Adolescent in-patient work: MBT in practice

Alan Larney
Brookside Young Persons’ Unit

Acknowledgments: Dr T Rossouw, Prof Fonagy, Drs A Bateman, D Bevington, P Fearon & E Bleiberg
Overview of the session

• Mentalizing the group

• Adolescence

• What is MBT? Theory, therapeutic techniques and stance

• Workshop

• Break

• Applying MBT - the Brookside model

• Case Examples

• Working with Self-Harm
“At your age, Tommy, a boy’s body goes through changes that are not always easy to understand.”
ANATOMY OF A TEENAGER'S BRAIN

THE BIRDS AND THE BEES Lobe

REBELLION CENTER

SUPER TURBO REBELLION CENTER

SELF IMAGE

FITTING IN GLAND

INTERNET/PHONE ADDICTIONS

PEER PRESSURE RESISTANCE

EPIPHYSIAL (Growing) CENTER

EVERY EPISODE OF THE SIMPSONS INDESTRUCTIBILITY CORTEX

SLAM DOOR REFLEX

CAR KEYS CRAVING

ABILITY TO BE SEEN IN PUBLIC WITH PARENTS

MEMORY FOR MUSIC

“COOL” GAUGE

MEMORY FOR CHORES, HOMEWORK, ETC.

SLANG DECODER

JUDGEMENT GLAND

MEMORY FOR MUSIC

LOVE FOR PARENTS

SLEEPING RESISTANCE

CAR KEYS CRAVING

SUGAR FOR MUSIC

ALL THE ANSWERS

MarkParisi@aol.com
“The developments of early adolescence may well create a situation where one is starting an engine without yet having a skilled driver at the wheel” (Steinberg, 2005)
Adolescence

- Rapid development and change
- Heightened emotions
- Friendships and relationships
- Taking risks and impulsivity
- Vulnerability
What is mentalizing?

In simple terms, mentalizing is your mind’s ability to:

• recognize your own thoughts and feelings

and

• imagine the thoughts and feelings of others.
‘Seeing oneself from the outside, and others from the inside’

- Allows us to make sense of behaviour, and both one’s own, and others’ relational and emotional worlds.

- Mentalization is a broad term that includes empathy and mindful introspection

- The capacity to mentalize fluctuates in all of us, depending on our affective arousal.
When we’re mentalizing…

- We’re curious about mental states
- We’re aware of our impact on others
- We’re aware that mental states are opaque
- We allow for different perspectives
- We have a non-paranoid attitude
- We maintain autobiographical continuity
When we’re not mentalizing…

• We can’t see other points of view
• We act on false assumptions, causing conflict
• We cannot communicate effectively
• We may feel or be misunderstood
• We may then ‘act out’ to relieve these aversive feelings, which may then elicit negative responses from others…
MBT regards mentalization as:

- a *fairly constant* and *mostly automatic* mental process
- essential for a meaningful and nuanced relationship with oneself, others and the world
- developed in the context of early attachment relationships
- developing from the ‘building blocks’ of early modes of mental functioning
- facilitating affect regulation
- *highly responsive to emotional arousal/stress*
Mentalization vs. Attachment System, Stress Reaction
MBT assumes that:

• Our sense of self and our capacity for emotional regulation are developed through caregivers’ (more or less) attuned responses to our emotions in infancy and early childhood

• These are thought to create an adequately meaningful set of self- and other-representations that structure the ways in which we relate to ourselves and to others.
‘The baby looks at his mother’s face and finds himself there’

D. W. Winnicott

‘She/he thinks that I think, therefore I am’
MBT suggests that:

- Consistently misattuned (or abusive or neglectful) responses from caregivers will not enable the child to build a sense of self that makes sense or feels tolerable, or to regulate his emotions effectively.

- Later in life, at times of high emotion, his ability to mentalize may break down more readily, leaving him vulnerable to misunderstanding himself and others, with recourse to earlier modes of mental functioning.
Alien Self

- A central concept in MBT theory
- Useful when thinking about young people and self-destructiveness
The Agentive Self

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

Attachment figure

Representation of infant’s mental state

Core of psychological self

Internalization

Inference

Infant

Infant internalizes caregiver’s representation to form psychological self

Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality ➔ mentalization (Fonagy & Bateman)
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

Attachment Figure

Absence of a representation of the infant’s mental state

Mirroring fails

Child

The nascent self representational structure

Internalisation of a non-contingent mental state as part of the self

The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics
Alien Self

- “We assume…that when a child cannot develop a representation of his own experience through mirroring (the self), he internalizes the image of the caregiver as part of his self-representation. We have called this discontinuity within the self the ‘alien self’” (Bateman & Fonagy, 2006; p11)
• Present in most of us, to some degree, on occasion
• The experience of the alien self is similar to an internal tormentor
• May be experienced as a feeling of deep inner hate; an inability to experience pleasure from one’s achievements; inability to appreciate compliments
• May evoke powerful self-destructive responses (e.g. self-harm, suicidal acts)
• Within an interaction, the alien self may be projected into an other, creating aversive feelings within the other, and leading to rejection or conflict.
Rationale for MBT

The ultimate goal of treatment is to enhance mentalization in young people and their families: to move away from a focus on behaviour that needs to be managed, towards a focus on relationships and internal states which can be understood and which will change once they are more meaningful to all concerned.
What does individual MBT look like?

