Making sense of self harm in adolescence and support for MBT-A

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Acknowledgements

- Prof Peter Fonagy
- Developers of MBT and MBT-F: Prof Fonagy; Anthony Bateman; Mary Target; Pasco Fearon; Eia Asen; Efrain Bleiberg.

What is mentalization?

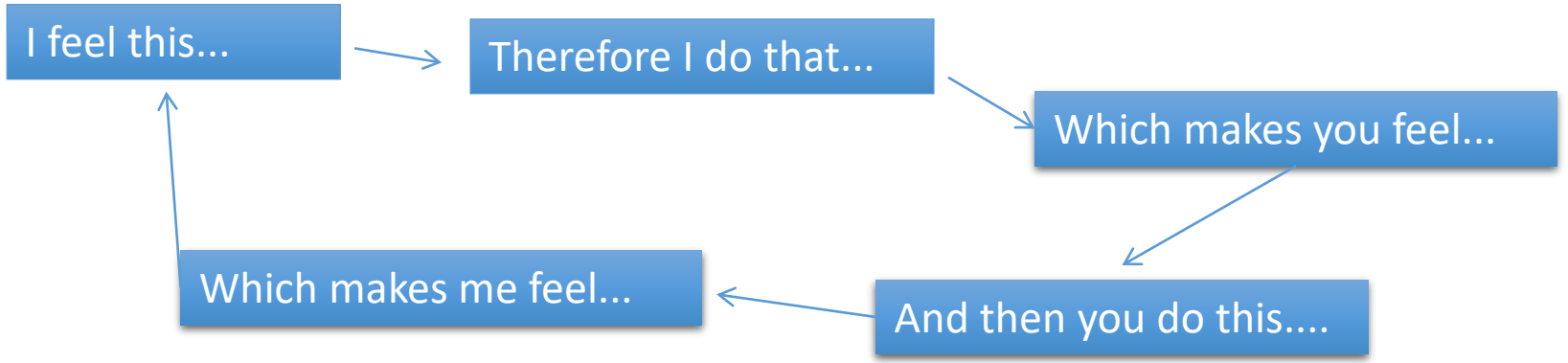
- Mentalizing renders behaviour intelligible; is the basis of self-awareness and sensitivity to others

Alan 2005

What is mentalization?

It is the ability to make sense of one's emotional and relational world

Seeing oneself from the outside and others from the inside



It is the focus on mental states and not on behaviour

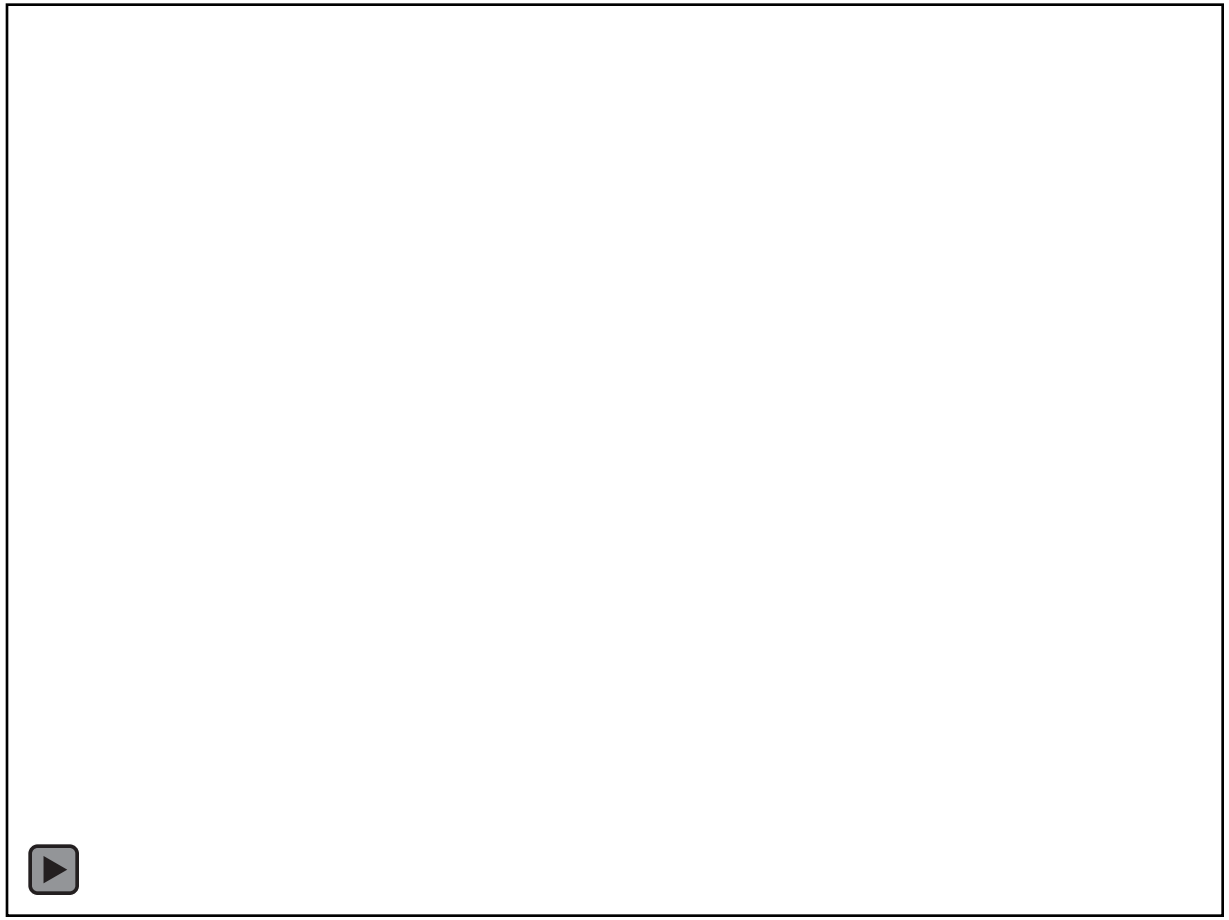
The MBT approach is based on a view that a core problem for many patients, especially those with BPD, is their vulnerability to a loss of mentalizing.

