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# SELF HARM IN YOUNG PEOPLE AND EVIDENCE FOR EFFECTIVE TREATMENT

I wanted to kill myself  
but I was scared it will  
ruin my make up.



# Example of what it feels like

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- “There are three of me. I feel a bit crazy
- The one is angry, anxious, does not want to eat, wants to punish me and hates me. That one does not want to be with people and does not trust people. That one does not care about me or what she does to me.
- The other me is happy, confident, enjoys people and feels good about myself.
- Then there is one in the middle, feeling confused between the two poles. “



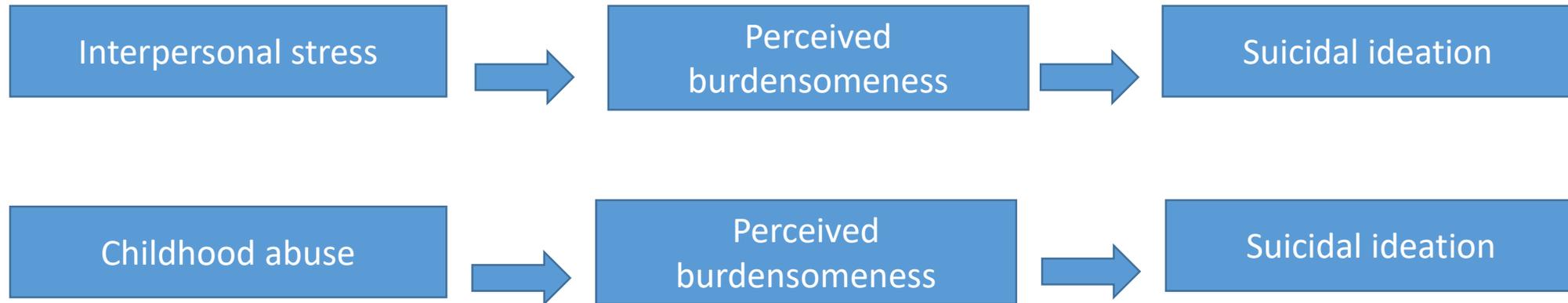
# Example of what makes her switch

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“I woke up feeling good and ok. Then I went to school and I heard that my boyfriend were hanging out with other friends at school. He did not call me as he usually does so I thought he was enjoying their company more than mine. They have more to offer and I am trouble. I thought he would not want to be with me and that I will loose him. It felt unbearable, so I contacted him and ended the relationship. I hated myself and felt he hated me. I wanted to cut but I could not as I was at school. Over the course of the day, I felt worse until I got home and then I cut myself. I then felt a bit better.”



Buitron et al, (2016)



Puzia et al. (2014)

Adolescents who have interpersonal relationships characterized by ongoing conflict and tension may come to believe that they are a drain or a burden on other people in their lives, and this belief of being a burden on others appears to play a role in the pathway from chronic interpersonal stress to suicidal ideation. (Buitron et al, 2016)

# What is mentalization?

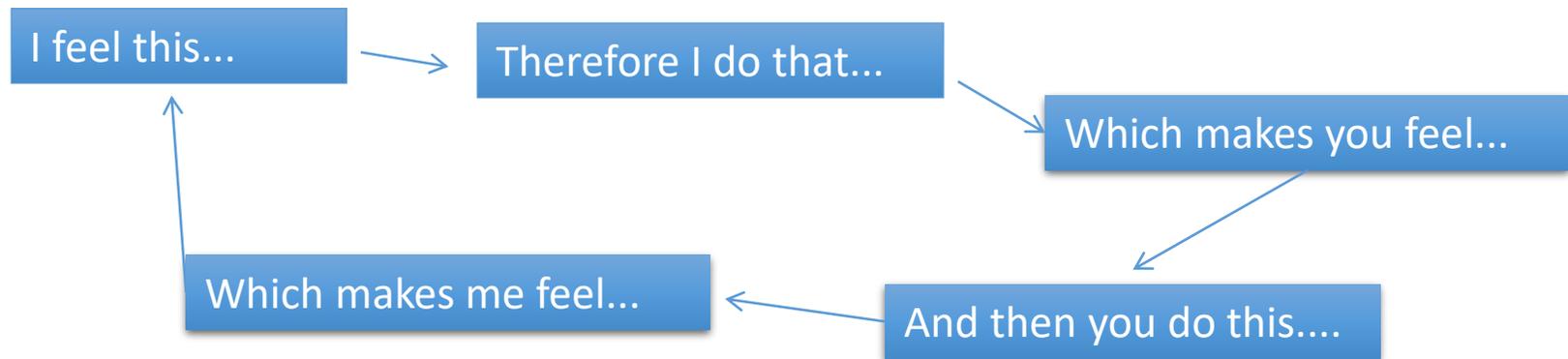
- Mentalizing renders behaviour intelligible; is the basis of self-awareness and sensitivity to others

Alan 2005

# What is mentalization?

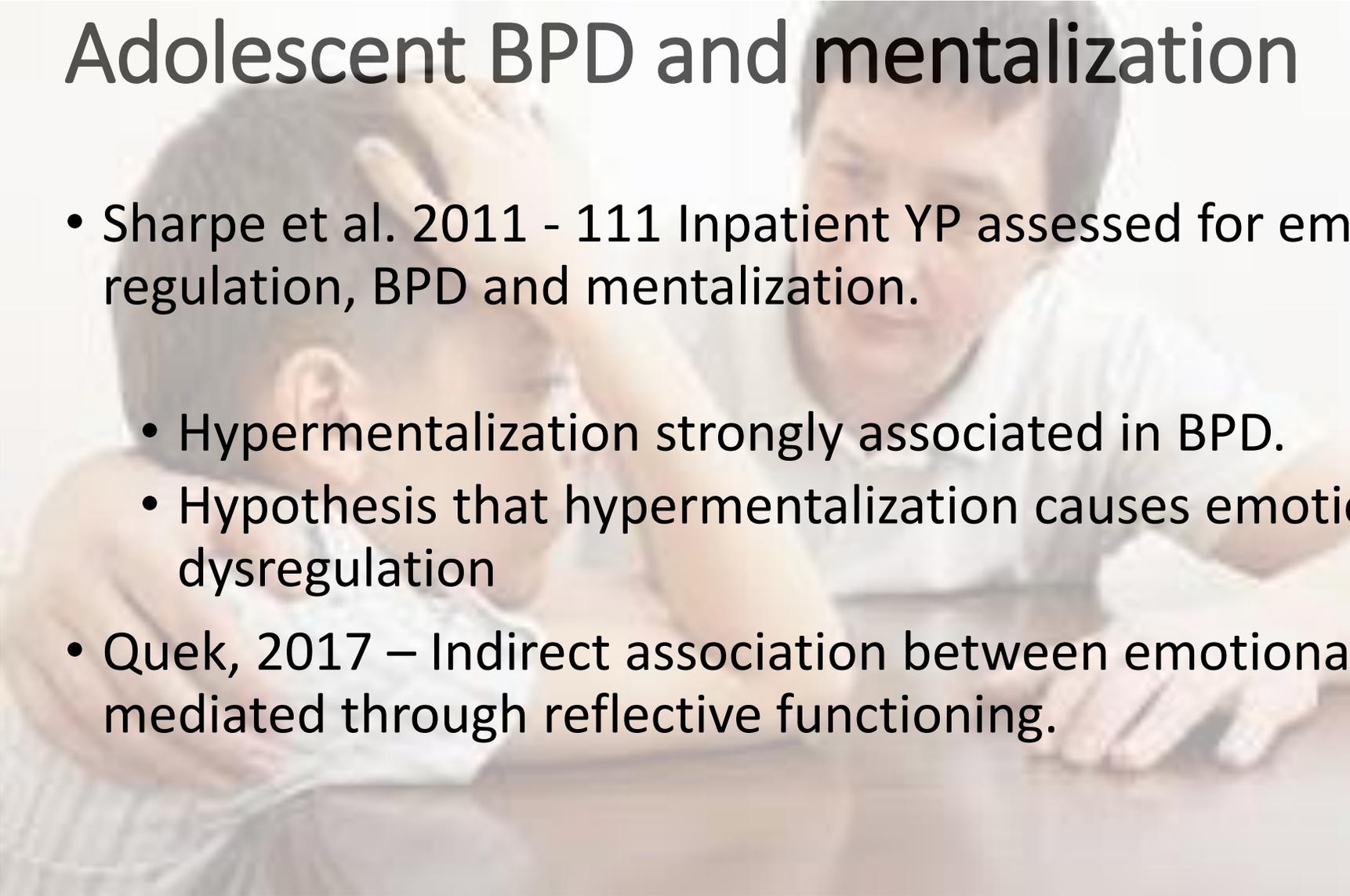
It is the ability to make sense of one's emotional and relational world

