experiences, and (b) stress/affect regulation in mood disorders and BPD [44, 41] are crucial here. We discuss these findings and highlight commonalities between mood disorders and BPD.

(a) Disruptions in mentalizing and attachment

The **mentalizing** approach originally developed in an attempt to understand patients with marked borderline pathology, and their difficulties in reflecting on the self and others, specifically in attachment contexts [45, 46]. In these circumstances, these patients tend to lose the capacity for more controlled, reflective functioning concerning the self, others, and the relationship between the self and others, and to switch increasingly to so-called nonmentalizing modes of experiencing subjectivity. These primitive, pre-mentalizing modes of function include *psychic equivalence* (in which mental events are considered to have the same status as physical reality), *teleological thinking* (the assumption that emotional

difficulties can be solved by doing, for instance, anger can be resolved by destruction of property or violence) and *pretend mode* (when subjectivity becomes completely separated from reality and mentalizing becomes excessive but lacking in depth and genuine meaning).

Mentalizing has the function of maintaining an illusion of self-integration or self-coherence by linking observed acts and experiences to plausible intentional states [47]. Because of the fragmentation of the self that results from the use of nonmentalizing modes, BPD patients are often characterized by a tendency to externalize "alien-self" parts, which are felt to threaten the self from within, in an attempt to restore coherence in the self-experience [48]. This need to externalize may be expressed in acting-out behavior, self-harm, and/or a tendency to coerce others into specific roles (i.e., that of the one who neglects, abandons, or criticizes the patient). Studies increasingly suggest [49] that this tendency might be rooted in disturbed attachment relationships and attachment trauma in particular in interaction with biological predisposition [50, 51].

There is good evidence to suggest that both depression and BPD are associated with impairments in mentalizing and in the neural circuits that are implicated in mentalizing [49, 52], including the medial prefrontal cortex, amygdala, hippocampus, and ventromedial parts of the basal ganglia [53-55]. Moreover, these dysfunctions have been linked to failure of top-down regulation and/or impairments in bottom-up input, reflecting hypersensitivity of limbic structures that in concert may be responsible for the impairments in autonomic regulation, emotion regulation, and neuroendocrine stress responses typically observed in mood disorder [53-55] and, in more extreme forms, in BPD [49].

The link between these formulations of the features typical of patients with BPD and patients with mood disturbances is obvious: many BPD patients suffer from mood problems because of **attachment disruptions** and resulting problems in self-esteem; and these issues are easily reactivated by current stress and arousal, particularly in interpersonal relationships.

Mood problems further impair mentalizing, leading to a vicious cycle characterized by hypervigilance to rejection/abandonment and increasing depression. Similarly, hypersensitivity to experiences of failure (either real or imagined), which have also been implicated in vulnerability to depression [56], trigger feelings of being unloved and unwanted [6], a feature typical of BPD patients.

Depression can thus be seen as a basic psychobiological reaction to experiences of (anticipated) loss and separation [57], either directly through the threat of loss and abandonment or indirectly through experiences of failure [58]. As such, depression can be expected to be central in BPD. Strong rejection sensitivity is indeed typical of BPD patients and has even been conceptualized as the interpersonal phenotype of BPD [59, 44]. Similarly, self-criticism (e.g., evaluation of the emotional self as characterized by unworthiness, inferiority, failure, guilt, and chronic fear of disapproval and rejection) is a key part of BPD [56]. Blatt and colleagues have argued in this context that problems concerning rejection sensitivity and dependency can be situated on a continuum ranging from more psychotic to more high-functioning histrionic levels of functioning [60]. The importance of mood problems in BPD, and thus comorbidity between mood disorders and BPD, should thus not surprise us. Recently, negative self-referential processing in combination with emotionality has been suggested to be an endophenotype of treatment-refractory patients who fail to achieve a satisfactory treatment response [61, 62].

In an attempt to regulate increasing levels of arousal (including depressed mood), individuals may begin to rely on secondary attachment strategies (i.e., attachment hyperactivating and deactivating strategies). This will likely bring about further limitations in mentalizing with regard to both one's own and other people's motivations and desires [63]. Increasing levels of depressed mood lead to further increases in arousal and stress levels,

resulting in impairments and distortions in mentalization, which in turn lead to a loss of resilience in the face of stress, and to a vicious cycle of increasingly depressed mood.

Congruent with these assumptions, insecure attachment has been related to vulnerability to both depression and BPD in children, adolescents, and adults [64, 65, 49]. Thus, both disorders share important developmental features. Likewise, research indicates that vulnerability to both depression and BPD is associated with personality traits or cognitive-affective schemas that are rooted in disruptive attachment experiences, notably interpersonal dependency and self-critical perfectionism [66-69]. Insecure attachment also prospectively predicts recurrent depression, more depressive episodes and residual symptoms, longer use of antidepressants, impairments in social functioning [70], and suicide [65].

The central role of attachment experiences in the causation of depression and BPD is further emphasized by findings concerning the central importance of **developmental adversity** and disruptive attachment experiences (in particular abuse and neglect) in the etiology of both disorders[41, 71], leading to a dysregulation of stress and affect regulation systems.

