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An Integrative-Relational Framework of Intervention at Casa de Alba – Therapeutic Community for Severe Mental Health

Introduction

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Context and Origins

Casa de Alba, founded by Romão de Sousa Foundation is a Therapeutic Community for Severe Mental Health Problems in Rural Portugal which is now celebrating the first year of existence. In this article, I will start by contextualizing the beginning of the project and my state of mind when I joined it; I will then give a brief glance through the theoretical and practical inspirations behing the project as well as some difficulties faced in the materialization of my original ideas; I finish with an overview of Mentalization Based Therapies and how Casa de Alba is slowly introducing and integrating a mentalizing frame in the day to day running of the communitty.

One of the difficulties I faced when I joined the project was the re-adjustment to a 'mental health culture' that is markedly different from the one in Britain. In Portugal psychiatry is, by and large, the dominant discourse. At the same time there is a push for deinstitutionalization and the close up of large psychiatric hospitals. All the legal documents keep using a medicalized, restricted and reductionist language concerning mental health problems. In the course of the readings I made, a number of words were repeated over and over in the documents and text books: illness, rehabilitation, remediation, deficit, handicap, disability, inability, and so on… When I recently re-read the Portuguese Mental Health Law 36/98 I was struck by the tittle "The Carrier of Psychic Anomaly", a title that puts the emphasis of the problem on the individual, detaching him from the social, familial, cultural or educative context. No matter how hard I looked, I could not see mental health documents using words such as meaning, dynamic, system, society, culture, psychological, symbolic, development, expression, constructionism, etc…

I guess my point here is that psychosis, schizophrenia or any other mental health problem cannot be seen in a linear, billiard ball fashion, cause and effect way. Art Bohart, researcher in psychotherapy, says something interesting about the epistemological problem of psychotherapy research and the production of manuals: no two therapies are therefore alike at a micro level, and therefore there really is no such thing as an independent variable that is being applied in the same way across clients. If this is the case, then the RCT is a crude instrument for the study of a subtle phenomenon (Bohart, 2008).

Such a complex predicament is, no doubt, the result of a multiplicity of influences: cultural, political, familial, anthropological, sociological and psychological, as well as, of course, genetic

and biological. When something is 'mental', coming from the 'mind', it necessarily goes beyond 'brain', 'body' and even 'matter'... I am not purposing here a Cartesian split between body and mind, on the contrary. I am suggesting that to think about 'mind' is not solely to consider an 'embodied entity' but also a subjective construction, even more, an inter-subjective enterprise as it is proposed that isolated 'minds' are a myth (Stolorow and Atwood, 1992). 'Minds' are the creative and psychological co-construction of individuals under a matrix of complex relational systems. Perhaps Freud was wrong in studying intra-psychic mechanisms and structures? In the same way, the focus of neurobiological research on the brain or on DNA may be a fruitless enterprise, as many others factor can be lost. From a relational standpoint, the dis-ease or the mental health problem, would always occur at the interface between intersubjective dynamic systems.

How can we explain such things as 'ego', 'identity' and 'meaning', as well the depth of love, hate, anguish, guilt or shame - many times at the core of psychotic breakdowns - without making use of pluralistic explanations and a multitude of disciplines?

Such complexities are about human lives and demand enormous responsibility of the workers, who must be aware of their need to compete with other professionals for the 'right' explanation of the phenomena, as well as the necessity to get rid of the anxiety that 'thinking' about the pain of another arises. To follow one single explanation feels 'safer' for the practitioner, providing an anchor for his own fears, protection from the unbearable feeling of uncertainty and of 'not knowing', and a sense of organization of the 'psychotic' chaos at hand. This "safe" explanation may relieve the professional, the family or even someone who pays for the treatment. It is, however, a disservice for the client as the totality of his being is left unseen.

Theory and Practice Inspirations

Therapeutic Community Philosophy

The therapeutic community (TC) movement emerged out of the treatment of traumatized soldiers during the Second World War. It was, in many ways, a revival of the moral treatment of Pinel in nineteen century France and of Tuke in the United Kingdom. Following a period of enthusiasm, moral treatment succumbed for more than a hundred years. The TC movement brings together some of these old ideas with new ones.

Tom Main (1946) introduced the term for the first time when some UK institutions that had historically been unhelpful or iatrogenic decided to change, humanizing the services, improving life conditions and giving more power of decision and participation to the residents (preferred term for "patients"). Clark (1965) defined the concept of "Therapeutic Community Proper", meaning not only a democratization of the power to take decisions that affect the management of the house but also in decisions related to the therapeutic plan of other residents. This meant that residents would become auxiliary therapists.