*Seeing oneself from the outside and others from the inside*



It is the focus on mental states and not on behaviour

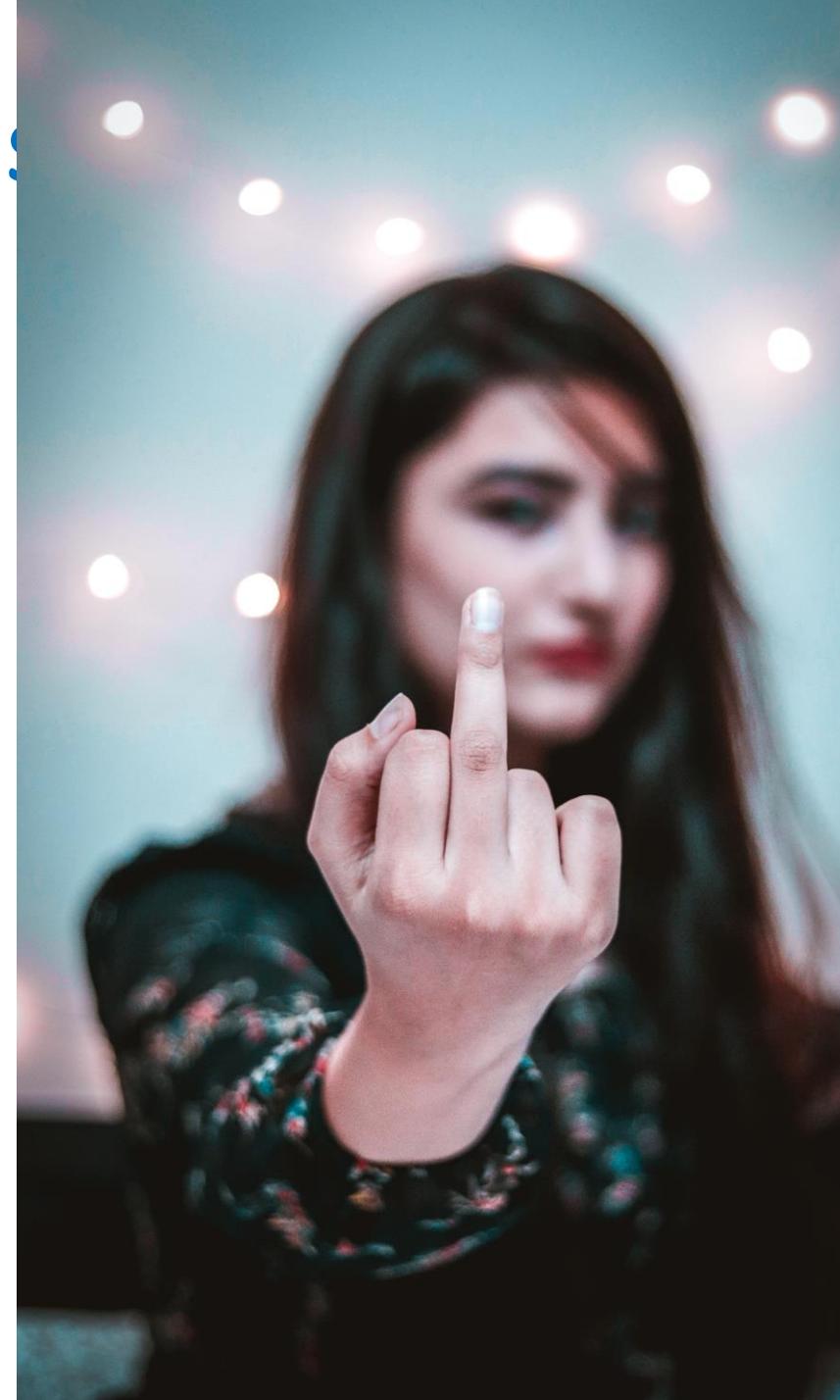
# Adolescent BPD and mentalization



- Sharpe et al. 2011 - 111 Inpatient YP assessed for emotional regulation, BPD and mentalization.
  - Hypermentalization strongly associated in BPD.
  - Hypothesis that hypermentalization causes emotional dysregulation
- Quek, 2017 – Indirect association between emotional abuse and BPD, mediated through reflective functioning.

# What is mentalization and what is hypermentalization?

- Mentalizing is crucial for interpersonal functioning. It helps us to make sense of what we feel and it helps us to understand other people as well as our impact on other people.(Bateman & Fonagy, 2011)
- Hypermentalization: Inaccurate mentalization, “overthinking”





# Effective mentalizing

- Curiosity about mental states
- Awareness of impact on others
- Awareness that mental states are opaque
- Allows for different perspectives
- Non-paranoid attitude

# Making sense of self harm: a Mentalizing model

- ◎ Mentalization develops in the context of an attachment relationship (Fonagy, 2000)
- ◎ At birth babies require their caregiver to accurately understand and respond to their emotional states – marked mirroring



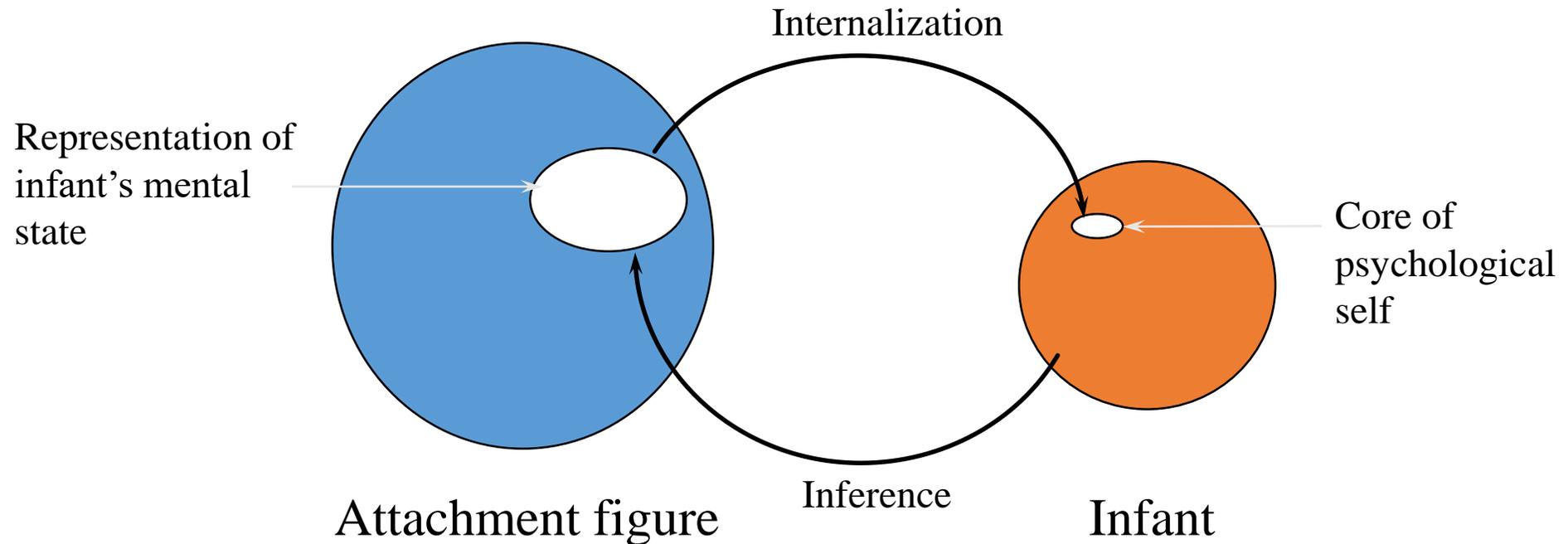
- ◎ Parent forms an internal representation of the infant as an intentional being, which is then internalised by the infant
- ◎ Secondary representation formed in the infant's mind



# Theory: Birth of the Agentive Self

*Attachment figure “discovers” infant’s mind (subjectivity)*

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*Infant internalizes caregiver’s representation to form psychological self  
Safe, playful interaction with the caregiver leads to the integration of primitive  
modes of experiencing internal reality → mentalization (Fonagy & Bateman)*

