Starting the Long Conversation:

Learning Strategies and Notes

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Background and Introduction

These notes accompany two films (available on DVD within NSW Psychiatry Training Networks or from HETI) and an audio tape of an interview (available for download from HETI). The first film shows a 50 minute (acted) assessment of a woman, "Anna Schofield" with chronic symptoms presenting for an assessment for psychodynamic psychotherapy with "Joan", a psychiatrist psychotherapist. The second film records a discussion of the assessment by an expert panel. The audio "session" demonstrates a different level of difficulty, showing an assessment with a "patient" with more dissociation.

The purpose of the filmed assessment is to show the way an assessment for psychotherapy can be done empathically, by engaging with the patient, gathering information in a way that continues and deepens that engagement of an initial therapeutic alliance into a safe therapeutic relationship, and overall begins the long conversation of a psychodynamic psychotherapy. The filmed discussion by the Panel then aims to tease out aspects of the assessment with particular reference to the Conversational Model, a contemporary relational model of psychodynamic psychotherapy. The audio, "Hard to talk: a patient with dissociation", (a generous bonus outcome from the rehearsal period for the film) represents a more difficult kind of interview with a more dissociative "patient", in order to consider the challenges this brings to interview technique, information-gathering and formation of the therapeutic relationship.

These films and audio are aimed at the trainee psychiatrist or psychotherapist who may be still grappling with shifting between styles of interviewing relevant to context and currently needs to consider how an assessment interview for psychotherapy, and an interview of a patient with a personality disorder, might differ from other assessments. This knowledge could then underpin further development of these assessment skills and is particularly relevant for those considering beginning a psychotherapy case, or moving beyond the first

stages of training. As complexity of clinical tasks increase, assessed in due course in clinical exams, a more sophisticated and flexible interviewing technique must be acquired to engage and assess patients with more difficult or complex presentations. You can view this film and the accompanying panel discussion in a number of ways to foster your learning. However two methods are suggested below, with offered frameworks for discussion, followed by some further notes on basic concepts and attached references.

In this film a particular model of therapy known as the Conversational Model was chosen as it is a contemporary model that has an evidence base for the successful treatment of Borderline Personality Disorder (Stevenson and Meares, 1992; Stevenson et al, 2005) and is useful for other consequences of chronic complex (i.e relational) trauma. It articulates a fine-grained set of techniques that foster empathic engagement. It was developed in collaboration between Russell Meares from Australia and his UK colleague Robert Hobson and then further developed by a team of psychotherapists trained in the Westmead Psychotherapy Program. Other outgrowths of the model can be seen in Else Guthrie's work with emergency department presentations and somatic presentations (see Guthrie et al, 2001).

The model explicitly focuses on the therapeutic relationship and the thoughtful use of language by the therapist to further this relationship and the therapy goals. As a long-term psychodynamic psychotherapy it aims to help a patient expand their sense of self and integrate traumatic aspects of experience. The therapeutic relationship is fundamental to this task. Within the connecting therapeutic relationship many hours of conversation take place. Over time both parties work to listen and understand the patient's experience and the shared experience of the conversations with a view to meeting the above goals of expansion, a developing capacity for self-reflection or reflective awareness, and integration. In order to do this many links are made together over time between aspects of the patient's past and present experience, including what happens in the therapy in "the here and now" between patient and therapist. Over time, through meeting and talking together, a capacity to reflect is fostered. This process begins in the assessment, which is the first of many conversations, the start of the long unfolding conversation. The recent publication of a clinician's guide to using this model provides a readily available resource which will be utilised below: *Borderline Personality Disorder and the Conversational Model: A Clinician's Manual* (Meares et al, 2012). A recent resource published by HETI is also used: *The Complete Clinical Assessment in Psychiatry,* edited by Phillips et al, and available from the HETI website

(http://www.heti.nsw.gov.au/Global/HETI-Resources/psychiatry/TheComplete Clinical Assessment in Psychiatry.pdf) and a copy should be available in every Training Network in NSW. Other relevant resources such as the RANZCP College website (http://www.ranzcp.org) and relevant articles or publications will also be cited.