Therapeutic Communities would then follow several different paths, under three main types:

1. Democratic (traditionally linked with personality disorders, prison services and young people)
2. Concept-Based (mainly linked with addictions) – started and developed in California, from 1958 onwards.
3. Anti-Psychiatry (tradition inherited mainly from R. D. Laing) – there is a total absence of hierarchy; no distinction between staff and residents; the term illness is not accepted or recognized.

Casa de Alba bends towards the democratic type, integrating contemporary relational thinking whilst detaching itself from radical anti-psychiatry models.

Main Characteristics

When entering Casa de Alba, or indeed many other therapeutic communities, the visitor will experience and observe a number of particular characteristics (Kennard, 1983):

Communal Informal environment where some of the habitual institutional boundaries are broken.

It will be difficult to distinguish between staff and residents. Sharing of feelings will be noticeable throughout the day either formally (during structured meetings) or informally within the house.

Regular Community Meetings

The main purpose of these meetings is to (Kennard, 1983):

1. Maximize the sharing of information;
2. Develop a sense of cohesion and belonging;
3. Decisions are taken together and openly (instead of being taken behind closed doors without explanation of the underlying reasons);
4. Opportunity to give and receive personal feedback (mirroring of self);
5. Vehicle to exert pressure in individuals whose attitudes or behaviour are disturbing or undesirable.

Engagement in the day to day running of the House and its management (instead of activities just to occupy).

Therapeutic communities of the democratic type share a number of beliefs and values that underpin the work (Kennard, 1983):

1. Problems are of relational nature
2. Theories such as Stern's (2003) RIG's – Representations of Interactions that become generalized – fit well in here. Some of these RIG's, later named "Ways-of-Being-With", may be maladaptive causing people a number of problems.
3. Symptoms are not exempt of meaning
4. Therapy as learning (knowledge and skills)
5. Equality between staff and residents (as much as realistically possible)

Problems

There are many difficulties and problems that arise when running a therapeutic community of this kind. They are extremely difficult to manage; it is hard to be democratic all the time. There is a natural tendency to restrict and regulate the behaviour of residents, usually to the convenience of management and administration. It is important to be aware of and to resist this tendency.

Another common problems is the risk of the TC ideology being marginalized in the professional field since there is a clear attempt to abolish or dilute established positions of power (such as biological psychiatry and empirical psychology).

Evidence Base

There is evidence for the effectiveness of TC's in mental health settings, either residential or non-residential. More than sixty studies have been undertaken in Denmark (Isohanni, 1993) and a few more in the UK (Chiesa et al, 2004). In the 60's and 70's the Henderson Hospital and the Cassel have been designated as "centres of excellence". Nevertheless, despite the evidence, TC's have the tendency to come and go in different periods depending very often on the political and social climate of the time.

Activities at Casa De Alba

Everything that happens in Casa de Alba in taken as an opportunity to learn. The relational environment within the house is the main therapeutic tool – this is called the therapeutic milieu. Apart from the therapeutic potential of the day to day activities there are a number of formal therapies in place. Dyadic psychotherapy, group and multi-family therapy are central. A number of other activities take place over the 5-Day week and also on Saturdays (Sunday is free of activities): psychomotor therapy, art therapy, horse riding, swimming, gardening, occupational therapy, motivational groups, employment and educational tasks.

Casa de Alba is not the only therapeutic setting where such activities take place. What distinguishes Casa de Alba and other TC's

from other traditional settings is that the focus is not on the activity or the behaviour but on the way the resident feels and thinks, his internal and relational world. These are discussed within the several "reflection points", in community meetings and in therapy.

Inovation

Most democratic therapeutic communities are underpinned in three main principles: democracy, psychoanalysis and milieu therapy. Casa de Alba makes a particular distinction and replaces psychoanalysis by mentalizing. Mentalizing, a relational-integrative concept is used to inform the democratic therapeutic milieu.

Why a Mentalization Based Service?

1. Because several studies demonstrate failures to mentalize in most areas of psychopathology (see Bateman and Fonagy, 2012)
2. Demonstrated efficacy in RCT´s (Bateman and Fonagy, 2008) and effectiveness in naturalistic studies (Pereira, 2014)
3. Healthier and better functioning services as demonstrated throughout the NHS in the UK and in other countries where many traditional services changed to mentalizing services.

Brief Outline and Principles of MBT

Historical Background and Contextualization

One of the current accepted definitions of mentalization (Allen, Fonagy and Bateman, 2008) refers to the process of implicitly and explicitly interpreting the actions of oneself and others as meaningful on the basis of intentional mental states (e.g. desires, needs, feelings, beliefs and reasons).

