Attempting an integration of therapeutic approaches to Borderline Personality Disorder via resilience and epistemic trust

Peter Fonagy, OBE FMedSci FBA
With Patrick Luyten and Liz Allison
With support from Nicolas Lorenzini

Slides from: P.Fonagy@ucl.ac.uk
The things I feel proud of
(just showing off, not relevant so you don’t need to listen!)
Some of the Mentalizing Mafia

- UCL/AFC/Tavistock
  - Prof George Gergely
  - Professor Pasco Fearon
  - Professor Mary Target
  - Prof Anthony Bateman

- University of Leuven
  - Dr Patrick Luyten
  - Dr Liz Allison
  - Professor Alessandra Lemma
  - Professor Eia Asen

- UCL/AFC
  - Dr Trudie Rossouw
  - Dr Dickon Bevington

Dr Liz Allison
And European recruits to the ‘Family’

- Dr Dawn Bales
- Prof Martin Debané
- Professor Svenja Taubner
- Dr Tobi Nolte
- Professor Finn Skårderud
- Professor Sigmund Karterud
- Dr Mirjam Kalland

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

---

---
More mafiosi (The American branch)

Menninger Clinic/Baylor Medical College/U Laval/Harvard
- Dr Jon Allen
- Dr Lane Strathearn
- Dr Karin Ensink
- Dr Read Montague

Yale Child Study Centre
- Prof Linda Mayes

UCL & Catholic University, Santiago
- Nicolas Lorenzini

The USA branch
- Dr Carla Sharp
- Dr Efrain Bleiberg
- Professor Lois Choi-Kain
- Dr Elisabeth Newlin
Articles Published Citing Papers About Mentalizing or Mentalization

Thérapies Basées sur la Mentalisation
The nature of BPD: A developmental view
Conceptualizing BPD from a **dimensional**, rather than a **categorical**, approach is particularly pertinent in the **emergence of BPD**, as a dimensional approach may better account for the **developmental variability** and **heterogeneity** observed during this age period.

**Section 3**: Dimensional model of personality pathology

- Impairments in self
- Difficulties in relatedness

A sensitive and precise diagnosis could be achieved by **combining** both approaches.
DSM-5: BPD in adolescence

**DSM-5** maintains the historical caution to attribute personality problems to an adolescent only in “relatively unusual circumstances” (APA, 2013; p. 647)

**Criteria A**
Judgment of severity of problems in
- identity
- self-direction
- empathy
- intimacy

**Criteria B**
4 or more of
- emotional lability
- anxiousness
- separation insecurity
- depressivity
- impulsivity
- risk taking
- hostility

ICD 11 has legitimised the diagnosis
Section III of DSM-5: diagnostic criteria for PD

- **Level of personality functioning**
  - *identity* and *self-direction* (category of *self*)
  - and *empathy* and *intimacy* (category of *interpersonal functioning*)
  - **Severity**: more than one PD diagnoses, or one of the more typically severe forms of PD.

- **Specific** personality disorder diagnoses (ASPD, APD, BPD, NPDM, OCPD, SPD)

- Pathological **personality traits** in five domains: *negative affectivity, detachment, antagonism, disinhibition* and *psychoticism*.
  - Within the domains, there are **25 trait facets**
DSM 5 Section III: Impairment in personality functioning is two or more of four indicators

- **Identity** (impoverished, poorly developed self-image, often excessive self-criticism; chronic feelings of emptiness; dissociative states under stress).

- **Self-direction** (instability in goals, aspirations, values, career plans).

- **Empathy** (impoverished ability to recognize feelings and needs of others, obliterated as a result of hypersensitivity).

- **Intimacy** (intense, unstable and conflicted close relationships: mistrust /neediness; idealization/devaluation, over-involvement/withdrawal)
Evaluation of DSM-5 Section III

• **Strengths**
  – *Dimensional* nature - research evidence that personality disorders are continuous with normal personality’ (Livesley, 2012, p.364).
  – The functioning scale is *severity* factor, which is a good *predictor of outcome* (Livesley, 2012).