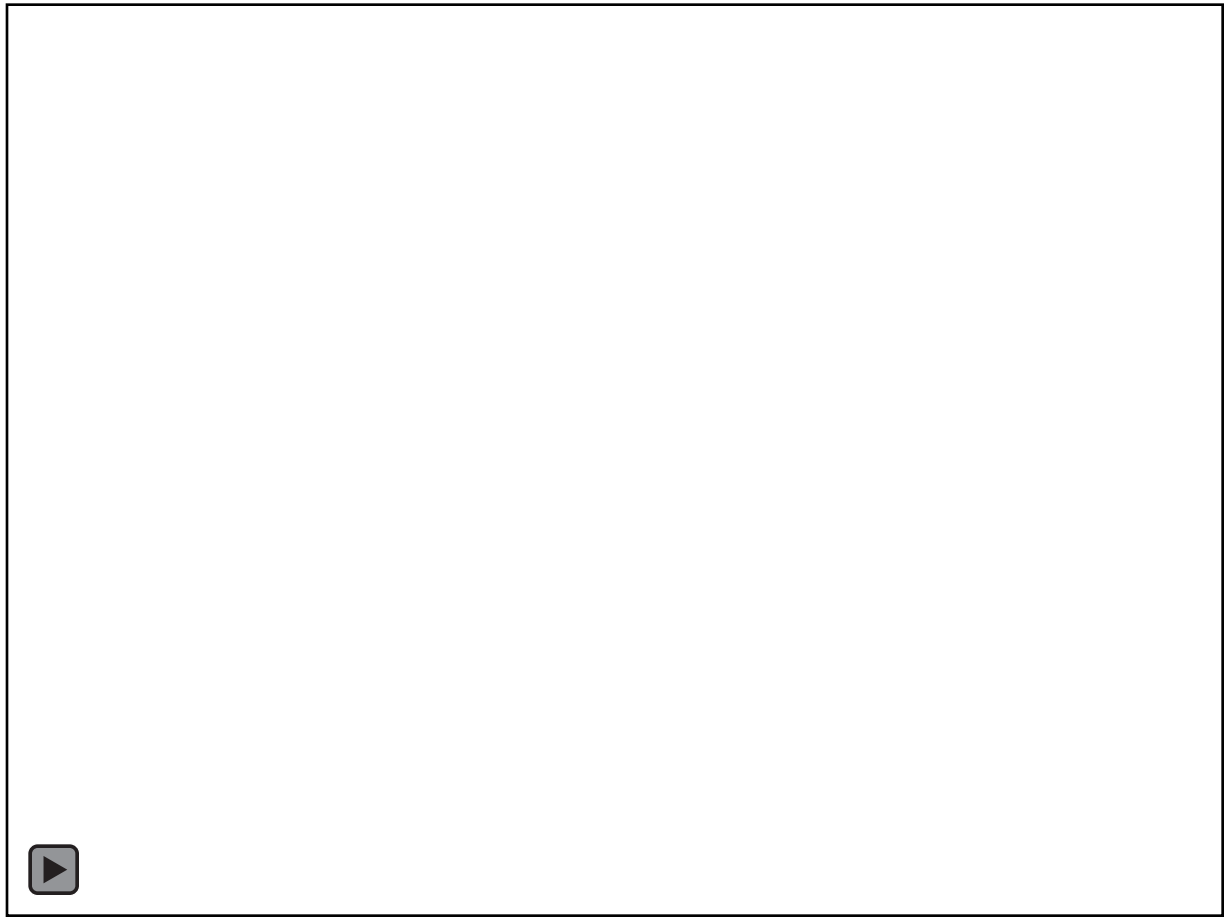
This vulnerability becomes associated with interpersonal sensitivity which triggers dysregulated emotions and impulsivity.

Mentalization based treatment hopes to address this vulnerability and in this therapy the aim in on improving the young person and families mentalizing ability.

The therapy is relational focussed and the therapist is seen as an active participant and a contributor to emotional impact on the patient.