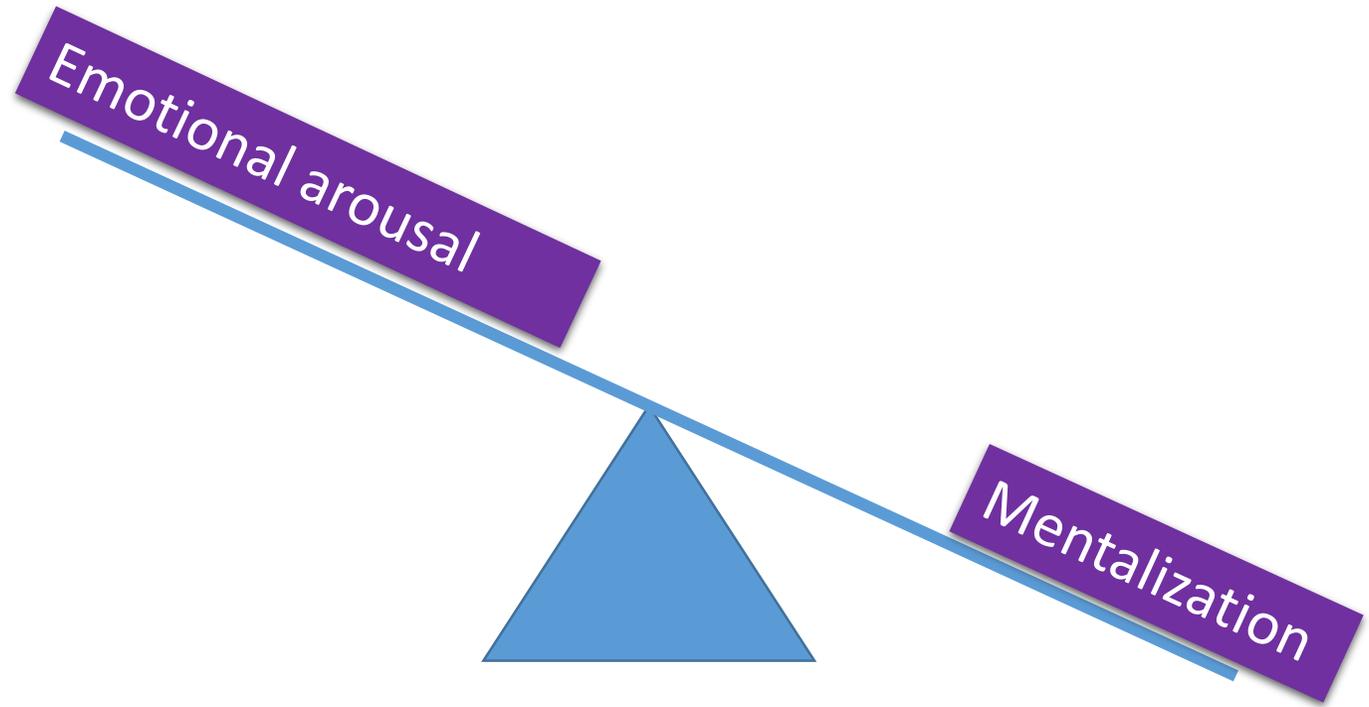
# Alien Self

- Present in most of us to some degree
- Only leads to fragmentation of the mind if the internal world is mostly dominated by the alien self
- The experience of the alien self is similar to an internal tormentor
- Can often be experienced as a feeling of deep inner hate; an inability to experience pleasure from one's achievements; inability to appreciate compliments, etc.



# MENTALIZATION MODEL TO UNDERSTAND SELF HARM





# Mentalization based treatment for self harm - RCT

Rossouw & Fonagy, 2012

# STUDY DESIGN

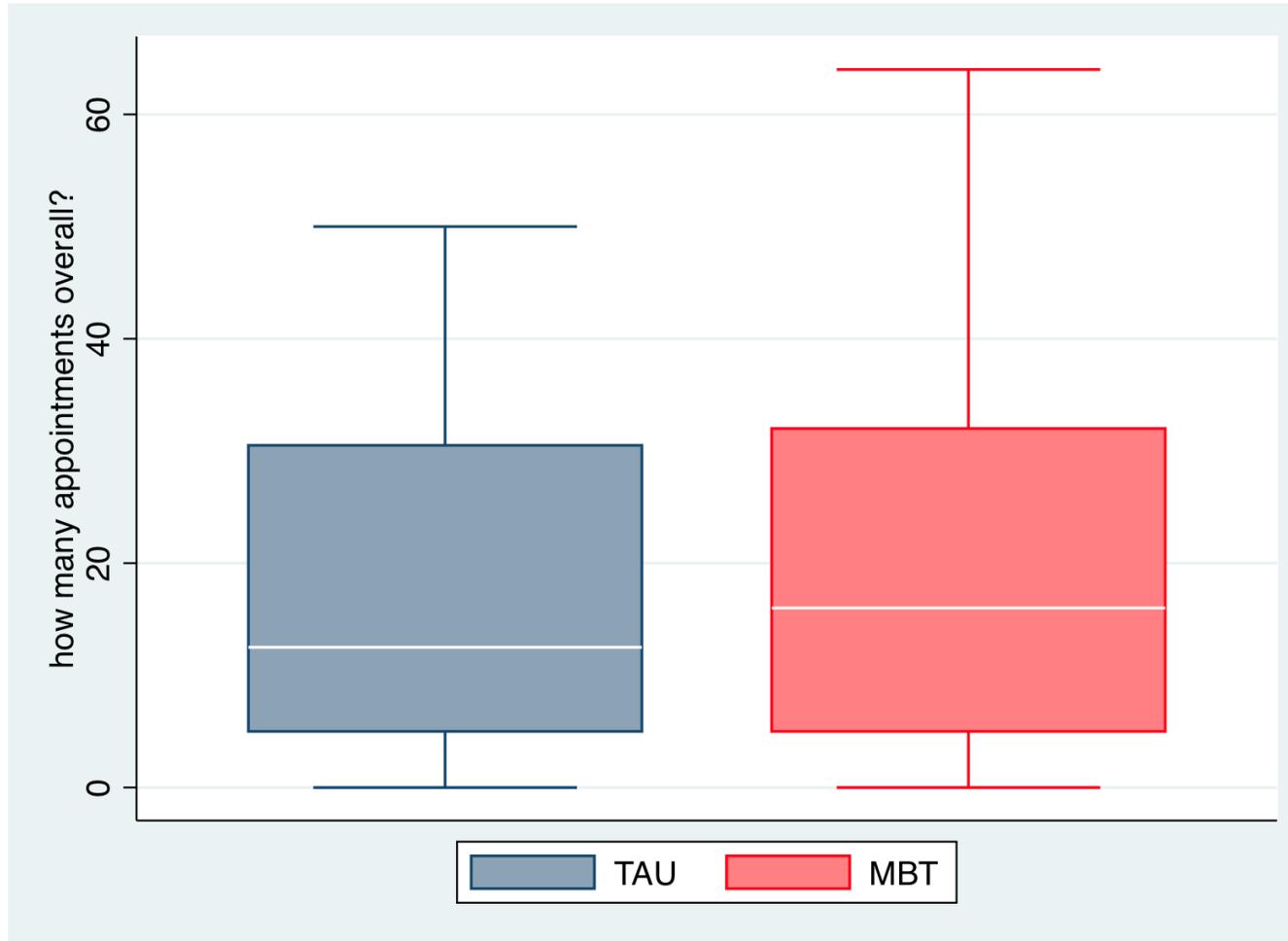
- Random allocation of young people presenting with self harm to either MBT or TAU
- N=80
- Assessments done every 3 months and at 12 months
- Assessment methods:
  - Risk taking and self harm: RTSHI (Vrouva, 2010)
  - Mood: MFQ (Angold, 1995)
  - BPD traits: BPFSC (Crick, 2005) and CH-BPD (Zanarini, 2007)
  - Dissociation: ADES (Armstrong, 1997)
  - Mentalization: HIF (Sandell, 2008)
  - Attachment: ECR (Brennan, 1998) and IPPA (Armsden, 1987)

## Demographics of sample

Characteristics at Baseline	TAU	MBT	Test Statistic	$p=$
Female, n/N (%)	35/40(87.5%)	33/40(82.5%)	$\chi^2(1)<1$	n.s.
Age, y, mean (SD)	14.8 (1.2)	15.4 (1.3)	t(78)=2.01	0.041
Chronicity of Self harming			$\chi^2(1)<1$	n.s.
less than 3 months	16/40(40%)	16/40(40%)		
3-5 months ago	4/40(10%)	7/40(17.5%)		
6-11 months ago	6/40(15%)	2/40(5%)		
1-2 years ago	11/40(27.5%)	12/40(30%)		
over 2 years ago	3/40(7.5%)	3/40(7.5%)		
Depression (MFQ $\geq$ 8), n/N (%)	38/40(95%)	39/40(98%)	$\chi^2(1)<1$	n.s.
BPD (CI-BPD $\geq$ 5)	28/40(70%)	30/40(75%)	$\chi^2(1)<1$	n.s.