• **Criticism**
  – ‘*unwieldy* conglomeration of disparate models’
  – clinical *utility* of trait model: too many *subcomponents* (Shedler et al., 2010).
  – retention of a *categorical/typal* model alongside the *dimensional* model → *incommensurability* (psychopathology is either continuous with normality or not) (Livesley, 2012).
ICD-11 (scheduled for publication in 2018)

• One general **dimensional diagnosis** for PD: ‘pervasive **disturbance** in how an individual experiences and thinks about the **self, others** and the **world**, manifested in **maladaptive** patterns of cognition, emotional experience, emotional expression and behaviour’ (Tyrer et al., 2015).

• **Entrenched** patterns ➔ significant difficulties in **interpersonal** functioning and **social collaboration**

• Disturbances across personal and **social situations**; and are **relatively stable** over time

• **Level** of impairment: mild, moderate and severe assessed as **extent of social dysfunction**, level of **risk to self** and others, and overlap of trait domains.
Typology in ICD-11

• **Domain traits** - not ‘categories but **five dimensions** that correspond to the underlying structure of personality dysfunction’ (Tyrer et al., 2015)
  
  – **Negative affective domain** traits: **distressing emotions** such as anxiety, anger, self-loathing, instability, vulnerability and depression.
  
  – **Dissocial trait**: **disregard for social obligations** and conventions and the rights and feeling of others.
  
  – **Disinhibition**: a propensity for **impulsive behaviour**, shown in irresponsibility, distractibility and recklessness.
Typology in ICD-11

– **Anankastic domain**: a narrow focus on the control and regulation of one’s own and others, expressed as **perfectionism**, perseveration, emotional and behavioural constraint, stubbornness, orderliness and preoccupation with meeting obligations.

– **Detachment domain**: emotional and interpersonal distance, expressed as social **withdrawal** or social **indifference**, isolation, the **avoidance of intimacy** or close friendship.
Severity in ICD-11

• **More severe PD, more than one domain** trait is likely to present (Tyrer et al., 2015).
  – **Just BPD** would classically involve an emphasis on negative affect;
  – **BPD** comorbid with **antisocial** personality disorder manifest **as moderate or severe personality disorder** with dissocial features and features of disinhibition as well as negative affect.
  – **Not** using the language of **typal** categorisation,
    • Helps understand behaviours in terms of severity **and**
    • typical styles of behaviour and their underlying cognitive processes.
Common features across new classifications

- Severity is co-occurrence of range of manifestations
- Implicit assumption of dimensional underlying structure
- Key to diagnosis is low psychosocial functioning across contexts
- Foregrounding of failure of interpersonal functioning (trust in relationships)
- Separation of diverse manifestation from a singular underlying clinical vulnerability
Example of Emergent BPD: Comorbidity

High psychiatric comorbidity and low psychosocial functioning

- Significant percentage of BPD adolescents meet criteria for externalising problems relative to other inpatients
  - ADHD
  - Oppositional disorder
  - Conduct disorder
- Substance-related disorders
- Internalising disorders
  - Mood disorders
  - OCD
  - PTSD
  - Separation anxiety
  - Social phobia

- At least 60% of BPD adolescents have complex comorbidity
  - Confluence of internalising and externalising disorders
  - Disruptive behaviour disorders and depressive symptoms in childhood predict adolescent BPD diagnosis

Ha et al., 2014; Eaton, 2011

Stepp, 2012
Comorbidity

High psychiatric comorbidity and low psychosocial functioning

Comorbidity in adolescent inpatients

- Mood disorders: 70.60%
- Anxiety disorders: 67.30%
- Externalising disorders: 60.20%

BPD

Non-BPD psychiatric controls

Ha, Balderas, Zanarini, Oldham & Sharp, 2014
Bridges internalizing and externalizing and shows invariance across gender in adolescent sample (Sharp et al., under review)

The scalar model did not result in a significantly worse fit than the configural model: robust $\chi^2_{\text{diff}}(6, N = 434) = 12.51, p > .05$, CFI = .95, TLI = .93, RMSEA = .05 (90% CI: .03-.07).

