# Mentalizing and Psychodynamic Approaches to Non-Suicidal Self Injury

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***In press: The Oxford Handbook of Nonsuicidal Self-Injury***
*Oxford University Press*
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## Introduction

Non-suicidal self-injury (NSSI) is a major public health concern (Garcia-Nietoet al., 2015), with lifetime prevalence rates in adulthood reported as ranging between 5.9% (Klonsky, 2011) and 23.2% (Muehlenkamp & Gutierrez, 2007). Lifetime prevalence of non-suicidal self-injury in international adolescent community-based populations has been found to be between 18 and 25% (Muehlenkamp et al., 2012; Swannell et al., 2014). There are also indications that NSSI is becoming more prevalent. A recent report in the United Kingdom, for instance, reported that the prevalence of non-suicidal self-injury in young women and girls nearly tripled since the year 2000, but this was not matched by a rise in the use of health or other support services by patients who self-harm (Agenda and the National Centre for Social Research, 2020). While we consider self-injury without suicidal intent (NSSI) to be a distinct phenomenon from those acts committed with an intention to die, it is evident that non-suicidal self-injury increases the risk of actual suicide and is in itself an urgent area for assessment and treatment (Gillies et al., 2018). An emphasis on the communicative and meaningful aspects of non-suicidal self-injury can be found in mentalization-based treatment approaches, which are part of the family of psychodynamic treatments.

In addition to suicidal ideation and behaviour, NSSI has increasingly been a subject generating significant interest. While NSSI is an important clinical issue in its own right

(American Psychiatric Association, 2013) it is now recognized as being a more robust prospective predictor of suicide attempts than a past history of suicide attempts (Ribeiro et al., 2016; see Chapter 5 - Theoretical models linking NSSI to suicide). NSSI in women and girls occurs at a greater frequency than for men and boys; women aged 18–33 were significantly more likely to report past-year non-suicidal self-injury than men and their greater psychological distress contributed to their higher NSSI prevalence (Lutz et al, 2022). Various factors can be cited as contributory to the higher rates of NSSI in recent years including the prevalence of self-harm sites on social media (see Chapter 39 - Media representations of NSSI, the increasing pressures on young people created by social media, and the restrictions and anxiety created by the Covid Pandemic. Differences in rates of NSSI according to gender are also found in particular populations, including the female prison population (Ministry of Justice, 2021).

This chapter offers an overview of the development of NSSI using a mentalisation based framework. First, we will outline a psychodynamic understanding of non-suicidal self-injury and describe how an Mentalization Based Therapy (MBT) model conceptualises it. This is followed by a synopsis of how MBT conceptualises NSSI, as a psychodynamic treatment approach that also incorporates aspects of DBT, CBT and systemic therapy. We offer two clinical case examples to illustrate basic treatment principles of MBT, and to describe how such treatment addresses the important issues of NSSI. The first focuses on the principles of treatment using MBT for NSSI, and the second for treatment of someone presenting with both violence against herself and against others. We then conclude, with recommendations for treatment using the MBT approach.

## Development of NSSI

***A Psychodynamic Understanding of the Development and Maintenance of Non-suicidal Self-Injury***

A psychodynamic perspective on self-harm and suicidal behaviour focuses on emotional experience, unconscious meaning and interpretation within a relational framework (Yakeley, 2018). An understanding of the possible unconscious meanings and functions of apparently self-destructive acts informs the assessment, treatment and management of people who engage in these. This model further holds that early experience, particularly in relation to primary caregivers, shapes an infant's sense of self and creates a template for development that can influence their relationship with others and with themselves across the lifespan, often without their conscious awareness of this. Attacks on their own bodies by adolescents can be viewed as attempts to create a separation from their primary carer, and may also express unconscious acts of hostility towards them. The force of sexual and aggressive impulses that strengthen in adolescence can now found their expression in action, rather than simply phantasy, and the guilt over these unacceptable feelings may also contribute to the young person wanting to punish themselves, and their bodies through non-suicidal self-injury, sometimes taking risks that result in their death, though this was not their intention (Anderson, 2008).

This view is consistent with high rates of early adversity and attachment trauma in particular young people who self-harm, and the emergence of these problems typically increases in adolescence coinciding with emergence of sexuality and physical aggression (Wright et al., 2005.)

As Freud (1923) described, the body ego is the first ego, and so infants gain a sense of themselves, their boundaries and their feelings through this body and how it is treated by another. Freud proposed that the mind and its experiences originally develop from the body and its experiences (Freud, 1923). The centrality of, and deep connection between body and

mind has further been explored and described by psychoanalytic authors including the child psychoanalyst, Esther Bick (1968), in her discussion of how maternal care directly impacts on the infant's sense of its skin, and Didier Anzieu (1974) whose discussion of the containing envelope of the skin helps us to see how attacks on this essential organ can serve as means of both locating and displacing aggression onto the body. This kind of self-directed violence can also serve as unconscious punishment towards the self and other significant others, notably the parents, who have given birth to this individual. In suicidal states of mind, the person is enacting unconscious phantasies whose meaning can be understood in various ways, as the contemporary analyst Stephen Briggs (2022) has outlined:

- Revenge: The solution to a grievance "the child wishes to rob the parent of her most precious possession" (Stekel, 1910).
- (Self) Punishment: Punishment of self will remove the problem (for others) or bring atonement – masochistic solutions.
- "Dicing with Death": On the model of "Russian roulette" in which an individual does not intentionally seek to die, but engages in activities that could easily result in death. Hale (2008); Maltsberger and Buie (1980; 1996); Campbell and Hale (2017).
- Elimination Phantasy: A further unconscious phantasy fuelling non-suicidal and suicidal acts is what Campbell and Hale (2017) refer to as the "elimination phantasy" in which sources of pain and humiliation are split off and evacuated. The elimination phantasy involves the identification of one part of the body as toxic and is therefore attacked in order to purify another, to preserve a good object. When the sources of pain and humiliation are, for example, the sexual organs that have been abused by another, these may directly be attacked, and injured, as a symbolic as well as actual form of protest.