(b) Disruptions in stress and affect regulation

Early adversity has profound effects on the developing stress system: indeed, studies suggest that attachment experiences play a key role in the developing stress system [72, 73 , 6]. Secure attachment experiences seem to buffer the effects of stress in early development, leading to a so-called “adaptive hypoactivity” of the hypothalamic–pituitary–adrenal (HPA) axis in early development, and to resilience in the face of adversity in later life [74]. By contrast, research [73, 75-77, 74] shows that insecure attachment experiences are associated with increased vulnerability to stress, as expressed, for instance, in HPA axis dysfunctions.

Together, these findings may at least partially explain the mounting evidence that vulnerability to depression is associated with an **increased stress response** to both daily and major life stressors [78, 41], explaining, at least in part, high comorbidity and overlap with BPD. Several studies do indeed suggest that insecure attachment experiences mediate the relationship between early adversity and vulnerability to depression through **impaired affect regulation**, **stress responsivity**, and **social problem-solving skills** [79, 80] – features that are also typical of BPD patients [81].

Moreover, although the evidence is still somewhat equivocal [82], there is some evidence that increased stress responsivity as a result of early or later adversity is particularly pronounced in individuals with genetic liability, which might also be the case in BPD [50]. For instance, studies suggest that a polymorphism of the 5HTT gene may be associated with increased stress sensitivity, resulting in increased vulnerability to depression [82] as well as BPD, although recent meta-analyses have called these findings into question [83, 82].

There is now also evidence [76, 84, 75, 85, 86] that the neuropeptides oxytocin and vasopressin, which are involved in neural systems underlying attachment [87, 76], play a key role in disrupted stress regulation in mood disorders and BPD. Oxytocin plays a role in affiliative behavior (including pair bonding, maternal care, and sexual behavior) as well as in social cognition [88, 89], and in reducing behavioral and neuroendocrinological responses to stress [76].

Early adverse attachment experiences are associated with decreased oxytocin levels and increased cortisol response [90, 91, 41]. High levels of attachment anxiety and avoidance have been associated with polymorphisms in the oxytocin receptor gene in patients with unipolar depression [92], and studies have also found dysregulated peripheral oxytocin release in depressed women [93]. Gotlib and colleagues reported that adolescent girls who were at risk for depression showed decreased activation in the reward processing system (and

particularly striatal areas), suggesting a marked reduced sensitivity to reward [94]. Similarly, low endogenous levels of oxytocin, polymorphisms in oxytocin-related genes, and negative (instead of positive) effects of oxytocin administration have also been documented in BPD [95-97, 93]. These findings suggest at least some overlap between depression and BPD in terms of a dysfunction of the oxytocinergic system (underlying attachment behavior and stress regulation), which may also explain the inverse effects of oxytocin administration in these patients [98].

What then is the difference?

Although patients with depression with and without BPD features probably need to be situated on a continuum with regard to underlying psychosocial and neurobiological mechanisms, at least four related differences seem to distinguish these groups of patients: (a) *the nature of depressive experiences*, (b) *the nature of mentalizing deficits*, which are more extreme in BPD patients in terms of both intensity and content, (c) *the nature of attachment experiences*, with BPD patients showing more disorganized attachment features as a result of more severe disruptions of the attachment system (which may be in part related to genetic as well as environmental factors), and (d) the profound loss of mentalizing in BPD patients, which, coupled with disorganized attachment features, typically leads, in the psychic equivalence mode, to strong and painful feelings of emptiness/lack of meaning. As a result, this intensifies feelings of identity diffusion and hypersensitivity to rejection, and increases pressure to externalize alien self-parts in a teleological attempt to get rid of these feelings. These tendencies, in our opinion, lead to a profound *lack of epistemic trust and an epistemic hypervigilance*, which necessitates a different treatment approach, as these features seriously threaten the ability to form a working alliance, and these patients typically lack the reflective capacities that are needed in many current evidence-based treatments for depression. We review each of these issues in more detail below.

When depression is not just depression

More than twenty years ago, Drew Westen and colleagues noted that "depression is not just depression" in BPD patients [3]. Indeed, studies since have amply demonstrated the phenomenologically very different nature of depression in BPD patients. Patients with marked BPD features have greater affective instability (which makes the relationship between stressful experiences and the onset of depression, so typical of depressed patients without such features, less obvious in BPD patients) [69]. Studies also suggest that patients with BPD features also have a greater painfulness of depressive experiences as evidenced by higher scores on self-report, but not observation-based, measures of depression [99, 4, 100]; more feelings of emptiness and diffuse negative affectivity [3]; higher levels of self-criticism [101, 102]; and a greater focus on fears of abandonment [103, 4] and shame [104, 105], which predict self-destructive behaviors, impulsivity, and interpersonal distress [4, 106].

Profound mentalizing impairments

From a phenomenological perspective, depression in patients with marked BPD features reflects a more severely non-mentalizing way of experiencing subjectivity as compared to depressed patients without such features. There are differences in intensity, but these also reflect differences in the quality (i.e., content) of mentalizing failures, which may have etiological underpinnings. Because of the ready loss of mentalizing in BPD patients, feelings of rejection and abandonment, in a *psychic equivalence* mode, can feel extremely painful in these patients. Feelings of unattractiveness are felt as an absolute truth. Zanarini and colleagues [107] noted this aspect of BPD phenomenology. We have attributed this to an underlying disorganization of the self, rooted in disorganized attachment and leading to alien-self experiences (e.g., "critical introjects") and the risk that increasing incoherence of the self generates stronger pressure to externalize (project and attribute to others) the alien-self

experience [108]. Greater self-harm and destructiveness may result, and these features also negatively influence the therapeutic relationship as therapists are more likely to become entangled in difficult transference–countertransference relationships [109-111].