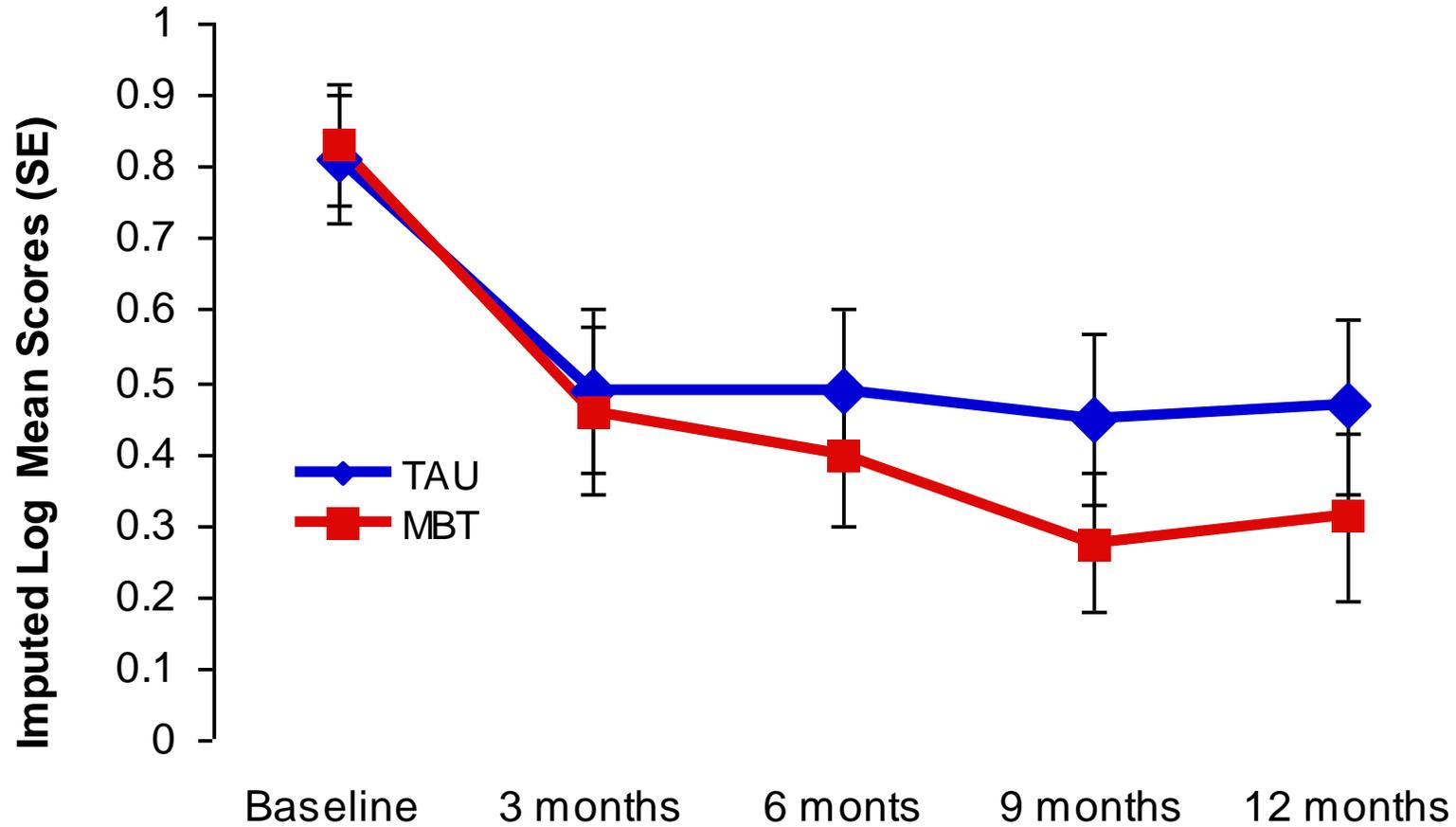
# RESULTS

# Overall number of appointments for self-harming adolescents in MBT vs. TAU trial



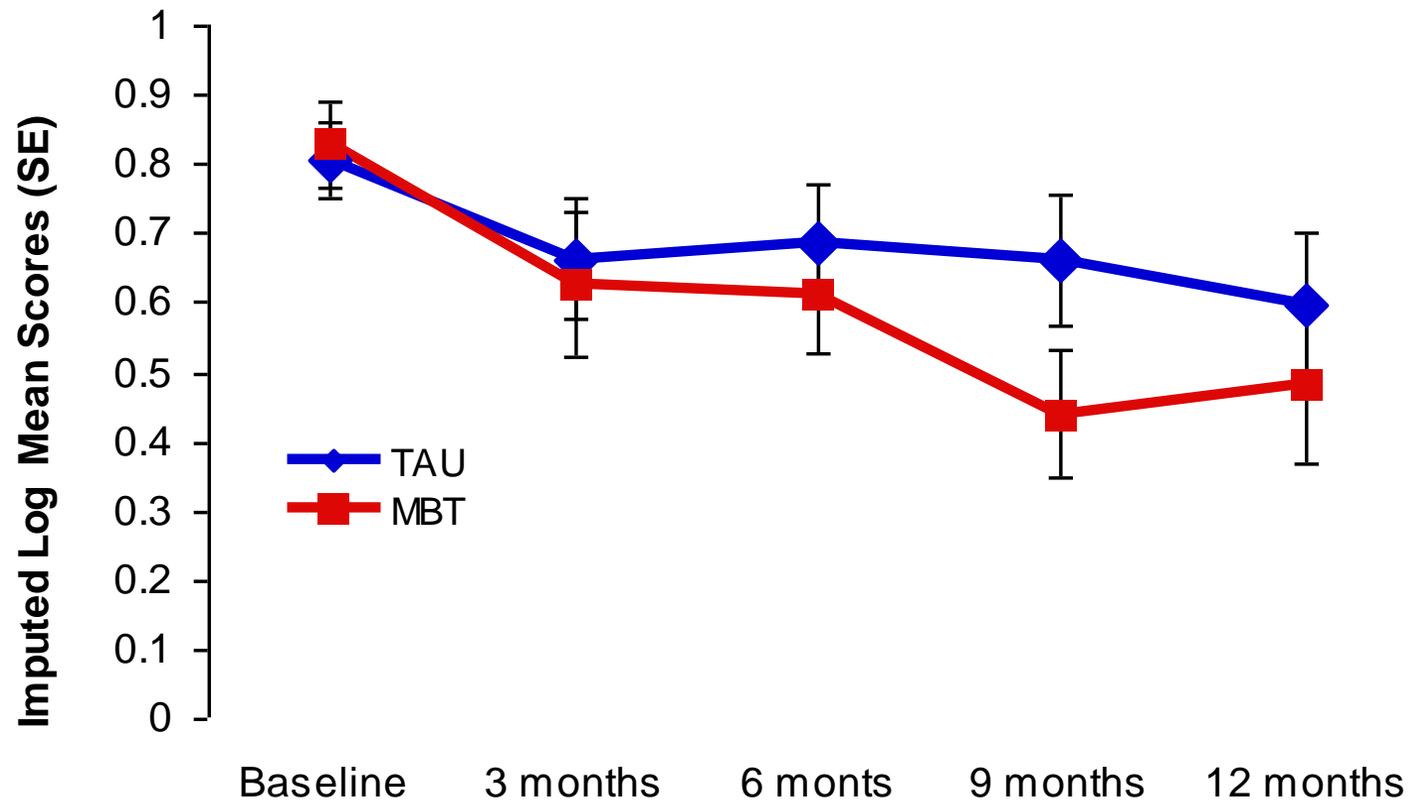
Group difference:  $\beta=2.95$ , 95% CI: -4.28, 10.17,  $t(78)=0.81$ ,  $p<0.419$ ,  $d=0.18$

# Self harm scores for TAU (n=40) and MBT (n=40) groups on the RSHI



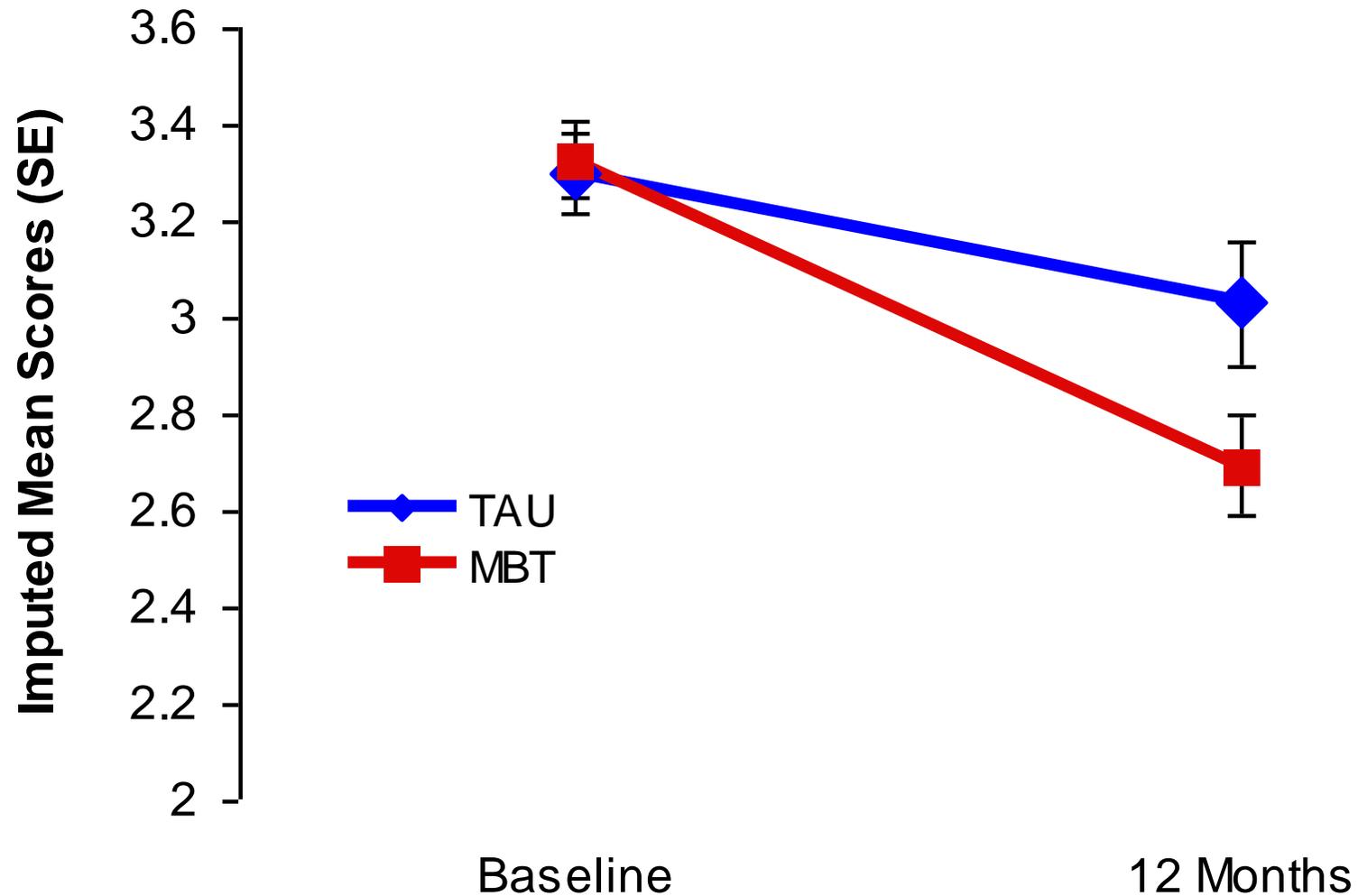
Group differential rate of change:  $\beta=-0.049$ , 95% CI: -0.09, -0.02,  $t(159)=-2.49$ ,  $p<0.013$ ,  $d=0.39$

