Clinical Update

California Society for Clinical Social Work

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INSIDE Update

Mentalization- Based Treatment for Borderline Personality Disorder
By Roseann Larson, LCSW

Treating clients with borderline personality disorder (BPD) can be challenging. Multiple crises can occur, with 'coping skills' going right out the window, leaving clients feeling more hopeless. During the past few years, I have adapted a useful mentalizing approach in my work with clients suffering from BPD. While mentalization-based treatment (MBT) is not a quick fix and may not be effective for everyone, its overall benefits have proven encouraging. Clients have become more reflective and have developed a better understanding of themselves and others. That, in turn, has led to greater emotional, behavioral, and interpersonal stability.

This is an overview of MBT, an evidence-based practice developed by Peter Fonagy, Ph.D., and Anthony Bateman, M.A., F.R.Psych., for the treatment of BPD. MBT is a form of psychodynamic psychotherapy that has its roots in attachment theory. Mentalizing in psychotherapy is not new; it is inherent in many therapeutic approaches. The primary focus of MBT is to help clients identify and experience emotions while getting mentalization back on track.

What is Mentalizing?
Mentalizing is a fundamental part of interpersonal relationships and communication. When we mentalize, we experience our feelings and are able to think at the same time about what is going on in ourselves and in others. We make interpretations based on intentional mental states -- desires, beliefs, and feelings. Mentalizing frequently happens automatically and non-consciously. We perceive what it is happening without putting much thought into it. At times, we mentalize in a more conscious, controlled, and explicit manner, taking the time to explore meaning and intent. Mentalizing helps us better understand misunderstandings. We are reflective and are able to keep 'mind in mind.'

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DISTRICT MEETINGS:

Greater Los Angeles District:

Coordinator Name:	Lynette Sim
Phone Number	(310) 394-7484
Coordinator Email:	lsim1@verizon.net
Date:	Saturday, June 7, 2014
Time of Meeting:	10:30 to 1:00
Presenter:	Kim Cookson, Psy.D.
Topic:	**The Trauma Resiliency Model (TRM): Processing and Healing from Trauma**
Location:	3267 Corinth Ave., L.A. 90066
RSVP:	Judy Messinger, messingerlcsw@yahoo.com

This presentation focuses on TRM as a mind-body approach that explores the concept of resiliency and the restoring of balance to the body and mind after traumatic experiences. It will include a brief overview of how trauma is processed in the brain differently than ordinary events and will describe some of the body based resiliency skills which clinicians may use. When the focus is on normal biological responses to extraordinary events, there is a paradigm shift from symptoms being described as biological rather than as pathological or as mental weakness. Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences.

Dr. Cookson, a clinical psychologist has a private practice in West L.A. and is the Trauma Training Director at Southern California Counseling Center. She is a Certified EMDR Therapist, an EMDR Consultant and a Trauma Resource Institute Trainer.

Future Meetings
Sept. 6 - James Long, MD - **Child Custody Issues**
Nov. 15 - Andrew Susskind, LCSW - **From Now On: Seven Steps To Purposeful Recovery**

Mid-Peninsula District:

Coordinators:	Virginia Frederick LCSW Joan Berman LCSW
Coordinator Phone:	650-324-8988
Coordinator Email:	ginnyfred@aol.com
Date:	May 16, 2014
Time:	12pm -2pm (New Time)
Location:	Jewish Family and Children's Service 200 Channing Street, Palo Alto (corner of Channing and Emerson) Parking available – 913 Emerson in the Underground parking (press the button and say you are with the Clinical Society to be admitted) as well as parking at 200 Channing and street parking.
Topic:	**Clinical Challenges of Writing for Publication**
Presenters:	Elise Miller PhD and Greg Bellow LCSW PhD
Credits:	1.5 CEU Credit
RSVP:	Registration on the website preferred click here

(Continued on Next Page)

DISTRICT MEETINGS (Cont'd):

Mid-Peninsula District, (cont'd):

Two clinicians – one the author of a recent memoir, and the other a specialist in the psychology of writing – will discuss common conflicts about and obstacles to developing, drafting, revising, completing, and submitting a paper/book for publication. The processes of writing and publishing can trigger conscious and unconscious conflicts about: competition, idealization, separation-individuation, and self-esteem that can disable or block those who seek the self-expression and professional promotion that comes in publicly exposing your ideas. This presentation, however, will focus on productive authors who have found ways of overcoming these common challenges. Greg Bellow will address how he moved from professional writing to writing a memoir, **Saul Bellow's Heart**, and Elise Miller will discuss what she has learned about the writing practices of productive clinical writers. This forum will invite discussion from the audience, who will leave with a deeper understanding of the universal challenges of writing as well as with some practical strategies for setting themselves up for success in their writing.

