

Managing the clinical encounter with patients with personality disorder in a general psychiatry setting: key contributions from neuropsychanalysis

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SUMMARY

Patients view their negative emotions as troublesome and they expect psychiatrists to deal with them, often wanting them taken away. We present a neuropsychanalytical understanding of the essential biological function of emotion and how it influences behaviour. Through a vignette, we demonstrate how this understanding can contribute to the psychiatrist's management of the clinical encounter, in particular regarding the patient's expectations about their emotions and the pressures placed on the clinician.

LEARNING OBJECTIVES

After reading this article you will be able to:

- describe the biological role of emotional drives, including their primacy in consciousness
- describe the link between drives, emotions and behaviour, how this contributes to an understanding of why patients develop difficulties and sometimes fail to learn from experience, and how common psychiatric challenges arise from patients' perceptions of their emotional drives
- describe how applying the above knowledge can help psychiatrists to manage the dynamics of the clinical encounter, in particular regarding patients' expectations about their emotions.

KEYWORDS

Clinical management; consciousness; emotion; neuropsychanalysis; personality disorder.

When patients are asked about their presenting complaints, they often describe an emotion: 'The problem is my depression/anxiety/anger'. In essence, they view their problem as a negative emotion that they experience. They then ask the psychiatrist to help them deal with this emotion, often asking for it to be taken away. How the

psychiatrist views this request will critically inform both their immediate response and how they subsequently deal with the patient's challenges, if the initial intervention fails.

This situation may be particularly challenging in patients with a diagnosis of personality disorder. People with such a diagnosis are often seen by psychiatrists as difficult or demanding and they can get under the skin of clinicians (Chartonas 2017). The aggression a patient directs towards a clinician (e.g. if they feel they have not been helped by the removal of the unwanted emotion) can be of such intensity that the psychiatrist's response may lead to escalating difficulty in the encounter (Maltzberger 1974).

The modern understanding of neuropsychological processes as functional systems in the brain (Luria 1973) is consistent with Freud's approach to the mind as a dynamic system of interacting components (Table 1). The emerging evidence of affective neuroscience, the interest of psychoanalysis in emotion and subjective experience, and the presenting complaints of psychiatric patients all point to the contribution that an integrative neuropsychanalytical perspective can make to the psychiatrist's ability to better manage potentially difficult clinical encounters. Although this article uses personality disorder in its clinical vignette, the issues it raises are generalisable to encounters with many patients with other psychiatric diagnoses.

This article expands on an earlier contribution of ours (Solms 2018a) and a related paper introducing the clinical innovations of affective neuroscience (Mizen 2020). We present in greater detail the management of the clinical encounter, in the belief that a neuropsychanalytically informed approach may be useful to psychiatrists, in terms of both attitudes (Lee 2022) and practice (Lee 2019; Kanter-Bax 2022).

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TABLE 1 Mapping of Freud's structural model to the brain

Freudian model	Brain region
Id	Extended reticulothalamic activating system (ERTAS), hypothalamus, periaqueductal grey (PAG) and basal forebrain nuclei
Ego	All cortex, but also basal ganglia and cerebellum
Superego	Primitive superego linked to amygdala (conflict between RAGE and other emotions, especially FEAR and PANIC/GRIEF but also PLAY, giving rise to paranoia, guilt and shame respectively). Mature superego linked to frontal cortex, through resolution of conflict and accepting third-person perspective (objective perspective on self)

Workings of the emotional mind

Drive → affect → behaviour

Since Freud's (1920) description of two drives – a libidinal 'life' and a destructive 'death' drive – there have been considerable developments in neurobiological knowledge. Humans, like other animals, are born with several innate needs. Panksepp (1998) – who developed the taxonomy and conceptualisation of emotion that is most widely used in contemporary neuroscience (Davis 2019) – described seven of these needs as emotional drives: SEEKING, LUST, CARE, PANIC/GRIEF, PLAY, RAGE and FEAR (Panksepp capitalised these terms to their scientific from their colloquial denotation). These seven drives are in turn linked to specific neural circuits, neurotransmitters and behaviours (Table 2).^a