- Self-Harm as a Sign of Hope: Motz (2009) has described this in terms of non-suicidal self-injury serving as a form of purification and release for the women who engage in it, as well as a sign of hope, in that it is testing the environment to see that it can survive assault. This is a development of Donald Winnicott's notion of the "antisocial tendency as a sign of hope"(Winnicott, 1956), in that the person who behaves aggressively is searching to re-find a good object that can withstand their aggression and remain intact. In a similar way the woman attacking her own body is searching for containment and survival, using this as an act of relating both to herself and another in order to obtain a response. There is the hope of positive relating.

Underpinning these psychodynamic approaches is the notion of non-suicidal self harm developing and being maintained in the context of interpersonal relationships, as comprehensively explicated by Briggs, Lemma and Crouch (2009) who incorporate suicidal ideation in their understanding of non-suicidal self-injury. This model is supported by Stänicke et al. (2018) in their study of adolescent NSSI, who describe how the action of self-harm may contain important emotional and relational content and an intention or wish to connect and communicate with others. Stänicke et al. (2018) emphasise the importance of relating self-harm to developmental psychological needs and challenges in adolescence, such as separation, autonomy and identity formation. They suggest that NSSI in adolescence may reveal both a need to express affective experiences and a relational need for care. NSSI does not take place in a void, but often occurs in an interpersonal context. Motz (2009) emphasises the communicative function of non-suicidal self-injury, "self -harm is a communication to oneself and others that serves several functions for the individual by offering them a variety of ways of relating to themselves and enacting certain essential roles. In this sense, self-harm

reflects a split and divided self, and its enactment offers a sequential series of rewards and compensations."

Hence, from a psychodynamic perspective, the treatment priorities include the therapist working carefully with the patient to understand and identify underlying emotional states and experiences that lead to the self-injurious action, offering containment to them, helping the patient to tolerate feelings that are contradictory or ambivalent and ensuring that the therapist themselves is able to manage disturbing countertransference feelings that may include anger, hopelessness, despair or confusion.

A recent meta-analysis involving twelve clinical trials showed that psychodynamic therapies were effective in reducing suicide (pooled odds ratio = 0.469; 95% CI [0.274, 0.804]) and self-harm at 6-month, but not 12-month, follow-up. There was also evidence for improvements in psychosocial functioning and reduction in number of hospital admissions (Briggs et al., 2019).

## A Mentalization Based Understanding of the Development of Non-suicidal Self Injury

### Mentalizing and Self-Harm

The MBT model can be seen as a further elaboration and extension of more traditional psychodynamic approaches to self-harm as its starting point was that many patients presenting with self-harm lack – either temporarily or more permanently – the capacities to mentalize, i.e., to reflect on their self-states and those of others. As a consequence, more insight-oriented approaches may not only be ineffective, but even harmful as they assume high level abilities of mental function. While traditional psychoanalytic therapies rely on a less active approach by the analyst, and sometimes adopt a more silent and neutral presence, this can activate the patient's already disturbed attachment systems and create levels of arousal that interfere with their capacity to self-monitor and self-reflect. Their high level self-appraisal capacities are reduced. MBT is based on an attachment model that pays close

attention to the activation or deactivation of the individual's level of emotional arousal and dysregulation. The therapeutic relationship serves as the secure environment within which the patient can learn to reflect on their mental and emotional experiences, their thoughts and assumptions that trigger behaviour designed to change these experiences, such as non-suicidal self-injury. In essence MBT focuses on pre-conscious processing, that is at the level of working memory, rather than unconscious process.

Mentalizing is the process by which we understand our own and others' behaviours from a reading of underlying mental states. Mentalizing can be understood as attentiveness to thinking and feeling in oneself and others, with central emphasis on the mental states of others. It can be thought of as "holding mind in mind." This approach was initially developed in the treatment of individuals with borderline personality disorder (BPD; Bateman & Fonagy, 2004). People with BPD have considerable problems with mentalizing and are well known to self-harm and make suicide attempts frequently. Improving the stability and effective deployment of mentalizing within the interpersonal and social world of the individual is the target of MBT on the basis that stability of mental function and ability to engage in constructive social relationships allows the individual to give up their reliance on harmful self-destructive action as a method of self-control. In sum, MBT is an effective integration of a mentalizing/attachment model, informed by psychodynamic principles. Relatively easy to train in, and subject to rigorous evaluations, MBT has been demonstrated to be effective across a range of psychological difficulties, throughout the age range (Storebø et al., 2020) . This model has been developed for individuals presenting with high levels of self-harm such as BPD and therefore it is possible to extend the model to self-harm more generally.

***The Development of Mentalizing and its Role in Non-suicidal Self-Injury***

Mentalizing theory is rooted in Bowlby's attachment theory (1969) and its elaboration by contemporary developmental psychologists, whilst paying attention to constitutional vulnerabilities. We are all philosophers of minds as we negotiate the social world and devote substantial amounts of "headspace" to wondering what is going on in other people's heads, and tracking our own thoughts of feelings. We see things beyond, behind, or simply different from physical objects, moving bodies, and expressive faces. Such mind-wondering, which is termed mentalizing, is central to social interaction, culture, and morality. It is also central to psychotherapy in which minds are the target of scrutiny.

It is a developmentally determined mental capacity starting in infancy and childhood within the context of attachment and probably only becomes stable by mid-twenties. Attachment problems lead to mentalizing problems and mentalizing problems fuel further attachment difficulties. Failures in early maternal/carer mirroring and reflective processes result in later developmental difficulties in mentalizing, so that the individual become overwhelmed by unstable self-experience, dysregulated negative feelings, distressing thoughts and misinterpretations of others' behaviour and intentions, all of which lead to the perceived need to take action to maintain mental stability. Problems with mentalizing lead to failure to regulate self-experience and internal emotional states and to understand others' motives accurately. The argument here is that mentalizing is the very process that is required to maintain a subjective experience of a self over time and in social interaction which is stable and coherent.