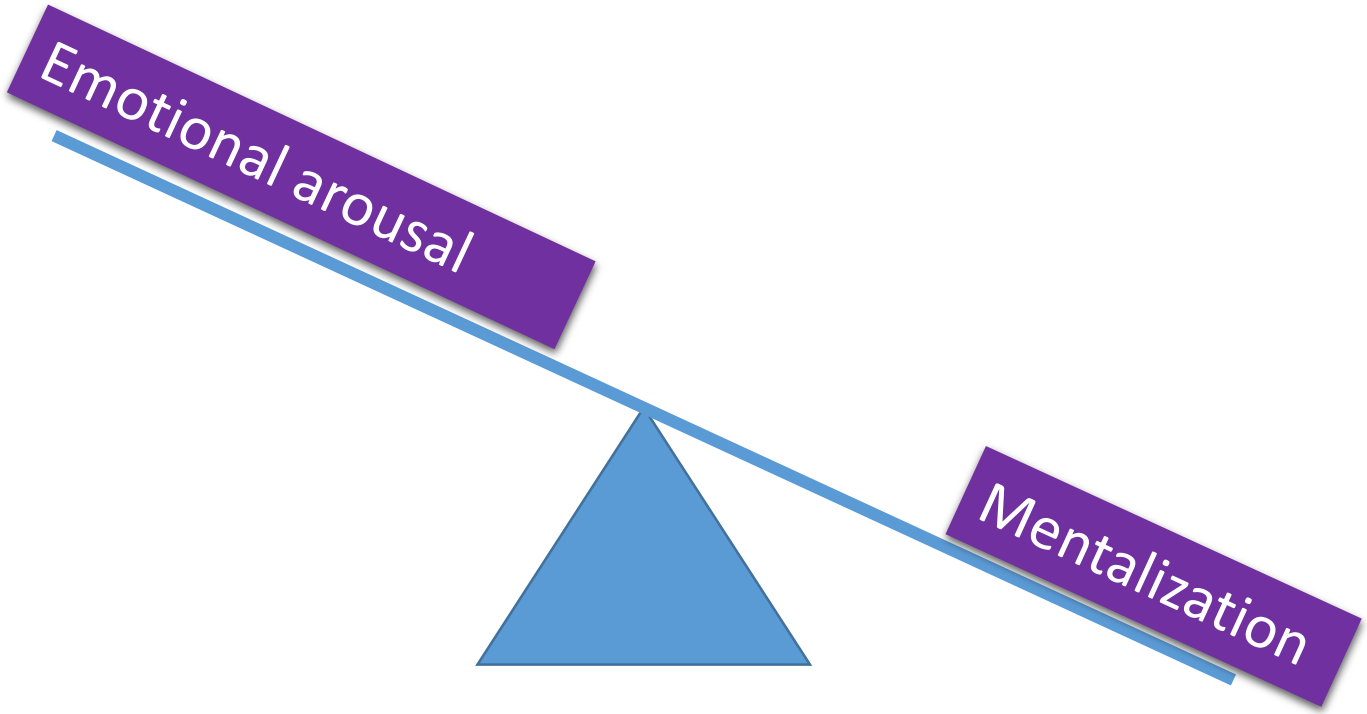
Let’s mentalize



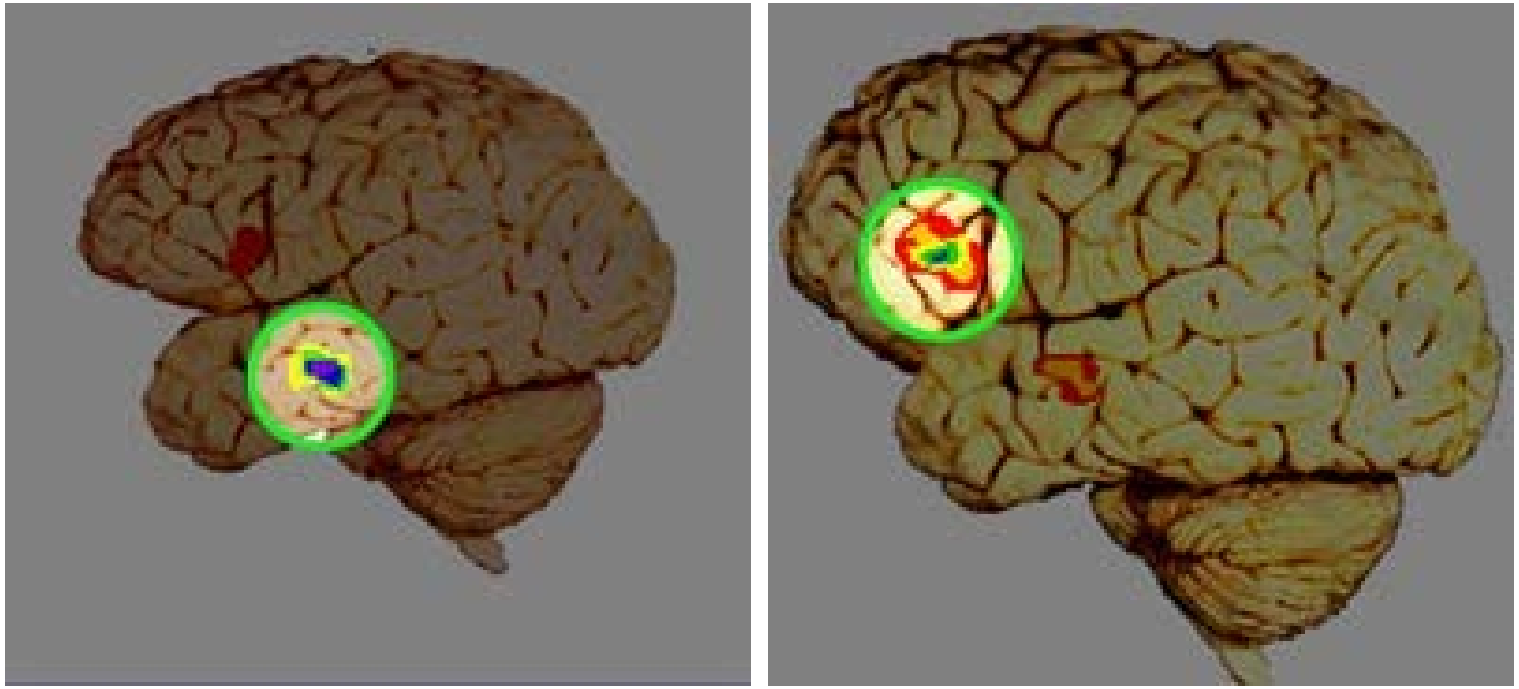


Effective mentalizing

- Curiosity about mental states
- Awareness of impact on others
- Awareness that mental states are opaque
- Allows for different perspectives
- Non-paranoid attitude

