

Potential space, dialectics, reflective function, mindfulness and mentalization; one concept in different bottles?

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Abstract

The therapeutic encounter becomes transformational through the creation of potential space, dialectics, reflective function, mindfulness or mentalization. This paper dialogues these concepts as employed by different therapeutic modalities within New Zealand, namely; Object-relations (Thomas Ogden and Donald Winnicott), the Conversational Model (Russell Meares), Dialectical Behaviour Therapy (Marsha Linehan) and Mentalization (Anthony Bateman and Peter Fonagy). It suggests that there is sufficient common ground to view them as one concept in different therapeutic bottles.

Introduction

Working in New Zealand has allowed me to wear different therapeutic hats. These include; clinical psychologist and psychotherapist for a DHB and in private practice, NZAP supervisor and infrequent panel member and case study marker, past psychology professional advisor, member of the local university psychology advisory board, and trainer of psychiatric registrars. When my ability to split is low, I witness a bewildering cacophony of divergent therapeutic styles, worldviews, competitive sniping, and theoretical disputes. It is remarkable how all of this diversity occurs within the small group of New Zealand mental health workers.

The seed of this paper was sown one hot afternoon in a Christchurch lecture theatre, the venue for the Gathering 2003 (The Annual NZ National Personality Disorders Conference). I was conscientiously listening to Dr Elizabeth Simpson explaining the centrality of dialectics and mindfulness in Dialectical Behaviour Therapy (DBT). Three days earlier, Professor Russell Meares had spoken of Reflective Consciousness in the Conversational Model. Simpson attended Meares' workshop. Meares acknowledged echoes of his work in Ogden's writings on the transitional object and potential space. A doodling cum-mind-mapping style of note taking facilitated my musing about the similarity of these concepts and their resonance with others such as symbolism and mentalization. I chuckled at the ironic possibility that theoretical orientations were being drawn towards integration in a field in which splitting is endemic, namely Borderline Personality Disorder. I started noticing strange occurrences; behaviourists sounding Tibetan singing bowls, meditating and discussing dialectical philosophy, and psychoanalytic therapists talking about statistics, outcome studies, and affect regulation.

This paper looks at the similarities between the concepts of potential space, dialectics, mindfulness, reflective function, and mentalization. It consists of brief excursions into a few theories popular with New Zealand psychotherapists, namely Ogden's conceptualization of Winnicott's potential space, Linehan on dialectics and mindfulness in DBT, Meares' reflective function, and Bateman and Fonagy's mentalization. Some important contributions, which were regretful excluded, include the Phenomenological-Hermeneutic, Jungian, Lacanian and Narrative perspectives.

Potential space: Thomas Ogden and object-relations

Thomas Ogden is a Californian object-relations psychoanalyst who has richly contributed to psychoanalytic theory. His work is well read amongst psychodynamic clinicians in New Zealand, particularly in the Auckland area.

Ogden (1985, 1986, 2001) clarifies and develops Winnicott's (1953, 1967) most important and evasive of concepts, 'potential space'. This is the intermediate area of experiencing which lies between fantasy and reality. Specific forms of potential space include the transitional object, analytic space, and the area of cultural experience and creativity.

Ogden proposes the idea of a dialectical process as a paradigm for the psychological activity, which generates potential space and meaningful symbol formation. In referring to the philosopher Hegel, Ogden explains the dialectic as a process in which two opposing concepts each create, inform, preserve and negate the other, each standing in a dynamic (ever changing) relationship with the other. The dialectical process moves toward integration, but integration is never complete. Each integration gives rise to a new dialectical opposition and a new dynamic tension.

Ogden shows how meaning cannot arise out of a homogeneous field but accrues from difference. During infancy there is no perception of difference but rather an undisturbed state of 'going-on-being'. In a state of 'good enough' primary maternal preoccupation, the mother meets the infant's needs in such an unobtrusive manner that they are not experienced as needs. The perception of difference and the need for symbols arise when the desire is not immediately met. The contrast between frustration and desire gives rise to the awareness of separateness from the mother leading to the differentiation between me and not me, and between fantasy and reality. A dialectical process between the differentiated poles is then set in motion. Given optimal conditions, in which an attentive mother moderates frustration, a dynamic interplay of three differentiated entities is set up. This triangularity, 'three-ness' as opposed to 'one-ness', consists of the symbol (thought or desire), the symbolized (what is thought or desired) and the interpreting subject (child/mother/therapist). It is within the triangularity of subject, symbol and symbolized that potential space originates. The development of potential space leads to the capacity to generate personal meanings represented in symbols.