Prior to a self-harming act, whether or not suicidal in nature, there is a collapse in mental functioning, a disorganised and painful mental state and a disruption to an experiential self. Mentalizing failures may lead to self-harm because the individual may revert to states of mind that antedate the full capacity for mentalizing. Examples of these include "psychic equivalence" functioning in which the person believes that what they think another person is

thinking about them must actually be true - so “I think he thinks I’m ugly” becomes a certain and rigid truth, rather than a speculation about another mind. Another non-mentalizing form of functioning is “teleological mode” in which the behaviour of another person is taken to be clear evidence of their mental state, so that “she did not smile at me” becomes the basis for the assumption that “she does not like me, she does not want to speak to me, she hates me.” Finally, in the pretend or as-if mode, the individual loses the capacity to distinguish between thoughts and feelings that are rooted in real lived experience and thoughts and feelings that are no longer related to such experiences. Mental states are decoupled from reality and the person lives in their own world, isolated and separated from others. At an extreme their inner life becomes fantasy with no grounding in external reality and they lose an ability to calibrate their inner experience with others. They are alone and unreachable.

The pain and distress that results from these mentalizing failures is such that the individual becomes emotionally dysregulated and these unmentalized or “alien-self” experiences are then discharged through physical means, such as drug or alcohol use, or violence against others or themselves. For instance, in psychic equivalence mode, the feeling that “I am ugly and useless” may lead to such painful feelings of helplessness and despair that the individual increasingly has the feeling that she needs to self-harm to “prove” – in teleological mode – that she is indeed ugly and useless. Hence, according to the MBT model, self-harm actions can be conceptualised as teleological attempts to get rid of feelings that are felt to be intolerable and have the potential to reinstate stability to a sense of self even if this is negative. But that does not actually address the underlying confusion surrounding mental states.

> The MBT approach to understanding the generation of non-suicidal self-harm has been well described by Anthony Bateman (2019).Even verbalising ‘I am suicidal’ or I have suicidal thoughts’, indicates **a mental escape procedure** has been activated; a

subsequent action itself means the escape procedure has been ineffective and the state of mind has become increasingly painful and threatening to self- coherence and self-existence. Suicide attempts and self-harm are a result of a disorganised and painful mind state. They are an end product rather than the problem creating pain. It is far too easy for clinicians to become focused on the thoughts or actions themselves because they are anxious and frightened about the level of risk. This results in a failure to explore the mental circumstances and interpersonal contexts that are leading to thoughts and actions about self-harm and suicide.

***The Evidence Base for MBT***

In treatment of individuals who self-harm there is emerging evidence base for taking into account the vulnerabilities in their mentalizing in the context of disturbed attachments. Randomised-control trials have demonstrated the efficacy of Mentalization Based Treatment for adolescents presenting with non-suicidal self-injury (Rossouw & Fonagy, 2012) in reducing self-harm and depression, which was mediated by improvements in mentalizing and reduced attachment avoidance. This finding was replicated in other studies, (Hawton et al., 2016), highlighting that MBT in combination with emotion regulation-based group therapy was associated with a significant reduction in repeated self-injury. These authors found significant treatment effects of MBT after 18 months treatment period with fewer engaging in self-harming behaviours. In the recent Cochrane review, evidence was found that MBT was more effective in reducing self-harm in BPD when compared with well conducted control treatments and showed high effect sizes (Storebø et al, 2020).

Evidence that MBT may be superior to other psychodynamic therapy in addressing the specific issue of non-suicidal self-injury has also been found, by Calati and Courtet (2016) in their metanalysis, concluding that there was no significant evidence to

suggest any other psychodynamic approach apart from MBT is effective for treatment of non-suicidal self-harm.

MBT treatment principles for self-harm can be seen in action in the following clinical case examples, anonymised and created for the purposes of this chapter, but based on actual presenting problems of a typical referrals. We present two cases, the first to illustrate the principles of MBT in NSSI and the second to illustrate MBT where harm to others as well as the self co-exist.

MBT is a structured treatment with an initial psychoeducation phase followed by focused individual and/or group therapy using a collaborative formulation agreed with the patient at the beginning of treatment. The psychoeducation includes information about good mentalizing, poor mentalizing, emotions and how to manage them, and attachment relationships. The patient uses the information provided to map their own mentalizing pattern and attachment style and how they relate to others. In general terms, as we have mentioned, the greater the activation of attachment process, the more vulnerable an individual is to a collapse in mentalizing, which potentially results in self-harm as a way of reinstating mental stability. Most serious risk-taking behaviours involve interpersonal sensitivity and attachment activation, hence a focus on relationships and attachment and mentalizing in treatment is likely to be helpful. The therapist will be exploring the patients' past mental states from the perspective of current mentalizing and keeping a close eye on the patient's capacity to mentalize in the session, and bringing them back to the optimal state of arousal that enables this.

**Case Illustration: Freya**

The application of an MBT approach to a typical presentation of a young woman with borderline traits is described below. Here, we focus on its use as a treatment of violent actions that are primarily self-directed.

*Freya is a 19-year-old woman, in her first year of university. Always prone to perfectionism, she has struggled with the transition from being top of her class at school to being one of many excellent students, where she is not the best, and in fact, considers herself to be performing in the bottom range of her class. She is constantly worried that she will not meet other's expectations of her. She is not being treated for clinical depression currently but, her self-esteem is lower than usual, and she has been feeling isolated, alone and ashamed and had on occasions picked at her skin enough to make it bleed. When she learned that she had obtained a lower second in the exams at the end of her first term she felt hopeless and despairing, convinced that this meant she would either fail the course altogether, or, at best, get a third-class degree. She was convinced that her parents would be devastated, and that her friends would re-evaluate her, having discovered that she was not the clever, accomplished girl she had always appeared. Disgusted with herself she reached for her razor and for, the first time ever, cut into her skin, making several delicate marks on the insides of her thighs, where the marks would not be visible. She has a history of depression and, when she developed a serious eating disorder at 16 was seen in an adolescent psychiatric unit where it was suggested that she had emergent personality disorder of a borderline type. Her depression and eating disorder stabilised after a brief period of inpatient treatment but seems to have re-surfaced recently. Since that first occasion she has cut herself at least four times, generally following her submission of course work, and the anticipation of it being marked low, but on one occasion it was after she found out about a party that she had not been invited to, though several of her close friends had been. Disturbed by her growing preoccupation with self-harm, Freya has decided, at last, that she needs to discuss this in therapy and presents at the clinic, explaining that she is 'addicted' to self-harm and is worried that it will leave permanent scars, and become a lifelong habit.*