The concept is rooted in Theory of Mind studies on philosophy as well as the later developments in cognitive science and developmental psychology; it has been used for some time in the study of autism and schizophrenia (e.g. Baron-Cohen, Leslie and Frith, 1985; Baron Cohen, 1995) being empirically tested for the first time in 1983 when Wimmer and Perner (1983) ran a false belief experiment with three year old children.

Over the years, the psychoanalytic literature has described similar phenomena under different headings. Freud's Bindung, translated to English as binding or linking, was first formulated in 1895's 'Project for a Scientific Psychology' as the mental activity of linking psychic instinctual energy in primary process with mental 'representation' in secondary process (Freud, 1895). Reformulated along the years, this concept referred to the transformation of somatic non-mental activity into something mental, allowing 'thought' to mediate traumatic memories. Freud (1914) also stressed that this representation of internal states could fail in various ways, which is at least analogous to what is meant nowadays by mentalizing failures.

Other concepts, such as Melanie Klein's depressive position (Klein, 1945) or Wilfred Bion's (1962) alpha-function are comparable to the notion of the acquisition of Reflective Function (RF), a concept that overlaps with the construct of mentalization (Fonagy et al, 2002). For both authors, the mother-child relationship provided the basis for the development of this capacity to symbolize. Similarly, the emergence of the true self in Winnicott (1962) or the acquisition of empathy in Kohut (1977), were dependent on the caregiver's psychological understanding of the infant. Winnicott (1962) also recognized, alongside Kohut (1977) and Fairbairn (1952) that the psychological self develops through the perception of oneself in another person's mind as thinking and feeling (Fonagy et al, 2002).

In the 1960's, French psychoanalysts applied the concept of mentalization to understand psychosomatic patients who displayed a lack of symbolization of mental states (Jurist, Slade and Bergner, 2008). The construct of alexithymia has also demonstrated some overlap with aspects of mentalizing, specifically relating to self-awareness (Goerlich et al, in preparation). A review of empirical evidence relating alexithymia with substance misuse was undertaken by Taylor (1997).

Allen (2006: p.7) defined mentalizing as 'perceiving and interpreting behaviour as conjoined with intentional mental sates'. The focus on intentionality is rooted in Dennett's (1978, 1987, 1988) studies on the prediction of behaviour; a state of mind is necessarily intentional since it is impossible not to be about something or directed at something. The philosophers of mind then extended Dennett's approach to include Freud's theory of the unconscious (Hopkins 1992; Wollheim 1995). Understanding aspects of behaviour that usually make little sense, such as dreams or neurotic symptoms, in terms of unconscious beliefs, thoughts, feelings and desires would make them meaningful and possible of being understood (Fonagy et al, 2002).

Fonagy (1991: p.641) introduced mentalization into British psychoanalytic discourse by defining it as 'the capacity to conceive of conscious and unconscious mental states in oneself and others'. The contemporary application of mentalization has been developed in great part by Peter Fonagy and his colleagues from University College London (UCL) and the Anna Freud Centre. Fonagy and colleagues' current conceptualization of mentalization combine insights and ideas derived from (Jurist, Slade and Bergner, 2008):

1. Neuroscientific research about the brain and the link between brain and mind, as well as about the way early relationships affect development;
2. Attachment theory and research about the properties of early (and potentially also later therapeutic) relationships that promote, or hinder, the capacity for mentalization;
3. Theory of mind studies in developmental psychology and in philosophy

Within the above principles, Bateman and Fonagy (2004; 2006) have developed a treatment programme for Borderline Personality Disorder, a problem intimately linked with attachment difficulties, affect dysregulation and mentalizing failures. This treatment programme was given the name of Mentalization-Based-Treatment and, more recently, Mentalization Based Therapy (MBT).

MBT is a psychodynamic treatment focusing on the here and now dynamics of the therapeutic relationship, as well as the value of understanding the nature of resistance in therapy. It draws, nonetheless, on a number of different approaches and perspectives. It relies on cognitive behavioural therapy in the attempt to understand the relationship between thoughts, feelings and behaviour; on systemic therapy through the consideration of family members and their behaviours, as well as the impact these have on each other; and on social and ecological principles via an understanding of the impact of context upon mental states (deprivation, hunger, fear, etc).

MBT is, therefore, an integrative and pluralistic treatment, providing a unique space for dialogue and collaboration between psychoanalysis and related disciplines.