- Unique association of BPD with attachment (CAI) after internalizing and externalizing controlled for (i.e. underlying social pathology)
Life-course structure to psychopathology

Need for longitudinal research designs

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

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

- Some individuals more prone to persistent psychopathology.
The $\rho$ factor in adolescent psychopathology

N= 2,230 Dutch adolescents

Laceulle et al., 2015 *J Pers.*, 83(3), 262-273
The $p$ factor in adolescent psychopathology

Model A: Three-correlated factor

N= 2,230 Dutch adolescents

Inadequate model fit

$\chi^2(723) = 5148.82$
CFI = .890
TLI = .875
RMSEA = .052
90% CI = .051-.054

Laceulle et al., 2015
The $p$ factor in adolescent psychopathology

Model B': Revised bi-factor model

N= 2,230 Dutch adolescents

Best model fit

$\chi^2(716) = 4665.65$

CFI = .902

TLI = .887

RMSEA = .050

90% CI = .048-.051

Laceulle et al., 2015
The $\rho$ factor in adolescent psychopathology

<table>
<thead>
<tr>
<th>Statistics, Loadings, and Correlations</th>
<th>Model A</th>
<th></th>
<th>Model B’</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized factor loadings</td>
<td>INT</td>
<td>EXT</td>
<td>Thought</td>
<td>P</td>
</tr>
<tr>
<td>Anxious-depressed</td>
<td>0.932</td>
<td></td>
<td></td>
<td>0.856</td>
</tr>
<tr>
<td>Withdrawn-depressed</td>
<td>0.711</td>
<td></td>
<td></td>
<td>0.736</td>
</tr>
<tr>
<td>GAD</td>
<td>0.900</td>
<td></td>
<td></td>
<td>0.822</td>
</tr>
<tr>
<td>Social anxiety</td>
<td>0.880</td>
<td></td>
<td></td>
<td>0.730</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>0.844</td>
<td></td>
<td></td>
<td>0.719</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>0.845</td>
<td></td>
<td></td>
<td>0.835</td>
</tr>
<tr>
<td>Delinquency</td>
<td>0.847</td>
<td></td>
<td></td>
<td>0.413</td>
</tr>
<tr>
<td>Aggression</td>
<td>1.016</td>
<td></td>
<td></td>
<td>0.655</td>
</tr>
<tr>
<td>Attention problems</td>
<td>0.783</td>
<td></td>
<td></td>
<td>0.726</td>
</tr>
<tr>
<td>Thought problems</td>
<td>0.855</td>
<td></td>
<td></td>
<td>0.869</td>
</tr>
<tr>
<td>OCD</td>
<td>0.907</td>
<td></td>
<td></td>
<td>0.894</td>
</tr>
<tr>
<td>Psychotic experiences</td>
<td>0.970</td>
<td></td>
<td></td>
<td>0.968</td>
</tr>
<tr>
<td>Factor correlations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalizing</td>
<td>0.440</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalizing</td>
<td>0.883</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.612</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laceulle et al., 2015

N= 2,230 Dutch adolescents
Bi-factor model with the item-loadings

Community-based sample aged 11-14 years (N= 23,477)

## Correlation between factor scores and predictors

<table>
<thead>
<tr>
<th>Predictor</th>
<th>2-factor model (Model 1)</th>
<th>Bi-factor model (Model 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internalising</td>
<td>Externalising</td>
</tr>
<tr>
<td>Gender (Female)</td>
<td>.13**</td>
<td>-.21**</td>
</tr>
<tr>
<td>Free School Meals</td>
<td>.04**</td>
<td>.14**</td>
</tr>
<tr>
<td>Income</td>
<td>.02*</td>
<td>.14**</td>
</tr>
<tr>
<td>Deprivation</td>
<td>-.1**</td>
<td>-.2**</td>
</tr>
<tr>
<td>Special Education Needs</td>
<td>.10**</td>
<td>.14**</td>
</tr>
<tr>
<td>School Attainment</td>
<td>-.1**</td>
<td>-.2**</td>
</tr>
</tbody>
</table>
Logistic regression predicting future caseness