***How Would we Work With Freya Using an MBT Perspective?***

***Principles of MBT Model in Treatment of Self-Harm***

The therapist will follow the principles below, to ensure that s/he remains adherent to the MBT model, retaining authenticity and an exploratory "not knowing" stance throughout, and validating and empathising with the patient's experiences. The "not knowing stance" is one in which the therapist expresses curiosity and interest in the patient's mind, rather than presenting themselves as an expert or making interpretations. This models the notion, central to MBT, that minds are not transparent. The validation of the patient's experience and empathy for their pain or distress is essential for engagement and also to reduce high levels of emotional arousal that can interfere with mentalisation. It is vital for therapeutic engagement and establishing trust. This is the first step to engaging them in a thoughtful process, where they feel that it is possible to understand the feelings that underlie their self-harm or other acts of violence. The basic stance of the MBT therapist can be summarised as follows:

- Maintain a not-knowing stance when exploring a theme, for example, if a patient says "all women hate me, including you, and I know it" the therapist could enquire about what feelings are evoked by that, where they get that thought from in that very moment, and most importantly what that means to the person, rather than assuming anything about what being hated means, challenging the cognition directly, or making an interpretation about why and how that belief and its attendant pain developed.
- See things from the patient's perspective.
- Validate their emotional pain – contingent and marked responsiveness.
- Join with mentalizing and provide judicious praise for successful mentalizing.
- Do not join non-mentalizing.
- Use affect focus, relational mentalizing, and clinician counter-responsiveness to identify effects of suicidality on therapy.

The clinical guidance below is for interventions that apply in the following circumstances:

1. At the beginning of treatment when assessing a patient who has history of suicide and self-harm behaviours.
2. Suicide or self-harm attempt has occurred.
3. Patient threatens imminent suicide attempt or self-harm.
4. Suicidal ideation is persistent.
5. Other recurrent self-destructive action occurs e.g., violence.

One of the most significant aspects to address is the risk of harm increasing. There are certain well known warning signs of change in risk, that could turn an act of self-harm into one with suicidal intention. The clinician needs to be aware of these and keep them in mind throughout treatment. They include the following:

- Increase in statements and thoughts of suicide, anxiety and depressive symptom
- Uncontrolled emotion
- Change in illicit drug use
- Recent loss events including failure of treatment and discharge from support due to breaking of a contract
- Social withdrawal
- Interpersonal strife in close relationships
- Describing and planning a method of dying and arranging personal matters with the aim of closure

***Initial Phase*.**

The formulation in MBT is developed between clinician and patient, identifying the patient's mentalizing vulnerabilities in detail, their mentalizing profile, which outlines their pattern of use of the main dimensions of mentalizing, and their propensity to use non-

mentalizing modes and the circumstances in which they are deployed. Mentalizing is loosely coupled with attachment and so the interaction between attachment and mentalizing in their lives is also identified. In treatment of self-harm, the clinician uses a formulation coupled with psychoeducation, and in conjunction with goal-setting (Grove & Smith, 2022).

In the case of Freya, the initial case formulation outlines Freya's vulnerabilities and also defines a crisis plan, in case her self-harm increases in frequency or intensity. The aim of psychoeducation is not solely transfer of knowledge. It is to support development of a joint framework for treatment and to increase collaboration and engagement in the MBT process in which Freya will identify her mentalizing and non-mentalizing modes of functioning and attachment styles activated in her relationships. In addition, the clinician sets out part of the agreement about the responsibilities for destructive behaviour being shared, rather than either party carrying the weight of it alone. An example of how this could be expressed is as follows:

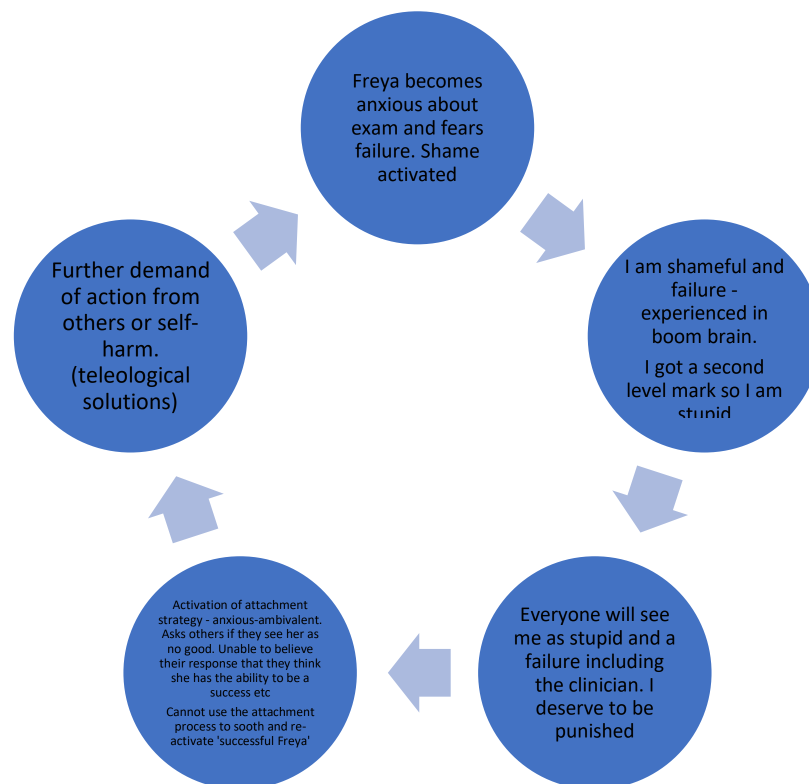
> "*You and I have to work on understanding what goes on in your mind before you self-harm, when mentalization goes 'off line'. This may mean we also go back to the point just before it went 'offline' and trace what was going on for you just then. This can help us to identify how best to manage and mentalize those thoughts and feelings rather than to self-harm, which we know can be dangerous for you. We need to agree that whenever you have dark thoughts and certainly if you do try to harm yourself, that we look at it in detail however painful it might be. We cannot ignore it even if only for me as it will be difficult to work on all your problems with the danger of serious injuries hanging over us both. Can we talk about this for a moment so we both have some understanding of our views on this?*"