Fonagy and colleagues main claim is that trauma impairs mentalization (Jurist, Slade and Bergner, 2008). Not having the experience of being thought about in a contingent way impairs the capacity of the infant to feel safe to think about the social world; mentalizing and the healthy development of intersubjectivity allows for the expansion of epistemic trust in relationships, a necessary key to open up the wish to learn about the World (Fonagy, 2013).

In MBT the attachment system is seen as a survival mechanism, interpersonally built, and serving as moderator for genetic expression (Fonagy et al, 2002). The capacity to mentalize (i.e. reflective function) is assumed to develop from the experiences of attachment and the ability of the caregiver to appropriately represent and mirror the emotional states of the infant.

This intimate process, allowing the infant to gradually pay attention to, and understand, what he/she is feeling or experiencing, was described in Gergely and Watson's (1996) social biofeedback model of parental affect-mirroring and then later developed by Fonagy et al (2002) under the name of contingent marked mirroring.

Disorganized or insecure attachment styles have been linked to failures in mentalizing during adult life (Fonagy et al, 2002). In traumatic experiences of abuse, for example, it is safer for the child not to understand (mentalize) what goes on in the mind of the abuser, as this could be too frightening. Attachment trauma, in this

way, promotes a defensive withdrawal from the mental word (Fonagy and Target, 1997). Later in life, close interpersonal situations leading to the activation of the attachment system will interfere with mentalizing as they can trigger overwhelming affect. This becomes, however, a double-bind problem as mentalizing is also needed to help regulate difficult emotions.

One of the 'revolutionary' aspects of these discoveries is the assumption that classical analytic technique will not work for patients with attachment disorders and personality problems as they may induce severe instability and regression (Jurist, Slade and Bergner, 2008). The same can be inferred for interventions currently used in addiction services, like Motivational Interviewing, CBT, or any other intervention that activate the attachment system without paying attention to the mentalizing deficit of the patient. Many of these interventions do not provide the patient with the necessary mentalizing skills to be able to use and internalize that attachment (Jurist, Slade and Bergner, 2008). The therapist must be able to create in his/her mind a representation of the mental world of the patient and then aim to communicate it in a way that helps the patient organize his/her mind. In MBT the activation of attachment is carefully monitored, running alongside the development of mentalizing skills within the framework of treatment and of the transference.

As I argued elsewhere (Pereira, 2011; 2012), the above considerations augur a paradigm shift in psychoanalysis as they discredit (at least for some patients) one of the major analytic techniques: transference interpretation. To avoid inducing states of instability and severe regression, the here and now therapeutic relationship must be modelled on early development and the delicate processes of co-regulation of affect that occur in secure attachment interactions. Thereupon, the concept of mentalization is unique in its particular emphasis on development. The process of treatment in MBT is also connected with psychoanalysis as it focuses on the dyad therapist-client and on the process of therapy; however, the focus is not on insight or interpretation but on current mental states (Bateman and Fonagy, 2006).

Within the multi-disciplinary milieu described above four central concepts have grown in the MBT tradition that is worth mentioning briefly (Bateman and Fonagy, 2006; Allen, 2006).

Mentalized Affectivity

This is defined as the simultaneous 'experience' and 'knowledge' of emotion. It is a major aim of MBT.

Psychic Equivalence

This is described as one of the prementalistic modes of functioning, antedating the development of mentalization. In this mode of functioning, mental representations are not distinguished from external reality. The internal has the power and importance of the external. For example, if a young child thinks there is a monster in the closet, a monster is in the closet (world=mind). Equally, if an adult patient reverts to a psychic equivalence mode they may assume, for example, that they know what the therapist is thinking and alternative perspectives will not be considered. There is a strong conviction of being right. This may also be the case in flashbacks or paranoid delusions where mental states are experienced as real.

Pretend Mode

In this prementalistic mode there is a separation between psychic and physical reality to a point where the connection between the two can no longer be achieved. Whilst this mechanism can help children liberating themselves from the frightening experiences of psychic equivalence, the relationship with reality is lost and, at the extreme, this can resemble dissociation.

Teleological Mode of Functioning

In this prementalistic mode of functioning changes in mental states are assumed to be real only when confirmed by physical observable action contingent upon the patient's wish, belief, feeling or desire.

The teleological mode arises in circumstances where the use of the intentional stance (mentalization) is only partially accessible (Fonagy et al, 2003). Gergely and Csibra (1997) have shown the opposition between a teleological mode and an intentional one; in the teleological mode the behaviour of the other is interpreted in terms of its observable consequences, not as being driven by desire (Fonagy, 2000).