Initially there is no self that can set up the triangular relationship, and it is the mother who is the first subject to set the dialectical process in motion. The 'otherness' of the father in the Oedipal triangle plays an important role in later developmental stages.

Ogden goes on to propose a theory of the psychopathology of potential space. His basic assumption is that the symbolic function is a direct consequence of the capacity to maintain psychological dialectics, and psychopathology is based on specific forms of failure to create or maintain these dialectics. A collapse of the dialectic in the direction of either the symbol or the symbolized, or the unavailability of a third to recognize the dialectic, results in an inability to symbolize and hence to create meaning.

Ogden links his formulation of potential space with projective identification. He shows how the recipient of projective identification loses the capacity to maintain the dialectic process of 'me' and 'not-me' in the course of his unconscious participation in the projection. Processing of the projective identification is described as the recipient's ability to re-establish this dialectical process leading to meaningful symbol formation and understanding (Thorpe 1992).

Ogden defines analytic space as an intersubjective state, generated by client and therapist, in which meanings can be played with, considered and understood. The client undermines analytic space through the use of projective identification. This is a communication by means of a direct induction of a feeling state in the therapist that is not mediated by verbal symbols. As a result the therapist feels locked into a fixed position or sequence of affective states, and experiences these states as reality rather than subjective. The therapist undermines analytic space by presenting interventions that constitute 'statements of fact' rather than interpreting the symbolic meanings of the client.

Dialectics; Marsha Linehan and dialectical behaviour therapy

Marsha Linehan is professor of psychology and adjunct professor of psychiatry and behavioural sciences at the University of Washington. She is the founder of Dialectical Behaviour Therapy (DBT) and introduced the concept of dialectics to mainstream behavioural psychology in the USA. Clarkin (1997) suggests that DBT has spread around the world as fast as, and in the shadow of, managed care.

DBT has gained in popularity, funding and influence within New Zealand in the past 10 years in some District Health Boards (DHB) and a few university psychology departments. MHP and participating DHBs are funding DBT training for 70 mental health clinicians. Dr Elizabeth Simpson, a psychiatrist trained under Linehan and Director of the Massachusetts Mental Health Centre DBT programme, and Mike Batcheler, Auckland DHB DBT coordinator and NZ trainer, are facilitating the 14-day training, spread over two years. The aim is to develop a New Zealand based

training capacity associated with Behavioraltech, the training company established by Linehan (Batcheler 2006).

Linehan first employed DBT to treat suicidal individuals in the 1970's using traditional behavioural problem solving techniques such as skills training, exposure and contingency management (Linehan 1981, 2000). She quickly realized that treatment that was focused solely on *change* did not work. Most of the clients were extremely sensitive to criticism, prone to emotional dysregulation and efforts to change quickly led to increased and overwhelming arousal, resulting in them shutting down emotionally, storming out of sessions or attacking the therapist. The programme then dropped the emphasis on change and focused on listening to and sympathetically validating the clients' responses. They found that the clients then began to panic at the prospect that life would never improve. Clients interpreted this as the therapist ignoring their suffering or treating it as of little consequence (Lynch et al. 2006).

Linehan postulates that a therapeutic stance, either with an exclusive focus on change, or acceptance, is experienced as invalidating. Using the research of Swan (1992) she reasoned that if a client's basic self-constructs were not verified, their arousal increased which led to cognitive dysregulation and the failure to process new information. To work effectively and keep both client and therapist in the room working on the problems, she had to figure out how to hold both acceptance and change in the therapy simultaneously. The wish to change painful experience had to be balanced with a corresponding effort at learning to accept Life's inevitable pain. This synthesis could engender both change and new acceptance.

The dialectical balance that the therapist strives for is to validate the essential wisdom of each client's experiences (especially vulnerability and the sense of desperation) and to teach the client the required skills for change to occur. In common language this sounds like "I accept you as you are, and you need to change".

The dialectic between acceptance and change became a fundamental principle in DBT, and led to the use of the term dialectical as a descriptor for the standard behaviour therapy used in the treatment.