The so-called "depressive realism" often reflects a more accurate and less rose-colored view of reality in those with depression without marked BPD features [112, 113]. In BPD patients, depressive realism shifts into psychic equivalence and often borders on the complete absence of an experience of symbolic representations or hypomentalizing: there is really nothing that is worth living for, the self feels completely empty, unattractive and unworthy.

Disturbed mood further impairs individuals' ability to mentalize. When the individual is depressed, mentalizing is likely to be distorted for both MDD and BPD patient, but in the latter group depression can trigger the re-emergence – either temporarily or more chronically – of modes of thinking that antedate full mentalizing, which can lead BPD patients to devalue the significance of subjective experience and prioritize physically observable outcomes (teleology, or judging experience solely by its physical outcomes). The loss of mentalizing leads patients to feel unable to accept anything other than a modification in the realm of the physical as a true index of the intentions of the other. This may be linked to the extreme focus on exterior indicators of mental states (such as gestures and expressions). The weight of evidence suggests that mentalizing tasks that focus attention on external features cause fewer problems for these patients; indeed BPD patients have been found to be hypersensitive to facial expressions [e.g., 114, 115, 116].

The ease with which BPD patients can lose reflective, controlled mentalizing probably also contributes to the ready emergence of a *teleological mode* of thinking. The failure of reflective mentalizing in BPD has been repeatedly demonstrated using attachment narratives [117-119] and has been shown to be reversible by psychotherapy [120]. Other

studies have shown BPD patients to be impaired on the Movie for the Assessment of Social Cognition (MASC), a video-based test of mentalizing which requires participants to recognize the mental state of characters as they interact in an everyday life group scenario involving relationships [121-123]. In patients with marked BPD features, a teleological stance often leads to frantic attempts to get attachment figures, including the therapist, to show that they care, like, and love the patient. Hence, patients may demand longer or more sessions, and, in more extreme cases, demand to be touched, caressed or hugged by their therapist, which may lead to boundary violations. While this can also occur in depressed patients without marked BPD features, such tendencies are mostly understood to be "not for real".

In psychic equivalence and the teleological mode of functioning, the subjective experience is one where the implication of failing to achieve the physical outcome is catastrophic and can feel like a choice between life and death. Suicidal ideation deserves special attention here, particularly as studies suggest highly increased rates of suicidal behavior in depressed patients with BPD features. A recent population-based study, for instance, showed that comorbid BPD features were strongly associated with suicide attempts in patients with major depressive disorder [124]. Similarly, Stringer and colleagues showed, in a study of 1838 depressed patients, that the suicide attempt rate ratio increased by a staggering 33% for every unit increase in BPD features [1]. Sharp and colleagues showed that BPD features predicted suicidal ideation (and self-harm more generally) over and above major depressive disorder in a sample of 156 adolescents admitted to a specialized treatment setting [125].

The tendency to function in the teleological mode may explain the higher levels of impulsivity and aggression that make these patients more prone to suicidal behavior [1]. In the case of depressed patients without marked BPD features, thoughts and feelings

concerning suicide are more embedded within an interpersonal context that is more readily available to the patients, with suicidal thoughts involving harsh self-criticism and anger turned toward the self, fantasies about killing hated parts of the self, and omnipotent fantasies about reunion with lost loved ones. In the case of depression and suicidal tendencies in BPD patients, these interpersonal links are less clear to the patient and it often seems to be the too-realness of painful inner states (feelings and emotions) that primarily leads patients to ideas or acts of suicide in an attempt to silence inner feelings of pain.

A feature of BPD phenomenology that distinguishes the condition from simple depression is hypermentalizing. Hypomentalizing, particularly in BPD patients, is often followed by *extreme pretend mode or hypermentalizing accounts* in which the relation to reality is severed [126, 123]. In the pretend mode, ideas form no bridge between inner and outer reality; the mental world is no longer fully coupled with external reality; explicit mentalizing has been overridden by implicit mentalizing; an excessive internal focus is unchecked by reference to external indicators; there is poor belief-desire reasoning, vulnerability to fusion with others' identity, and a tendency to become lost in the complexity of the world of beliefs and desires with which physical reality is only loosely coupled. In hypermentalizing, groundless inferences are made about mental states, sometimes reminiscent of confabulation [123, 127]. Hypermentalizing accounts of interpersonal events often strike the clinician as overly analytical, repetitive and lengthy in nature, colored by depressive themes (e.g., guilt and shame). In BPD patients, hypermentalizing accounts are typically more self-serving (e.g., to receive attention or compassion, or to control or coerce others), and affectively overwhelming interpersonal accounts that often lack any coherence. Mentalizing impairments in depressed patients with marked BPD features manifest in extreme hypermentalization–hypomentalization cycles.

The limitations of mentalizing may account for the need for long-term interventions for BPD [128], in contrast to the effectiveness of a range of short-term therapies for MDD patients [129]. We would argue that mentalizing deficits can generate problems in the formation of therapeutic alliances in treatments of BPD patients [130, 131]. Brief, focused treatment packages assume a capacity for insight and reflectiveness that is likely to exceed the patients' abilities to mentalize effectively, particularly under conditions of arousal. Increased arousal could further disrupt the possibility of effective higher order cognitive function.

