The Interpersonal Dynamics consultation in an inpatient therapeutic community for severe personality disorders: mentalising transference and countertransference dynamics.

Dr Mattia Beggi, Lakeside Mental Health Unit, Twickenham Road, Isleworth, TW7 6AF

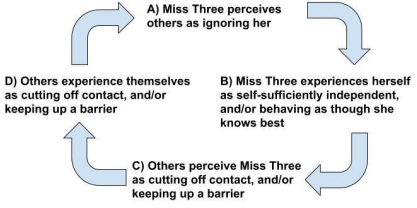
Introduction

We piloted the Interpersonal Dynamics (ID) consultation in an inpatient therapeutic community for patients with severe personality disorders, with the aim of better understanding the interpersonal dynamics between its patients and staff, which are at the core of its treatment and care model.

Methods

The ID consultation is a structured group reflective practice for staff about a patient, which allows staff to explicitly mentalise transference and countertransference dynamics by systematically analysing four interpersonal perspectives:
A) how the patient perceives others, and
B) experiences him/herself in response to them
(A and B represent the patient's transference to staff);
C) how others perceive the patient, and
D) experience themselves in response to him/her
(C and D represent the staff's countertransference to the patient).
For each perspective the most salient interpersonal items are chosen out of a list comprising 32 items (2 items per each cluster, as in Table 1).
By linking the four interpersonal perspectives with the items identified for each of them, staff can identify interpersonal dysfunctional cycles that repeat relationship patterns from past to present (i.e. enactments, e.g. Figure 1):

Figure 1. *Miss Three's abandoning interpersonal cycle*



We conducted six ID consultations (approximating half of our inpatient population), and we then performed a thematic analysis to identify common themes across different consultations.

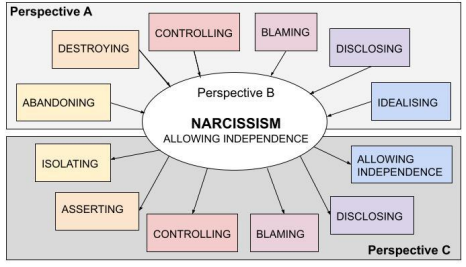
Table 1. *Interpersonal clusters and items*

CLUSTERS	Items
ALLOWING INDEPENDENCE	1 Self-sufficiently independent 2 Behaving as though knowing best
AFFIRMING	3 Supporting and agreeing 4 Accepting and admiring
IDEALISING	5 Treating her/him as special 6 Idealising
PROTECTING	7 Attending to and caring in every way 8 Instructing and patronising
CONTROLLING	9 Domineering and imposing 10 Manipulating and exploiting
BLAMING	11 Accusing 12 Putting down and humiliating
DESTROYING	13 Intimidating and attacking 14 Rejecting and excluding
ABANDONING	15 Abandoning 16 Ignoring
ASSERTING	17 Defying and opposing 18 Insisting on her/his position
DISCLOSING	19 Over-revealing and intrusive 20 Pouring out concerns and anxieties
REACTIVE IDEALISING	21 Over-involved 22 Over-sympathetic
DEPENDING	23 Over-relying 24 Draining
SUBMITTING	25 Appeasing and complying with 26 Giving up in despair
TAKING OFFENCE	27 Indignant and self-justifying 28 Hurt and touchy
RECOILING	29 Running away from 30 Showing disgust towards
ISOLATING	31 Cutting off contact 32 Keeping up a barrier

Results and discussion

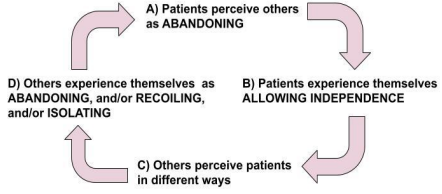
As shown in Figure 2, all our patients utilise narcissistic defences of becoming superiorly independent (perspective B), which could be central against different adverse object relationships, such as others being abandoning, destroying, controlling, etc. (perspective A).
The staff's perceptions of patients (perspective C) might 'mirror' the patients' perceptions of staff (perspective A) [as suggested by similar (e.g abandoning and isolating) or same (e.g. controlling) clusters in A and C], and this might be mediated by the patients' 'narcissism' (perspective B). This mirroring of clusters also suggests our patients' identifications with their aggressors, in that they end up becoming (perspective C) the others they fear (perspective A):

Figure 2. *Narcissism as defence against different adverse object relationships; and mirroring of clusters between perspective A and C*



So, patients can reverse their past passive roles of victims into active roles of aggressors in the present with staff, whilst staff can get caught up in interpersonal dysfunctional cycles where they end up becoming like those same aggressors. We found several such enactments, as captured by the abandoning (e.g. Figure 1), blaming, destroying, asserting, disclosing, and also idealising clusters. Abandonment is virtually always enacted between our patients and staff, and we hypothesised a common 'abandoning' interpersonal cycle, mediated by the patients' narcissistic independence (perspective B):

Figure 3. *Common abandoning interpersonal cycle*



As shown in Figure 4, some patients can perceive others (perspective A) as either 'all good' via idealisation (in green, i.e. affirming, and/or idealising, and/or protecting), or 'all bad' via devaluation (in purple, i.e. blaming, and/or destroying, and/or abandoning). This intrapsychic splitting can become, via projective identification, an interpersonal splitting among staff, as we also found corresponding splitting between staff who can idealise and staff who can devalue patients (perspective D):

Figure 4. *Intrapsychic and interpersonal splitting*

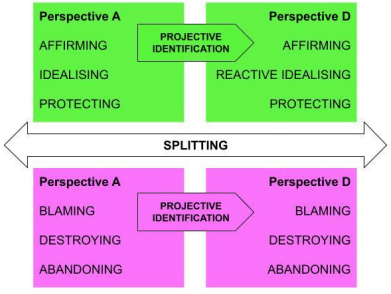
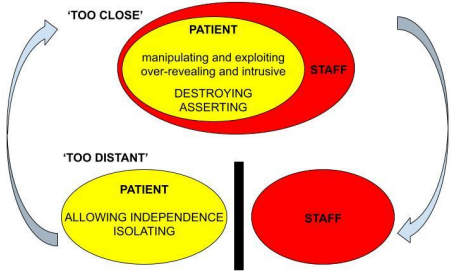


Figure 5 shows how some patients (in yellow) can cyclically move from being 'too close' (i.e. merged) to being 'too distant' with staff (in red). They can become too close by being manipulating and exploiting, and/or over-revealing and intrusive, which make them claustrophobic, leading to destroying and asserting defences in order to move away from this merged state. On another extreme, they can also become 'too distant' by allowing independence and isolating defences, which make them agoraphobic, therefore the need to get inside staff again, giving rise to a 'claustro-agoraphobic dilemma':

Figure 5. *Patients' behaviours in light of underlying claustro-agoraphobic dilemma*



Conclusions

The ID consultation brought light to our patients' internal worlds, as externalised interpersonally in the treatment setting with staff.
It constituted a triangular space which helped staff to mentalise difficult transference and countertransference dynamics, so that they could move from dyadic subjective experiences with patients to triadic objective perspectives, from passive reactions to active thinking and understanding.