Linehan points out that most theorists are aware of dialectics through the socioeconomic theory of Marx and Engels. Although extending back over thousands of years, Hegel is generally credited with reviving and elaborating the philosophy of dialectics. Hegel discerned that specific forms of arguments come and go in a complex interplay, with each argument creating its own contradiction, and each contradiction in turn being negated by a synthesis that often includes or enlarges upon both preceding arguments, beginning the entire process anew. In her review of the history of dialectics, Linehan quotes Wells (1972) who has documented a shift toward dialectical approaches in most social and natural science during the last 150 years.

According to Linehan, dialectical observations that most influence the practice of DBT are:

The whole is a relation of differing parts that hold no independent significance.

The whole is more than the sum of its parts.

Parts and wholes are interrelated (and defined in relation to one another).

Change is an aspect of all systems, and is present at all levels of any given system.

Some of the favourite DBT sayings are; a) opposing events or statements are highly dependent upon each other for existence and resolvable at further levels of abstraction or across time, b) life is both intensely meaningful, and painfully meaningless, c) clients intensely desire change and are often highly fearful of failing or making the attempt, d) changing is both hopeful and terrifying.

A example of a common dialectic heard in a treatment team is clinician A saying, "This is a lovely client, who has suffered terribly and we ought to go out of our way to help her", and clinician B replying "She is nasty, manipulative and sabotages treatment – discharge, don't indulge". Simpson teaches that the ability to flush out the hidden conflict and look at the unwanted polarity requires a passion and ease with anger. In one of her workshops she facilitated a role-play of a residential team debating adolescent male's suspected misdemeanour in a treatment setting. She tried to get a good argument/split/dialectic going between the group members and finally made a strategic retreat by saying "You New Zealanders are such *nice* people".

Simpson maintains that it takes about five years of stable team membership to develop the quality of "radical genuineness" and "irreverence" (2 favourite DBT terms) to work clinically with dialectics. Back in my DHB adult mental health team I did a quick survey of staff retention. I was not surprised to learn that I was the only person who had been in the team for more than six months. Staff turnover is endemic in the New Zealand health system leading to fragmentation and unstable group dynamics. Similarly, managers have short half-lives and are often 'upwardly bullied' and 'scamper off' to greener dialectics across the fence.

Linehan employs the image of a see-saw to explain the concept of dialectics in the treatment of suicidal clients. Therapist and client are on opposite ends of the see-saw connected by the board. Therapy is the process of going up and down, each participant sliding back and forth trying to balance it so that they can get to the middle together and climb up to a higher level. The higher level, representing growth and development, can be thought of as a synthesis of the preceding level. Dialectically speaking, the ends of the see-saw represent the opposites (thesis and antithesis) and moving to the middle and up to the next level represents the integration or synthesis of these opposites, which immediately dissolves into opposites once again.

In psychotherapy the client continually moves back and forth on the see-saw and the therapist moves accordingly, trying to counterbalance. Linehan shows that the difficulty in treating a suicidal BPD client is that instead of being on a see-saw, therapy takes place on a bamboo pole perched precariously on a high wire stretched over the Grand Canyon. When the client moves backwards on the pole, the therapist moves backward to gain balance, and the client moves back again to regain balance. Because the pole is not infinitely long the therapy is in danger of falling into the canyon. Thus the task of the therapist is not only to maintain balance, but also to maintain it in such a way that both therapist and client move toward the middle rather than back off the ends of the pole. This is often counterintuitive for the therapist.

One of the techniques advocated by Linehan to deal with this type of dialectic is called “irreverent communication”. This is an ‘offbeat,’ ‘unorthodox style’ that provokes the client, pushes them off balance so that rebalancing can occur. It is designed a) to get the client’s attention, b) to shift the affective response, and c) to get the client to see a completely different point of view. For example if the client says “I am going to kill myself” the therapist may respond with “I thought you agreed not to drop out of therapy”. Another of Linehan’s examples is of a client who kept failing to keep her job. She tried to convince Linehan that the stress of such constant failure was reason enough to kill herself. She also implied that Linehan did not understand or appreciate how stressful it was, since Linehan was obviously a successful professional. In the middle of a highly intense and emotional discussion, Linehan calmly, irreverently, and matter-of-factly said “Oh! But I do understand. I have to live with a similar amount of stress much of the time. You can just imagine how stressful it is for me to have a client constantly threatening to kill herself. Both of us have to worry about being fired!” Linehan states that used judiciously, irreverent reframing facilitates problem solving and at the same time does not reinforce suicidal behaviour. Linehan’s books, and trainers, continuously reinforce the idea that therapists need to be mindful of what behaviour they are reinforcing (see Pryor 1999).