Members earn 1.5 CE credits at no cost. Credits for non-members are $10.00 per unit. Non-member clinicians are welcome and may attend at no charge (no CE certificate). MSW students are encouraged to attend. Our meeting begins at 12:00 with sign in and networking, then at 12:15 our formal meeting starts with CSCSW business then our speaker. Bring your flyers and business cards. Course meets the qualifications for 1.5 hours of continuing education credit for MFTs, LPCCs, and/or LCSWs as required by the California Board of Behavioral Sciences.

Sacramento-Davis District:

Coordinator Name:	Nathan Stuckey
Coordinator Phone Number:	(951) 285-6322
Coordinator Email:	nstuckey13@gmail.com
Date:	Saturday, May 17, 2014
Time of Meeting:	10:00 a.m.
Presenter:	Nathan Stuckey, ACSW
Topic:	**Rare Obsessive-Compulsive Disorder**
Location:	Friends Meeting House, Sacramento, Ca

Trichotillomania (or Hair Pulling Disorder) is a little understood disorder in which clinicians are likely to encounter at some point in their practice. Due to high degree of shame associated with the disorder and its symptoms, many people do not outwardly acknowledge their struggle. Instead they will seek assistance for more general challenges such as anxiety or obsessive-compulsive disorder.

This presentation will focus helping clinicians understand the symptomology and research of this condition. Specifically, clinicians will learn of the changes made with the new release of the DSM-V, including differential diagnosis. Through the use of art therapy, clinicians will be given insight into what it is like to struggle with the condition as well as to how to help a potential client process the challenge of resisting the urge to pull their hair. Clinicians will learn various practical interventions that they can readily utilize in practice to assist clients in decreasing hair pulling behaviors.

Nathan Stuckey, MSW, ACSW is a graduate of Sacramento State. He is the district coordinator for the Sacramento/Davis chapter of CSCSW. Nathan has over four years experience in community mental health settings, working with both children and adults. Nathan currently works as mental health clinician with Stanford Youth Solutions, a community mental health agency serving youth and families in Sacramento, Ca.

Law and Ethics: 7 Fundamental Principles of Practice

Presented by: Myles Montgomery, JD, LCSW

Co-Sponsored by:

CALIFORNIA SOCIETY FOR CLINICAL SOCIAL WORK &

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CSCSW

(6 CE Hours)

OAKLAND, CALIFORNIA

May 30, 2014

8:30 Registration-Workshop begins at 9 a.m. to 4:30 p.m.

Trans Pacific Centre
1000 Broadway, Room 2
Oakland, CA 94607

$65 Students* **$120 Members** **$150 Non-Members**

While there are many aspects of Law and Ethics for psychotherapists, this presentation highlights seven, which are fundamental to those practicing in the field of psychotherapy. Included in this comprehensive presentation are a review of concepts related to confidentiality, risk-management, advertising, and documentation in plain English. Relevant developments in the area of case law will also be discussed. To register online go to http://www.clinicalsocialworksociety.org/Default.aspx?pageId=1631911&eventId=844392&EventViewMode=EventRegistration.

*Student price is for students currently enrolled in a program of a mental health discipline.

Objectives:

- Participants will be able to identify at least three practices related to protecting client confidentiality.
- Participants will be able to explain the holding of the *Tarasoff* decision and know at least three recent cases related to it.
- Participants will be able to explain at least three requirements related to advertising their services.
- Participants will be able to explain the role of informed consent.
- Participants will be able to explain how psychotherapists may use testing as part of their practice.
- Participants will be able to explain the elements of a malpractice law suit and the disciplinary procedure under the BBS.

This course meets the qualifications for 6 hours of continuing education credit for **MFTs, LPCCs, PhD's and LCSWs** as required by the California Board of Behavioral Sciences. The Sanville institute is approved by the California Psychological Association to provide continuing professional education for psychologist. The Sanville Institute maintains responsibility for this program and its content. BBS CE Provider # PCE 1 CPA PAS Provider #SAN 150

A boxed lunch will be provided for participants that pre-register. Lunch cannot be guaranteed for at the door registration.

Refund Policy: A full refund may be issued up until 7 days prior to the presentation date. No refunds will be issued after 4/12.

Myles Montgomery is a practicing social worker and attorney in Sacramento, California. Myles has worked with individuals and families, in a number of capacities, for the past ten years. Myles was a civil litigator, with a focus on fraud and predatory lending suits in the mortgage industry. Currently he has a full time private practice. In addition, he teaches Law and Ethics at Alliant International University and holds similar classes throughout California. When not working, Myles enjoys reading across disciplines, spending time with his family, and long-distance running.