# Depression scores for TAU (n=40) and MBT (n=40) groups on the MFQ



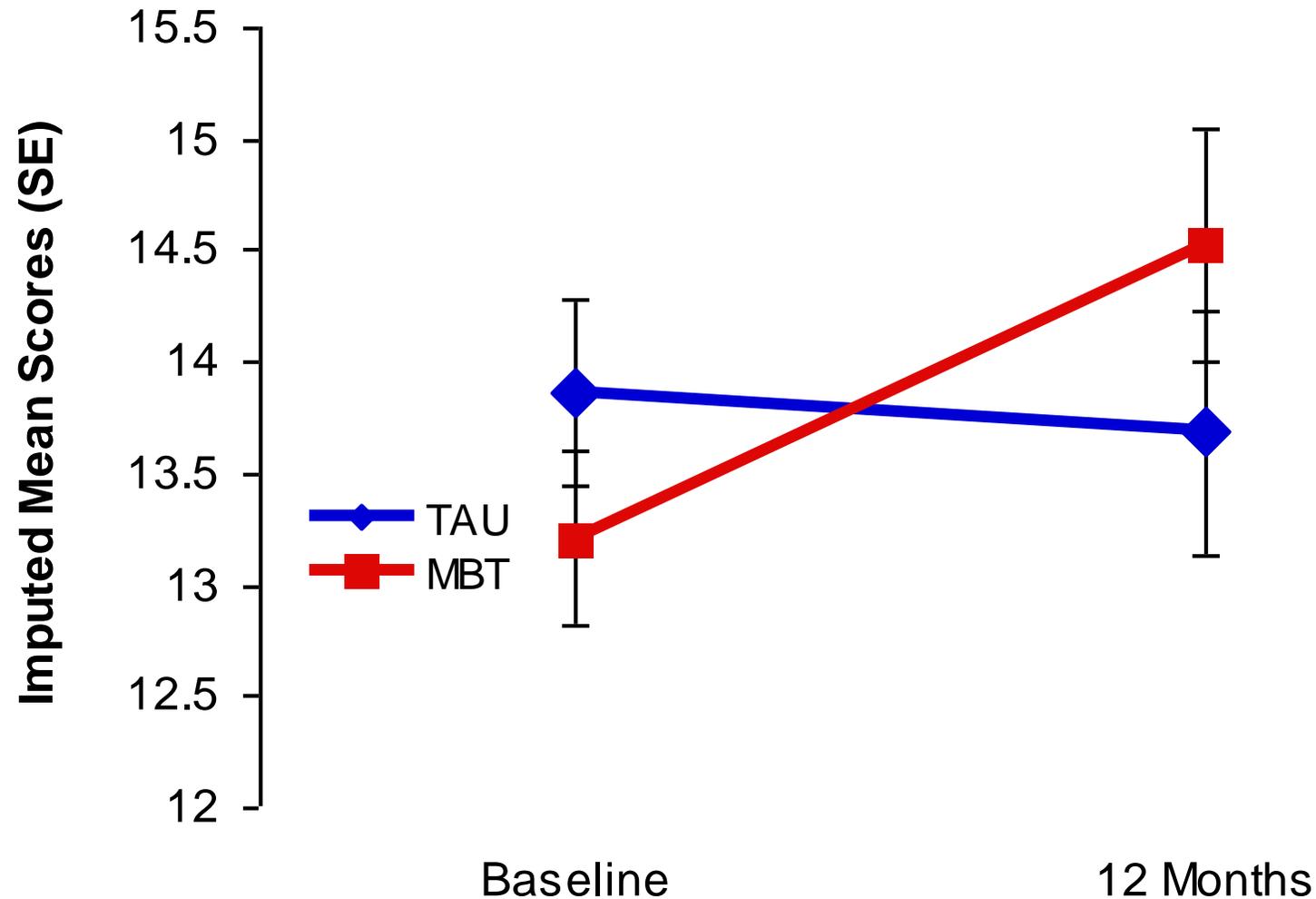
Group differential rate of change:  $\beta=-0.046$ , 95% CI: -0.09, -0.01,  $t(159)=-2.25$ ,  $p<0.024$ ,  $d=0.36$

# Borderline personality features scores for TAU (n=40) and MBT (n=40) groups



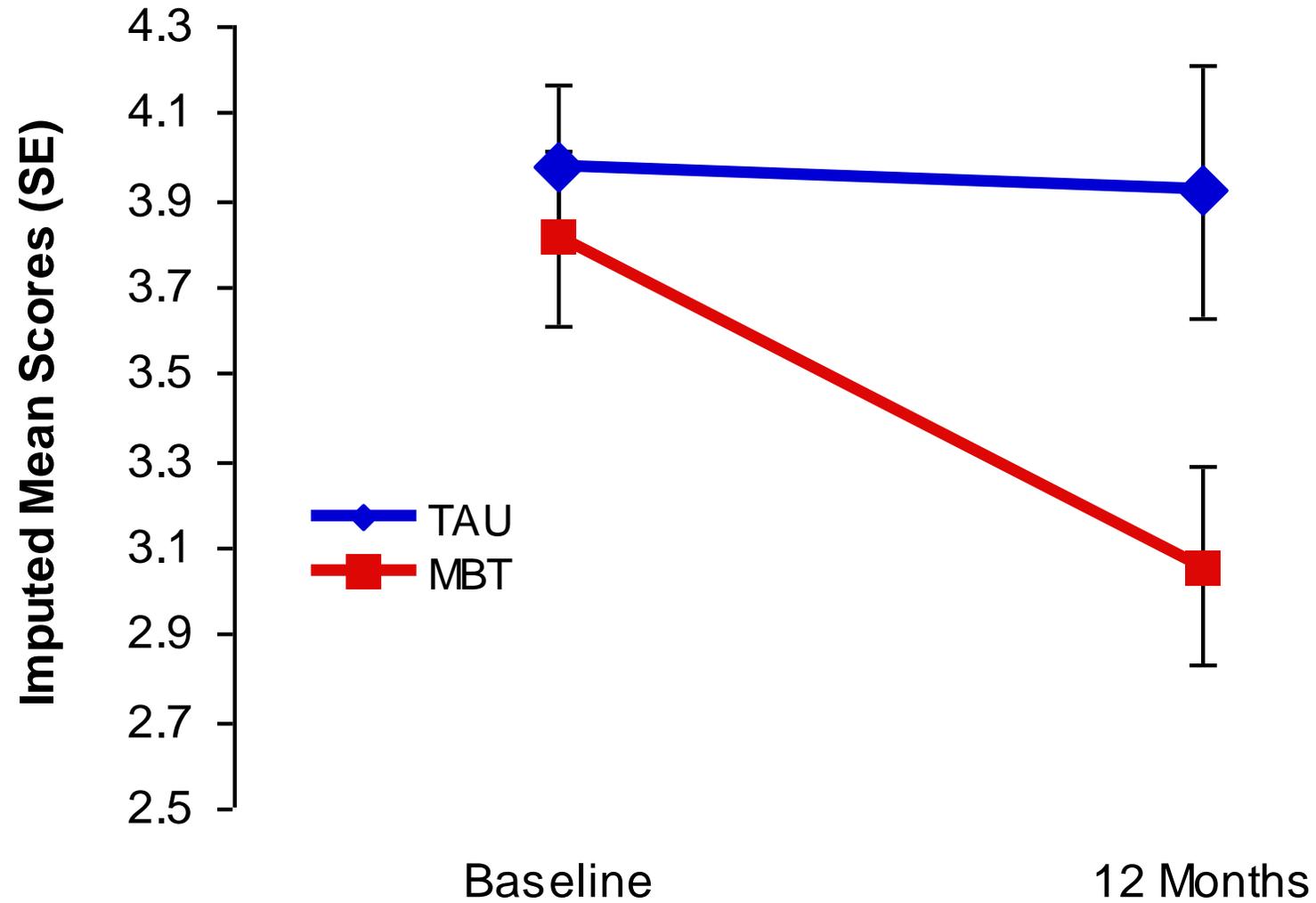
Group differential rate of change:  $\beta=-0.361$ , 95% CI: -0.7, -0.03,  $p<0.034$ ,  $d=0.34$