Linehan maintains that a dialectical point of view is compatible with psychoanalytic theory, in that both stress the inherent role of conflict and opposition in the process of growth and change. But how would someone conceptualize and deal with the suicidal threat discussed above from a psychoanalytic perspective? Authors such as Maltzberger and Buie (1974) would formulate the interaction as one of the client placing, via projective identification, unbearable feelings of rage and hopelessness into the therapist for safe keeping. Psychodynamically the task of the therapist is to initially adhere to the old adage, ‘don’t just do something, sit there’ and then to identify, contain and process the feelings and give them back in a more manageable form (Thorpe 1989). If, for whatever reason, the therapist is unable to do this, the feelings are prematurely re-projected, usually with greater anxiety attached, for example, by ‘unthinkingly’ and hastily calling the crisis team.

Mindfulness

Mindfulness is a core skill in the DBT 'tool bag' and is taught at the beginning of each group skills training session. It is a recent psychological version of meditation derived from the Zen Buddhist tradition, although Linehan is quick to point out similarities in Christian and other contemplative practices.

Linehan (1973 a & b) uses Kabat-Zinn's (2003) definition of mindfulness as a means of non-judgementally and purposefully paying attention in the present moment. The aim is to teach the clients to take control of their minds and be in the present moment instead of straying off into the past and future concerns and distractions. This is achieved through various exercises such as observing, describing, participating without self-consciousness, focussing on one thing at a time, and focus on outcome rather than principle. Mindfulness is the opposite of being on automatic pilot, participating in life without awareness and engaging in impulsive and mood dependent behaviours.

Linehan describes three primary states of mind; a) Reasonable Mind - the ability to think thinking rationally and intellectually, b) Emotion Mind - the influence of emotions on behaviour, and c) Wise Mind, which is a dialectical synthesis of the first two, giving rise to a form of intuitive holistic experience.

Mindfulness has recently become a 'hot' topic in psychology and there are large groups of CBT clinicians in New Zealand linked to email discussion groups and doing weeklong Zen-like retreats. A related book that is appearing on many clinicians' bookcases is Teasdale, Williams and Segal's *Mindfulness-Based Cognitive Therapy for Depression* (2002). This therapy prevents relapse in clients with highly recurrent depression by combining mindfulness medication with CBT. Using insight (rather than concentration) meditation the client lets their mind wander freely, and adopts a non-judgmental attitude towards the kaleidoscopic flow of mental contents and states. This entails turning one's attention towards, rather than away from, distressing thoughts and feelings, then observing changes in the distressing and depressing thoughts and feelings.

Teasdale writes that this approach does not aim to change the *content* of thoughts, as a good CBT therapist would, but rather to change the *experience* of mental states. Clients are taught that emotional disturbance is caused by thoughts and cognitions that are *mental events*, not *realities*. Research indicates that it is the client's relationship to their negative thoughts and feelings that is the curative aspect. Rather than becoming mired in depressive rumination, clients are able to let their depressing thoughts pass through, to construe them as mental processes rather than reflecting the absolute truth. Being aware of their mental state they can temporarily feel bad without succumbing to depression. The result is being less prone to relapse.

Reflective consciousness; Russell Meares - the conversational model

Russell Meares, Professor of Psychiatry at Sydney University and Director of Psychiatry at Westmead Hospital, has developed a psychotherapy unit specializing in the treatment of personality disorders. Meares used to regularly visit New Zealand. He was the keynote speaker at the 2003 NZAP and 2003 Personality Disorders conference.

Meares (1999, 2003) describes how the behavioural purge following the First World War decimated interest and research into issues such as the self, inner processes and consciousness in psychology. To repair this gap Meares returned to earlier philosophers and psychologists. Collaborating with a London Jungian, Robert Hobson (1971), using concepts such as amplification and imagination, Meares developed the Conversational Model. The relationship is seen as the transformative aspect of therapy rather than the more traditional psychoanalytic view that places interpretation as central. Using Heuling Jackson's work of the 'double self', Meares stresses the mutative value of *reflective consciousness*. Reflective consciousness leads to the development of a strong sense of self, which mitigates and protects against the ravages of PTSD. Dipping into recent neurophysiology, Meares points out how the orbito-frontal cortex is the area in which consciousness and intentionality arise. Any assault on the system may result in an inability to integrate memories and assimilate new experiences.