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Legal Update
By Myles Montgomery, JD, LCSW
How Do I Handle A Subpoena?

A Stressful Situation

The term subpoena comes to use from a combination of the Latin prefix *sub* (meaning "under") and *poena* (meaning "penalty"). In the context of a court proceeding, these "penalties" include arrest, fines or jail. Thus, therapists need some predictable steps to avoid these outcomes.

No doubt, receiving a subpoena is a stressful event for therapists of all stripes. Being unfamiliar with court procedures and fearing the worst, therapists receiving subpoenas can become disturbed and distracted from their work. Subpoenas do not have to remain an unknown quantity to therapists and handling them can be manageable.

Varieties of Subpoenas

Some subpoenas require only that a therapist turn over specified documents; others require that the therapist show up to a legal proceeding with documents in hand. The latter variety of subpoena are known as *subpoenas duces tecum*. Besides the difference in what is required by the subpoena, they may also issue from different places. Typically, a subpoena will issue from an opposing attorney. When a subpoena issues directly from a Court, it is an order and must be followed.

Quality of Service Matters

The two pillars of the legal system in the United States are *notice* and *hearing*. The relationship between notice and hearing is integrated so that most court hearings (i.e., trials, depositions, etc.) are only valid if all parties involved have been properly noticed. Proper notice of a party or witness to the case generally involves service of a subpoena. In order for a subpoena to be served validly, it must be delivered personally. This means that for a therapist to be effectively served, he or she must receive the subpoena ***in person***. Delivery by mail is not valid service. Additionally, California Code of Civil Procedure 1985.3 requires that a copy of the subpoena served upon a therapist must also be served upon the *patient*.

While this notice requirement may provide an incentive for therapists to evade personal service, such efforts are ill-advised (even if highly desired). California Code of Civil Procedure 1988 provides a Court the power to send a Sheriff to break into a building when an attorney can prove that a witness is evading service. In sum, attempting to evade a subpoena may lead to even less desirable situations. Imagine this scenario playing out in front of your clients.

Subpoenas and the Psychotherapist-Patient Privilege

Because subpoenas concern legal proceedings, we are instantly concerned with the concept of testimonial privilege, as this is what determines whether or not client information is to be disclosed. When a client elects not to allow disclosure of his or her personal information, the client is understood to be "raising" the psychotherapist-patient privilege. When a client raises this privilege, the therapist must keep the client's information from being disclosed, unless and until the presiding judge orders the therapist to divulge the client's information.

By contrast, when client chooses to allow disclosure of privileged information, he or she is said to be "waiving" the psychotherapist-patient privilege. As with all court proceedings, the privilege against disclosure belongs *exclusively* to the **client**. Although a therapist may raise the psychotherapist-patient privilege, it is not absolute and limitless. As noted earlier, client consent waives this privilege immediately.

In summary, access to any client information may be subpoenaed and, if the client consents, the therapist must disclose it. However, it may be the case that a client is unaware that his or her therapist has received a subpoena. In this case, the therapist need not disclose any client information prior to discussing the subpoena with the client. As a matter practice, it is prudent for the therapist to receive the client's consent to release the information in writing.

Hypothetical Scenario

How might this play out? Imagine that a therapist received a subpoena, which was followed by a phone call by the attorney from which the subpoena originated. Meanwhile, the client is unaware of the subpoena.

At this point, the therapist is under no obligation to disclose any information to the inquiring attorney. In fact, the therapist must raise the psychotherapist-patient privilege and refuse to disclose any client information. The next step for this therapist would be to contact the client and inform him or her of the subpoena's receipt.