We become aware of these drives through the affects they generate, which inform us how well or badly we are doing in relation to meeting the specific needs they measure (Solms 2021). Biological needs become mental when they are felt, before which they are managed mainly by autonomic regulatory mechanisms (Solms 2018b). This points to the vital function of affect – it makes us aware of our currently unmet needs through feelings. Affect is therefore a value system – feelings of pleasure signal biological states that enhance our chances of survival and reproductive success, and unpleasurable feelings signal the opposite (Solms 2018b). Neutral affect is the ideal state for the organism, since it indicates the relative satisfaction of all needs. Feelings of pleasure and unpleasure, by contrast, indicate whether one is moving further from or closer towards this ideal state: the homeostatic settling point for each need in question. One literally feels one's way through life's problems (Solms 2018b). Without feelings, the organism is not equipped to

deal with uncertainty. Moreover, once a problem is solved, the solution becomes a prediction as to how to deal with similar situations in future.

An example of this is the tribulations of a romantic relationship – the individual is keen and curious (SEEKING), they have sexual feelings (LUST) and these need to be balanced with PANIC/GRIEF (anxiety that a loved one might abandon them), RAGE (seeing the loved one with an ex-partner), FEAR ('He may be abusive; I need to remove myself from this situation'). We can then recognise the importance of PLAY (the ability to set boundaries, follow social rules and achieve mutuality in a relationship). Balancing all these needs is challenging enough for the most robust of us – one can see the extent of the challenge with an individual whose formative years have led to adverse experiences in the regulation of these very emotions.

Our ensuing behaviour (the enactment of learned predictions) is intended to meet these needs; but, as we will see below (see also 'consolidation' in Box 1), when a prediction fails to do so but is nevertheless endlessly repeated, it may constitute failure in the individual's development and a psychiatric disorder (which may manifest as the patient presenting with symptoms of a mood disorder such as depression or mania, or an anxiety disorder such as generalised anxiety disorder). Although the patient sees the desired solution as a removal of their symptoms (of the feelings they do not want), at a biological level these feelings are a clinical indicator that the patient's underlying emotional needs are not being met, they are homeostatic 'error signals'. Thus, while the clinician may empathise with the patient's request and understand it from the subjective viewpoint of the patient, it does not make biological sense to treat their symptoms without addressing their cause.

Learning

The felt drive, i.e. the experience of an affect, is a demand on the mind to perform predictive work – essentially, to resolve an emotional need through trial-and-error behaviour or thinking. Learning occurs when such behaviour or thinking (virtual behaviour) is inserted into the drive → affect → behaviour cycle, i.e. when problem-solving is interposed between drives and behaviour. This is why cognition becomes conscious – so that we become aware of how we are dealing with our currently unmet needs (Solms 2018b, 2021). Although many of our actions occur effortlessly and without thought, i.e. unconsciously, cognitive learning is necessary to establish optimal action policies to meet our needs when dealing with uncertainty (as illustrated in the vignette below, where there is a

a. There is no consensus in contemporary science concerning the denotations of 'emotion', 'affect' and 'feeling'. In this article, we use the term 'emotional' drives to distinguish them from bodily drives (such as hunger, thirst, sleepiness); we use 'affects' to denote valenced mental states in general (both emotional and bodily) and we use 'feelings' to denote the subjective experience of affects.