Suggested strategies for using this resource:

A. Viewing the films with suggested discussion/reflection points

The use of this resource will require the dedication of a few hours of time, to:

1. View the film

2. Reflect on it, alone or in a group

3. View and reflect on the Panel's discussion of the film

4. Read and reflect on the suggested references.

5. Take relevant issues to supervision and trial new practices in your interviewing

NB: Consider gaining supervisor and patient permission to tape your interviews so that reflection and feedback are based on authentic interactions.

6. Consider reiteration and revision of parts of the above process to consolidate your learning

The above process will be helped by personal or group reflection. Take time to discuss or write down your initial responses and, along with other issues that might come up, consider the following aspects. Some can be saved for later consideration and some may serve as a springboard for other learning:

a) The way Anna presents herself and her story, particularly noting her language and other aspects of her Mental State Examination and her history

b) The way Anna and the interaction makes you feel and how this shifts during the interview.

c) How would you summarise why Anna has presented for treatment at this time?

d) How was this information obtained? What kind of techniques and language are used?

e) How does the process of information-gathering and the kind of information obtained differ from a psychiatric assessment done in other settings? What are the tensions that must be negotiated?

g) Are aspects of this style of interviewing relevant to other settings: eg the interview of a patient in crisis in the Emergency Department or in distress or disturbance on a hospital ward?

h) Reflect on how you might have conducted such an interview previously and what you might now seek to change

i) Reflect on the centrality of the therapeutic relationship to this and all psychiatric and clinical encounters. Those doing the Competencies Based Fellowship Program should review the EPA on the Therapeutic Alliance at this point (http://www.ranzcp.org) and plan some Workplace Based Assessments with their supervisors. Audio-taped or video-taped assessments are an excellent basis for a WBA. For those in more advanced stages of training, reflect on the likely vicissitudes of the therapeutic alliance in a therapy with "Anna" and what that might require.

j) Does the Panel Discussion raise issues that you feel you need to understand more about? Do you now need to read further and consider how the information gathered on technique can be incorporated into your own practice?

k) Reconsider your initial formulation of Anna's current presentation.

m) Review the current literature on treatment of BPD. Many treatments are now available and have established efficacy and the previous notions of this diagnosis as being "unanalysable" or "untreatable" are no longer tenable in general (although as per all diagnoses some patients have "treatment-resistant" disorders). Reflect on the barriers of stigma and a shared culture of therapeutic nihilism.

n) What role might the strong feelings generated by these patients (countertransference) and the trauma they have experienced have played in the generation of these clinical attitudes? Are there times when our health services are themselves "traumatized" and less coherent?

o) Take the time to become familiar with ASCA's Practice Guidelines *for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (http://www.asca.org.au).

This group, representing consumers who have survived child abuse, commissioned the production of guidelines for the treatment of consumers with a chronic complex trauma background. One set informs the individual clinician's care and another informs services.

B. Using the assessment film as a stimulus for sessions based on *The Complete Clinical Assessment in Psychiatry*

Another strategy for using the film is to use it as the clinical stimulus for learning sessions based around *The Complete Clinical Assessment in Psychiatry* (Phillips et al, 2012). This work offers a substantial frame for teaching and learning sessions. Appropriate sessions would include those on psychiatric assessment and interviewing (Sessions 1-2), phenomenology (Session 6, here with a focus on personality, trauma, anxiety and depression), mental state examination (Sessions 7-9), personality style (Sessions 9-10), reflective interview skills (Sessions 12-13), the therapeutic alliance (Session 14), formulation (Sessions 15-16) and psychodynamic formulation (Sessions 18-19).

These would be ideally done in a group setting facilitated by a senior clinician or educator, but study on your own would still yield many useful questions that could be taken to supervision.

Summary of the participants' approaches to the interview.