A useful example of the teleological mode of functioning can be found in the following statement from Bateman and Fonagy (2006: p.23): 'a commitment by a psychoanalyst to be available several times a week at an early hour is not experienced as an indicator of commitment. It is taken for granted as a standard template of therapeutic support. It is deviating from this template in accordance with the patient's wishes (giving them the illusion of control) that is experienced as meaningful; special acts such as checking in with patients between sessions, emailing offering weekend appointments, allowing between sessions contact, etc are demanded as physical proofs of commitment'.

A similar example could well be applied in the day to day running of drug and alcohol services: a patient who arrives late for his appointment is denied his methadone prescription and given another appointment. The patient protests violently threatening the staff member who as a result becomes even more defensive. Such acts of violence may arise because the patient is unable to monitor their own internal state and is incapable of taking the perspective of the other, who is considered hostile until proven otherwise. If the member of staff is only focused on the violent act itself, the underlying mental processes that led to the outburst will remain unchecked and unaltered, ready to fuel the next action (Bateman and Fonagy, 2004).

Fragile mentalizing will be evident when the patient regresses to earlier psychological modes of functioning: teleological, psychic equivalence and pretend mode. The aim is to develop mentalized affectivity states, particularly in the face of difficult interpersonal situations that activate the attachment system.

Treatment Structure

> *Structure is needed to form a framework around therapy that is neither intrusive nor inattentive and which, much like a benevolent uncle, can remain in the background but be around to catch things when they get out of control (Bateman and Fonagy, 2004: p.184).*

The description of the treatment structure I will use was gathered mainly from Bateman and Fonagy's (2004, 2006) treatment manuals. These manuals have been developed specifically for the treatment of Borderline Personality Disorder. However, MBT has transferable features that can be adapted to other disorders and settings. The Anna Freud Centre and University College London (UCL) are at the forefront regarding new applications of MBT in the UK. Other sites, like the Menninger Centre in the US and other international projects, for example in the Netherlands and Finland, are actively working on the development of this approach. Pereira (2014) took inspiration from Bateman and Fonagy's (2004, 2006) guidelines in his attempt to research the applications of MBT to several concomitant personality disorder types presenting with co-morbid substance addiction within an NHS Psychotherapy Service. That was a major aim of his research project and one that represented the clinical reality. Whilst Pereira (2014) was undertaking this research, another MBT study for dual diagnosis (MBT-DD) was underway in Stockholm (Philips, Kahn and Bateman, 2012) legitimizing further these ideas.

Bateman and Fonagy (2006: p.37) state that 'the overall aim of MBT is to develop a therapeutic process in which the mind of the patient becomes the focus of treatment'. They describe two variants of MBT: The first is a day hospital programme in which patients attend initially on a 5-day per week basis. The maximum length of time in this programme is 18-24 months. The second adaptation of MBT is an 18-month intensive out-patient treatment which consists of one individual session of 50 minutes per week, and one group session of 90 minutes per week. In both programmes the group therapist is different from the individual therapist.

Both variants include the use of medication and regular psychiatric reviews (within the treatment team to avoid splitting) as well

as the involvement of all relevant external agencies or parties (e.g. GP, CMHT).

In their treatment programme, Bateman and Fonagy (2006) make the general point that anything that reduces the capacity to mentalize is in clear opposition to the programme. Sexual relationships between group members ('pairing of minds'), the use of violence and aggression (taking too much 'mind space') or the use of drugs and alcohol are all seen as incompatible with engaging in the programme. 'Drugs and Alcohol alter and interfere with exploration of mental states and as such negate the overall aim of treatment' (Bateman and Fonagy, 2006: p.47). There is even some overlap between the areas of the brain responsible for mentalizing and those that are affected by drugs and alcohol (see Bateman and Fonagy, 2004; 2006).

Although I agree unreservedly with Bateman and Fonagy (2004; 2006) regarding the difficulties created by the use of drugs and alcohol, I challenge their view on addiction as exclusion criteria for treatment. I believe MBT has potential to treat these patients, who are otherwise excluded from most psychotherapeutic treatments. As a matter of fact, the authors (at least Anthony Bateman) have actually changed their minds very recently, since they are now testing MBT in patients diagnosed with BPD and Substance Use Disorder (Philips, Kahn and Bateman, 2012). Of course their inclusion in treatment must be done in a thoughtful and boundaried way and the present study is just a preliminary attempt to include some level of substance misuse in an outpatient mentalization-based psychotherapy programme. MBT programmes are also being expanded in many arenas outside the borderline constellation, and there are some interesting attempts of working with substance misusing mothers and their babies (e.g. Soderstrom and Skarderud, 2009). However, MBT had not been used, thus far, in mainstream drug and alcohol services. The randomized controlled trial under study in Stockholm is the first serious attempt of testing whether MBT works for this population and what variations are required. Another attempt, already described earlier, was made in the Netherlands, although not specific for drug addiction and delivered without modifications (Bales et al, 2010; Bales et al, 2012). Pereira (2014) studied the effectiveness of MBT for patients with mixed personality disorders whilst actively using drugs, showing that the work is possible and worthwhile.