Meares relates the story a journalist who survived years in solitary confinement without the expected ravages of PTSD by continuously telling himself stories. The stories preserved his sense of self, which bolstered him against PTSD. Similarly, Victor Frankl (1963) in his classic book "Man's Search for Meaning", claims that he survived the concentration camp through meaningfully writing his book on Logotherapy.

The aim of psychotherapy, according to Meares, is to facilitate the emergence of dualistic-reflective consciousness. This replaces a constricted and static mode of being with a sense of liveliness.

I listened with a somewhat critical ear when attending one of Meares' one-day workshops. His ideas seemed like plagiarised existential-phenomenological and psychoanalytic concepts. However, my scepticism melted by the end of the day when I found myself in the most wonderful comforting reverie. Meares' presence and style of presentation opened a creative and therapeutic space for me. The feeling, which imperceptibly took hold of me, was as reminiscent of being spirited away by a piece of inspirational music - somewhat bewitching and mesmerizing - like being in a good therapy session.

Meares previously facilitated a three-year training in the conversational model for a group of South Island therapists. DHB clinicians found that one of the difficulties

was that the training was not in manual form, which made it difficult to train generic case managers without psychotherapy backgrounds. A few DHB clinicians then met Anthony Bateman and Peter Fonagy at an international conference and concluded that the Mentalization Based Treatment (MBT) was a useful extension of Meares' approach. The Christchurch group, particularly the DHB based clinicians, seem to have moved towards the MBT approach and made it the theme of the 2006 National Personality Disorders Conference.

Mentalization; Anthony Bateman and Peter Fonagy

Anthony Bateman is Clinical Head and Research Head of Psychotherapy Services, St Ann's Hospital, North London and Honorary Senior Lecturer at the Royal Free and University College Medical School, London. Peter Fonagy is Professor of Psychoanalysis at London University and Chief Executive of the Anna Freud Centre. Bateman and Fonagy, were the keynote speakers and facilitate a three day workshop at the 2006 Personality Disorders Conference in Christchurch.

The term *mentalization* entered the literature in 1977 although Bateman and Fonagy (2004) argue that it has been part of psychoanalytic thinking since its inception. Fonagy and Target started publishing in 1991 when they discussed the deficits in mentalization, which resulted from trauma and severe character disturbance (Fonagy and Target 1997). Holmes (2006) points out that 'mentalization' has not yet appeared in either Pontalis (1973) or Rycroft's (1982) psychoanalytic thesauruses. The term is also a relatively new addition to the New Zealand therapeutic vocabulary and was discussed by Stuart Twemlow in Auckland 2000 (Bolton 2001). Jeremy Holmes' three seminars (Auckland June 2006) and the visits of Bateman, Fonagy and Allen (September 2006) have sparked a significant interest in mentalization.

Bateman and Fonagy (2004) define mentalization simply as the ability to comprehend and use knowledge of one's own and other's states of mind. It is the capacity to grasp the mental states underlying human behaviour and to think about mental states as separate from, but potentially causing actions. Holmes (2006) sees four inter-related aspects of mentalization: a) a 'meta-cognitive' phenomenon which refers to the capacity to think about thinking, b) the meanings we attribute to our own and other's actions, c) intentionality towards projects, desires and wishes, and d) a process.

The exercise of mentalization promotes a number of critical developmental achievements, a) the sense of agency or ownership of one's own behaviour, b) the capacity for social reciprocity and empathy, c) the ability to regulate one's affects, d) to tolerate frustration and to set one's own goals and ideals, and e) the capacity to symbolize (Green 2005)

Mentalization is an activity related to persons not objects. When engineers theorize about the structure of materials they are engaged in sophisticated mental activity,

but they are not mentalizing. Similarly when we treat people like objects, we cease to mentalize.

Mentalization is similar to, but differentiated from, concepts such as empathy, insight, observing ego, potential space, reflectiveness, and psychological mindedness. Jon Allen (2005) states;

In some way or other, you have been using the concept of mentalizing to think about your clinical work all along, not to mention the fact that you have been a full-fledged mentalizer since your early childhood. You are mentalizing whenever you are making sense of what goes on in your mind-your own mind and the mind of the other person. Thus you mentalize when you do psychotherapy (p 1).