The agreement of joint goals early in treatment specifies self-harm and suicide attempts and other destructive behaviours as a clear focus for the initial sessions. Reducing

risk is the most important step. As part of this process the clinician takes a thorough history of Freya's attachment relationships and details of her actions of self-harm including the context of events that led to the self-harm and what happened before she self-harmed, in terms of her thoughts and feelings. Exploring attachment histories can be done effectively by mapping the patient's description of former important relationships not only with parents but also with partners and friends. Using basic attachment strategies as a template the clinician considers the characteristics of two aspects of insecure attachment – overinvolved and anxious or anxious and avoidant. This is done in MBT, initially in a MBT introductory psychoeducation phase in which patients can be given prototypes of attachment strategies and asked to rate themselves in discussion with the clinician. Importantly, the clinician probes for triggers of attachment processes which are likely to have led to destabilisation of mentalizing, asking the patient to think backwards to a point at which they felt calm and stable prior to the event. This intervention is one often used in the beginning of an MBT intervention and is known as "Stop and Rewind." This initial phase of developing a framework and using it to explore Freya's mental processes leading to events of self-harm might help her begin to restore mental stability and reduce the risk of further self-harm episodes. This formulation (see figure 1) is re-visited throughout treatment as more information and better understanding of her self-harm is developed.

**Figure 1**

*Initial Formulation Agreed With Freya of her Cycle of Self-Harm.*




The introduction to MBT will help Freya understand the collaborative approach, and its aims of emotional regulation, cognitive and affective balance, and the goal of restoring mentalizing, with less reliance on evacuating painful feelings into self-dir.ected acts of violence, or, alternatively, overdosing on drugs, withdrawing altogether from social situations and becoming isolated, afraid of the negative judgement she perceives that others will definitely have of her now, based on her exam performance.

**Treatment Phase.**

The intervention steps followed by an MBT clinician with a patient who has reported a suicidal or self-harming event are as follows:

**a) Fact find about the incident followed by using a not-knowing stance.**The therapist needs to gather a full picture of the events around the self-harming incident, particularly

focussing on the interpersonal situation that led to it, or any thoughts and beliefs that the patient had. This is the essential ‘fact finding’ component that might give some indication of the current level of risk. The clinician is instructed in MBT to empathically validate the painful experiences that the patient was struggling with. Empathic validation in MBT required the clinician to show that they can see how the patient was experiencing things and also what effects this is having or has had on them. In other words, it is both past in terms of when the event occurred and also present in the sense of the effects it is now having on the patient.

*As you talk to me I am getting a sense of you keeping a picture in your mind of you as someone who can do well and be respected and well thought of by others like you parents but that seems to get lost when you are anxious. The effects on you now is that you doubt yourself terribly and feel a failure and this was confirmed by your exam results. You fear that now everyone sees you as a failure and you have lost that sense of yourself as someone who can succeed not just for others but for yourself.*

The move to the current experience is a step towards generating ‘we-mode’ indicating that the patient and therapist are working together to learn more about events leading to NSSI.Strong attempts are made, once this picture is painted, to identify the point where mentalizing went off-line, the re-wind, and the patient decided to or felt compelled to take action. This requires the therapist to slowly, tenaciously and without judgement or ascribing meaning to the action to help the patient identify their feelings at each point in the story.

MBT is seeking the point of vulnerability for the patient in terms of when anxiety undermines mentalizing and Freya no longer can access a self that can do well meeting her own standard and be seen as a success by others. This can only be identified by going back to find a point when mentalizing is stable and tracing this forward towards the point at which it

is apparent to the patient that their mentalizing became less stable but prior to the uncontrollable cascade into the low mentalizing which results in action.

**b) Managing mind states.** Most patients in treatment will have some understanding of mind states from the MBT- Introductory phase. Like Freya, the patient needs to become sensitive to their changing mind states and in particular to be increasingly aware of the development of low mentalizing functioning such as psychic equivalence and teleological function, both of which become common during the onset of self-harming thoughts and behaviours. These prototypical low mentalizing states are fixed formations of mental function. In psychic equivalence the person considers that whatever they are thinking is a reality. Thoughts and feelings become facts. They have no doubt and fail to question the accuracy of their thoughts - a thought of being a bad person is a reality and unquestioned and not balanced by uncertainty or additional self-experience making the whole thought or feeling exquisitely painful. In teleological mode mental states are based not on impressionistic internal scrutiny and attunement with others' states of mind but on what happens in reality. So, I can only be understood through my actions, and others' actions inform me of their motives – you are what you do and not what you say; self-harm expresses an otherwise inexpressible mental state. Inevitably, dominance of this mode of understanding of the world leads to considerable confusion and serious misunderstandings between people.

The MBT clinician locates the beginnings of psychic equivalence and the context in which Freya begins to realise that her thoughts became rigid and certain. For many patients it is possible to label these mind states and help them to rewind themselves once they realise they are in them. Once psychic equivalence is recognised by the patient you may find a short-hand term with the patient describing the specific state of mind that proceeds self-harm. For instance, Freya found a description of her mental state at the point in terms of the – "Boom Brain Time"; when in teleological mode she learned to recognize this as her – "Action

Brain" being active. This may help the patient become more sensitive to the onset of these states and begin to stop them before they dominate.

**c) Identify the core domain of problem – interpersonal and affective.** The evidence shows that many suicide and self-harm attempts in BPD occur in interpersonal contexts and in a state of high emotion. In Freya's case she is convinced that her parents, tutors, and others will judge her negatively on the basis of her exam results, and that the fact her friends have not sought her out is evidence of this. Negative interpersonal events predict self-harm. It is not an easy task to differentiate interpersonal/social interaction disturbance from problems with intrapersonal emotional regulation as both mutually influence each other. Identifying a hierarchy between interpersonal process and emotional regulation as the primary pathology in BPD and related conditions is impossible as there is circularity. High emotions distort how a person reads social meaning and how they understand others' mind states, resulting in interpersonal discord and confusion; interpersonal discord stimulates problematic intrapersonal emotions and misperceptions of others' motives. Nevertheless, the clinician uses a "not knowing" stance to explore the interaction between interpersonal process and emotional dysregulation, trying but never succeeding to identify the "chicken from the egg".

The most common error is to assume that the problem is primarily related solely to managing emotion and then trying to implement emotional management strategies without generating the detail of the interpersonal context to identify the patient's personal sensitivities. Only if their interpersonal sensitivities are recognised will it be possible to start exploring the relational and attachment processes that are central to the problems of people with BPD and many others who self-harm. Their often insecure early attachments are evident in the ways that they respond to these interpersonal slights, and the impact of these experiences on their fragile sense of self.