The Patient: Anna Schofield, aged 43, has obviously struggled with finding balance and stability in her life since her teenage years (although underlying difficulties may well have been present before). She has been unable to form and maintain lasting close and satisfying relationships and to find and hold down meaningful employment. Over the years Anna has had several contacts with medical professionals to try to sort out her life but with little lasting success. Someone in her support group has mentioned therapy and Anna has approached her GP for a referral. Nevertheless, Anna is ambivalent about the whole thing. On one level she hopes desperately that something will come of it this time. However, her whole life's experience has conditioned her to believe that this doctor like all the others is probably unable or unwilling to help her. Anna may expect the doctor to act 'clinically', to ask searching questions, write down her answers and then come up with some kind of solution to her situation.

The ambivalence and incoherence Anna demonstrates are very common in Borderline Personality Disorder (BPD) and certain other personality disorders.

The Therapist: The doctor's approach is to run an assessment and suggest some follow up meetings. Instead of the "clinical approach", that Anna may have expected, the doctor takes a more gentle approach and encourages Anna to open up. The doctor acknowledges that she is following what Anna says, tries to not critique or judge her, and yet nudges her forward in an overall attempt to build real rapport and deepen the conversation. Throughout the interview the therapist attempts to make use of opportunities as they become available, *picking up significant verbal or non-verbal information, reflecting, clarifying, acknowledging, amplifying* and *representing* what Anna says. In clinical terms, the doctor's approach will be one of *empathic resonance, understanding and validation*. Nevertheless Joan attempts to resist being drawn immediately into the attachment-dependency dyadic system, e.g by repeating, "..we will work together..", in order to keep a collaborative stance rather than an 'idealized' one of solving it for Anna. However this collaborative stance is reparative and "new" rather than dismissive or defensive.

This approach by the doctor is in line with principles of the Conversational Model including, "staying with what is given" which refers to staying as close as possible to the themes and the actual words/gestures of what the patient brings, so that the connection to the patient in the moment, "the here and now", is optimised. Two chapters in the *Clinician's Guide* (Meares et al, 2012) are particularly relevant here: Chapter 6, 'General Principles of the Conversational Model' and the section in Chapter 7 on 'Establishing the therapeutic relationship'. These chapters refer to issues discussed by the Panel and a reading of them will guide your understanding of the particular techniques of listening, fostering connection through attunement and language use that the Model suggests. Articles are also readily available from the ANZAP website (Australian and New Zealand Association of Psychotherapy) on the Model and its techniques: http://www.anzapweb.com. These techniques will help with interviewing "difficult" patients, particularly those in distress and with disorders of self, but are techniques that generalize well to general psychiatry and help foster the therapeutic alliance (McLean, 2011).

In line with the principles of the Model, the therapist's focus is on taking care of Anna's sensitivities and, as much as possible, on making her feel safe, understood and *valued.* This assessment session is simply the first of what is hoped to be a long series of more and more

productive interactions leading to a gradual process of connection, personal and shared insight, and an emergent confidence and coherence.

The arc of the interview

1. Developing rapport

At the beginning Joan consciously creates an atmosphere where Anna will begin to feel safe enough to talk about her problems. Though it is a difficult process, Joan more or less successfully gets onto her wave length. This first section is an important platform for the rest of the interaction. Anna feels safe enough and valued enough to tell her story.

2. Exploring relatedness with significant others and listening to the general history

Joan teases out the story relationships with family and others. Joan wants to know whether Anna has at least one other person to whom she has felt close to and continues to feel close to. In this case, it turns out to be Anna's sister Jen, who has been a mother figure for Anna. This intimacy is often lacking in the lives of people with BPD as carers and people in their lives have not proved stable. Joan listens attentively to Anna's narrative and how she relates it. She notices the ambivalence, the hesitancy and the shifts in her affect.