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Chi-square</th>
<th>Odds-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=10,270</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2-factor model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising</td>
<td>.49***</td>
<td>76.4</td>
<td>1.80</td>
</tr>
<tr>
<td>Externalising</td>
<td>1.41***</td>
<td>689.64</td>
<td>4.11</td>
</tr>
<tr>
<td><strong>Bi-factor model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising</td>
<td>.22</td>
<td>4.43</td>
<td>1.25</td>
</tr>
<tr>
<td>Externalising</td>
<td>1.43***</td>
<td>413.74</td>
<td>4.16</td>
</tr>
<tr>
<td>P-Factor</td>
<td>2.33***</td>
<td>479.01</td>
<td>10.30</td>
</tr>
</tbody>
</table>
BPD as the ‘g/P-factor’ of personality pathology (Sharp et al 2015)

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

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

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

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

UNACCEPTABLE MODEL FIT

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

Sharp et al., 2015 *Journal of abnormal psychology*
<table>
<thead>
<tr>
<th></th>
<th>BPD</th>
<th>AVPD</th>
<th>OCPD</th>
<th>SZTPD</th>
<th>NPD</th>
<th>ASPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AVPD</td>
<td>.60</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCPD</td>
<td>.48</td>
<td>.46</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SZTPD</td>
<td>.61</td>
<td>.43</td>
<td>.22</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPD</td>
<td>.47</td>
<td>.18</td>
<td>.55</td>
<td>.01</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>ASPD</td>
<td>.55</td>
<td>.31</td>
<td>.04</td>
<td>.16</td>
<td>.56</td>
<td>-</td>
</tr>
</tbody>
</table>

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

Excellent model fit:

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

Sharp et al., 2015 Journal of abnormal psychology

N=966 inpatients
P factor in PDs: Exploratory bifactor model

Excellent model fit:

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

Only factor loadings >|30| are shown

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

![Diagram showing factor loadings and model fit metrics.](chart.png)
The ‘P’ Factor (Caspi et al., 2013)

- Ungendered chronic Psychotic conditions
- Partially gendered Personality disorder
- Gendered ‘Neurotic’ conditions

Impairment
Persistence

Externalizing
Gendered Style
Internalizing

Male → Gendered Style → Female
Happiness versus disorder

• What makes you experience positive mental health is not the same as what makes you develop psychological problems.

• Predictors of happiness are more generally based on social structure:
  – democracy, religiosity, voter turnout
  – social trust shift the distribution
  – self-esteem, success and interpersonal security

• Happiness research has two approaches:
  – Hedonic approach: defines well-being in terms of pleasure attainment and pain avoidance;
  – Eudaimonic approach, focuses on meaning and self-realization & degree to which person is fully functioning.
Some examples of happiness studies

• Four years after the hurricane only exposure to hurricane stressors was predictive of unhappiness. In contrast, pre-disaster happiness and post-disaster social support were protective against the negative effect of the hurricane on survivors’ happiness (Calvo et al., 2015, Journal of Happiness Studies, 16, 427-442).

• Relationship between social trust and happiness (Bartaloni et al., 2015 Social Interaction Research
  – “Generally speaking, would you say that most people can be trusted, or that you can’t be too careful in dealing with people?”
  – “Would you say that most of the time people try to be helpful or that they are mostly looking out for themselves?”
  – “Do you think that most people would try to take advantage of you if they got the chance, or would they try to be fair?”
Relationship social trust and happiness

\[ Y = 0.00 + 0.652X^{***} \]
\[ N = 7 \]

<table>
<thead>
<tr>
<th>Index of social trust</th>
<th>0.696**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend of log GDP</td>
<td>0.678**</td>
</tr>
<tr>
<td>Constant</td>
<td>-6.83e-09</td>
</tr>
</tbody>
</table>

Observations: 7
Adjusted \( R^2 \): 0.763

\( t \) statistics in parentheses
* \( p < 0.10 \), ** \( p < 0.05 \), *** \( p < 0.001 \)