Within the therapeutic relationship a secure attachment would enable a patient like Freya to begin to make sense of her non-mentalizing activities and generate a sense of control and capacity in relation to these, essentially becoming able to integrate aspects of the "alien self" as she in increasingly able to reflect on her own states of mind and to identify and regulate them. This relates clearly to the use of non-mentalizing modes of functioning as Fonagy and Luyten (2018) explain in their work in attachment, mentalization and the self:

> Understanding and recognizing the pre-mentalizing modes is important because they often appear alongside a pressure to externalise unmentalized and self-hating aspects of the self (so-called "alien-self" parts). Torturing feelings of badness, possibly linked to experiences of abuse that are felt to be part of the self but are not integrated with it (the "alien-self" parts), can come to dominate self-experience. We assume that these discontinuities in internal experience (when the person feels aspects of their self-experience to be of themselves or their own, and yet also to be alien) generate a sense of incongruence, which is dealt with through externalising.

Through mentalization based treatment, Freya can focus on painful feelings that she finds overwhelming by discovering an empathic other who validates these feelings, and helps her to identify them. This is essentially, the therapist offering a form of contingent marked mirroring that she may not have received from a carer earlier in life. In terms of identifying and working with Freya's attachment strategies which are activated as soon as she thinks about her close relationships and undermine her mentalizing, the MBT clinician follows a number of steps. First, the attachment strategies deployed by Freya are identified in the first phase of psychoeducation and placed in the formulation (see earlier); second, the way in which they play out in current life with friends and others are noted; third, the effects they have within her relationships are mapped; and fourth, Freya and clinician agree to sensitise

themselves to when they may be active within the interaction between them and use this to explore in detail what it tells them about Freya and her relationships in the "real" world.

**d) Therapist stance.** In MBT, the therapist must be mindful of the main aim of the work, which is to enable the patient to gain a sense of curiosity and reflection over their mind, and will approach this task with compassion and without judgement or an interpretive stance. Empathy and seeing things from Freya's perspective serve to offer a form of reflective functioning of which she, like so many other patients, was often deprived early in life, and can help them stand back from the feelings and behaviour with which they are preoccupied, in order to reflect on what triggered them, and restore a mentalizing capacity. Therapists must avoid the stance, offered by clinicians in other modalities, by resisting the temptation to take over the patient's mentalizing, even if it is poor, to tell them what is in their mind or what they feel. Because therapists are generally good mentalizers it is tempting to use this capacity to manage the patient's low mentalizing but this will not help the patient to name their feelings, explore their impact and shift the focus away from their certain, rigid and unhelpful thoughts about events, and reliance on behaviour to alleviate the pain of their mental states.

The therapist stance in this treatment model is one of humility, authenticity, transparency, empathy and "not knowing". There is plenty in Freya's history and current experiences to be empathic with. Freya does not have a formal psychiatric diagnosis of BPD but her early experiences include being sent to boarding school at an early age, feeling rejected by her parents and misunderstood by those around her. She is the only child of older parents, from a Northern European country, who were themselves rather alienated in the United Kingdom. Her mother suffered from depression, and her father worked long hours. Her reliance on self-harm and sense of abject failure due to lower-than-expected exam results, her difficulty tolerating painful feelings, and wish to simply have people around her care for her, or if not, to drop out of life altogether, indicates that she does not have the inner

resources to manage her subjective experience of self. This implies she may not have had an early experience of reflective parenting, when her feelings were named, reflected back to her in contingent (accurate) marked (related to her mental experience) mirroring, whereby a parent or carer shows the child that they understand what she is feeling, enabling that child to internalise this sense of their own mind - we learn about ourselves through the mind of others. This lack of interpersonal reciprocity leaves her with an impoverished capacity to mentalize - that is to identify, regulate and differentiate her own mental states, and feelings from those of others. In interpersonal situations where her attachment system is triggered, she quickly feels overwhelmed and wholly inadequate, unsure how to self-soothe, or even how to understand what she feels. Empathic validation of her experiences of being seen negatively by others is essential to the therapeutic process.

**e) Managing non-mentalizing modes.** When a series of events, like the work-related failure perceived by Freya, destabilises her and awakens fear of punishment, loss, and abandonment by those on whom she relies, she collapses into a non-mentalizing mode and seeks comfort and care. But as she desperately tries to manage her instability the fears of punishment begin to be increasingly experienced in psychic equivalence and so gain a reality that is increasingly painful. Her fear of punishment becomes “I deserve punishment” and “I am a failure.” She will enter a kind of “fight or flight” mode where she attempts to exert influence over her sense of vulnerability, and change something external in order to manage such painful internal feelings. She will engage in non-mentalizing including teleological thinking, whereby only behavioural outcomes are important, and where any expression of emotional response from others does not “count” and is not perceived as valid, or meaningful. Only external outcomes, like being given a good mark, or having a friend come over to take her out matter. Being told by a teacher she perceives her as good and valuable, or by a friend that they care about her, does not have credibility. She believes she is only as good as the

mark she achieved on the test, and does not give weight to her internal worth; her sense of self is fragile and she is destablised.

Freya is also likely to make assumptions about the mental states of others, and this is an important aspect of non-mentalizing modes. When distressed and feeling low she will equate what she believes another person to be thinking to be the truth, thereby equating what she believes with the actual truth, expressing certainty about another's mental states. This mode of psychic equivalence can clearly be seen in people with depression, borderline personality disorder and antisocial personality disorder, conditions which are associated with self-harm, who typically act with certainty about other people's mental states, assuming that what they believe about them, based on their own fears, and rigid interpretation of someone's behaviour, is the truth. Their beliefs become facts.

In violent individuals this misinterpretation of mind states can lead to retaliatory violence as an attempt to restore the sense of self that has been lost through what they believe is the other person's disrespect of them. The violent action is an attempt to re-set their sense of self. When someone is depressed and interprets the behaviour or mental state of someone else as a rejection of them, self-harm is an attempt to get rid of the painful state of mind, through action. Again, this is a means to try and stabilise the self, and may also serve as an attempt to generate a response from others, to glean attention and care from others. This will meet teleological needs, that is, will give the person a sense that the other person is attending to them, something they do not experience from the emotional expression of care or concern.