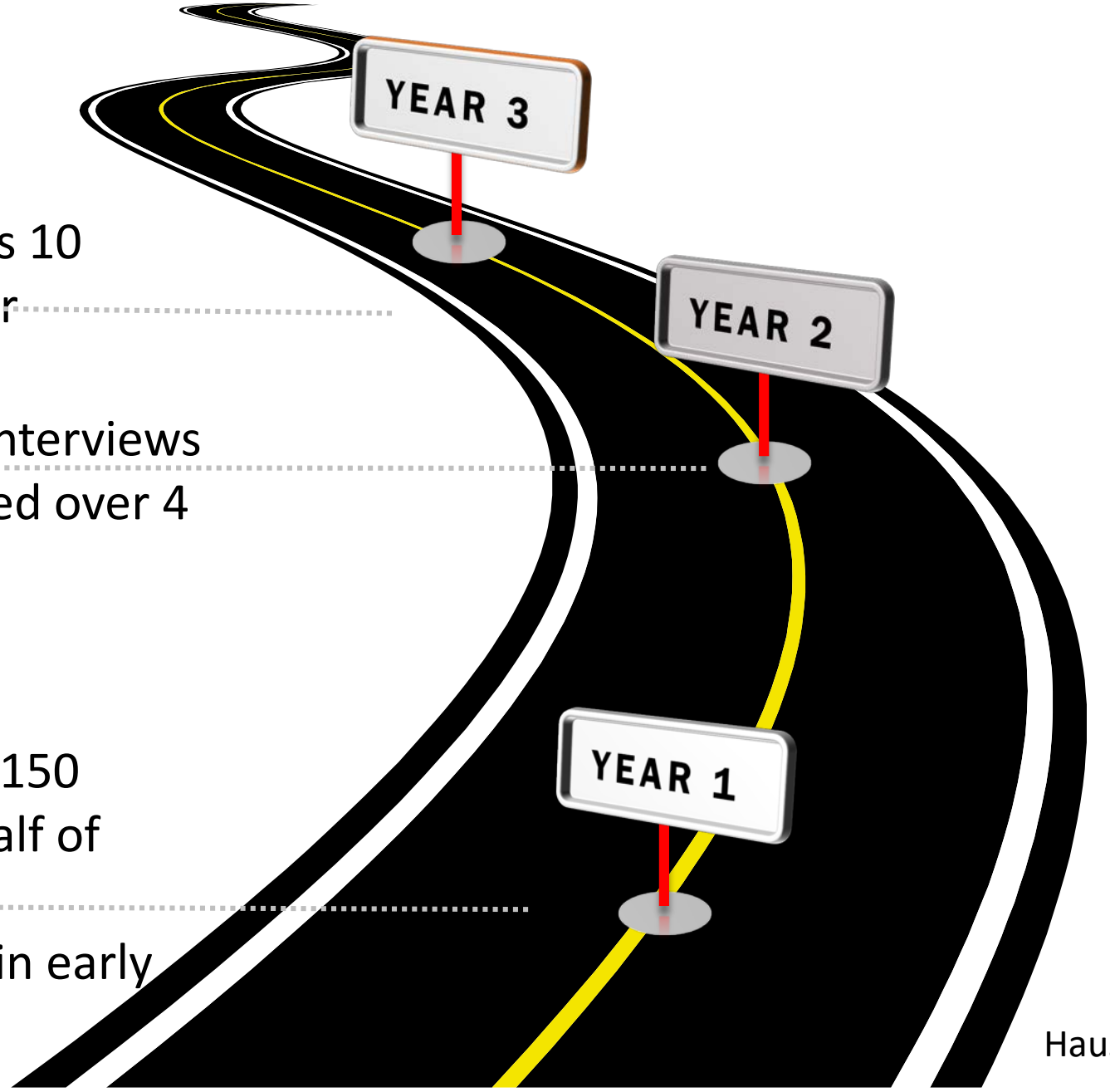

Emotional arousal
Mentalization

Adolescents and Adults process emotions differently



When reading emotion, adolescents **(left)** rely more on the amygdala, while adults **(right)** rely more on the frontal cortex.

Mentalization and transition to adulthood



In depth interviews 10 years later

Annual interviews conducted over 4 years

Followed up 150 teenagers, half of them were hospitalized in early adolescence

Hauser et al, 2006

Outcome

- A surprising number of YP who were former patients were functioning in the top half of all adults in terms of social and emotional functioning, quality of relationships.

- They were interested in psychological experience and thought about themselves and others' experience, and they felt hopeful and optimistic about the future.
- Hauser et al (2006) identified 3 key protective factors:
  - Reflection, the capacity and willingness to recognise, expreience and reflect one's own thoughts, feelings and motivations
  - Agency, that is a sense of oneself as effective and responsible for one's actions
  - Relatedness, that is, valuing of relationships that takes the form of openness to the other's perspective and of efforts to engage with others