If therapy activates the attachment system, which in turn increases the risk of interpersonal misunderstanding, there will be a risk of getting into a vicious cycle of increasing self-criticism, rumination, helplessness, and suicidal thoughts. We have consistently argued that in order for BPD patients to benefit from psychotherapy, the initial focus must be on the recovery of mentalization, which provides the necessary basis for the patient to engage in a reflective psychological process [32, 132]. Depressed patients with marked BPD features (and chronic depressed patients more generally, many of whom have BPD features), thus seem to have lost the "self-righting tendency" that is associated with the capacity for controlled mentalizing.

Attachment in BPD and mood disorders

This brings us to attachment issues. We believe that the typical features of depression in those individuals with marked BPD features are related to a *disorganization* of the attachment system, rather than the organized insecure attachment strategies that are typical of depressed patients without marked BPD comorbidity. Whereas *organized* types of insecure attachment (i.e., anxious-ambivalent and anxious-avoidant) reflect relatively stable ways of dealing with stress and arousal (i.e., respectively using predominantly attachment hyperactivating and deactivating strategies), individuals with *disorganized* attachment often

show marked variability in the use of attachment hyperactivating and hypoactivating strategies, reflecting a lack of a coherent, organized attachment strategy when faced with increasing stress and arousal [133]. Studies suggest that for these individuals the caregiver has served as a source of both fear and reassurance, so that activation of the attachment system produces strong conflicting motivations. Research has found that histories of prolonged or repeated separation [134], intense marital conflict [135], and/or severe neglect or physical or sexual abuse are often associated with this pattern of attachment [136], although the evidence linking such developmental histories to BPD longitudinally is still quite limited. However, studies do suggest that frightened or frightening states of mind [137] in attachment figures prospectively predict BPD features. Lyons-Ruth and colleagues, for instance, found that such severely disrupted maternal communication and maltreatment were independent predictors of BPD symptoms at age 18 [138]. Early separation from the primary caregiver has been found to predict a slower decline of BPD scores through adolescence [139]. The role of disorganized attachment in BPD may account for (a) the often-noted fears of abuse that are triggered by attachment relationships in these individuals, (b) the fact that their attachment system is extremely readily activated, and (c) that while they seem constantly preoccupied with attachment relationships, they tend also to engage in idealization-denigration and push-pull cycles in relationships.

Few studies have compared attachment in depressed patients with and without marked BPD comorbidity [6], and existing studies on attachment in depression often fail to control for comorbidity with BPD and trauma. In an unusual study, Choi-Kain and colleagues [140] showed that patients with mood disorder could be differentiated from those with BPD in terms of attachment style, even on self-report questionnaires, consistent with the case being built here. Both MDD and BPD patients showed greater preoccupation and fearfulness than community controls, in agreement with other studies that have found higher levels of insecure

attachment (and particularly organized insecure attachment styles) in patients with MDD [141, 142, 70, 64, 80]. However, BPD patients had higher levels of both preoccupation and fearfulness, and only patients with BPD simultaneously showed preoccupation *and* fearfulness. These findings suggest more profound disruptions of attachment in BDP than MDD patients and may be indicative of the lack of any functional regulation strategy to reduce attachment distress that we have hypothesized [143-145]. These assumptions are further supported by the findings by Shedler, Westen, and colleagues with the Shedler-Westen Assessment Procedure (SWAP); based on clinician ratings, they found that a borderline-dysregulated spectrum emerged as a separate and coherent personality prototype characterized by strong fears of rejection, abandonment, and isolation, and by becoming attached quickly and intensely [146].

Attachment and epistemic trust/hypervigilance

Finally, more recently, we have argued on the basis of pioneering work by Dan Sperber [7, 147] and Corriveau et al. [148] that secure attachment experiences not only pave the way for the acquisition of mentalizing, but also, more generally, for the formation of "epistemic trust", defined as an individual's willingness to consider communication conveying new knowledge from someone as trustworthy, generalizable, and relevant to the self [9]. Corriveau's study demonstrated that attachment security increased the likelihood of an infant trusting the reliability of a communication source when it was reasonably credible, while preoccupied and anxiously attached children over-relied on the views of the attachment figure (mother) in an ambiguous situation [148]. The latter pattern could be considered the consequence of a kind of *epistemic dependency,* in which the child has developed a chronic lack of confidence in their own understanding. While secure attachment empowered a child's confidence in their own experience, beliefs and judgment, an avoidant attachment history was associated with epistemic mistrust, leading to a tendency for the child to reject even plausible

information from the attachment figure and an increased likelihood of accepting the information coming from a stranger. Finally, disorganized attachment, rooted presumably in a history of misattunement, led to mistrust of information from both attachment figures and strangers.

It seems to us that attachment disorganization therefore leaves the individual in a terrible quandary about "whom to trust?" The person whose insecure attachment history precludes confidence in their own experiences and beliefs is left in a permanent and irresolvable state of epistemic searching. They seek others to confirm or deny their own understanding, but they are also not able to trust the information they receive, ultimately generating a state of epistemic hypervigilance. While organized insecure attachment styles can be associated with either considerable epistemic mistrust (in the case of avoidant attachment) or excessive trust (in the case of preoccupied-anxious attachment), we believe that disorganized attachment is associated, particularly in attachment contexts, with a confusing combination of *low epistemic trust* and *epistemic dependency,* leading to marked *epistemic hypervigilance*. Of course, such a disorganized state would place serious limits on these patients' capacity to benefit from more insight-oriented psychotherapeutic approaches.