3. Exploring the ability to cope with difficulties

Joan tries to elicit how Anna has coped previously in difficult situations. She looks out for any conscious and unconscious coping mechanisms that Anna uses to help maintain equilibrium within herself and the family e.g to stop her mother from interfering further; to prevent any possible aggression developing etc. Because there is sufficient connection with Joan, she begins to talk more deeply about her past.

4. Developing a shared understanding

In the preceding parts of the interview, Joan has built an understanding of Anna, her symptoms, her story, her relationships, her resources and her coping mechanisms. Now Joan gives Anna some brief feedback on what she has heard and seen, to offer a shared understanding of how things have come to be the way they are. This is a collaborative attempt at an initial *formulation* and serves to show that Joan and Anna are moving onto "same page."

Joan acts on the assumption that they will both meet again, arranges the next appointment and then they say goodbye. This last part of the interview seems to provoke some anxiety for Anna who seems to be worried that she won't be seen again. Joan reassures her, but is also firm, outlining a *frame*, which will be a framework for their meetings and the interview closes pretty much on time.

Differences in other assessment interviews with patients with BPD

As the Panel point out, this interview has a particular quality due to the anxiety and dependence that Anna displays. She is less forthcoming about her daily life and in another interview the interviewer might come away with a greater sense of how the patient was living day-to-day. The emptiness of Anna's account of her life leads to Joan exploring more of the past than might be common, but in this setting Anna seems to respond to this. Also some interviews may have more covert or overt hostility. This needs patience and practice to manage this thoughtfully and without "reaction".

In some interviews dissociation is so extreme for some patients that information-gathering and rapport-building are very difficult. Take the time to listen to the audio of a second "version" of Anna called "Hard to talk: a patient with dissociation", available on the HETI website, who is much more dissociative and note the limits this places on aspects of the interview. In other settings such as a busy Emergency Department, although the goals may be seemingly "modest" (eg leaving a patient less distressed or dissociated than we found them while achieving a plan on how to move forward safely), the process of empathic and non-reactive therapeutic engagement is crucial to trauma-informed care and ultimately makes the work more effective and satisfying for patient and clinician alike.

Anna's state of mind and mode of interaction: observations and origins

Anna presents herself in a way that is one kind of Borderline Personality Disorder (BPD) presentation. The general tone is one of anxious dependence with distress, sadness and some irritability. She alternates between vagueness and clarity and shifts between giving eye contact and looking down at the floor and agitatedly grasping her handbag. As the interview moves along we then get some genuine smiles and at times see a little settling in her body and speech.

When Anna tells her story, she often does so quickly, but vaguely and with ambivalence and a child-like quality.

How might this ambivalence and incoherence have come about?

Modern attachment theory and developmental neuroscience has helped us to understand that human beings develop cognitively, emotionally and socially in relationships. They form their coping strategies initially within the context of repeated interactions with care-givers. Anna's mother had post-natal depressions. A mother with repeated post-natal depression often has a diminished capacity to look after and bond with a child, let alone two. An infant needs to have a mother's eyes and a natural smile reflect her love of the infant i.e. the infant needs to discover him or herself in the eyes of the mother. However in cases of depressed mothers, the infant is unable to meet the mother's eyes, because of the inherent lack of interest or recognition that the infant will find there and the gaze is avoidant or unfocussed. Infants are born hardwired to attach – but if there is no readiness from the mother to attach, the infant has to look elsewhere – a grandparent, father, or sibling or other care-giver.