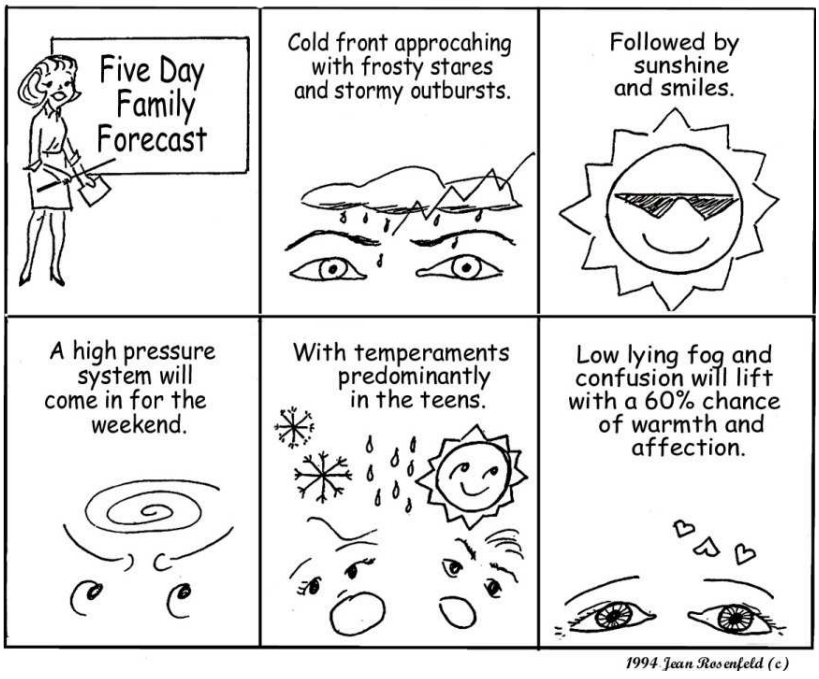
Contrast this scenario with an order that issues directly from a Court. Such orders are often of the *duces tecum* variety and require that a therapist personally show up to the legal proceeding with the requested documents. Again, when the Court issues such a requirement, the psychotherapist-patient privilege has been effectively waived by the Court.

What To Do/ Not To Do

In conclusion, receiving a subpoena, while stressful, does not need to be unmanageable. The following are some basic tips for therapists in the handling of a subpoena:

- **Do not** contact opposing attorney.
- **Do not** immediately comply with the subpoena and provide client information or documentation.
- **Do** contact the client and discuss the matter, as the client may not even realize a subpoena was sent to you.
- When appropriate, **do** raise the psychotherapist-patient privilege unless/until court orders otherwise.

Myles Montgomery, JD, LCSW is a practicing social worker and attorney in Sacramento. Myles teaches law and ethics at Alliant International University and holds seminars for the CSCSW. As a therapist, Myles employs EMDR and works with families, couples and individuals. (916) 422-2301. montgomerylcsw@gmail.com



The Case for Psychoanalysis: Exploring the Scientific Evidence
By John Thor Cornelius, MD
Lecture published on YouTube
February, 2014
ww.youtube.com/watch?v=EkxoExMB9Mw
reviewed by Susan L. Boulware, PhD

Until 25 years or so ago, psychodynamic theory and technique (for the purposes of this review and Dr. Cornelius' lecture, psychoanalysis and psychodynamic psychotherapy are synonymous) were the bread and butter of graduate education and training. Somewhere in the early 1990's, when managed care began gaining a foothold in the insurance industry, so called "evidence based treatments" gradually took over graduate education and training in all mental health disciplines. "Evidence based practices" are a euphemism for medications and cognitive behavioral therapy and its variants. The evidence base for psychodynamic treatments has been ignored and unrecognized. Both Dr. Cornelius and I have had the startling experience of teaching students in various settings who believe that psychodynamic treatment is useless and archaic because they have been told this by their instructors. In fact there is a significant and robust body of evidence for the efficacy of long-term psychodynamic treatments, in the Unites States as well as Europe.

Why has this evidence been ignored and psychodynamic principles marginalized? I believe the political and economic agendas of the large professional governing bodies of mental health practice in collusion with the insurance and pharmaceutical companies has, at least in part, created this situation (for more on this see Frie and Coburn, 2011; Welch, 2008; and Whitaker, 2010). But, those who teach and practice psychoanalysis are also responsible, preferring to remain in their ivory towers as an elite and special group without need of inclusivity and engagement with other scientific disciplines. Thus, the psychoanalytic community has lost much political and scientific credibility and clout. Admittedly, the health care situation in the United States is in crisis, particularly for mental health needs, and it is understandable that those paying want the most efficacious and cost effective treatments available. However, much of the evidence as to what is effective clinically and financially is ignored, deliberately or otherwise.

In his 45-minute lecture, Dr. Cornelius, a psychoanalyst and psychiatrist in Sacramento, California, lays out the research evidence for the efficacy of psychodynamic treatments. He challenges the perception that CBT and medications have "tons" of conclusive evidence for their effectiveness and that psychodynamic treatments have no efficacy. In simple and understandable language he covers the very basics of statistical research to give the listener a basis for comparing the studies. The goal of his lecture is to show that psychodynamic treatments have efficacy and that they distinguish themselves from other treatments. This is not a polemic against CBT and medications. Dr. Cornelius is a psychopharmacologist and uses medications in his treatment of his patients. Additionally, like most of us who practice psychodynamically, he incorporates other strategies besides traditional psychoanalytic ones into his overall treatment approach.