Within the therapeutic context, the particular and profound difficulties in communication that arise from epistemic hypervigilance often give the BPD patient a peculiarly rigid and unreachable quality, often leading to intense feelings of frustration on the part of the therapist. It is now to the question of how mentalization-based treatments can serve to reach patients with mood disorders with marked features of BPD that we will turn.

Implications for treatment

A spectrum of mentalization-based interventions

Throughout this chapter we have argued that a mental representation model that relies heavily on reflective capacities is less appropriate in the treatment of BPD patients and mood problems in the context of BPD, and might even be associated with iatrogenic effects. Given the greater propensity to revert to nonmentalizing modes, with increasing pressures to externalize alien-self parts, and their often profound levels of epistemic hypervigilance, these patients are unable to form the kind of working alliance that is typically required in these treatment models. Structured interventions (and brief interventions in particular) for depression rely upon capacities for relating to the therapist and for insight that these patients simply do not possess. Indeed, many current treatment models for depression are based on the premise that the patient has the capacity for epistemic trust or that this capacity, at the very least, can be reactivated relatively easily. In patients who largely lack epistemic trust, a mental process focus is indicated. Yet, as noted, patients with less comorbidity in terms of BPD pathology may also benefit from a mentalizing or metacognitive focus, as is also demonstrated by studies demonstrating the effectiveness of mindfulness-based approaches in patients with mood disorders, although it must be said that these approaches seem particularly effective in chronically depressed patients, many of whom probably have comorbid personality pathology [149, 150, 6]. In patients with greater epistemic trust, a mental process focus may be easier to combine with a mental representation focus and with the use of more "traditional" expressive techniques.

Over the past years, together with a number of colleagues, we have developed Dynamic Interpersonal Therapy (DIT), a treatment model that combines both perspectives. DIT illustrates how a combination of a mental representation and mental process approach may be used in a brief treatment format aimed at treating depressed patients who may have

some, but not marked, BPD features. For the more severe spectrum of depressed patients with marked BPD features, Mentalization-Based Treatment for BPD might be more indicated. When working with patients with BPD features, the first task at hand is often to establish a trusting relationship that can be the basis for exploring the influence of mental states on mood, something that is taken for granted in many treatment models for depression.

Dynamic Interpersonal Therapy (DIT) for depression

DIT is an integrative treatment that represents a distillation of evidence-based brief psychoanalytic/psychodynamic treatment models [151, 5]. DIT incorporates a mental representation and a mentalizing approach. With regard to the first of these, this is done by taking a so-called Interpersonal Affective Focus (IPAF) as the focus of the treatment. More traditional supportive and expressive techniques are used to develop this focus in interaction with the patient and to work it through. DIT also includes a strong mentalizing focus, using more directive and mentalizing interventions to increase reflective capacities in the patient. Hence, rather than focusing on content, a focus on fostering reflective processes is often thought to be equally if not more effective in DIT. Similarly, transference interpretations are limited, and are mainly made in order to clarify the IPAF, particularly in patients who have a strong transference response (which, if unaddressed, hampers the therapeutic process). The use of the transference in DIT is also appropriate when patients have few interpersonal relationships and thus the therapeutic relationship becomes an important vehicle to identify and work through the IPAF.

This is congruent with studies that show a negative relationship between a high frequency of transference interpretations and both the therapeutic relationship and outcome in brief and long-term psychoanalytic treatment, even in patients with high levels of personality functioning [152]. A study by Hoglend and colleagues [153, 154], for instance, found no differences in the efficacy of two psychodynamic treatments that differed only in terms of the

use of transference interpretation (i.e., with and without the use of such interpretations) both at treatment termination and at 3-year follow-up, except in patients with low levels of personality functioning. These patients responded better to treatment with a low frequency of transference interpretations (0–3 per session) compared to treatment without transference interpretations. Moreover, in these patients, increases in insight mediated the relationship between transference interpretations and improvements in relational functioning [155]. Hence, transference interpretations may be a "high-risk/high-gain" strategy in relation to patients with (marked) BPD features: they may lead to increased insight but also increased defensiveness and disturbances of the therapeutic relationship and the therapeutic process [156]. The other important implication from this study is that, in patients with higher levels of functioning, a more general interpersonal focus that does not use transference interpretations is as effective. These findings provide further confirmation, in our opinion, of the need to address the immediacy and strong nature of attachment imperatives (and subjective experiences more generally) – fuelled by epistemic hypervigilance and attachment disorganization – in patients with (marked) BPD features. In patients with more epistemic trust, as in patients with organized insecure attachment features, such a focus is less intensely required.

Similarly, while past experiences and their influence on current functioning are acknowledged in DIT, they are not the major focus. The focus is on the IPAF in DIT, that is, the patient's current interpersonal functioning as it relates to the presenting symptoms, keeping in mind that a discussion of past experiences, and particularly traumatic experience, may easily overwhelm patients' mentalizing capacities.

DIT is a time-limited (16 sessions) intervention that thus primarily targets the capacity for mentalizing (mental process focus) and connections between mood symptoms and interpersonal functioning (mental presentation focus).