In addition, the mother if unable to attend to a child's basic needs may be leaving the child poorly regulated, i.e. unable to deal with discomfort, irritability, hunger, pain and the like – as a result of not being soothed when soothing is required, not being comforted or offered security when the child is fearful or in discomfort. This chronic state of affairs is what we term emotional neglect. If no satisfactory attachment figure is available, the infant/child can grow emotionally insecure; if the attachment figure is inconsistent, available only sometimes, and not at other times of vital necessity, one outcome is that the child grows up ambivalently, uncertain of themselves and untrusting of the environment, uncertain about trusting/not trusting relationships, including the therapeutic relationship should they seek therapy. The reason for this lack of trust in the therapist is because the experience of the first basic relationship is one of anxious mistrust – this is etched into the neural circuits as a representation, a schema, an internal representation of what early significant relationships mean. Hence to trust anyone would of itself be dangerous – so the patient may start by attaching no importance to the therapist, but at the same time have a longing to be listened to and acknowledged: they show ambivalence. This kind of mental state can be underpinned by a real sense of fear and a disorganized state of mind (see the table Attachment States of Mind (McLean) on p238 of *Complete Clinical Assessment* (Phillips et al, 2012), but organizes often into a preoccupied/ambivalent state of mind as the primary presentation (see the right hand

box in the table). For further discussion of attachment review the chapters by McLean (2012a) in the *Complete Clinical Assessment* and Haliburn (2013) on traumatic attachment. An online module on anxiety and attachment (McLean, (2012b) is also available and take the opportunity to refer to seminal works by Bowlby (1979; 1980) and the modern integration of theory and research with reference to psychotherapy in Wallin (2007).

Some further aspects of ambivalence

Examples of ambivalence may be:

"I don't know if you can be of help" and then go on telling the story.

"I've seen a number of therapists since I was 18 – nothing helped".

"Not sure .....(very quietly and turning eyes and gaze down) if anyone wants to help....."

"No one seems to care" then goes on relating problems as if she wants the therapist to care.

Body posture might show this mixture of guarding, e.g. a tense/protective posture at the beginning with gaze often avoidant but as the patient relaxes into the interview, their eyes might flit up and seek engagement and linger more. Their body will shift to show more relaxation, less tension and some encouraging little signs of liveliness by the interview's end: e.g., a natural smile, a little natural hand gesture, rather than the tight clenching or wringing.

Anna gives her history in a less than straightforward manner, as BPD patients generally do – with changing mood, and hesitancy, as if checking to see what Joan thinks of her, whether she can be trusted with the story. However she becomes more engaged when the doctor is empathic and responsive and "tunes in" to her.

Her emotional response is changeable: sometimes really desperate, other times indifferent, or dependent. This erratic affect and relatedness indicates her underlying disorganization and incoherence-an instability which is typical of a patient with moderate-severe BPD. Her dependence will signal to Joan that she feels that she wants help, but her ambivalence will let Joan know that there may well be some tumultuous times ahead in the therapy as this deep ambivalence about self and other is played out in the *transference-countertransference.*

Anna demonstrates ambivalence in many things: She is uncertain about whether she can be helped, whether she is in fact beyond help and whether perhaps she is even deserving of help. She is ambivalent towards her mother, her father and towards most people she relates with, including Joan. She quickly undoes negative statements she makes about her father, in

particular. The people she knows, beginning with her family, have shown themselves to be ultimately unknowable, and Joan being a stranger is completely unknowable at this point. The therapy has begun and the aim is that Anna will come to trust Joan and herself overtime and develop the sense of being valued and responded to that will build up the process of reflection that we call 'self' and that over time she will integrate the traumatic experiences of her life, some of which were mentioned briefly in her assessment.

One Closer Annotation of the Interview (as an example)

In the first few minutes Anna is unclear as to the reasons for referral – (group and GP mentioned) – this perhaps may indicate an external motivating influence. She quickly begins "rattling off" issues of early history (childhood / school) as if this would justify her being there. She looks preoccupied. Her mother's illness, a partner's mistreatment, the role of her elder sister, are all snippets of information mentioned briefly, without coherence. Two hospitalizations, one involving "cutting leg" and another "a few years later" are mentioned but later on we are not sure of the time line: confusion of time may be evident as a sign of her disorganization around trauma. She says, "I'm not coping" and Joan meets this with, "I can see that", which is an aligning rather than an interrogating response.