Bateman and Fonagy (2004) see mentalization as a specific form of symbolic function that is central to psychoanalytic and attachment theory, and appeared concurrently in both arenas. In linking attachment with mentalization, he shows how it is critical for the mother to mentally 'contain' the baby and respond in a manner that shows awareness of the child's mental state yet reflect coping. Thus if secure attachment is the product of successful containment, insecure attachment may be seen as the infants identification with the caregiver's defensive behaviour. A number of empirical findings show that attachment security is a good predictor of metacognitive capacity in the domains of memory, comprehension and communication.

Secure attachment provides a relatively firm base for the acquisition of a full understanding of minds. The secure infant feels safe in thinking about the mental state of the caregiver. By contrast, the avoidant child shuns the mental state of the other, while the resistant child focuses on its own state of distress to the exclusion of intersubjective exchanges. Disorganized infants may represent a separate category; hypervigilant to the caregiver's behaviour, they may appear to be acutely sensitive to the caregiver's mental state yet fail to generalize this to their own mental state.

Fonagy shows how victims of childhood sexual abuse cope by refusing to conceive of their attachment figure's thoughts. By recognizing the hatred or murderousness implied by the parent's acts of abuse the child is forced to see him/herself as worthless or unlovable. They thereby avoid having to think about their caregiver's wish to harm them. This disrupts their capacity to depict mental states in themselves and in others and leaves them to operate on inaccurate, schematic impressions of thoughts and feelings. A vicious cycle develops in which the psychological isolation of maltreatment amplifies distress, activating the attachment system. Mental proximity becomes unbearably painful, and the need for closeness is expressed at a physical level. The child paradoxically may be driven physically closer to the abuser. Their ability to adapt to, modify or avoid the perpetrator's behaviour is likely to be further constrained by limited mentalizing skills.

A pervasive lack of consideration for the child's intentionality may have functional and neuro-developmental consequences. Neglect and maltreatment during the first few years of life have been shown to manifest a significant loss of cortical function in the fronto-temporal areas - the areas involved with inferring mental states. Researchers such as Arnsten (1998) in his paper *The Biology of Being Frazzled* shows how a neurobiological switch is from the pre-frontal cortex to the activation of the posterior-limbic system takes place.

Bateman and Fonagy (2004) point out that 'wise mind' in DBT is phenomenologically similar to mentalization. However, while DBT conceptualises wise mind as a teachable skill, mentalization is seen as a developmental psychological process. Acquisition of mentalization mostly takes place outside consciousness through the presentation to an individual of a view of their internal world, which is stable, coherent, clearly perceived and adopted as the reflective part of their self. This gives rise to three therapeutic guiding principles in mentalization; a) to establish a continuous attachment relationship with the client, b) to create an interpersonal context in which understanding of mental states is a focus, and, c) to create (mostly implicitly) a situation in which understanding the client's self as intentional and real is a priority and to ensure that this endeavour and aim is clearly perceived by the client.

Conclusion

Psychotherapy styles practiced in New Zealand appear to have widely divergent theoretical, philosophical and therapeutic worldviews. This results in considerable envious and competitive sniping between different groups. However, it is suggested that concepts such as potential space, symbolism, dialectics, mindfulness, reflective function and mentalization share a common ground phenomenologically and clinically. This paper briefly reviewed these concepts as presented within their respective theories. In order to avoid a forced and premature synthesis, the concepts were left to speak and dialogue for themselves. Time will tell whether the common ground will draw together previously conflicting and discordant groups of clinicians. By employing the mutative function, inherent in the concepts themselves, a dialectical process may be set in motion giving rise to an integration, followed by new dialectical oppositions and dynamic tensions.

References

- Allen, J.G. (2005). *Mentalizing*. Unpublished paper.
- Arnsten, A.F.T. (1998). The biology of being frazzled. *Science*, 280, 1711-1712.
- Batcheler, M. (2006 August). Personal communication.