Bartolini, Stefano; Mikucka, Malgorzata; Sarracino, Francesco. Money, Trust and Happiness in Transition Countries: Evidence from Time Series. In: Social Indicators Research: an international and interdisciplinary journal for quality-of-life measurement, Vol. 0, no. 0, p. 0 (0)
The nature of resilience: BPD as a failure of resilience
Understanding the ‘P’ or ‘g’ factor as an absence of expected resilience
From disease- to health-oriented research: A paradigm shift.
Formerly: Investigating the mechanisms that lead to stress-related illness
Now: Investigating the mechanisms that protect against illness
Basic assumption of resilience research: Resilience is not simply due to an absence of disease processes but reflects the work of active adaptation mechanisms with a biological basis (Kalisch et al)
Active refers to any resource demanding process and may apply to cognitive as well as behavioral processes (Kalisch et al., in press)
Resilience has been conceptualised variously as a...

- Tool
- Outcome
- Process
- Dynamic interaction
- Capacity
- Transactional relationship
- Characteristic
- Potential
- Act
- Asset
- Value
- Attitude
- Strength
- Skill
- Resource
- Knowledge
- Recovery
- Disposition
- Competency
- Response
- Performance
- Functioning
- Adaptation
- Tendency
- Positive influence
- Ability
- Protective factor
The ability of a system to resist dynamically a perturbation or adverse condition that challenges the integrity of its normal operation and to preserve function as a result in reference to some initial design or normative functional standards (Rudrauf, 2014).
Bringing order to the conceptual chaos

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

Mediating mechanisms
- psychological
- or biological

Outcome

May overlap conceptually and/or interact statistically

RESILIENCE
The role of systemic factors

Factors

Individual factors
- Social support
- Social status
- Personality
- Life history
- Coping style
- Genetic background
- Brain function

Systemic factors
- Quality of family, school, or community

Mediating mechanisms

Outcome

Resilience

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

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

Not Enough

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

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

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

...but by context-dependent evaluation of motivational relevance
A theory of PD and Resilience

- **Multiple processing units** cover the same function in the brain
  - Some processing units more efficient than others and output is taken from most efficient processing units
  - Circumstances change and demands for adaptation may reverse the hierarchy of efficient functioning of these processing units

- **HOC** is capable of shifting processing between units of the brain to identify most effective processing units

- **Resilience** is appropriate appraisal (monitoring) of
  - External (social) environment
  - Internal functioning of processing units

- **HOC** is developmental capacity based on early relationship with caregivers because it is intersubjective capacity (Rudrauf, 2014, Advances in Neuroscience)
### Positive appraisal style theory of resilience (PASTOR)

**Factors**
- $F_1$
- $F_2$
- $F_3$
- $F_4$
- $F_5$
- $F_6$
- $F_7$
- $F_8$

**Mechanism**
1. Positive appraisal style
2. Positive reappraisal
3. Interference inhibition

**Outcome**
- Resilience

---

*Kalish et al., 2014*
Lack of resilience in BPD: Interpretative and regulatory role of explicit mentalizing

- Individuals with BPD have **limited capacity** to exercise this regulative role of mentalizing and the **appraisal processes** needed to **reduce stress** of any experience are **not there**

- Ample **evidence** of **limitations of appraisal** in BPD

- In BPD poor appraisal may be **more severe** than in MDD or GAD (but no evidence for this).
Lack of resilience in BPD: Failure of reappraisal of negative experience

- Mentalizing model for trauma has **reappraisal of physical and psychological experience** at its core (Allen, 2013)

- Patients with **BPD** have **specific deficit in reappraisal proper**
  - BPD partially **closed to acquiring social information to support** process of **reappraisal** (epistemic mistrust)
  - Reappraisal **requires mentalising traumatic event** (depicting mental states around traumatic event (TF-CBT, EMDR all enhance Mz of trauma)
    - Cannot generate positive reappraisals
    - Cannot mitigate (adjust) negative appraisals

- Links to Gunderson and Lyons-Ruth’s **interpersonal hypersensitivity** model except that hypersensitivity is consequence of failure of reappraisal following **stressful interaction**
Lack of resilience in BPD: Failure of inhibition of negative appraisals and emotional reactions

• BPD limited in capacity for the inhibition of conflictive negative appraisals and interfering emotional reactions to information processing.