Strategies Of Treatment

> *The mentalizing stance is an ability on the therapist's part to question continually what internal states both within his patient and within himself can explain what is happening now (Bateman and Fonagy, 2004: p.203).*

Four main strategies are recommended in Bateman and Fonagy (2004): (1) enhancing mentalization, (2) bridging the gap between affects and their representation, (3) working mostly with current mental states, and (4) keeping in mind the patient's deficits.

The task of the therapist is to facilitate the patient's understanding and identification of emotional states whilst helping him to locate them within a present context with a linking narrative to the recent and remote past.

The gap between inner experience and its representation engenders impulsivity (Bateman and Fonagy, 2004). The therapist's work is to assist in the 'elaboration of teleological modes into intentional ones, psychic equivalence into symbolic representation, and linking affects to representation' (Bateman and Fonagy, 2004: p.206)

Transference

Transference interpretations undertaken in a classic fashion are likely to generate anxiety and be experienced as abusive. It is only safe to use the 'heat' of the therapist-patient relationship and to explore different perspectives towards the middle or end of therapy or once a strong therapeutic alliance has been established and stable internal representations recognized (Bateman and Fonagy, 2004). Even then, Bateman and Fonagy (2004) caution that change in borderline patients is engendered by brief and specific interpretations rather than complex statements about the repetition of past relationships.

> *With borderline patients, transference is not used in the clinical situation as a simple repetition of the past or as displacement and should not be interpreted in this way. Transference is experienced as real, accurate, and current by the borderline patient and needs to be accepted by the treatment team in that way (Bateman and Fonagy, 2004: p.207).*

Retaining Mental Closeness

This process resembles the infant-caregiver relationship and the provision of empathic responses by the caregiver, offering feedback to the infant on his or her internal state and enabling developmental progress. The job of the therapist is to represent accurately the feeling state of the patient and its accompanying internal representations (Bateman and Fonagy, 2004).

Working with Current Mental States

Bateman and Fonagy (2004) put emphasis on the present and the 'here and now' in considering the influence of past events. This is different from continually focusing on the past; the task of the therapist is to bring the patient back to the present and link the events described with the 'here and now' (Bateman and Fonagy, 2004).

For Bateman and Fonagy (2004), the classic technique of conflict interpretation will distance the treatment from a focus on current mental states. A difficulty with second order representation in the mind of borderline patient is likely to make him respond to terms such as breast or penis not as metaphors but as the objects themselves (Bateman and Fonagy, 2004). I confirmed this several times in clinical practice and common sense has gradually and intuitively moved my stance closer to the mentalizing position.

Mentalizing in Casa De Alba

The mentalizing concepts described above are useful within the entire treatment programme. They are actively used in the supervision of therapists, for example, helping to facilitate reflection and the integration of different approaches. We do not use mentalizing as a new modality (we know that no two therapies are alike!) but as an aid for reflection and a way to focus in the main therapeutic goal of attuning with the patients` affect so that they increase mentalizing capacity and emotional regulation.

We are not using formal MBT nor do we aim to use a single form of therapy. We know from research that psychotherapy is effective, but that the type of therapy makes little difference in outcome (Lambert and Bergin, 1994; Bateman and Tyrer, 2004). What matters the most are the common elements of the different therapies, mentalizing being one of the fundamental ingredients (Pereira, 2014).

Compromise with Practice Base Research

To evaluate the effectiveness of the work, Casa de Alba established links with local Universities (e.g. Évora University) being currently involved in a number of different projects, such as the International Project for the Development of IPPS (Individualized Patient-Progress System). IPPS developed an innovative software for the monitoring and evaluation of psychological treatments. The IPPS is the first feed-back system combining standardized measures with Patient-Generated Measures. The work is done in collaboration with the CORE IMS (COREims) and is integrated in the CORE-NET System (Sales e Alves, 2012).