In this talk, Dr. Cornelius explicates in a logical and stepwise manner the research evidence for medications, CBT, and psychodynamic psychotherapy. He makes an important distinction between "end of study" results, those obtained at the completion of the study, and "long term results," those data gathered weeks, months or years after the official end of the treatment study. To summarize he shows that psychodynamic treatments have the same or somewhat better outcomes, than antidepressant medications or CBT at the end of the studies. He then goes on the discuss the "long term results." What Dr. Cornelius shows is that the benefits of CBT and medications decay after the end of the active treatment phase, to the point where many of the participants return to their pre-study condition. However, most of those who participated in psychodynamic treatments continue to improve after the end of the study. Not only do they maintain their benefits of the treatment but also they continue to improve.

Most notable, are the studies by Peter Fonagy and his colleagues on the treatment of borderline personality disorder (BPD). He has developed "mentalization based therapy" based on the principles of psychoanalysis and attachment theory and research. Those of us who have treated patients with severe personality disorders know the difficulty in treating this population. Fonagy and his colleagues developed an 18-month treatment protocol at the end of which 57% of participants no longer met the criteria for BPD. Eight years after the completion of the study, 87% of the participants no longer met the criteria. Only 13% of those in the control group reversed their symptomatology in both time periods. This is a remarkable finding given that this is a population noted for its intractability. Clearly psychodynamic treatments are effective and the benefits increase over time.

Why is this the case? Psychotherapy is about a relationship not a procedure. Contemporary psychoanalysis and psychodynamic psychotherapy is informed by research in attachment, affective and cognitive science, developmental studies, and non-linear dynamic systems theory, among others. Humans are social animals, we do not live in isolation from others of our species, and we develop who we are as individuals, for better or worse, in the context of relationships. Our attachment systems throughout our lives influence our identities and our perceptions of others and ourselves. This forms our neuronal architecture, our identities, and our expectations in relationships. A relationship with a therapist that is attuned to the patient's abilities, personality and needs, regardless of the treatment modality, in short a good attachment experience, will allow the person to develop different and more constructive and adaptive schemas. Psychodynamic psychotherapy changes the person's internal personality structure, the neuronal architecture. This is why psychodynamic treatments accrue benefit over time; positive experiences of agency and connection create more of the same resulting in increased ability to regulate affect and interpersonal situations which increases self-esteem, agency, resilience and flexibility, which then increase ability to regulate affect and relational conflict and so on.

Dr. Cornelius has presented a very cogent case for psychodynamic treatment as a cost effective treatment for mental health concerns. I believe he is attempting to reinvigorate clinical practice by expanding treatment options with the inclusion of a psychodynamic sensibility into the overall treatment context. He is not advocating for the exclusion of medications or CBT and its variants from treatment, but for the inclusion and appreciation of psychoanalytic approaches. We want to be successful as therapists and we want our patients to improve. His lecture is a starting point to gather the evidence needed to counter the current trend in mental health treatment to consider only medications and CBT as appropriate and to include psychodynamic approaches in the meaning of "evidence-based practices." It is a refreshing corrective to what most of us have experienced with students, colleagues, patients, insurance companies, and training sites.

Susan L. Boulware, PhD, is a psychoanalyst in private practice in Sacramento, CA. She is clinical faculty in the Department of Behavioral Health and Psychiatry at the University of California, Davis, School of Medicine, and adjunct faculty at Alliant International University. She can be reached at 916-492-9442, and susanboulwarephd.com and slboulwarephd@sbcglobal.net

References:

Frie, R. and Coburn, W. J. (2011). "Persons in Context: The Challenge of Individuality in Theory and Practice." Routledge, New York.

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Welch, B. ((2008). "State of Confusion: Political Manipulation and the Assault on the American Mind." Thomas Dunne Books, New York.

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Holding, Waiting, Watching
By Beth Siegel, PsyD, LCSW

We are all both victims and survivors of Malaysia flight MH370. Every one of us has faced an uncertain event in our lives that forces us to have to bear painful anticipation; we have all had to wait; to be patient, holding out hope, holding our breath for something; something that is unexpected, something unanticipated, something that is frightening, something in which we did not know and did not understand in our lives. Some *something* that is unexplainable that we cannot grasp. The waiting is excruciating; the not knowing is a painful desperate heartache. The uncertainty feels as if it will never end; there will be no answers, no reasons.