• Assessment, including collaborative written formulation

• Focus on exploring feelings and their meaning, and situating them in an interpersonal context

• Therapeutic relationship as a testing ground and a place to model mentalizing

• Particular attention given to episodes of non-mentalizing in or outside sessions; developing mentalizing skills

• Interpersonal/current, rather than intrapsychic/historical.
The therapeutic stance in MBT

- Genuinely humble - never assuming that you ‘know’
- Self-reflective
- Inquisitive/curious
- Respectful
- Non-didactic, non-critical
- Playful
- Responsible - for one’s own mistakes and misunderstandings, and for the patient’s emotional arousal in session
- Judicious use of the self - with necessary boundaries
Putting the stance into practice

- Empathy, empathy, empathy
- Primary concern is patient’s state of mind, not behaviour (not ‘what happened’, but ‘how did you feel?’)
- Present focus - keep it current
- Active questioning and challenges
- Highlighting alternative perspectives
- Explore in the relational realm not just the intra-psychic
- Taking explicit and open responsibility for our emotional impact on our patients; using ourselves to practice mentalizing in session
- Return to simple, empathic statements if patient becomes distressed or out of control
The MBT therapist continually questions their own and patient’s internal mental states:

- How might he/she be feeling?
- What is happening now?
- Why is the patient saying this now?
- Why is the patient behaving like this?
- Why am I feeling as I do now?
- What has happened recently in the therapy that may justify the current state?
Therapeutic techniques in MBT:

- MBT is a ‘broad church’ in terms of technique - you can use a variety according to the needs of the patient

- However - these need to be affect-focused, not overly complex, and current.

- A common framework for approaching what a patient may bring involves ‘mentalizing the moment’:
  - Identify affect
  - Explore emotional context
  - Define interpersonal context
  - Examine broad interpersonal theme
  - Explore transference
Using questioning comments to promote exploration:

– What do you make of what has happened?
– Why do you think that he said that?
– I wonder if that was related to the group yesterday?
– I wonder if you might have felt that I was judging you?
– What do you make of X feeling suicidal in the group?
– Why do you think that he behaved towards you as he did? What might he have been feeling?
Summary

- Simple and short utterances
- Affect-focused
- Focus on patient’s mind, not behaviour
- Relate to current event
- Keep it tentative - you never actually ‘know’ what the patient is feeling (and it’s never one thing); and they should be encouraged to embrace not-knowing and to stay curious about themselves and others
About Brookside

• Adolescent Tier 4 service in North East London (however receive admissions nationally)
• Inpatient (4 HDU beds, 14 open ward beds)
• Day patient (approximately 14 young people)
• Presentations; Self-harm and suicidality, emerging PD, trauma, depression, anxiety, eating disorders, psychosis, ASD, OCD.
• Often complex social backgrounds
The Process of Admission and Treatment

1. Assessment

2-week period of MDT assessments, including a variety of psychometrics and an assessment of mentalizing capacity, culminating in a shared formulation document and a CPA

2. Welcoming

Formulation, contract, crisis plan and psychoeducation.
3. **Working**

Enhancing mentalization skills, gaining impulse control, practising awareness of own and others’ mental states; milieu work

4. **Launching**

Increasing independence and responsibility, consolidating stability, develop plans for the future, understanding issues around ending and focusing on affective states associated with loss, discharge planning and liaison with other services.
The Brookside Model

- MBT contract and log
- MBT-informed policies and responses
- MBT Induction day
- MBT contract and log
- 2 x weekly individual MBT
- 2 x weekly MBT Small Group
- Weekly MBT family therapy
- MBT-informed Group programme
- Weekly MBT key time
- Staff MBT training
- Family MBT training
- 2 x weekly MBT Small Group
Case presentation: Justin
Background to the case

• Justin: 14-year-old boy

• Taken into care aged three after witnessing mother’s repeated sexual exploitation and being severely neglected, physically and possibly sexually abused

• Placed with three different foster carers; adopted with siblings at age four
Background (2)

- Sexually abused by adoptive grandfather aged 10-12
- Admitted to the unit following a major overdose, after recent disclosure of sexual abuse
- Anti-social behaviour (stealing, lying, aggression); unboundaried and compulsive sexual behaviour
Initial Assessment