DIT consists of three phases (initial, middle and ending), each with specific aims and strategies. The primary task of the initial phase (sessions 1–4) is to identify one dominant and recurring unconscious interpersonal pattern, the IPAF, which is assumed to be central to the onset and/or maintenance of the depressive symptoms. This pattern is underpinned by a particular representation of self-in-relation-to-an-other that characterizes the patient's interpersonal style and leads to difficulties in his/her relationships. These representations are typically linked to particular affect(s) and defensive maneuvers. Affects are understood to be responses to the activation of a specific self-other representation in the patient's mind. This particular way of formulating derives from Kernberg's work [157], and is thus heavily influenced by mental representation models. For example, an IPAF might focus on a self-representation as "helpless victim" in relation to others whom the individual feels constantly criticize and neglect him/her. The defensive function of this constellation is to defend against underlying feelings of frustration and aggression and to reverse the role and triumph over criticizing others. These patterns and their high (interpersonal) costs are highlighted, which leads the patient to relinquish these patterns. Hence the focus on the IPAF combines a mental representation and mentalizing approach. In patients with marked impairments in mentalizing, interventions often address much more basic dynamics, such as (a) affect recognition and affect differentiation, (b) linking affect to depressed mood and anxiety, and (c) linking affect to the IPAF. Hence, both components – the mental representation and the mental process focus – allow the therapist to tailor his/her interventions to the specific mentalizing capacities within the session, with greater weight to mentalizing and supportive interventions in patients with BPD features.

The middle phase (sessions 5–12) involves: (a) maintaining a focus on the agreed IPAF, (b) helping the patient to identify areas of difficulty in his/her relationships and understand his/her characteristic ways of managing these difficulties, pointing out the

interpersonal "costs" of these strategies; (c) stimulating the patient's capacity to think about and understand his/her thoughts and feelings (the mentalizing focus), and how these underpin strange or self-defeating behaviors and patterns of relating; (d) attending to the patient's affective state; (e) focusing on the therapeutic relationship as a live example of the IPAF in action; (f) helping the patient practice the skill of recognizing internal states (feelings and thoughts, wishes, etc.), and connecting these to the week's events and to the IPAF. This phase may prove very difficult for patients with BPD features, as they may be easily overwhelmed by more interpretive work; thus, in these patients, a greater emphasis on support, validation, and mentalizing is needed. Often, it is very difficult to delineate a specific IPAF as the focus of treatment, as the IPAF (and thus the use of attachment hyperactivating and deactivating strategies) seems to change constantly. For instance, at the start of the treatment the patient might present as a hopeless victim in the hands of others. This pattern might soon change to the opposite direction, only to then change back to the original pattern and so on, leading to confusion in both the patient and the therapist. This reflects, in our opinion, a disorganization of the attachment system that seriously impacts on the treatment process, as neither the patient nor the therapist is sure what exactly they are trying to address from a mental representation perspective – particularly as the patient typically lacks the capacity to simultaneously consider both patterns and their interrelationship. This should alert the clinician to the possibility that DIT may not be the treatment of choice for this patient.

The final phase (sessions 13–16) is devoted to helping the patient explore the affective experience and the conscious and unconscious meaning of the therapy ending, reviewing the progress made, and helping the patient to anticipate future difficulties or vulnerabilities. Work in these final sessions involves: (a) systematically addressing the patient's feelings, unconscious fantasies, and anxieties about the termination of therapy; (b) responding to any signs of regression (e.g., a deterioration in the patient's symptoms) near the

end of treatment by linking this with the patient's feelings and fantasies regarding endings; (c) helping the patient to review the therapy overall (e.g., whether he/she has achieved his/her initial aims); and (d) the therapist writing a "goodbye" letter for the patient, which sums up the original agreed formulation and what progress has been made in working on the issues identified in it.

Responses to the impending end of treatment are more likely to be more extreme in patients with BPD features, and therapists may be "seduced" by the patient to offer additional sessions as the approaching end of treatment generates abandonment anxieties and feelings of aggression in the patient, leading the therapist to increasingly worry about the patient. Again, a more validating approach is helpful here, and lowering the patient's level of arousal is needed before he/she can adopt a more reflective stance.

Although DIT is currently a manualized, short-term treatment, the techniques and principles used can be flexibly integrated with other (longer-term) treatments. Patients with more marked BPD features, in particularly, may benefit from a longer, more open-ended treatment approach. This may focus in more detail on the relationship between current and past relationships and functioning, and aim at more profound changes in character.

Earlier, we reviewed evidence suggesting that BPD features may impede treatment response in brief treatments. Whether this is also the case in DIT is ultimately an empirical question. Over the past decades, evidence for both more traditional intrapersonal and more interpersonal brief and long-term treatments in depression with and without comorbid personality pathology has been accumulating [158-162]. In line with these findings, a recent small pilot trial showed that DIT was associated with a significant reduction in symptoms in all but one case, to below clinical levels in 70% of the patients studied [63]. Further research is needed to investigate the influence of BPD features on DIT. A large randomized trial is currently underway that will address these issues.

Mentalization-Based Treatment and mood problems in BPD patients

MBT originated in the treatment of patients with BPD, many of whom struggle with intense and chronic feelings of depression [6]. The treatment evolved precisely out of dissatisfaction with more traditional, insight-oriented treatments, as these overestimate the mentalizing capacities of BPD patients. Here, we present the core principles and techniques of MBT, with a focus on depression in BPD. We also review preliminary evidence suggesting that MBT may be particularly effective in reducing depression in BPD.