- Bateman, A.W. & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: mentalization-based treatment*. New York: Oxford University Press.
- Bolton, K.M. (2001) Review of Aetiology of Violence, Dr Stuart Twemlow. *Sidelines – AFCP Newsletter*. <http://www.psychotherapy.co.nz/ReviewofAetiologyofViolence.htm>
- Clarkin, J.F. (1997). La Personalita' e I disturbi personalita' Onstituto di Clinica Psichiatrica Translated into Italian by Paulo Migone. *Personality and the Disorders of Personality*. 3 day intensive course at the University of Parma.
- Fonagy, P., and Target, M. (1997). Attachment and reflective function: Their role in self-organisation. *Development and Psychopathology*, 9, 679-700.
- Frankl, V.E. (1963). *Man's search for meaning: an introduction to Logo therapy*. Oxford: Washington Square Press.
- Green, R. (2005). The Gathering. http://www.cdhb.govt.nz/conference/mindsinthe_making/documents/Gathering2006.PDF. Retrived 12/2/2006.
- Hobson, R.F. (1971). *Imagination and Amplification in psychotherapy*. *Journal of Analytical Psychiatry*. 16, 79-105.
- Kabat-Zinn, J. (2003). Mindfulness-based stress reduction (MBSR). *Constructivism in the Human Sciences*, 8(2) 73-107.
- Linehan, M.M. (1993a) *Skills Training Manual for Treating Borderline Personality Disorder*. Gilford: New York.
- Linehan, M.M. (1993b). *Cognitive-Behavioural Treatment of Borderline Personality Disorder*. Gilford: New York.
- Linehan, M.M., Rizvi, S.L., Shaw Walch, S, & Page, B. (2000). Psychiatric Aspects of Suicide. In K. Hawthorn & K. van Heeringen (Eds), *International handbook of suicide and attempted suicide*. Sussex, England: John Wiley & sons, 147-178.
- Lynch, T.R., Chapman, A.L., Rosenthal, Z.M, Linehan, M & Kuo, J.K. (2006). Mechanisms of change in Dialectical Behaviour Therapy: Theoretical and Empirical Observations. *Journal of Clinical Psychology*: 62(4), 459-480.
- Maltsberger J.T., & Buie. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry*. 30, 625-633.
- Meares, R (2003). Hughling Jackson's contribution to an understanding of dissociation. *American Journal of Psychiatry*. 156 (12) 1850-1855.
- Meares, R (2003). One-day workshop. The Gathering: Christchurch
- Ogden, T.H. (1979). On projective identification. *The International Journal of Psycho-Analysis*, 60 (3) 357-373.
- Ogden, T.H. (1985). On potential space. *The International Journal of Psycho-Analysis* 66 (2), pp. 129-141.

- Ogden, T. (1986). *The Matrix of the Mind. Object Relations in the Psychoanalytic Dialogue*, Northvale: Jason Aronson.
- Ogden, T.H. (2001). Reading Winnicott. *The Psychoanalytic Quarterly*, 70 (2), 299-323.
- Ogden, T.H. (2004). This art of psychoanalysis. Dreaming undreamt dreams and interrupted cries. *The International Journal of Psycho-Analysis*, August (85) 4857-4877.
- Ogden, T.H. (2004). The analytic third: implications for psychoanalytic theory and technique. *The Psychoanalytic Quarterly*. 73 (1) 167-195.
- Pryor, K. (1999). *Don't shoot the dog. The new art of teaching and training*. New York: Bantam books.
- Segal, Z.V., Williams, J.M.G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
- Swann, W.B. Jr., Stein-Seroussi, A., and Giesler, R.B. (1972). Why people self-verify. *Journal of Personality and Social Psychology*. 62, 392-401.
- Thorpe, M.R. (1989). *A Phenomenological investigation into the psychotherapist's experience of identifying, containing and processing the patient's projective identifications*. Thesis submitted in partial fulfilment of Ph.D. Rhodes University.
- Thorpe, M.R. (1992). Language and the process of change in psychotherapy. *Melanie Klein and Object Relations*. 10(2), 52-68.
- Wells, H.K. (1972). Alienation and dialectical logic. *Kansas Journal of Sociology*. 3, 7-32. Quoted in Robins et.al. (2004).
- Winnicott, D.W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psycho-Analysis*. 34 (2) 89-97.
- Winnicott, D.W. (1967a). The location of cultural experience. *The International Journal of Psycho-Analysis*, 48 (3), 368-372.
- Winnicott, D.W. (1967b). The capacity to be alone. *The International Journal of Psycho-Analysis*, 39(5),416-420.