- Long-standing history of problems in schooling
  - statemented
  - school exclusion

- Poor social development
  - limited peer relationships

- Previous enjoyment of sports-based and practical activities

- Ambition to be a rugby player or in the army
Initial assessment: Groups

- Anxious and avoidant
- Refusing to attend school
- Reluctant, tentative engagement, low in confidence
- Limited communication
- On the periphery of the peer group
- Would leave unit at any given possibility
Initial assessment (2)

- Craving positive feedback and praise
- Wanting to win, be the best
- Sabotaging others work
- Achieving, mastery, mood
Early thoughts on mentalizing

- **Beliefs**
  - pessimistic re his ability and sense of agency
  - ‘I can’t do this, I’m not good at that, I’m not going to try that because…’

- **Feelings**
  - anxiety, shame leading to avoidance

- **Desire**
  - to achieve, excel, experience positive agency
  - ‘I want to be recognised for doing well. Staff noticing the good things, not just the bad things’
On the unit

- Closely engaged with certain members of staff
- Central figure in the peer group
- Frequently sexually involved with other young people
- Broke into and smashed up unit greenhouse
- Smashed a window on the unit
- Shot a peer with a BB gun
- Dented staff cars and let down tyres (junior female staff)
- Stole a wallet and other items
- Stole staff keys on several occasions
- Persistent lying about anti-social behaviour
- Frequently found in staff areas
Summary of the work

1. Create safe boundaries; structure; reduce self-destructive and anti-social behaviour

2. Enhance strengths; enable him to generate a sense of mastery; engage in a range of occupations; weekly ‘reflect and notice’; review educational needs; achievement and reward charts.

3. Making sense of and mentalizing Justin’s behaviour

4. Mentalizing the trauma: helping Justin develop a mentalizing narrative; addressing repetition-compulsion of aggressive behaviour eliciting abandonment
Family work

- Parents unwilling to engage in formal family therapy; sense of fragility

- Good working relationship gradually established through collaboration around responding to Justin’s anti-social behaviour

- Joint meetings between therapist and parents at Justin’s request
Individual MBT with Justin

- 7 months of twice-weekly individual MBT
- Very concrete non-mentalising, impulsivity, acting out
- Here and now focus
- Flexible to level of emotional arousal
- Giving agency with boundaries
- Some shifts in mentalizing abilities
- CT: seductiveness and vulnerability
- Teleological mode post sessions – liaising with team to mentalize and contain behaviour
Clinical vignette

• Weekend incident

• Monday session
  • ‘rewind’ to incident
  • affect intensified; given book to write in
  • started writing about the sexual abuse
  • left suddenly

• Thursday session
  • worked with the feeling states described in Justin’s writing
  • ‘I feel angry, like no one cares and everyone is against me’
  • Used to mentalize weekend incident (and others)
Progress

• Helping others, opportunities to lead and do well; rugby; gym; library; school

• In therapy, more able to be in the room; increasingly curious about biological family, history and background

• Anti-social behaviour decreased; sexualised behaviour continues.
The Future

• A supportive school & Education inclusion service
• 2 x half days working as an apprentice chef
• 1 day at the local college Infill program – Sports Science
• 1 afternoon a week mentoring at a local gym
• 1 day Outdoor Pursuits project
Mentalizing the work: challenges

- Split between Justin’s presentation inside sessions and outside, on the unit
- Maintaining a mentalizing stance in the context of repeatedly broken boundaries and harm to others
- Working with disavowed aggression; evident excitement in antisocial acts; subsequent re-creations of abandonment
- Managing staff splits
- Struggle to engage family
Working with self-harm

• Shared formulation
• Stages of change model - pre-contemplation
• Mentalising the person: intensive empathy
• Mentalising the system
• Skills work
• Crisis cards and plans
• Red card systems; use of objects
• Paradoxical interventions/harm minimisation: the ‘self-harm station’
• Safe place work
Case Example: Anna

- Age 13
- Presented with suicidal behaviour (drinking bleach, taking an overdose of unknown tablets) and past self-harm
- In foster care since 2009 following physical abuse by her mother
- Father sexually abused her elder sisters
- Anna was sexually abused by her grandfather
- Family difficulties - mother was in care
• Early days at Brookside: antagonising peers; sharing razorblades; struggling to engage with therapy or groups
• Groupwork - helping her to be curious about others’ feeling states and vice versa
• Family work - willingness to engage with her mother
• Individual work - curiosity, validation, clarifying
• Working with staff to help them be curious about her feelings and behaviour
• Helping other YPs to mentalize about Anna
• Anna became increasingly reflective and able to empathise with and interpret the behaviour of a new YP acting out in a similar way
• Recent regression as new foster placement starts and treatment comes to an end