Rather early on Joan makes move of "finding out about your mother". There is then the early emergence of a story of maternal postnatal depression and paternal angry control that puts her sister in the carer role with Anna "assisting" in the care of her mother and doing things to please dad. This story makes "sense" of the situation, although seems to "leave out" the patient as a full active participant, restricting her in the field of action as a reactant, without much voice for her own self or needs.

Within this story Joan notes a positive affective shift and comments, "your face lights up when you speak of dad". Anna moves onto recount feeling special, where she felt like "his little girl", but began having difficulty meeting his expectations of achievement (as she grew older). She conveys a sense of loss. Joan recognizes the difficulty of this and acknowledges it.

A story emerges of a difficult treatment history with many therapists and various medications. She says: " [I] don't understand why I'm not doing better". She then reveals the importance of accommodation in her life: "Everything needs to be right for mum". Joan seeks

to recognize the possible deficit in her care and relationships. However Anna is inclined to rationalize, to make excuses that bypass recognition of her own needs.

She refers to a change of schools, a decision made by her father without reference to her wishes. Her behaviour and affect are anxious; she is fidgety with some tense gestures (forehead rubbing) but not much anger, although the content would suggest the appropriateness of anger in this context. Anna refers to sense of confusion and loss and self-harm at this time ("cutting leg"). Joan recognizes the "aloneness" of patient's situation. However when she prompts Anna re the possible experience of anger / frustration, Anna responds again with rationalization / excuses for others. Yet there is some passion in her statement: "they wouldn't listen!" Joan then refers to "old feelings coming up again", i.e. the emergence of traumatic material and Anna acknowledges that it is intrusive: "I can't stop it". This interaction, in its acknowledgement of traumatic experience in a "here and now" way, collaboratively leads to a stronger connection between Anna and Joan. This is an important moment, as a safe connection can allow, in time, the processing of trauma. At this early stage this gentle acknowledgment is a small but powerful beginning.

We can then note "boredom" as a recurring theme with a sense of distance in her appearance at times and Anna's description of "cotton wool in head": all these suggestive of dissociation and flagging a trauma system. We then hear about further traumatic events surrounding relationships. She describes a turbulent relationship with a past boyfriend with some naivety: "just worried about him." The infidelity in that relationship provokes an overdose and a bad experience in hospital. Medication further distanced her from herself ("made me fuzzy"). A second relationship and a second overdose follow with a sense of being blamed emerging. The overdose was described as "showing him", as a retaliation for sexually aggressive, traumatic ("rough") behaviour. However that self-harm was 20 years previously – "I've never done it again". Joan allays fears that emerge re hospitalization, recognizing her strengths ("you've managed") when patient does not seem willing to do so.

She goes on to talk of her sister Jen as "alright", and Anna does seem to be the one who is struggling to make her life function. When Joan recognises the loss associated with her sister leaving home, Anna's affect becomes calmer.

The story then details systematic devaluation by her father “all this therapy; medication; why aren’t you better?”. Joan then undertakes a medication review associated with a partial symptom review e.g. of sleep.

Anna then comments on the relationships with her father who does things for her -“bought foxtel” – and her affect brightens a little. Joan “stays with what is given”. For Anna it seems as if nothing has happened in last 20 years. References to not achieving, not being able to think, “not knowing”, seem to characterize the state. There was no mention of other relationships.

She is unhappy with meds and discloses (like a child with a guilty secret) “sometimes I don’t take them”. She reveals that she does “like running”, despite her father’s disapproval but injury prevents her doing it: “hurt my foot – so I can’t”. Joan avoids polarizing discussions around medications, emphasizing instead the need for consistency and review in due course.

Issues around weight emerge with a description of bingeing and exercising, and are dealt with by Joan directly (described as concerns about “weight consciousness”). The possible relational implications are expressed and recognized: that perhaps she is no longer being the slim “little girl” her father had valued. Joan in fact dramatizes the eating behaviours referring to the abstinence as starvation: “sometimes you starve.” It becomes clearer that the old ways of coping are “not working” (e.g. exercise doesn’t make her feel better anymore) and Joan *recognizes* the significance of this.