Using an MBT approach can help the self-harming person to understand the various distortions in their thinking, and their own lack of faith that others can respond to their distress, and care for them, without needing to take particular actions to elicit these responses, or in the absence of certain behaviours being demonstrated by others that 'prove' their care.

**Case Illustration: Rita**

The second case illustration demonstrates how MBT can be used to help a woman with both self-harm and violence against others, with a complex personality and long history of disturbance. While we are not explicitly describing the application of MBT to people with ASPD here, the use of MBT with antisocial personalities specifically is increasingly used as an effective intervention. MBT is used to target symptomatology in individuals with antisocial traits or personality disorders who struggle to mentalize other people's minds and their own, with destructive consequences (Fonagy et al., 2020). The following case shows how both antisocial and borderline traits can co-exist in a vulnerable and risky woman and how both are amenable to modification through MBT, as well as suggesting that an MBT-informed approach can also be of use to the staff who are working with her.

***Clinical Illustration: Illustrating Framework of Mentalizing for Intervention***

*Rita is a 42-year-old prisoner, has a long history of violence against others, substance misuse and self-harm through overdose of illegal and prescribed medication and ligatures. Although she was known to mental health services since adolescence, she has not had a sustained period of psychiatric and psychological care as an outpatient, as she would disengage frequently, and was eventually arrested for criminal damage and grievous bodily harm in her early twenties. Her crimes took place in the context of substance misuse. She is diagnosed with "emotionally unstable personality disorder" and also shows clear traits of antisocial personality disorder. Her understanding of her difficulties is that she has been badly treated and/or neglected for most of her life, and that others consider her to "have a PD," which she sees as an unhelpful label, and does not understand how she can be considered both antisocial and borderline, as she thought only men were given the former diagnosis.*

*In prison she has frequent self-harm episodes and occasional verbal outbursts at staff, particularly when instructed to go back to her room, or when asking about appointments, and*

*not being given the answers clearly or quickly enough. When she erupts most aggressively, she displays physical violence, generally throwing objects at others, and has been "adjudicated" for these offences, leading to time in the segregation unit. She has little hope of leaving prison in the near future, as she becomes violent and "disruptive" as the prospect of release comes nearer, a behavioural pattern she recognises as destructive and familiar, and, at some level, wants to break free from. She has been moved from prison to prison as staff describe her as a "heartsink prisoner" because she is so "demanding" of their time and attention. A closer look at her history reveals that she came to the UK as an unaccompanied minor, and spent considerable time in the care system, with infrequent contact with relatives who had immigrated her, and no contact with her parents or sister, who remained in Ethiopia. She will not talk about her past and often presents a confusing and chaotic picture of her life in England prior to prison, which appears to have elements of fantasy, in that she describes a highly glamourous lifestyle where she associated with Premier League footballers and went to nightclubs.*

*Her self-harm at points of transition increases dramatically and she is more or less constantly placed on an Accessing Safer Care in Custody and Teamwork (ACCT) book, a record of those prisoners deemed at significant risk of suicide or self-harm. She is clear that she does not want to die, but that self-harm is an effective coping method for distress, alleviating her depression and turning psychic pain into physical pain. It distracts her from her traumatic memories of previous abuse, and of her offence, which was a near fatal assault on her partner. Additionally, when she self-harms she is tended to by the nurse on the spur, and prison officers are required to have at least four conversations with her per day, something that would otherwise not happen. She describes a sense of pure release when she has tied ligatures, and although she is aware that it could be fatal if she tied one too tightly, and was not checked on at regular intervals by an officer, she is adamant that this is a way of*

*trying to stay alive, rather than an attempt to die.*

*Rita has a long history of being abandoned, rejected and abused, and clearly does not trust those in positions of authority. She has no experience of benevolent authority, but only of being betrayed and punished by those in charge. She has little sense of her own mind, let alone that of others, and only feels safe when she is able to evacuate her feelings through actions, that is to use teleological modes to get away from painful mental states. Furthermore, these actions lead to direct consequences, behavioural manifestations of other people's care, that are the only kind of expressions of care she can understand. This reinforces her perceived need to remain a person who self-harms, who is checked on at regular and frequent times (known in the criminal justice and psychiatric services as being "under observation" or "observed", with records being made of the number of times she is observed, and the numbers of conversations that are held with her. The ACCT book itself becomes a concrete example of care, and even if she leaves the unit where she is resident, the book will go with her, outlining her self-harming risks and acts, and ensuring that staff document events in the requisite pages. The book has great significance for her, as demonstrated when Rita gave a favoured prison officer a "Thank you" card, depicting him, herself, and the orange ACCT book, placed carefully between them.*

*Rita, while fearful and distrustful, also has a strong need for others to take care of her, as she was so deprived of this in her earlier life, and so she is constantly monitoring the behaviour of the prison staff, nursing staff and clinicians who attend the unit, and who see her because of her status as a "prolific self-harmer." She derives a sense of identity from this, and closely watches the workers to see if other women receive more care than she does, as measured in terms of their number of daily "observations". She was outraged when she saw that another woman in the unit was being observed more frequently than she was, and demanded to know why this was, escalating her self-harm in the form of ligatures, as if*

*deliberately creating a risky situation to ensure the attendance of prison officers at her cell door more often. The irony of this situation is that this attendance, or "observation" was hardly a meaningful interaction, but simply involved the officer looking through the hatch to see if Rita appeared to be alive or moving. If she could not be seen, as she was lying under the bedclothes, and not fully visible, the officer would enter the room, talk to her, ask her if she was okay, and if Rita didn't respond, would remove the covers to see her neck, where often she would have tied a ligature. The officer would simply reach for their ligature cutter and remove the tie, sometimes without saying a word.*