You are the parent who has lost a terminally ill child. You are the child of a parent who has cancer. You are someone waiting in the lobby of a hospital for a physician to bring you the 'news.' You are a country who is fighting for your sovereignty. You were the family member of someone who worked in the twin towers in NYC. You are the United States of America in one of the worst recessions since the Great Depression. You are in a crowd watching a President who has just been shot. You are marching for civil rights and risking your life. You are a community who has just experienced a school shooting. You are the parents of a child who has been kidnapped. You are the wife of a slain husband who was a police officer. You are the victim of a crime. You are the earthquake yet to come; the tsunami that hasn't occurred yet; the landslide that hasn't happened and the oil spill waiting to happen. You are the trees that have yet to burn in a forest fire. You are the iceberg waiting to sink the Titanic. You are the families of an airliner that has disappeared. You are history that hasn't been made yet. You are history in the making.

We yearn for answers, for solutions, for explanations, for reasons. We yearn for justification; we long for resolve. We long for closure. We long for completion. Bearing uncertainty is unbearable. Some of us do it better than others. We are runners; we try Zen, religion, yoga, anti-depressants. We use food, exercise and alcohol to soothe us. We want a higher power. We want to make sense of this useless, purposeless, pointless event in our lives that has caused us so much disappointment. Some of us but not most of us grieve. We cannot escape from the phenomenon of uncertainty, yet we cannot accept this. We try. We make predictions, we have hunches, we turn to the experts in science and we look to our leaders for inspiration and hope. We are exposed to media that asks questions, makes assumptions, educates us, and attempts to soothe our breaking hearts. <u>We want to know.</u> This is our nature as human beings.

Anxiety about the unknown drives insanity, creates riots and violence, and stirs societies into unrest. Anxiety at our own front door, in our own homes, in our own communities, looking in our own mirrors with the unknown staring us in the face is terrifying. We feel mangled, sunk, out of sorts, unbalanced, desperate. Albert Einstein claimed that when disaster strikes, we are shipwrecked; we are thrust from our ordinary daily routines into an unfamiliar, isolated landscape where we are castaways. Lost and waiting to be found, we feel like we are drowning. This temporary life that we live in; this impermance-is now cast upon us, rudely and ruthlessly. Surely life cannot be so unfair; we just cannot believe it. Surely, this is not true; this is not so; this is not life as we know it; this is not happening to us.

We are unable to see clearly. Telescopes and binoculars are blinding. Our glasses are out of focus. Our minds are fooled. Our minds are protected and we see and think that what we want and pray for will happen. Thank God for this-for the vulnerability of being just plain human is not enough to carry us through this shipwreck. Surely someone will see it our way and will understand that we cannot give up hope. We want the universe to be kind and gentle and not give us too much despair. We hope the world will be unyielding. We have been good in our lives and do not deserve this tragedy.

We turn angry. We will not feel our sorrow. It is too soon. We need to know who or what is responsible for

this sadism. That the world is an uncertain place (or for that matter unsafe) is nowhere to be found in our consciousness. Someone must take responsibility. We must know that a mistake was made and that justice will prevail. We seek this. We seek to pinpoint the error; the carelessness, and who will pay for the crime.

What makes this wounding survivable? All of the above. One hour at a time, leading us back to reality. For inevitably, we go on being, as D.W. Winicott stated. We endure the pain, one tear at a time. That is grief; that is how grieving goes. We kick and scream and cry. Then we sleep. Then we do it all over again, for loss cannot be avoided in this precious world of ours where the uncertainty of life is just a day away. Where life sometimes does not bring us answers. Where we are subject to unbearable uncertainty of loss of life, loss of love, and loss of connection. We are all grieving the loss of Malaysia Flight 370.

Beth Siegel, MSW, PSY.D. is in private practice in Costa Mesa treating individuals and couples in psychodynamic psychotherapy and psychoanalysis. She is involved in both the Orange and Los Angeles county psychoanalytic communities and is on faculty at NPI. She recently received a certificate from the Los Angeles Institute and Society for psychoanalytic studies in trauma. She is a member of The Soldiers Project, serving Veterans and their families returning from the Iraq and Afghanistan wars. She can be reached at http://psychotherapypracticeca.com/ and 714 556-1957.

Mentalization- Based Treatment for Borderline Personality Disorder

(Continued from Page 1)

What does poor mentalizing look like? Clients say things like: "Things went black…, I broke down…, nothing mattered anymore…, I needed to get drunk, it was my only option." They have a preoccupation with rules and responsibilities – the "shoulds" and "should nots." They express thoughts and feelings with great certainty and use terms like "always," "never," and "absolutely." They provide excessive detail without mentioning thoughts, feelings, or motivation. They deny that they have problems. They blame others. They focus on external social factors and physical labels.

In contrast, what does good mentalizing look like? Clients are able to observe their own mental functioning and appreciate the ever-changing nature of their thoughts and emotions. They maintain a healthy amount of skepticism. They are generally aware of how their emotions impact themselves and others. They acknowledge possible misunderstandings and operate free of paranoia. They have a genuine interest in others. They see others' perspectives and are able to reflect on them.