Joan also expresses empathy over the infidelity of her past partner with Anna’s “best friend” and Anna mentions being “really angry” (when took an overdose) 32 mins into interview. Joan gives a coherent response *linking* anger to infidelity with best friend. She puts the pieces together by representing it as “betrayal”, here *amplifying* and adding something to patient’s account.

Anna’s comment, “I decided I’d never do that again” is recognized by Joan: “that says something”. This is followed by an inquiry into ongoing thoughts of suicide. These are admitted by patient but her determination to not act on them is also recognized.

Anna's sense of anxious dependence is demonstrated in her comment: "you'll help me". Joan recasts this as "we'll work on it together". Anna describes a pattern of being "put in the too hard basket.... I don't think I'm that hard". Joan responds to this with further pattern recognition – "you've been 'let down' by quite a few". Relationships are queried and Anna responds:"I can't make them work", "I'd like to have one".

In relation to affect regulation, patient comments "it feels like it's happening to someone else". This sense of being at a distance from herself and an external locus of control is important. She returns to a discussion of her father and difficulties scholastically: "when I was having trouble, he couldn't understand why I wasn't his brainy little girl". Joan speculates that it seemed that she felt OK in primary school but Anna does not seem convinced. This is perhaps a moment of dysjunction and a clue that her early life was very difficult, although managed by her with an accommodative strategy of compulsive achievement that worked for a time. Joan's feedback, including the recognition that, as Anna's mother got better, more conflict with her parents became evident, meets with recognition by Anna. Similarly the recognition of the legitimacy of anger and tentative exploration of possible difficulty in experiencing anger is again acknowledged by Anna. Joan recognizes Anna's motivation for change as a prelude to establishing a framework for further assessment with a view to therapy.

During this exchange the patient's primary anxiety / concern, as to whether she will be accepted into the therapeutic relationship is evident and may well be an anticipation of rejections / exclusions that have happened before. Joan is open to Anna's suggestion re a diary – writing down things that happen -- and demonstrates a two way process in aspects of negotiation of the frame.

At the close there is a warmth present and a sense of eagerness for the relationship from Anna.

Comments

Take time to note how broken Anna's speech is at times, how often the personal pronoun "I" is not present and Anna as an agent in her own life is not a clear presence. This fragmentation of language represents the fragmentation of self, present in those with BPD.

Consider making your own close annotation and taking questions to your supervision or group tutorials.

Continuing the conversation.

We are offered the beginning of something in the film and the ensuing psychotherapy might unfold in a number of ways. For a chance to see some examples of how things can proceed, consider referring to the therapies described in the *Clinician's Manual* (Meares et al, 2012) and the *Metaphor of Play* (Meares, 2005). There are also some journal or online conference papers (Haliburn, 2009: McLean and Korner, 2013) and book chapters (McLean and Proctor, 2012; McLean 2013) by the authors that give a window in the experience of various psychodyanamic psychotherapies.

A note on the process and thanks:

We wished to make a film that would show an assessment of a patient with a personality disorder due to chronic complex trauma but without compromising confidentiality. We had found previous acted versions available in the film literature somehow inauthentic and had hoped to capture more of the lived experience of these sorts of interviews. So, after consideration, we chose to avoid the rigidity of a full script and the assessment was acted as an extended improvisation performed before camera by an experienced actor with an experienced health professional (JH) after several intensive rehearsals. The performance by the actor Annette van Roden demanded that she work at the outer limits of the technique of improvisation and we thank her for her courage and commitment to her craft. We are very grateful to all concerned, especially the directors of the two films, Paul Heinrich (the Assessment) and Kaya Finlayson (the Panel Discussion), for making this very difficult task so much easier. We thank: HETI for the ESF funding that enabled this project; the Pam McLean Centre who have the wisdom and expertise to foster this kind of cooperation with actors and creatives; the Faculty Members of the Westmead Psychotherapy Program who encouraged this endeavour and donated their time and energy to be Panel Members.

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