The MBT approach is based on a view that a core problem for many patients, and typically those with BPD, is their vulnerability to a loss of mentalizing in combination with epistemic hypervigilance. MBT places mentalizing at the center of the therapeutic process. At its core is the argument that MBT works through the therapist establishing an enduring attachment relationship with the patient while continuously stimulating a mentalizing process in the patient.

The basic aim of the treatment is to re-establish mentalizing when it is lost and maintain mentalizing when it is present. Therapists are expected to focus on the patient's subjective sense of self. To do so, they need to (a) identify and work with the patient's mentalizing capacities; (b) represent internal states both in themselves and in the patient; (c) focus on these internal states; and (d) sustain this focus in the face of constant challenges by the patient over a significant period of time. In order to achieve this level of focus, mentalizing techniques need to be (a) offered in the context of an attachment relationship; (b) consistently applied over time; and (c) used to reinforce the therapist's capacity to retain mental closeness with the patient. Congruent with our assumption of severe attachment and mentalizing impairments in patients with BPD, which typically give rise to epistemic hypervigilance, MBT is manualized to facilitate the achievement of these primary goals, and entails a strong focus on mentalization techniques while avoiding harm to a group of patients

who may be particularly vulnerable to the negative effects of psychotherapeutic interventions. This may be particularly important when dealing with feelings of depression in patients with severe BPD features. As noted above, depressive experiences in these patients are often marked by excessive feelings of self-criticism, emptiness, and meaninglessness, and associated with a high risk of self-harm. In such states of mind, a focus on "insight", particularly when focused on events in the past and when combined with a more neutral and distant therapeutic stance, is at best unhelpful and at worst likely to be iatrogenic. The MBT approach therefore entails a titrated but more or less exclusive focus on the BPD patient's *current* mental state and with special attention paid to avoid generating iatrogenic effects, as this focus inevitably activates the attachment system. Hence, treatment should avoid situations where patients are expected to talk of mental states that they cannot link to subjectively felt reality; this is particularly important when speaking about depressive experiences,. When feeling depressed, BPD patients all too readily revert to psychic equivalence mode, rendering depressed feelings even more painful and real, or to an extreme pretend mode, leading to profound feelings of helplessness and self-criticism. Thus, the MBT approach involves (a) a de-emphasis of "deep" unconscious interpretations in favor of conscious or near-conscious content addressing the here and now (e.g., "what happened just now that you feel like this?"); (b) a modification of the therapeutic aim, especially with severely disturbed patients, from insight to recovery of mentalization (i.e., achieving representational coherence and integration) (e.g., "I can see that you feel rejected, but let us pause and reflect for a minute on what just happened, and what he could have meant by saying that to you"); (c) careful avoidance of the use of descriptions of complex mental states (e.g., conflict, ambivalence, unconscious) that are incomprehensible to a person whose mentalizing is vulnerable, and instead sticking to the here and now or "working memory"; (d) avoidance of extensive discussion of past trauma except in the context of reflecting on the

patient's current perceptions of the mental states of maltreating figures and changes in their own mental state from being a victim in the past versus their experiences now. As noted, patients with BPD features often tend to dwell on traumatic experiences in the past, especially when depressed; this can lead to hypomentalizing–hypermentalizing cycles ("I am abused, I am bad, there is nothing that anyone can do about this, I am beyond help – what if this never happened, if he hadn't done that to me, my life could have looked completely different; I often think about this, and it tends to drive me crazy, it is all so painful"). These cycles tend to spiral out of control and lead, in a teleological mode, to increasing thoughts about self-harm and/or suicidality. Hence, in MBT, instead of encouraging the patient to explore such thoughts further, he/she is redirected toward exploring the influence of these thoughts on current thoughts and feelings and/or their relation to current events.

The theoretical model proposed in this chapter also implies that in order to maximize the impact on the (depressed) patient's ability to think about thoughts and feelings in relationship contexts, especially in the early phases of treatment, the therapist is probably most helpful when his/her interventions (a) are simple and easy to understand, (b) are affect focused, (c) actively engage the patient, (d) focus on the patient's mind rather than on his/her behavior, (e) relate to a current event or activity – whatever is the patient's currently felt mental reality (in working memory), (f) make use of the therapist's own mind as a model (e.g., by the therapist disclosing his/her anticipated reaction in response to the event being discussed, i.e., talking to the patient about how the therapist anticipates that he/she might react in the same situation), (g) are flexibly adjusted in complexity and emotional intensity in response to the intensity of the patient's emotional arousal (i.e., withdrawing when arousal and attachment are strongly activated).

The key task of therapy is thus to promote curiosity about the way mental states motivate and explain the actions of self and others, *even* in depressed states of mind (i.e.,

"finding meaning and coherence where none is felt or expected"). Therapists achieve this through the judicious use of the "inquisitive stance", in which they highlight their own interest in the mental states underpinning behavior, qualify their own understanding and inferences (and show respect for the opaqueness in mental states), and demonstrate how such information can help the patient to make sense of his/her experiences. This inquisitive yet "not-knowing" stance is often exactly the opposite of the depressed patient's state of mind, which is characterized by a lack of curiosity to explore mental states, or excessive certainty about mental states of the self and others. Pseudomentalization and other fillers that are particularly characteristic of depressed states (e.g., "All previous treatments have failed, I am a patient who does not respond to any treatment, nobody knows what to do with me"), and which replace genuine mentalization, must be explicitly identified by the therapist, and the lack of practical success associated with them should be clearly explained ("Well, I can see how you feel, and I can begin to understand why you feel like that, but it is not really helping us today, as you yourself said that these feelings drag you down"). In this way, MBT therapists can help their patients to learn about how they think and feel about themselves and others, how their thoughts and feelings shape their responses to others, and how "errors" in understanding self and others may lead to inappropriate actions.