Mentalization based treatment for self harm - RCT

Rossouw & Fonagy, 2012

STUDY DESIGN

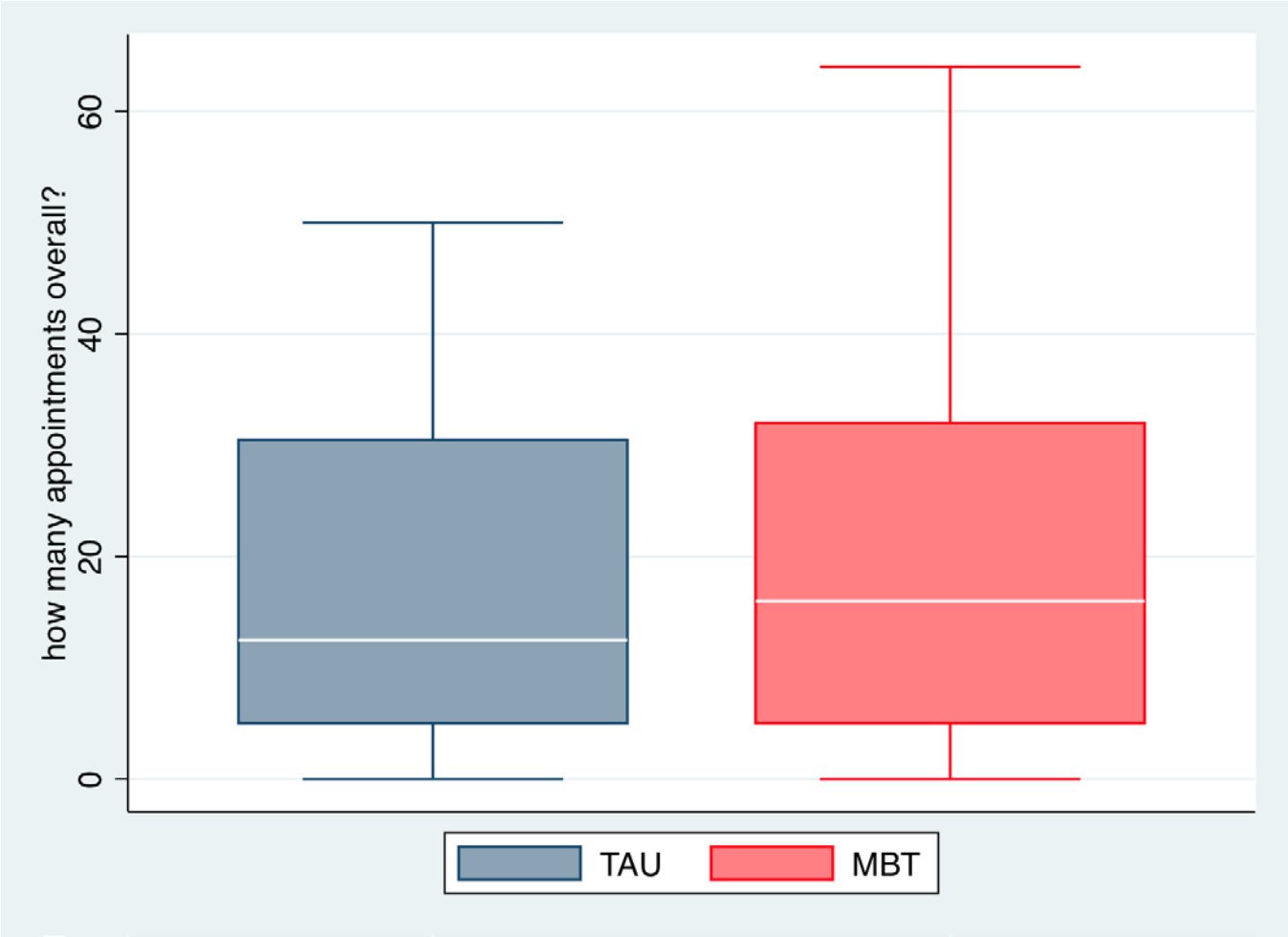
- Random allocation of young people presenting with self harm to either MBT or TAU
- N=80
- Assessments done every 3 months and at 12 months
- Assessment methods:
  - Risk taking and self harm: RTSHI (Vrouva, 2010)
  - Mood: MFQ (Angold, 1995)
  - BPD traits: BPFSC (Crick, 2005) and CH-BPD (Zanarini, 2007)
  - Dissociation: ADES (Armstrong, 1997)
  - Mentalization: HIF (Sandell, 2008)
  - Attachment: ECR (Brennan, 1998) and IPPA (Armsden, 1987)

Demographics of sample

Characteristics at Baseline	TAU	MBT	Test Statistic	*p*=
Female, n/N (%)	35/40(87.5%)	33/40(82.5%)	$\chi^2(1)<1$	n.s.
Age, y, mean (SD)	14.8 (1.2)	15.4 (1.3)	t(78)=2.01	0.041
Chronicity of Self harming			$\chi^2(1)<1$	n.s.
less than 3 months	16/40(40%)	16/40(40%)		
3-5 months ago	4/40(10%)	7/40(17.5%)		
6-11 months ago	6/40(15%)	2/40(5%)		
1-2 years ago	11/40(27.5%)	12/40(30%)		
over 2 years ago	3/40(7.5%)	3/40(7.5%)		
Depression (MFQ≥8), n/N (%)	38/40(95%)	39/40(98%)	$\chi^2(1)<1$	n.s.
BPD (CI-BPD ≥5)	28/40(70%)	30/40(75%)	$\chi^2(1)<1$	n.s.