# Mentalizing scores on the HIFQ for treatment groups



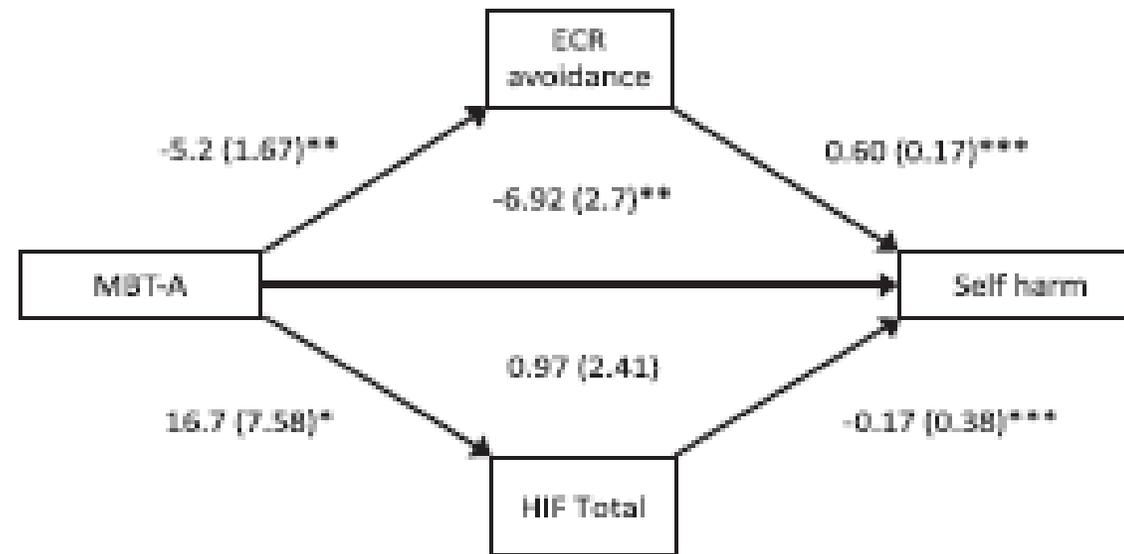
Group differential rate of change:  $\beta=1.49$ , 95% CI: 0, 2.98,  $t(159)=1.99$ ,  $p<0.049$ ,  $d=0.32$

# Attachment avoidance scores from Experiences in Close Relationships Questionnaire for treatment groups



Group differential rate of change:  $\beta=-0.696$ , 95% CI: -1.48, 0.08,  $t(159)=-1.75$ ,  $p<0.081$ ,  $d=0.28$

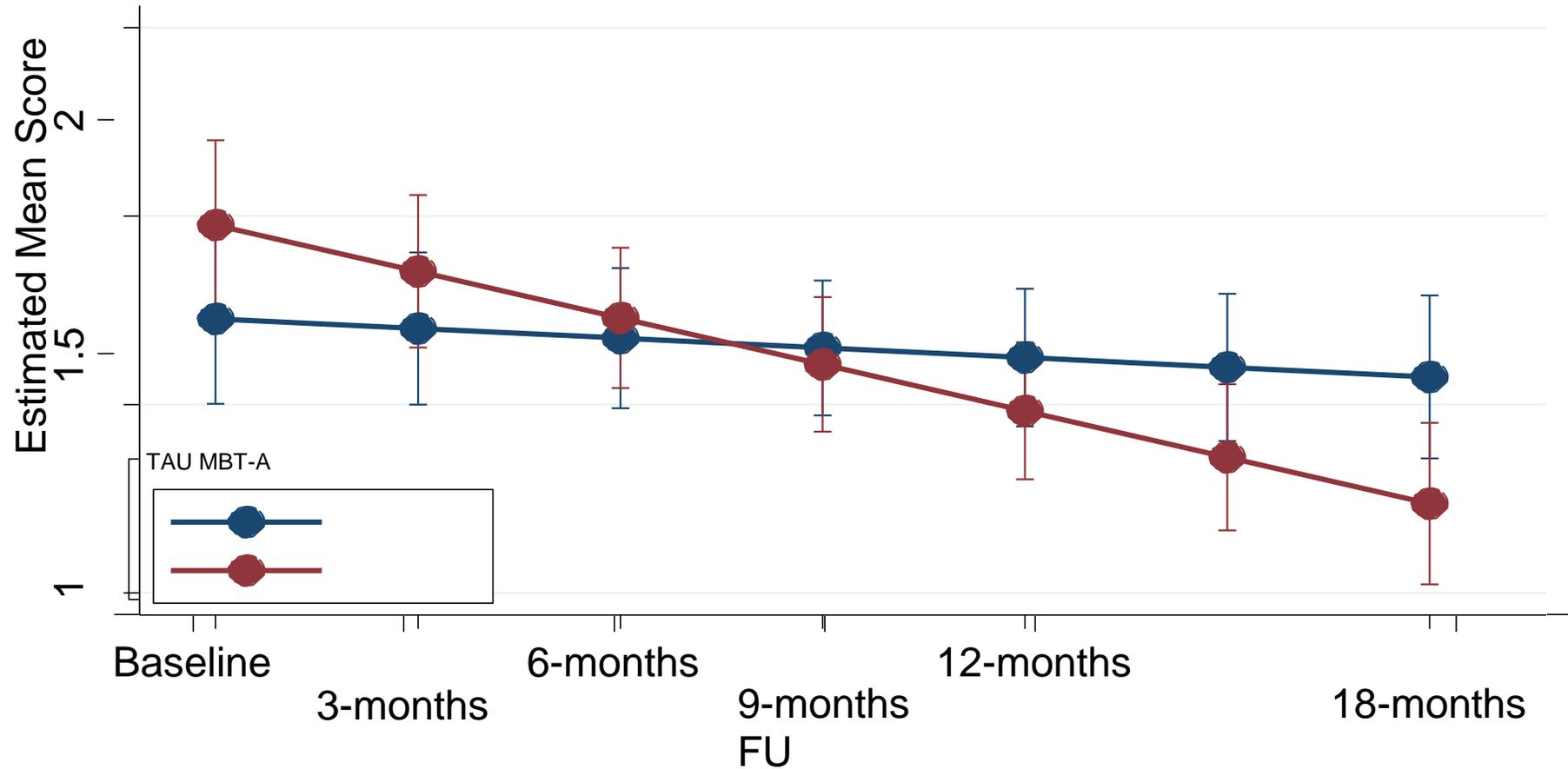
**FIGURE 2** Mediation of effect of mentalization-based treatment for self-harm in adolescents (MBT-A) on self-harm scores at the end of treatment. Note: Path coefficients (SE) are shown with the association of MBT-A on self-harm. The coefficient for the path controlling for specific indirect effect of Experience of Close Relationships Inventory (ECR) avoidance and How I Feel Questionnaire (HIF) change is shown in italics. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .



18 month follow-up data

# RTSHs analysis: Log\_Risk\_taking Score

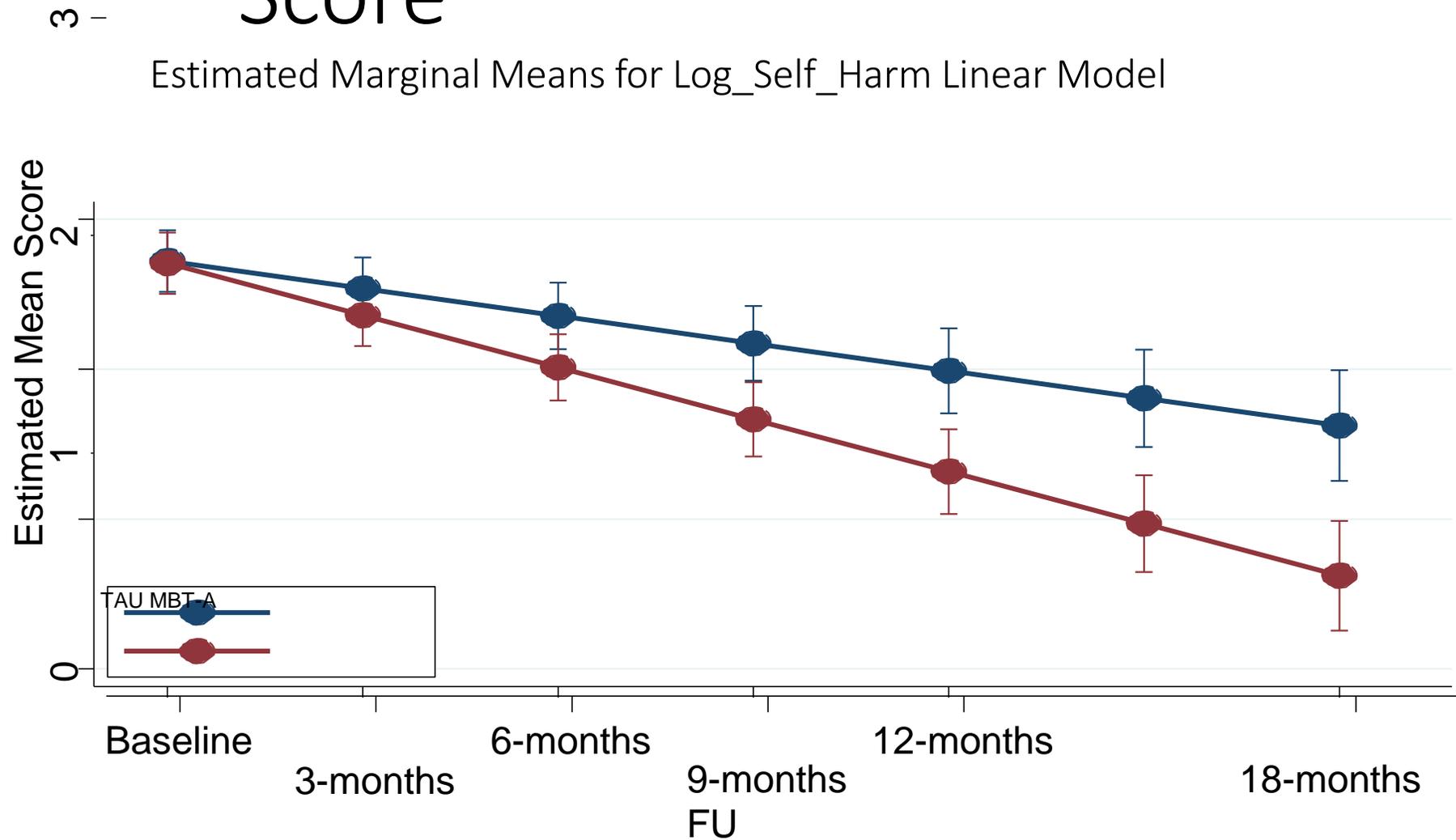
Estimated Marginal Means for Log\_Risk\_taking Linear component