TABLE 2 Panksepp's emotional drives

Basic emotional system	Key brain areas	Key neuromodulators	Function and psychological attributes
SEEKING/ Expectancy system	Nucleus accumbens, VTA (mesolimbic and mesocortical outputs), lateral hypothalamus, PAG	Dopamine (+), glutamate (+), opioids (+), neurotensin (+), orexin (+), many other peptides	Engaging with the world; interest, curiosity, expectancy
RAGE/Anger	Medial amygdala to BNST. Medial and perifornical hypothalamus to PAG	Substance P (+), Ach (+), glutamate (+)	Attacking objects that frustrate satisfaction of other needs
FEAR/Anxiety	Central and lateral amygdala to medial hypothalamus and dorsal PAG	Glutamate (+), DBI, CRF, CCK, α -MSH, NPY	Escaping danger
LUST/Sexuality	Corticomedial amygdala, BNST, preoptic hypothalamus, VMH, PAG	Steroids (+), vasopressin, oxytocin, LHRH, CCK	Finding sexual partners
CARE/ Nurturance	Anterior cingulate, BNST, preoptic area, VTA, PAG	Oxytocin (+), prolactin (+), dopamine (+), opioids (+/-)	Nurturing vulnerable and dependent others; linked to 'maternal instinct'
PANIC/GRIEF/ Separation	Anterior cingulate, BNST, preoptic area, dorsomedial thalamus, PAG	Opioids (-), oxytocin (-), prolactin (-), CRF (+), glutamate (+)	Attaching to caregivers ('attachment theory' is linked mainly to this system)
PLAY/Joy	Dorsomedial diencephalon, parafascicular area, PAG	Opioids (+/-), glutamate (+) Ach (+), cannabinoids, TRH?	Forming social hierarchies; maintaining boundaries and facilitating reciprocity

α -MSH, α -melanocyte-stimulating hormone; Ach, acetylcholine; BNST, bed nucleus of the stria terminalis; CCK, cholecystokinin; CRF, corticotropin-releasing factor; DBI, diazepam-binding inhibitor; GABA, gamma-aminobutyric acid; LHRH, luteinising hormone-releasing hormone; NPY, neuropeptide Y; PAG, periaqueductal grey; TRH, thyrotropin-releasing hormone; VMH, ventromedial hypothalamus; VTA, ventral tegmental area.
Source: adapted from Panksepp (2011).

conflict between emotional drives such as SEEKING, LUST and CARE).

Successful action policies entail successful emotion regulation and *vice versa*; for example with FEAR, escaping from a dangerous situation relieves the anxiety.

Unconscious versus conscious action policies

Cognition is mostly unconscious – roughly 95% of goal-directed activities are executed unconsciously (Bargh 1999) – whereas, as stated above, affect is intrinsically conscious. Short-term memory (Fig. 1), and especially working memory, i.e.

thinking, is a very limited resource that must be used sparingly. Therefore, the ongoing products of short-term memory (conscious thinking) need to be transferred to long-term memory (unconscious prediction) as rapidly as possible. This process is called consolidation. The opposite process is called reconsolidation, i.e. making an unconscious prediction labile again, subjecting it to revision and then consolidating the updated prediction (Solms 2018b).

We now present a vignette to illustrate how a neuropsychanalytical approach can help psychiatrists in their approach to commonplace encounters with patients.

BOX 1 Glossary of terms

Consolidation Making what is conscious unconscious, i.e. transferring from short-term (mainly working) memory to long-term memory, and ultimately to non-declarative long-term memory.

Emotional needs or drives Panksepp identified seven innate emotional needs (Table 1), which, when unmet, are expressed as negative affects and which drive compulsive behaviour.

Reconsolidation Making an unconscious prediction labile again, subjecting it to revision and then consolidating the updated prediction.

The vignette

Nina is a 25-year-old woman who presents in a psychiatric out-patient clinic. She is unemployed, with two young children, and repeatedly has relationships with unreliable men. She has a long-standing history of contact with psychiatric services, suggestive of a borderline personality disorder, with frequent presentations to the emergency department for self-harm, at times requiring admissions under a Mental Health Act section.

She has received multiple psychiatric diagnoses. These include personality disorder (described as unspecified but also variously – or in combination – as