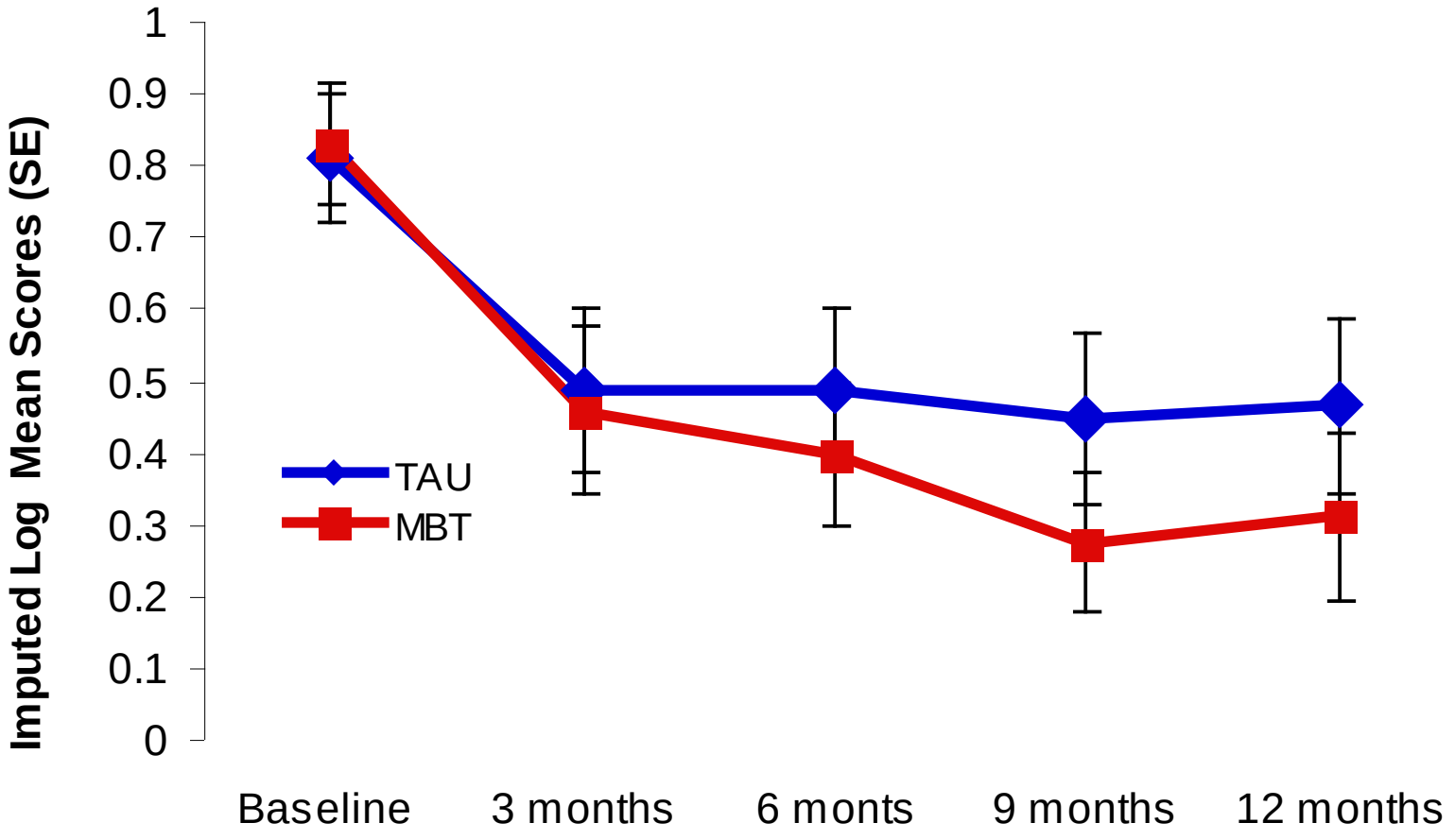
RESULTS

Overall number of appointments for self-harming adolescents in MBT vs. TAU trial



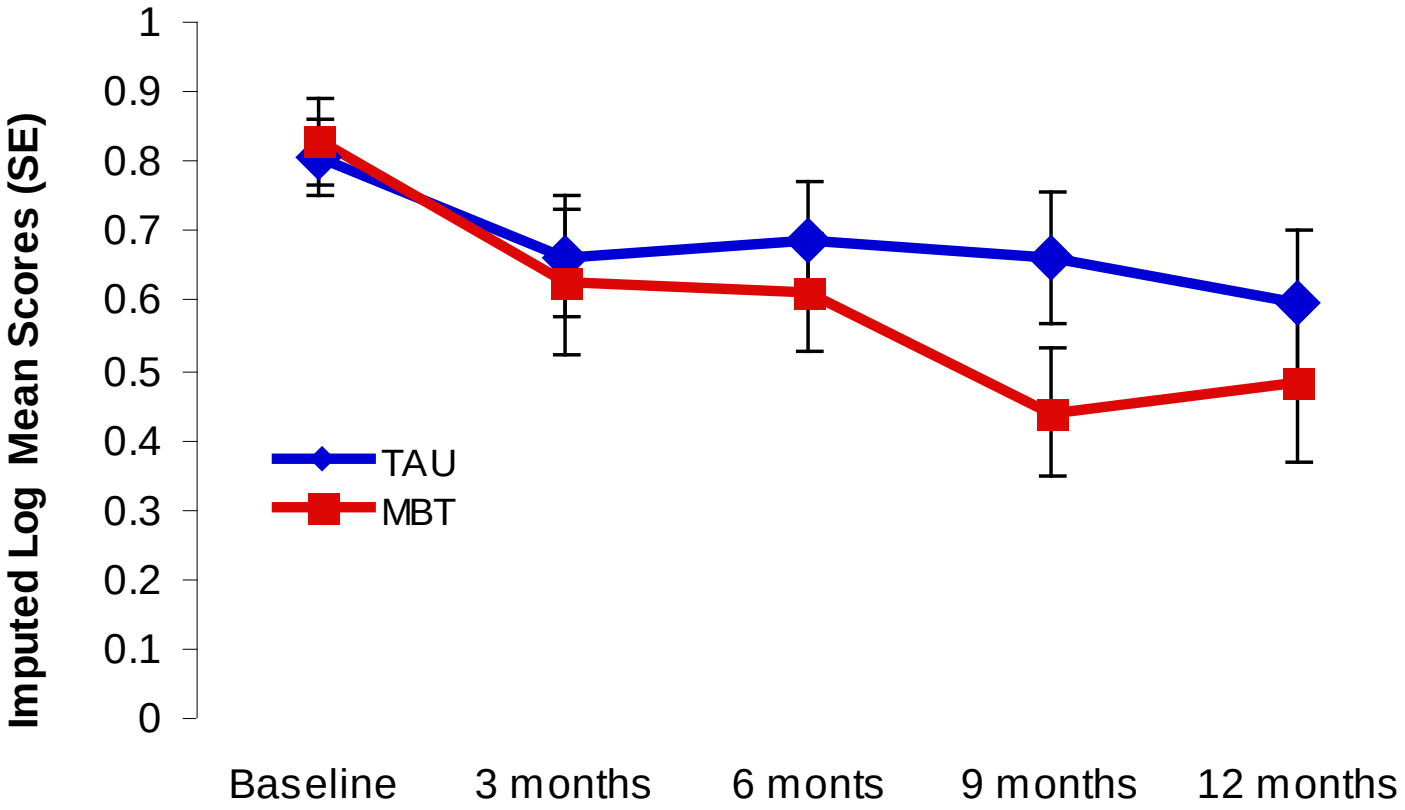
Group difference: β=2.95, 95% CI: -4.28, 10.17, t(78)=0.81, p<0.419, d=0.18