• Cannot inhibit re-traumatizing triggers leaving them vulnerable to the threat-associated sensations when remembering a traumatic event & reinforce sense of threat.

• Consistent with Marsha Linehan’s emphasis on emotion dysregulation as the basic problem in BPD.

• Links to impairment of habituation notion that New, Koenigsber and others (2014) identified and which may have genetic basis (Goodman et al., 2014).

• This description of the subjective outcome also dovetails with the concept of the alien self - the looming of unmanageable anxiety incapable of reappraisal.
Lack of resilience in BPD: Failure of inhibition of negative appraisals and emotional reactions

- This shift in perspective involves a recognition of the significance of **enhancing** the **capacity for inhibition** in the **treatment** of BPD.
- Individuals who are **really poor at mentalizing** require more than cognitive interventions (talking), but interventions that **relate to the body** more directly.
- We have always had a view that **mentalizing** was **embodied** but we haven’t treated this fact with enough seriousness.
- The role of **physical activity** in **strengthening** the **inhibition** at the same time as **helping** to **restore mentalizing** (e.g. systemic family therapy techniques, or if you have an adolescent you can’t communicate with, **go running** with them, and discuss what the running was like).
‘P’ Factor

Resilience
‘P’ Factor

Resilience

Normal/
Typical
‘P’ Factor

Resilience

BPD
‘P’ Factor

Resilience

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

- The ‘P’ factor of general vulnerability to psychopathology is actually an indication of the absence of resilience (psychological equivalent of immune system response, Higgitt & Fonagy, 1992)
  - The nature of the stressor (abuse, bullying, neglect, maltreatment or everyday social stress) is not relevant
  - Most toxic stressors attack the mechanisms of resilience
- While patients with ‘neurotic’ problems (regardless of severity) have high resilience (unlikely to be effected by subsequent stressors) those with BPD have low resilience and are likely to succumb to psychosocial stress
The current bio-psycho-social MZ model of BPD as an absence of resistance to social stress

- ‘P’ and ‘R’ are inversely related because they are identical at the level of mechanisms
  - Low ‘R’ reflects an adaptation consequent on serial communication problems in development combined with genetic vulnerability characterized by epistemic hypervigilance which prevents or undermines a reappraisal process and results in apparent rigidity (imperviousness to social influence)
  - The failure to engage in meaningful reappraisal creates a general vulnerability to psychosocial stress (low ‘R’) which yields to the high prediction of future psychopathology from ‘P’
  - Increasing mentalizing increases epistemic trust which in turn generates resilience through improved capacity for appraising and re-appraising stressful events
  - The underlying deficit is inflexible utilization of brain processing systems because of developmental limitations of HOC (higher order cognition)
Asen’s Summary of our model of resilience: The Mental Immune System (MIS) (steps towards an ecology of health-oriented therapies)

- There ‘exists’ (sort of) a ‘mental immune system’
- If the Mental Immune System is down, the individual is more likely to ‘catch’ illnesses
- Symptomatic treatments may be necessary but will not protect against future relapses
- Symptomatic treatments may stop the MIS from developing (‘trauma mafia’ interventions)
- MIS enhancing interventions may lead to long-term reduction of ‘p’ – they aim to strengthen resilience
Summary: Resilience

- **Resilience** is an **active** process / mechanism (and outcome) – not a static entity.

- It can be defined as ‘the quality of a system to **maintain integrity** when challenged’ *(i.e. maintaining its functioning)*.

- Resilience (outcome) is related to:
  
  a) **Predictive Factors**: social support, personality, life history, genetics *(systemic factors are most important – what’s undermining the functioning of MIS)*

  b) **Mediating mechanisms** The Black Box