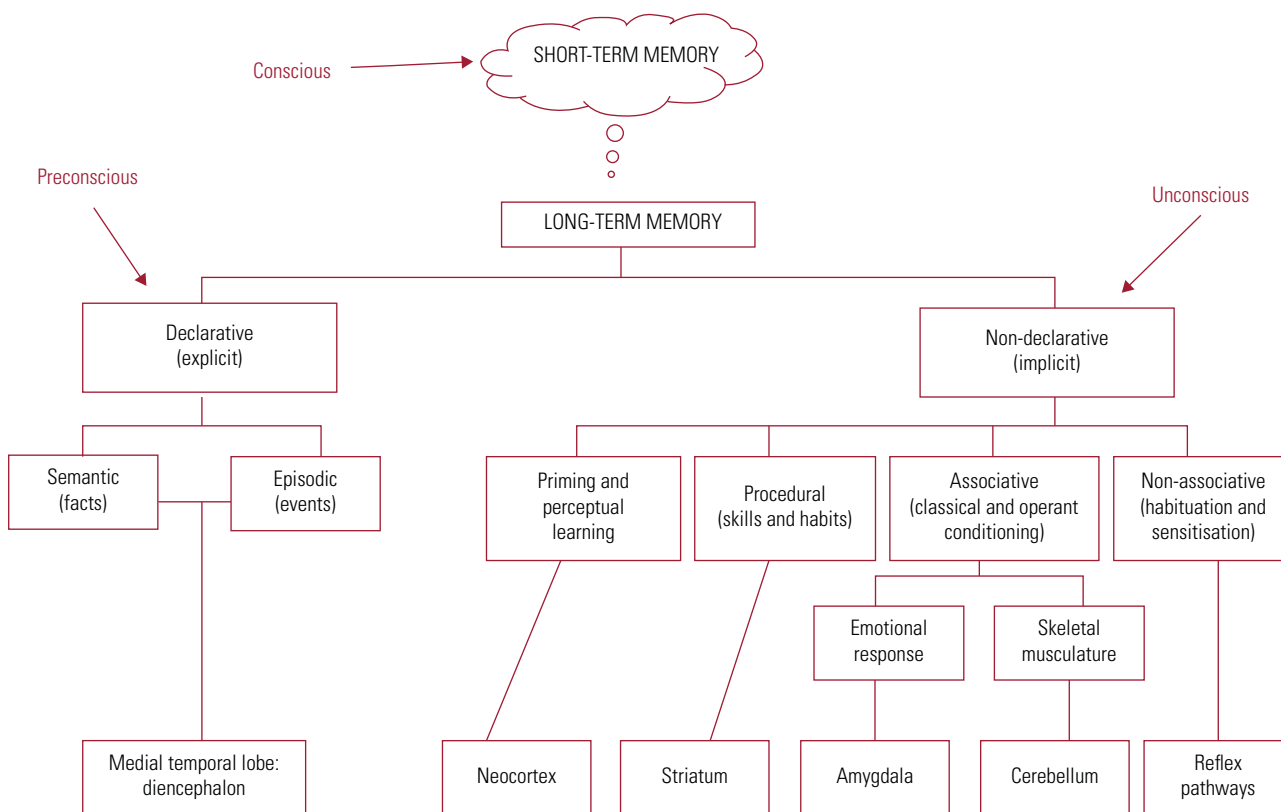


FIG 1 Short-term and long-term memory systems.

borderline, dependent, antisocial, histrionic, avoidant). She has also been diagnosed as having depression, bipolar affective disorder, post-traumatic stress disorder or simply ‘anxiety disorder’. Unsurprisingly, she has been on a wide range of psychotropic medications, including antidepressants, antipsychotics and mood stabilisers. She is presently on sertraline, venlafaxine, quetiapine and lamotrigine.

At the start of the meeting, Nina seemed anxious, polite and eager to please the psychiatrist. However, she has become increasingly agitated during the session. She now says: ‘I just want to feel better. I want to stop suffering so much pain’. In the rest of the encounter, she makes the following statements and raises the following questions (either explicitly or implicitly):

- ‘Can you get rid of my feelings? I feel depressed, hopeless, angry, anxious’
- ‘Why do I keep on doing these things?’ (She is referring to entering into intimate relationships very quickly)
- ‘What is my diagnosis? Why have I had so many different diagnoses?’
- ‘Can the medications help me?’
- ‘Why should I stop my recreational drug use when it is the one thing that keeps me going?’
- ‘I don’t want to have any relationships anymore’

- ‘I’ve been seeing psychiatrists for years – why are you all so useless at helping me?’
- ‘How long will it take for me to get better?’
- ‘I just want to understand my childhood, then I will know what to do’.

Aspects of this scenario are commonly encountered. How does the psychiatrist respond?