Self harm scores for TAU (n=40) and MBT (n=40) groups on the RSHI



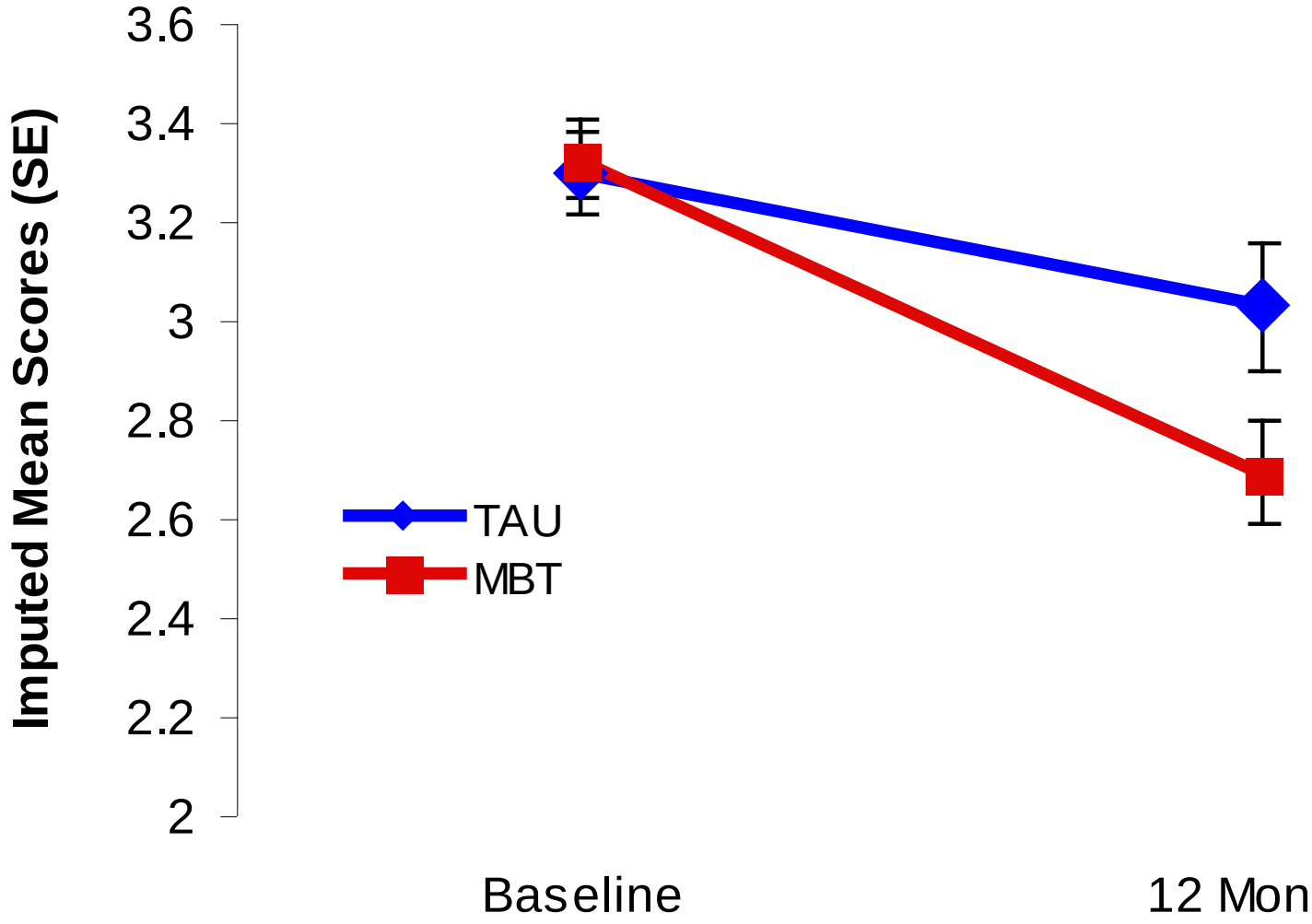
Group differential rate of change: β=-0.049, 95% CI: -0.09, -0.02, t(159)=-2.49, p<0.013, d=0.39

Depression scores for TAU (n=40) and MBT (n=40) groups on the MFQ



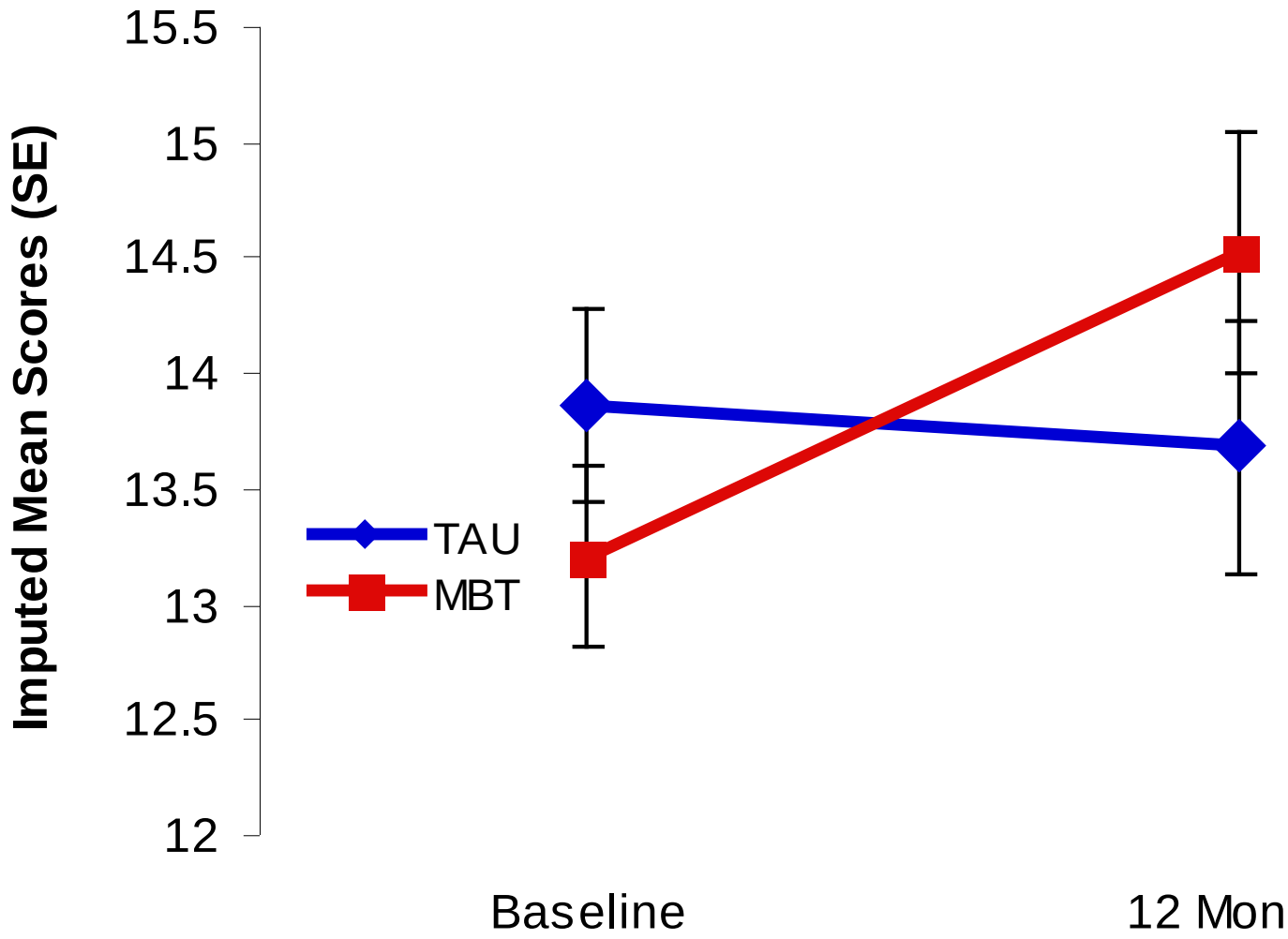
Group differential rate of change: β=-0.046, 95% CI: -0.09, -0.01, t(159)=-2.25, p<0.024, d=0.36