Conclusion

The aim of Casa de Alba is to help individuals and families affected by mental health problems, making use of Therapeutic Community theory and a range of psychological therapies and psychosocial interventions to create an environment where thought and reflection can replace unprocessed pain and acting out. Working within a relational-integrative framework, Casa de Alba has constituted a multi-disciplinary team to help look at the multiple facets of mental pain and hurt inhabiting the residents and their families. Using interpersonal relationships and the group as vehicles of transformation, the team of Casa de Alba gives priority to their

own self-awareness and personal growth to enable professionals to understand and manage difficult enactments and the recovery of mentalization in everyday interactions.

References

Allen, J. G. (2006) *Mentalizing in Practice.* In: Allen, J. G. and Fonagy, P. (eds.) Handbook of Mentalization Based Treatments. Wiley, Chichester.

Allen, J. G., Fonagy, P. and Bateman, A. W. (2008) *Mentalizing in Clinical Practice.* Arlington, USA: American Psychiatric Publishing

Bales, D, Andrea, H., Smits, M. and Hutsebaut, J. (2010) Mentalization-based Treatment for borderline personality disorder: a summary of the evidence, new evidence and recent developments in different dosages and treatment population. In: *First International Congress on Borderline Personality Disorder, Berlin, Germany. 02 July 2010.*

Bales, D. et al. (2012) Treatment Outcome of 18-Month Day Hospital Mentalization-Based Treatment (MBT) in Patients with Severe Borderline Personality Disorder in the Netherlands. *Journal of Personality Disorders, 26, 568-582.*

Baron-Cohen, S., Leslie, A. M. and Frith, U. (1985) Does the autistic children have a 'theory of mind'? *Cognition, 21, 37-46.*

Baron-Cohen, S. (1995) *Mindblindness: an essay on autism and Theory of Mind.* Cambridge, MA: Bradford MIT Press.

Bateman, A. W and Tyrer, P. (2004) Psychological treatment for personality disorders. *Advances in Psychiatric Treatment, 10, 378-388.*

Bateman, A. W. and Fonagy, P. (2004) *Psychotherapy for Borderline Personality Disorder: mentalization based treatment.* Oxford, Oxford University Press.

Bateman, A. W. and Fonagy, P. (2006). *Mentalization-Based Treatment for Borderline Personality Disorders – a practical guide.* Oxford, Oxford University Press.

Bateman, A. W. and Fonagy, P. (2008) 8-year follow up of patients treated for borderline personality disorder – mentalization based treatment versus treatment as usual. *American Journal of Psychiatry, 165, 631-638.*

Bateman, A. W. and Fonagy, P., eds. (2012). *Handbook of Mentalizing in Mental Health Practice.* Arlington: American Psychiatric Publishing.

Bion, W. R. (1962) *Learning from Experience.* London, Heinemann.

Bohart, A. C. (2008) An adjudicational case study approach for assessing psychotherapy outcome. In: *Systematic Single Case Study Research Conference. Glasgow, UK, April 14th 2008.*

Chiesa, M., Fonagy, P., Holmes, J. and Drahorad, C. (2004) Residential versus community treatment of personality disorders: a comparative study of three treatment programs. *American Journal of Psychiatry, 161 (8), 1463-1470.*

Clark, D. H. (1965) The therapeutic community – concept, practice and future. *British Journal of Psychiatry, 111, 947-954.*

Dennett, D. (1978) *Brainstorms: philosophical essays on mind and psychology.* Montgomery, VT: Bradford.

Dennett, D. (1987) *The Intentional Stance.* Cambridge, MA: MIT Press.

Dennett, D. (1988) Precis of 'the intentional stance' with peer commentary. *The Behavioural and Brain Sciences, 11, 495-546.*

Fairbairn, W. R. D. (1952) *An Object-Relations Theory of the Personality.* New York, Basic Books.

Fonagy, P. (1991) Thinking about thinking: some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psycho-Analysis, 72, 639-656.*

Fonagy, P. and Target, M. (1997) Attachment and reflective function. *Development and Psychopathology, 9, 679-700.*

Fonagy, P. (2000) Attachment and borderline personality disorder. *Journal of the American Psychoanalytic Association, 48 (4), 1129-1146.*

Fonagy, P., Gergely, G., Jurist, E. L. and Target, M. (2002) *Affect Regulation, Mentalization, and the Development of the Self.* New York, Other Press.