When we mentalize, we experience our feelings and are able to think at the same time about what is going on in ourselves and in others. We make interpretations based on intentional mental states -- desires, beliefs, and feelings.

A central concept in mentalizing is that internal states are opaque in that one cannot know what is taking place in another's mind. When a person consciously mentalizes, he or she adopts a curious, non-knowing attitude about their own minds as well as others. Depending on circumstances and one's own emotional state, a person's ability to mentalize can be compromised. In those who suffer from BPD, the capacity for mentalizing is more fragile and often fails in the context of close interpersonal relationships where there is high emotional arousal. Failures of mentalizing can lead to poor emotional regulation, impulsivity, self-harm behaviors, suicidality, fluctuating self-image, interpersonal problems, and unstable relationships.

Developmental Deficit Model

Fonagy and Bateman identify the core deficit in BPD as fragile mentalization with a hypersensitive attachment system. Attachment theory suggests that the development of the self occurs in the affect regulatory context of early relationships. According to Fonagy and Bateman, the capacity for mentalizing develops when there is a secure attachment. The caregiver is attuned to the infant/child, with marked contingent mirroring of their emotional experiences. The infant/child learns that the information being conveyed by the caregiver can be trusted. Growing up in a mentalizing culture promotes a secure attachment and facilitates mentalizing capability which, in turn, helps with self-regulation.

Fonagy and Bateman posit that the absence of marked contingent mirroring is associated with the later development of disorganized attachment. When there is psychological trauma in childhood, there is hyper-

activation of the attachment system and normal development of mentalizing is disrupted. Insufficient development of mentalization impairs capacities for self-awareness and self-regulation. Biological factors (such as temperament) and environmental factors (such as an invalidating environment, early separation, loss, neglect, and other trauma) contribute to problems with mentalization. Unmentalized emotions can result in self-destructive behavior.

Emotional Activation and Poor Mentalizing

The most important factor in poor mentalizing is intense emotional activation. For clients with BPD, feelings are triggered faster and are experienced more intensely. The "fight or flight" response can happen quickly and can last longer before the client returns to baseline. MBT can raise the threshold level before a client becomes emotionally activated. It can also assist a client to regulate their emotional intensity levels more effectively. The end result is a client with more emotional control and a greater ability to return to baseline in a reduced period of time.

In the context of the therapeutic relationship, the attachment system is inevitably activated. When using MBT, the therapist's intention is to maintain a moderate level of emotional arousal in the client while the client strives to recapture their mentalizing ability. At the same time, we as therapists work to sustain our own ability to mentalize as we stay attuned to the mind of the client. If a client with BPD feels misunderstood, the client will often react in a highly aversive and aroused manner. It is therefore essential for the therapist to stay personally engaged in mentalizing and to actively understand the client's mind. We provide contingent and marked mirroring, and a mind through which clients can find themselves. We recognize non-mentalizing and aim to get the clients re-attainment of mentalization back on track.

Fonagy and Bateman delineate mentalizing precursors, often seen in clients with BPD, which constantly inform our treatment. These primitive modes of interpreting meaning from experiences are normal developmentally in the first 3-4 years of life. There are three general types: psychic equivalence, pretend mode, and teleological stance. In psychic equivalence, the internal experience equals the external. Clients make false assumptions and are intolerant of alternative perspectives. For example, if a client believes that he or she is inherently bad and observes their therapist frown, that reinforces the client's own belief that they ARE bad. The therapist's counter-transference response can be one of confusion; we are not sure what to say and we may feel angry.

In pretend mode, there is no connection between internal and external. There is a disconnect between thoughts and feelings, dissociation, false self, excessive detail to the point of meaninglessness, or intellectualization. Counter-transference response to pretend mode might be one of boredom.

Finally, when a client is in a teleological stance, there is a faulty belief that something needs to be done to create change, or a need for physical proof. This is seen in self-harm behavior such as cutting as a way to stop the internal sense of badness. There are demands for acts of demonstration of affection, such as a client who simply must have that extra appointment as proof that their therapist cares. Counter-transference response to a teleological stance might be one of anxiety or an urge to do something.