Managing the encounter

Drive → affect → behaviour

Affect

‘Can you get rid of my feelings? I feel depressed, hopeless, angry, anxious’ and ‘Why do I keep on doing these things?’ The psychiatrist may develop a more informed and effective response to the patient by taking the following stance. Psychiatrists should realise that affect is here to stay; in fact, that it serves an important function, namely announcing that a need is unsatisfied. Affect serves a homeostatic function – rather than being a ‘nuisance’, it is important for adapting to situations. It is the underlying need (perceived through affect) that leads to the behaviour (the attempt to meet that need) that can be problematic for the individual. The realisation of the meaning of this behaviour – i.e. of what it was predicted to achieve – and that the behaviour does not work may serve, with regards to the

patient, to (a) make the prediction underlying the behaviour more conscious, (b) make her more willing to see it as problematic (although understandable), (c) to think of more effective ways to meet the need in question and (d) then attempt to act in more effective ways. Although it is more the role of a long-term psychotherapy to reach point (d), it is helpful for the psychiatrist in the everyday clinical encounter to realise that change will not occur quickly and to acknowledge this limitation of their role in the short term. This may help the psychiatrist to set more realistic objectives in their treatment of the patient and to be less subject to ‘countertransference’ feelings of frustration or impatience arising from attempting to achieve too much too soon. A clearer understanding of the biological role of emotion (as a signal of an unmet emotional need) also allows the psychiatrist to be more aware of the limitations of a purely symptomatic approach. Although the distressing emotions – e.g. depression or anxiety – need attention, modulation of them through medications will not address the underlying unmet need.

Knowledge that there are several basic emotional needs, not only the ‘libidinal’ and ‘destructive’ ones classically proposed by Freud, helps the psychiatrist to identify the patient’s actual emotions and their underlying needs in a more specific, accurate and nuanced way, and to understand the resultant behaviours (i.e. what the patient is trying to achieve through these behaviours). It may also help with the psychiatrist’s own feelings (‘Why is this patient so confusing and contradictory?’).

The conflicting emotional needs of SEEKING, LUST, FEAR, RAGE, PANIC/GRIEF, CARE and PLAY require cognitive problem-solving (i.e. learning through experience) to negotiate them. In individuals diagnosed with borderline personality disorder, the conflicting nature of these needs may be particularly accentuated and the ability to negotiate them may be particularly attenuated.

The attachment system is especially implicated in people with borderline personality disorder (Lorenzini 2013), with an intense activation of the PANIC/GRIEF drive. At the prospect of separating from her partner, the patient in our vignette may start with ‘protest’ behaviour (e.g. self-harm if she feels that her partner is not responding to her persistent demands for demonstration of love). The panicky feelings may be combined with anger, which produces a conflict between PANIC/GRIEF and RAGE. This problematic conflict may be shown in the patient wanting to be always close to her partner while at the same time wanting to attack him. This only increases her panicky feelings. The insolubility of this conflict may be followed by despair, with the patient seeming to give up on

everything. From these initial conflicting primary emotional needs (i.e. conflicts between the seven basic emotions), secondary emotions ensue – such as guilt (which serves to inhibit RAGE in order to preserve the attachment: ‘I am bad’) (secondary emotions are therefore acquired, they are not innate emotional drives). As part of attachment bonding, the patient may also have a strong CARE need (the need to nurture her children and also her partner), which can be at odds with LUST (she has been unfaithful to her present partner, even though she has genuinely loving feelings towards him). In the patient’s relationship to the psychiatrist, she is at times clinging but also outraged and attacking when the clinician does not respond as she wants: ‘Why can you not see me again next week? Do you not believe I’m suicidal? I think this is unacceptable – can I have a change of psychiatrist?’ Within this response there seem once more to be PANIC and RAGE in conflict with one another.

‘What is my diagnosis? Why have I had so many different diagnoses?’ The lack of discriminatory ability in psychiatry to make accurate diagnoses is well known. This limitation is compounded by the clinical presentation, involving the feeling of negative affect when moving away from a homeostatic settling point. This feeling may be variously described by the patient as ‘I feel anxious’, ‘I feel depressed’ and ‘I feel stressed’. The psychiatrist who is unable to discriminate between the primary emotions in question when a patient uses these terms loosely may tend to overdiagnose, misdiagnose or rapidly switch diagnoses. We would do well to not add to the acknowledged difficulty in accurate assessment of patients with personality disorder, given the condition’s wide range of non-discriminant symptoms and extensive comorbidities (Lee 2021).