Fonagy, P., Target, M., Gergely, G., Allen, J. G. and Bateman, A. W. (2003) The developmental roots of borderline personality disorder in early attachment relationships: a theory and some evidence. *Psychoanalytic Inquiry, 23 (3), 412-490.*

Fonagy, Peter. Freud memorial professor of psychoanalysis. *(Personal communication, 28th of February 2013)*

Freud, S. (1895) *Project for a scientific psychology.* In: Strachey, J. (ed.) The Standard Edition of the Complete Psychological Works of Sigmund Freud (S. E.), Vol. 1. Hogarth Press, London, pp. 283–397.

Freud, S. (1914) *On Narcissism: an introduction.* In: Strachey, J. (ed.) The Standard Edition of the Complete Psychological Works of Sigmund Freud (S. E.), Vol. 14. Hogarth Press, London, pp. 67–104.

Gergely, G. and Watson, J. (1996) The social biofeedback model of parental affect mirroring. *International Journal of Psychoanalysis, 77, 1181-1212.*

Gergely, G. and Csibra, G (1997) Teleological reasoning in infancy: the infant's naive theory of rational action. A reply to Premack and Premack. *Cognition, 63, 227–233.*

Goerlich, K. S., Aleman, A., Martens, S. and Hooker, C. (manuscript in preparation) I Know How You'll Feel: affective mentalizing in alexithymia, an fMRI study. [Online]. Available from dissertations.ub.rug.nl/FILES/faculties/medicine/2011/k.s…/05c5.pdf [Accessed 23rd March 2013].

Hopkins, J. (1992) *Psychoanalysis, interpretation, and science.* In: Hopkins, J. and Saville, A. (eds.). Psychoanalysis, Mind and Art: perspectives on Richard Wolheim. Oxford, Blackwell, pp. 3-34.

Isohanni, M. (1993) The therapeutic community movement in Finland - past, current and future views. *Therapeutic Communities 16, 4, 263-68.*

Jurist, E. L., Slade, A., and Bergner, S. (2008) *Mind to Mind; Infant Research, Neuroscience, and Psychoanalysis.* New York, Other Press.

Kennard, D. (1983) *An Introduction to Therapeutic Communities.* London: Routledge.

Klein, M. (1945) *The Oedipus complex in the light of early anxieties.* In: Love, Guilt and Reparation and Other Works: The Writings of Melanie Klein, Vol. 1. Hogarth Press, London, 1975, pp. 370-419.

Kohut, H. (1977) *The Restoration of the Self.* New York, International Universities Press.

Lambert, M. J. and Bergin, A. E. (1994) *The effectiveness of psychotherapy,* in A. E. Bergin and S. L. Garfield (eds) Handbook of Psychotherapy and Behaviour Change. New York: John Wiley

Pereira, J. G. (2011) Mentalization and psychoanalysis. Paper presented at Psychoanalysis, Culture and Society: a postgraduate conference. *Middlesex University Centre for Psychoanalysis, London, June 2011.*

Pereira, J. G. (2012) Integrative Attempts: a relational model of psychotherapy integration. *British Journal of Psychotherapy Integration, 9 (2), 56-71.*

Pereira, J. G. (2014) What Works in Mentalization Based Treatment: systematic case studies in personality disorder and addiction. *Unpublished Doctoral Dissertation.* Middlesex University, London.

Philips, B., Kahn, U. and Bateman, A. W. (2012) *Drug Addiction.* In: Bateman, A. W. and Fonagy, P. (eds) Handbook of Mentalizing in Mental Health Practice. Washington, American Psychiatric Publishing, pp. 445-461.

Sales, M. D. and Alves, P. (2012) Individualized Patient Progress Systems: why do we need to move towards a personalized evaluation of psychological treatments. *Canadian Psychology, 53 (2), 115-121.*

Soderstrom, K. and Skarderud, F. (2009) Mentalization-based treatment in families with parental substance use disorder: theoretical framework. *Nordic Psychology. 61 (3), 47-65.*

Stern, D. N. (2003) *The Interpersonal World of the Infant: a view from psychoanalysis and developmental psychology.* London: Karnac (2nd edition, first published in 1985 by Basic Books).

Stolorow, R. and Atwood, G. (1992) *Contexts of Being: the intersubjective foundations of psychological life.* London: The Analytic Press.

Taylor, G. J. (1997) *Substance use disorders.* In: G. J. Taylor, R. M. Bagby and J. D. A. Parker, (eds) Disorders of Affect Regulation: alexithymia in medical and psychiatric illness. Cambridge, Cambridge University Press, pp.166-189.

Winnicott, D. W. (1962) *Ego integration in child development.* In: The Maturational Processes and Facilitating Environment. Hogarth Press, London, pp. 56-63.

Wollheim, R. (1995) *The Mind and its Depths.* Cambridge, MA: Harvard University Press.

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