Basic MBT Interventions

The spectrum of MBT interventions include: empathizing and supporting; clarifying, elaborating, and challenging; affect focus and basic mentalizing; and mentalizing the relationship. Basic MBT techniques are simple and short. They focus on the client's mind and internal experiences, not on their behavior. The therapist must show genuine empathy toward the client regardless of how the therapist may actually feel. We as therapists must get the client to know and describe what they are experiencing in the moment, what they are thinking, and what they are feeling. It is vital that we explore and probe the client for clarification. We must be genuinely curious and non-knowing about their experiences. This is validating. We help the client to understand and label emotional states, and to transform misunderstanding into meaning. At the same time, we generate alternative perspectives and provoke curiosity within the client about their own and others' possible motivations. We might ask: "How do you think he got to that…, What do you think was going on with her…, I wonder if he was feeling…, Why do you think she did that…,What is it that makes you so certain?" We should not hesitate to let the client know when we are confused and are therefore seeking more specificity about their perspective. We should stay attuned to when the client is non-mentalizing and rewind back to the point in the session before they lost their mentalizing ability. Just as we are attuned to the client's mentalizing failures, we should also identify and reinforce positive mentalizing by the client.

In MBT, contrary moves are used. If the client is knowing, we as therapists shift to unknowing. If the client is focused on herself, we move the client to focus on others. If the client is emotionally distant, we shift to emotional closeness. And if the client is rigid and certain, we move to direct the client toward questioning and possible doubt. We use statements from our own perspective, remaining tentative about the client's reality. For example, we might say things like: "My sense is …, I imagine…To me you seem…, My understanding is…. " In short, we as therapists focus the client's attention on our experience of them, thereby enabling exploration of 'a mind by a mind.'

Using a mentalizing approach, we are attentive to affect shifts by the client. We can then explore what is happening in the here and now for the client. We prompt the client to elaborate on what he or she just experienced and on their current feeling states. When the client is highly aroused, we shine a light on that arousal and collaborate with the client to understand what that may be about. At the same time, we accept and explore enactments. We continually monitor and acknowledge our own mistakes which could have contributed to the client's high state of arousal. And we repeatedly return to empathy and support if emotions become too high.

If the client is knowing, we as therapists shift to unknowing. If the client is focused on herself, we move the client to focus on others. If the client is emotionally distant, we shift to emotional closeness.

MBT Program Structure

Based on their research, Fonagy and Bateman recommend that an intensive outpatient MBT program consist of 18 months of individual and group mentalization-based therapy, and medication management. There is an introductory, psycho-educational 12-week explicit group with emphasis placed on understanding central concepts of MBT. There is an ongoing implicit mentalizing group which focuses on promoting mentalizing about oneself and others. The MBT program has a treatment team consisting of individual and group therapists, as well as a psychiatrist. The treatment team works collaboratively to provide a support structure for both clients and clinicians.

Benefits of MBT

The core of mentalization-based therapy is to enhance the client's reflective processes, thereby improving mentalization abilities. With improved mentalizing, clients are not as easily knocked off their center. They develop a more stable sense of self and are less emotionally dysregulated. That, in turn, leads to a reduction in self-destructive behavior and enhanced interpersonal effectiveness, decreasing their vulnerability to conflicts with others.

Reference:
Bateman, A., Fonagy, P. (2006). *Mentalization-Based Treatment for Borderline Personality Disorder, A Practical Guide.* Oxford University Press.

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Clinical Social Work in 6 Words - Continued

Sitting, sharing, shedding light, speculating and summarizing.

Diminishing frequency, intensity, duration of anguish.

Playful, good enough holds true self.

- -

Can you describe what you do in 6 words? Try it – and send it to jrosenfeld@clinicalsocialworksociety.org

The DSM 5: Transitions

Presented by: Stan Taubman, PhD, LCSW

Co-Sponsored by:

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This workshop is designed for the clinical practitioner who has some familiarity and experience with DSM differential diagnosis using the DSM-IV. The workshop will familiarize participants with major changes from the DSM-IV to the DSM5 including changes in the classification system, definition of mental disorder, loss of the 5 axis system, new diagnoses, deleted diagnoses, unchanged diagnoses, and criteria changes. The presentation will also identify common diagnostic errors and introduce participants to the new Assessment Measures which are included in the DSM-5 Manual. To register online click the link below or cut and paste into your brower:
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Stan Taubman, PhD, LCSW has been in clinical practice since 1968. He currently is the Program Director of Berkeley Training Associates and teaches on the faculty of the University of California, Berkeley, graduate program in Social Work. He is the former Director of the Alameda County Medi-Cal Behavioral Health Plan, as well a Director of Management Services for the Alameda County Behavioral Health Care Services Department. His clinical experience includes private practice, mental health inpatient, outpatient and day treatment programs, child welfare and medical social work. Dr. Taubman is the author of *Ending the Struggle Against Yourself* (Tarcher/Putnam Publishing), click here to purchase Ending the Struggle Against Yourself as well as numerous journal articles addressing both clinical and administrative issues.

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