‘Why should I stop my recreational drug use when it is the one thing that keeps me going?’ Recreational drug use manages the negative feelings but not what is causing those feelings (i.e. the learned – and frequently unconscious – prediction about how to meet the relevant need). Drug use thus reduces SEEKING behaviour (i.e. it may reduce the ‘wanting’, ‘foraging’ instinct) and hence it makes sense to discourage the patient from this and from other activities that similarly divert healthy SEEKING.

‘I don’t want to have any relationships anymore’ All Panksepp’s emotional drives can – for the most part – be satisfied only by other people; this is a defining distinction between ‘bodily’ and ‘emotional’ needs, both of which are equally biological. Therefore, the patient’s wish for ‘no relationships’

or to isolate herself makes no biological sense; so the psychiatrist must clarify this need rather than support the patient's wish. This also relieves pressure from the psychiatrist having to argue for the need for relationships from a 'personal values' perspective – it is a mammalian issue.

The role of the psychiatrist

'Can the medications help me?' and 'I've been seeing psychiatrists for years – why are you all so useless at helping me?' There is no robust evidence for the use of medications to treat personality disorder. National Institute for Health and Care Excellence (NICE) guidelines recommend avoiding the use of medications for borderline personality disorder or individual symptoms (NICE 2009). Despite this, it is estimated that 92% of patients with borderline personality disorder receive psychotropic medication, mainly antidepressants or antipsychotics (Paton 2015). Also, patients with a diagnosis of personality disorder are often in crisis, increasing the risk of emergency prescribing and polypharmacy (Silk 2011).

The role of psychiatrists from a medications perspective is at present not definitive, but medications may serve a supportive or complimentary role. The effect size of the use of antidepressants (0.31; Turner 2008) versus psychodynamic psychotherapy for personality disorder (1.46; Leishenring 2003) suggests that psychotherapy, rather than psychotropics, may be the preferred intervention. The medications presently used are limited in effectiveness and lack specificity (the psychotropics currently in use work mainly via the extended reticulothalamic activating system, so they may be expected to have non-specific effects) and they do not address the underlying reasons (the learned predictions) why the patient suffers the particular feelings in question. It is therefore important to think of the dynamics of prescribing (i.e. the countertransference pressure to 'do something', possibly resulting in overprescribing; Konstantinidou 2023) and to keep in mind that a psychotherapeutic intervention may address the problematic feelings more directly, at the causal (as opposed to symptomatic) level. The understanding by psychiatrists of the importance of developing an appropriate response to the patient's emotional needs may help place due emphasis on their own behavioural interventions, which psychiatrists may not currently value sufficiently, for example providing continuity, stability and structure, rather than overly optimistic emphasis on the role of medication.

Learning and consciousness

'How long will it take for me to get better?' Such questions point to a limitation of current psychiatry:

psychiatrists' interventions frequently do not help patients learn better (more effective) ways of meeting their emotional needs (which in turn leads to better emotion regulation). This is the goal of psychotherapy. Psychiatrists may prescribe medications that reduce the symptoms but do not alter the causes. This may be an important step before psychological therapy can occur, and some patients may not want to do the necessary psychological work; however, it is useful for psychiatrists to realise that medications are not addressing the underlying issues definitively.

Non-declarative (i.e. unconscious) memories are difficult to unlearn, hence the frequent need for long-term therapy. It is useful for psychiatrist to (a) realise the limitations of intervening at the non-specific level where current psychotropics act (i.e. the upper midbrain) and (b) thus not to expect the kinds of improvement that may be achieved by working at the more specific, cortical level (by bringing into awareness the stereotyped responses the individual has automatised, so that they can be revised through reconsolidation). It is necessary for affects to be felt; feelings provide the link between needs and behaviour. And it is the problematisation of the stereotyped responses to these feelings (i.e. as manifested in the 'transference') that occur in the patient's relationships (including their relationship with the psychiatrist) and the thorough working through of alternative responses that provides the definitive intervention. This is the goal of psychotherapy.