Adjusted for Age: Random Slope

Group differential rate of change: Beta=-0.098, 95% CI: -0.17, -0.03,  $t(437)=-2.64$ ,  $p<0.0041$ ,  $d=0.25$

# RTSHs analysis: Log\_Self\_Harm Score



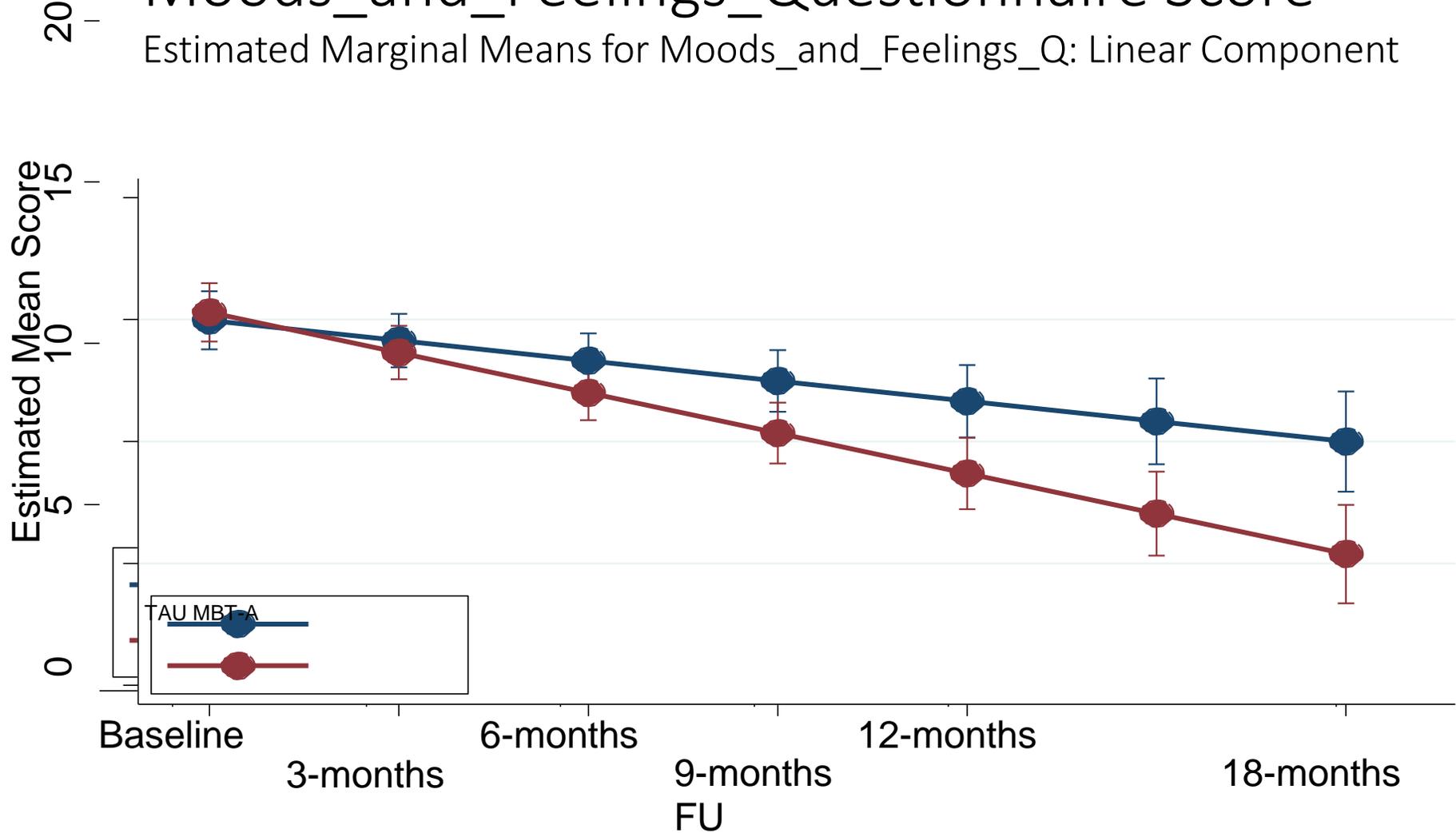
Adjusted for Age: Random Slope

Group differential rate of change: Beta=-0.165, 95% CI: -0.26, -0.08,  $t(437)=-3.51$ ,  $p<0.0002$ ,  $d=0.34$

# RTSHs analysis:

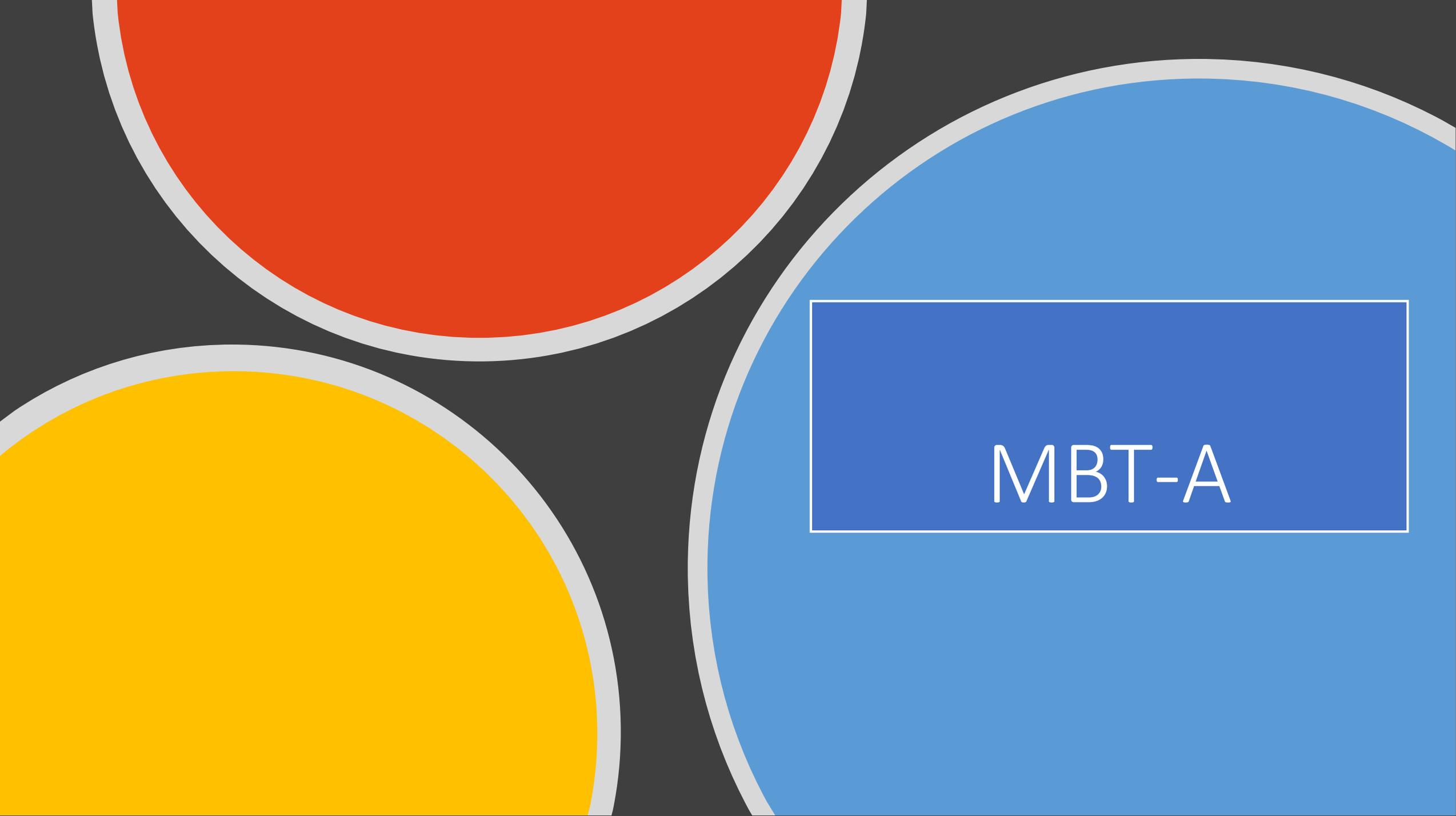
## Moods\_and\_Feelings\_Questionnaire Score

Estimated Marginal Means for Moods\_and\_Feelings\_Q: Linear Component



Adjusted for Age: Random Slope

Group differential rate of change: Beta=-0.824, 95% CI: -1.45, -0.21, t(437)=-2.61, p<0.0045, d=0.25



MBT-A

# MBT: KEY CONCEPTS OF MODEL

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The underlying principle is that behaviour difficulties and family conflict regularly result from mentalization failure

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Mentalization failure in one individual rarely exists in a bubble of isolation – it often migrates into the interpersonal world where many relationships fall prey to it.