Hence, working with depressed mood in MBT typically entails the following sequence, which closely follows the more general MBT approach: (a) the therapist identifies a break in mentalizing (described above as psychic equivalence, pretend mode, or teleological mode of thought) as a result of depressed mood ("I feel so helpless, everything I do is bound to fail, I cannot see where this is leading us"); (b) the patient and therapist "rewind" to the moment before the break in subjective continuity ("What happened just now so that you feel like that – is it related to something that I said?"); (c) the current emotional context for the break is explored by identifying the momentary affective state between patient and therapist

("You started talking about your job, and this is what seems to have happened, you became very self-critical"); (d) the therapist explicitly identifies and acknowledges their own contribution to the break in mentalizing ("Is it related to something that I said or did?"); and (e) the therapist seeks to help the patient understand the mental states implicit in the current state of the patient–therapist relationship (to *mentalize the transference*) ("When you said that, I started to feel helpless as well").

The therapist's mentalizing therapeutic stance throughout this process should include: (a) humility deriving from a sense of "not-knowing" ("Well, I can see that you feel helpless now, but I want to understand why that is, because I am concerned about you and why you feel like that"); (b) whenever possible, taking time to identify differences in perspectives ("Well, you seem very sure that he said that to hurt you, but there may perhaps be other reasons for him saying that"), (c) legitimizing and accepting such different perspectives ("I now can see why you thought that, but can you accept that he may have meant something different?"); (d) active questioning of the patient in relation to his/her experience, asking for detailed *descriptions* of experience ("what" questions) rather than *explanations* ("why" questions) ("So what did you feel then?"); and (e) eschewing the need to understand what makes no sense (i.e., saying explicitly that something is unclear) ("Sorry, but you lost me there").

An important component of the mentalizing stance is the therapist monitoring his/her own mistakes and owning up to them. This not only models honesty and courage through such acknowledgments, and tends to lower the patient's arousal through the therapist taking responsibility, but it also offers valuable opportunities to explore how mistakes can arise out of inaccurate assumptions about mental states, which are opaque, and how such misunderstandings can lead to massively aversive experiences. Importantly, through "staying with the patient" even when the patient feels completely helpless and hopeless, a sense of

concern and controllability is communicated – that is, that these states of mind are not as threatening, uncontrollable and meaningless as they seem.

In this context, it is important to be aware that the therapist is constantly at risk of losing his/her capacity to mentalize in the face of a nonmentalizing patient. Especially when the patient is severely depressed, the therapist can feel as if they are being "sucked into a black hole", leading to hypomentalizing; alternatively, the therapist may be in such a state of high arousal, for example because of the patient's threats to self-harm, that she/he feels compelled to intervene teleologically (e.g., by prescribing medication or having the patient hospitalized). Consequently, we consider therapists' occasional enactments as an acceptable concomitant of the therapeutic alliance, and something that simply has to be owned up to. As with other instances of breaks in mentalizing, such incidents require that the process is "rewound" and the incident explored. Hence, in this collaborative patient–therapist relationship, both partners involved have a joint responsibility to understand such enactments.

Research evidence for the effectiveness of MBT for the treatment of BPD, including depression in BPD, is consolidating. A follow-up study of BPD patients 5 years after all treatment was complete (and 8 years after initial entry into treatment) compared patients who had been treated with MBT versus those who received treatment as usual (TAU), and found that those who received MBT remained better than the TAU group. Superior levels of improvement were shown for diagnostic status (13% vs. 87%), service use (2 years vs. 3.5 years), and other measurements such as use of medication, global function, and vocational status. Importantly, MBT was also superior in reducing levels of suicidality (23% in the MBT group vs. 74% in TAU group) [163] and in reducing the severity of depression as assessed with the Beck Depression Inventory (unpublished data).

In relation to adolescence and the emergence of BPD traits, a more recent study by Rossouw and Fonagy [164] comparing the effectiveness of a version of MBT developed

specifically for adolescents (MBT-A) for adolescents who self-harm against TAU found that MBT-A was more effective in reducing both self-harm behavior and depression. The improvements generated by MBT-A appear to have been mediated by improved levels of mentalization, reduced attachment avoidance, and amelioration of their emergent BPD features: individuals in the MBT-A group showed a recovery rate of 44%, compared to 17% in the TAU group.

Conclusions

This chapter has presented a mentalizing approach to mood problems and BPD. We consider patients with BPD and mood problems to be situated on a continuum. However, four related features seem to distinguish, in relative terms, individuals with mood problems with and without marked BPD features: (a) the nature of their depressive experiences; (b) the severity of their mentalizing impairments, and particularly the extent they feel pressured to externalize alien-self parts; (c) insecure, but organized, attachment in response to stress and arousal versus disorganized attachment; and (d) problems with epistemic trust versus epistemic hypervigilance. We described DIT, a manualized treatment for depressed patients without marked BPD features that combines a mental representation and mental process focus that can be flexibly tailored to individual patients. For patients with more marked BPD features, more traditional and longer-term MBT might be indicated, as a result of the more marked impairments in mentalizing, attachment, and high levels of epistemic hypervigilance in these patients.

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