'I just want to understand my childhood, then I will know what to do' This is what psychiatrists often hear. An understanding of compulsive behaviours as being programmed actions that are laid down in the first 2–3 years of life, before declarative memory matures, means that much of what led to the patient's 'faulty' action patterns is non-representational in nature from the outset, as it occurred so early in their life. This applies especially to attachment behaviours, since attachment (in humans) occurs in the first 6 months of life. These non-declarative memories cannot be retrieved, as such. Instead, the prediction underpinning the patient's behaviour may be inferred from the function it serves (what emotional need is it trying to meet, albeit unsuccessfully?) through examining the so-called 'transference'. 'Transference' may be understood as the automatised enactment in adult relationships of non-declarative predictions formed in childhood relationships. An understanding of this will help the psychiatrist to make sense of their patients' dysfunctional behaviours.

Conclusions

A neuropsychanalytical approach helps the psychiatrist in the clinical encounter in three ways:

- assessment – (a) in psychiatric diagnosis (e.g. specifying and classifying the negative affect reduces the potential for confusion of diagnoses) and (b) in psychiatric formulation (e.g. the drive → affect → behaviour approach encourages the clinician to consider the motivation or function (what need the symptom or behaviour is in the service of) and thus the meaning of a problematic behaviour – this allows psychiatrists to understand the psychology of their patients within a biological context);
- management (e.g. understanding the potential limited usefulness of symptomatic medications and of the time required for long-term memory predictions to be modified);
- interaction with patients (e.g. an appreciation of the patient's conflicting drives and behaviours, which are automatised, and the difficulty of managing seven conflicting drives may help psychiatrists when responding to patients).

Knowledge of the primacy of affect can help psychiatrists to accord emotions their due importance for understanding psychopathology rather than focusing exclusively on treating it symptomatically. With increased understanding of the biological function of emotion as a signal of unmet need, psychiatrists will do well to refocus their assessment and management techniques accordingly.

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T.L. and M.S. contributed equally in conceiving, designing, drafting and critically reviewing the intellectual content of this article.

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Declaration of interest

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MCQ answers

1 b 2 c 3 c 4 a 5 c

MCQs

Select the single best option for each question stem

1 Regarding the role of affect:

- a affect has little biological role
- b affect is a value system, making us aware of our needs through feelings
- c lack of affectivity is an alarm signal to the biological system
- d a feeling of pleasure indicates one is moving away from the homeostatic settling point of a need
- e cognition, far more than affect, is the driving force behind human behaviour.

2 Regarding the link between needs, emotions, behaviours and thought:

- a behaviours determine needs and emotions
- b thoughts determine needs
- c the meaning of behaviours may be clarified through an understanding of the associated needs and emotions
- d effective behaviours are those that most successfully negate the underlying need
- e it is through conscious thinking that most of our actions become effortless and automatic.

3 Regarding Panksepp's seven basic emotional systems:

- a they exclude PLAY, which is related only to childhood and is too frivolous to be considered as an innate emotional system
- b we become aware of these systems through cognition, i.e. the cortex is the seat of awareness of the seven basic emotional systems
- c we become aware of these systems through affect, i.e. felt affects inform us how well or badly we are doing in relation to the specific needs they measure
- d balancing the needs of all the basic emotional systems is easy for anyone who does not have a mental illness
- e unwanted feelings of the patient serve no biological function.

4 Regarding what is conscious and unconscious:

- a cognition must become conscious so that we can link it with our unmet needs
- b cognition is by definition a conscious process
- c at most, 5% of goal-directed activities are executed unconsciously
- d affect is intrinsically unconscious
- e behaviour is intrinsically conscious.

5 Regarding the predominant clinical role of the psychiatrist with regard to affect:

- a use of the present range of psychotropic medication addresses the underlying cause of psychopathology
- b the effect size of antidepressants compared with psychodynamic psychotherapy indicates that psychodynamic psychotherapy is clearly less effective than antidepressants
- c limitations of the psychiatrist's role may be better appreciated through an understanding of the biological function of emotions
- d when the patient regards their affect as unwanted and unwelcome, the psychiatrist's role in prescribing medications is a definitive intervention
- e the psychiatrist should focus on cognition rather than affect.