When the clinician began to meet Rita for a brief series of sessions with an MBT focus, to help her mentalize and reduce the focus on self-harm, she explored with her in what sense this ligature-cutting could be seen as an example of care, or could help her to understand what particular mental state or feeling had led her to tie it. It took six or seven weeks before Rita was able to distinguish between the rote act of cutting a ligature, and the act of an officer asking to talk to her about her feelings. She saw the former in teleological terms as far more indicative of care than talking as she found it impossible to mentalize other people's minds. In this case, Rita was so far from having an awareness of her own mental states when the clinician first met with her, that the goal of her being able to mentalize the other, (i.e., to see that an officer who sat with her, cared about her, and wanted to help her, at least as much as one who simply, silently, cut her tie), was not one she could achieve easily. The roots of her difficulty in understanding her own mind, and then being able to see herself from the outside, as others saw her, and interpreted her challenging behaviour, could be found in her early parenting. She had not had another mind to hold her in mind, to name her different feelings and thoughts, that underlay her behaviour in infancy, and so the only means she had of expressing herself was in action, unarticulated. This parental function, that enables mentalization in those lucky enough to have good enough care in early life, is known as

'reflective functioning' and it is the mechanism through which the infant learns, from its carer, how to name and understand their feelings. Without reflective functioning the growing child is simply caught up in a feeling, acting them out, devoid of a sense of what is going on inside of them and how to manage it. Furthermore, Rita had almost no way of understanding that what she imagined, if she did, what the officers were thinking, could be altogether different from what they actually were thinking or feeling, as she judged this solely on the basis of their behaviour. If they checked on someone else more than to Rita, or spoke to her but didn't ask specifically about tying ligatures, this proved to her that they did not care about her. She often repeated to staff her certain belief that staff did not care whether she lived or died.

In order to work with this challenging behaviour and help the staff to manage their countertransference feelings of frustration, boredom and anger, or, alternatively, the wish to rescue Rita, or placate her and meet her needs for care by keeping her on the ACCT book constantly, and observing her several times a day, the clinician organised regular meetings with the Prison Officers, including those from Safer Custody, and Nurses, as well as a care coordinator the Mental Health In-reach Team, to share the formulation of Rita's self-harming, following a collaborative introductory session with her. There was also reflective space provided for the staff to try to mentalize their own countertransference feelings and to reflect on ways that they sometimes responded unhelpfully or teleologically. For example, Rita would often buzz through to the office on her cell bell repeatedly and the officers would assume that they knew what was in her mind, and sometimes neglect to answer this persistent calling. This, they realised, was an example of their non-mentalizing, assuming that they knew what was in her mind, a state that could lead to a dangerous situation where a sudden decline in her mental state could lead to a fatal act of self-injury whilst they assumed it was 'just another cry for more attention'. High frequency of an action by an individual with

repeated consequential interpersonal reaction easily induces assumptions about mental states in the reactor who may be desensitised against the severity of the action and begin to see it as of low importance. As well as using a mentalization-based approach to understanding Rita and supporting the staff, a short-term series of focussed individual MBT sessions were offered, in which Rita could begin to identify and explore her non-mentalizing modes, and reflect on what triggered them. She could also identify times when she could mentalize well. Through this combined approach, Rita was able to reduce her self harm in frequency to fewer than three times a week, while before treatment she was self-harming at least twice a day on average. A Self Harm Strategy has been implemented throughout the prison, using a mentalization based approach to help the prison and probation officers, teachers, chaplaincy, nurses, GPs, psychologists and senior managers to focus on the feelings and thoughts that underlie behaviour, rather than making rigid assumptions and responding in equally non mentalizing ways. The evaluation of this project is in process

**Summary and Conclusion**

As we have emphasised, violence and self-harm are often the expression of dysregulation in people with highly disturbed early attachments commonly based on developmental trauma. Earlier vulnerabilities, whether genetic or environmental, and usually both, sensitise an individual to current stressors. These are then experienced as unbearable challenges to which the patient has limited resilience. Stress reactions, anxieties, and painful mental states automatically trigger attachment processes which further dysregulate the person and activate proximity seeking. The patient will try to get support from a partner, friends, or services, only to find that the response they receive lacks appropriate contingency to their desperation. Further panic ensues as this frantic attempt challenges their self-existence further, mentalizing is disrupted, leading to experiences being processed in non-mentalizing modes. This makes any affective and cognitive experience increasingly acute and painful

because the mind loses capacity to differentiate reality from inner experience. Doubt is lost and certainty of belief dominates. Only action can then change mental processing and teleological solutions are required. The use of action to relieve anxiety is part of the function of non-suicidal self-injury, as it is intended to focus the mind away from painful thoughts, memories and experiences, locating a place for these on the body itself. It therefore offers a temporary solution to overwhelming and unwanted feelings. By engaging in self-injury, the person feels that they are taking charge, and changing their inner experience through this externally directed action.

MBT treatment operates using an approach that addresses the underlying difficulties in integrating thoughts and feelings, and in being able to resist the urge to find teleological, or action-based interventions for painful thoughts and emotions. MBT is founded on attachment-based models, and has an emerging empirical basis. The underlying premise is that individuals with an insecure attachment system will find this is activated at times of transition, separation, reunion and loss, with the result that they will be destabilised in terms of their mental functioning, that is, the arousal of this system will tip them over into a "non-mentalizing" mode in which certain attempts will be made to stabilise the system. These attempts will be frantic, and not ones in which thought and reason are predominant, but ones in which action is sought to bring about a reduction in the painful affect. Examples of actions include use of alcohol or substances, risk-taking of various kinds, violent actions including violence against the self –self-harm. Other methods of coping with painful feelings, induced by a destabilised attachment system include dissociation, which can also be found in traumatised individuals and can take the form of emotional shut-down and psychological defensiveness, as expressed through "pretend mode" functioning. Here the individual engages in a kind of pseudo self-exploration in which the language of emotional expressiveness is used but there is a paucity of emotional content. When working with individuals in non-

mentalizing modes, it is essential to bring them back into a mentalizing state, and what must first occur is that their arousal levels need to be reduced, to enable them to regulate their thoughts and feelings—overwhelming feelings will blow rationality out of the water and make any kind of therapeutic contact involving thought impossible. MBT attempts to balance out the affective and cognitive, and to restore a sense of connection between the two poles, that for individuals with personality disorder, or highly disrupted attachments, has often oscillated to extremes, leading to a failure of integration and reliance on violent, non-mentalizing action to evacuate feelings. As the authors have shown, this model of treatment has efficacy in reducing the major public health issue of NSSI, and is applicable to individuals who demonstrate not just borderline personality traits, but also those with co-existing antisocial traits.

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