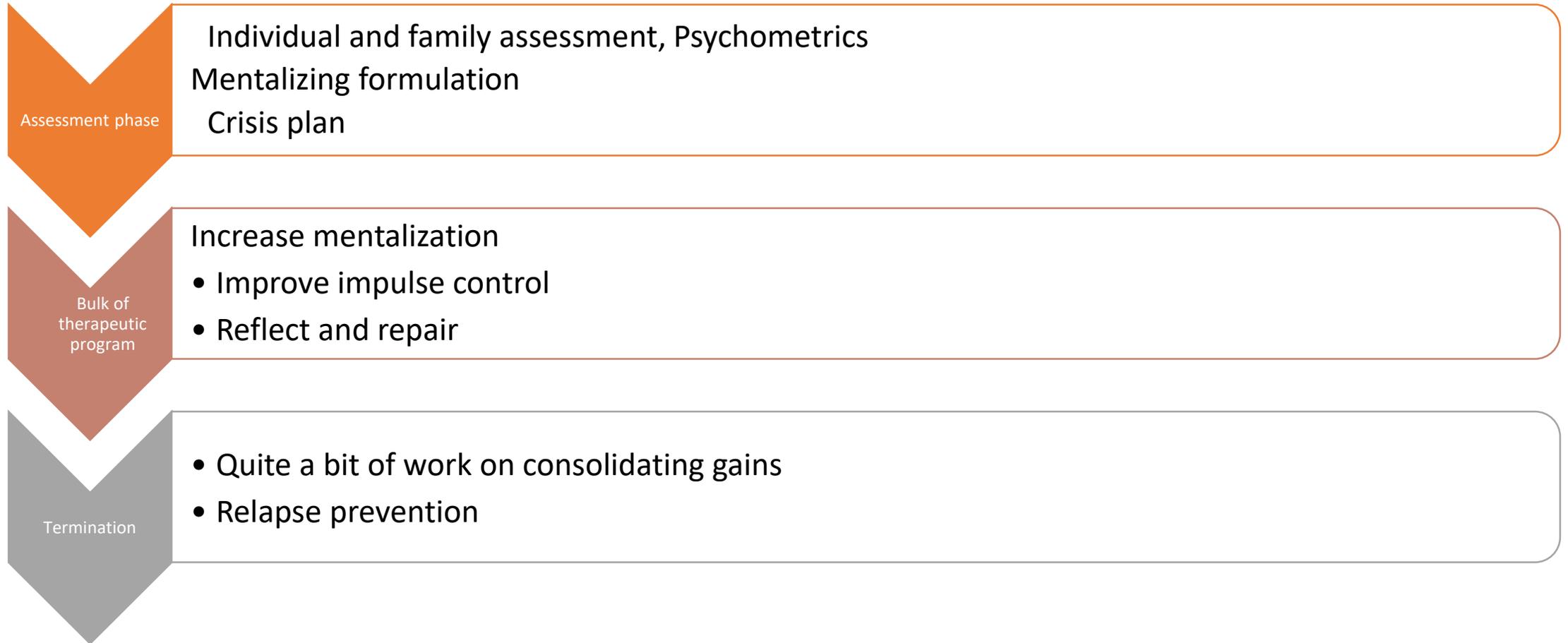
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The primary aim of the model is to improve YP and their family's awareness of their own mental states and the mental states of others.

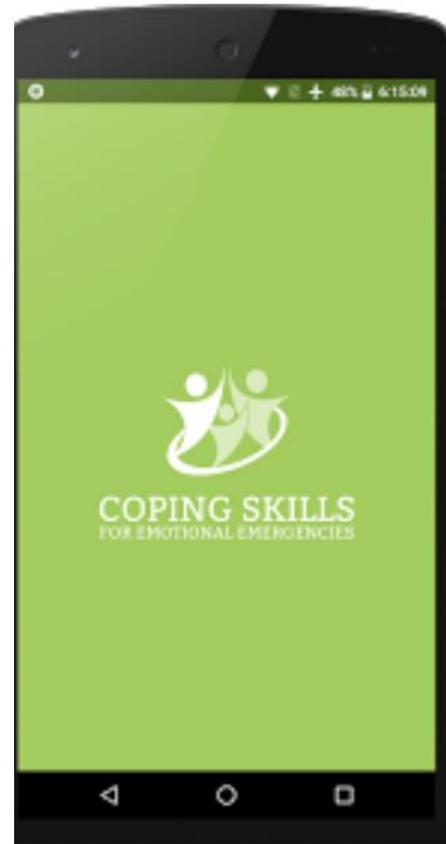
# Structure of MBT-A

- Out patient program
  - Combination of individual MBT-A and MBTF
- Inpatient/daypatient program
  - Combination of individual MBT-A and MBTF and MBT Group

# Structure



# Helpful apps



## Crisis plan for parents:

As we spoke, X's self harm is often in the context of very strong feelings that she finds hard to manage. Here are 3 do's and 3 don't's which may help you at times of risk:

### **Do's:**

- Listen
- Understand
- Help to mentalise

### **Don't's:**

- Panic
- Blame
- Punish



Don't blame her and don't blame yourself. Just try and understand what she felt before she wanted to harm herself and help her to speak about the feelings and the events leading up to the feelings. If the events involved you, listen and try and understand *her* perspective without becoming defensive. You don't have to hold the same perspective, but it is important that you validate her perspective. If there was a misunderstanding between you which you contributed to, own up to it. You are not here to win battles but to restore the connection between you.

If she is very aroused, speaking too much is not helpful. Just be kind and supportive and say things like: " I am not angry with you, I am here to help you and keep you safe. Something has made you so upset. I don't know what it is and if it is something I have done, I am sorry. I really want to understand. Talk when you are ready, but until then, I will just be with you to keep you safe."

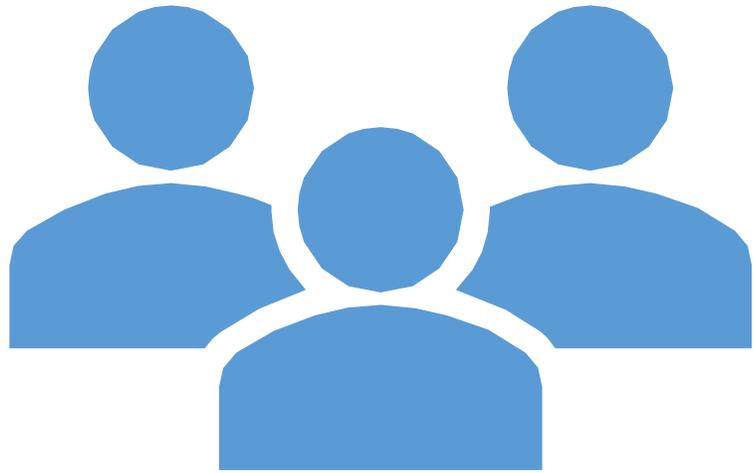
If she wants to hurt herself, you could say: " I really don't want you to hurt yourself. You deserve so much more. Let's try one of the alternatives. I will help you, shall we get a bowl of ice?"

If she is suicidal, you could say: “ Killing yourself is not an option. I love you and do not want you to kill yourself. You are not alone.

We will get through this together. I am going to stay here with you to keep you safe. Let’s try and think of something that will help right now. Will distraction help such as going for a walk or watching TV?”

If all else fails, call the clinic or if it is after hours, you may have to take her to the emergency department.





# Our role as Psychiatrists

# Basic MBT principles

- Therapeutic stance
  - These youngsters have no sense of their own worth, skills or talents. They relate to themselves in dehumanised ways with no sense of compassion.
  - It is crucial to embody humanisation, warmth and compassion
  - Validation, support and empathy
  - Curiosity about mental states



Aim is to increase  
the young person  
and their families'  
ability to mentalise

le. To help all to be  
more accurate at  
representing the  
mind of the other

# Concluding comments

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- We need to help these kids find humanity about themselves
- Find hope
- But in the meanwhile they need different coping strategies to keep them safe
- We need to help them connect with something in themselves that can have mastery
- Our view is that this can be established through improving metallisation – more accurate view of themselves and a greater ability to imagine the minds of others.





Thank you  
for listening