Borderline personality features scores for TAU (n=40) and MBT (n=40) groups



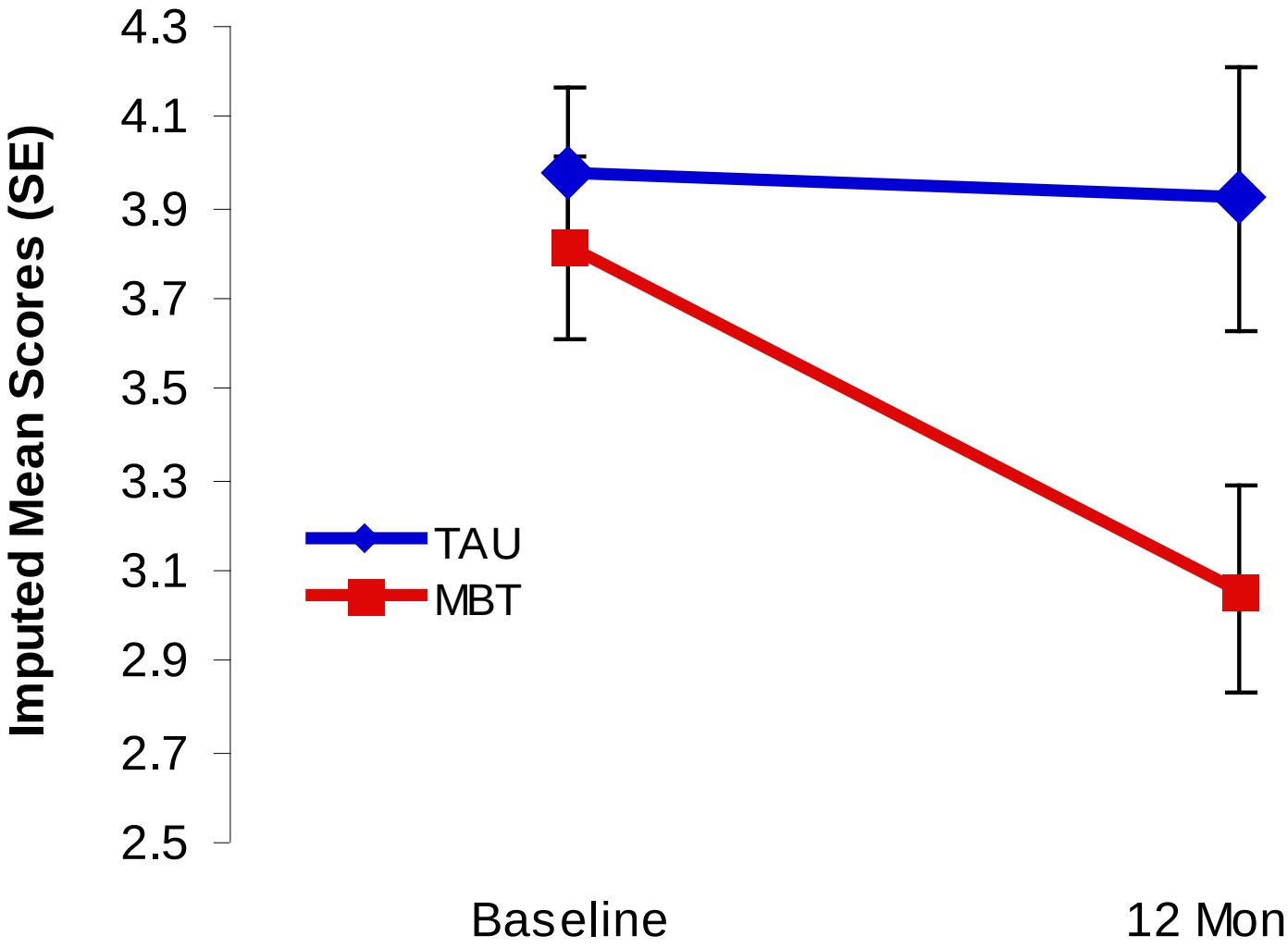
Group differential rate of change: β=-0.361, 95% CI: -0.7, -0.03, p<0.034, d=0.34

Mentalizing scores on the HIFQ for treatment groups



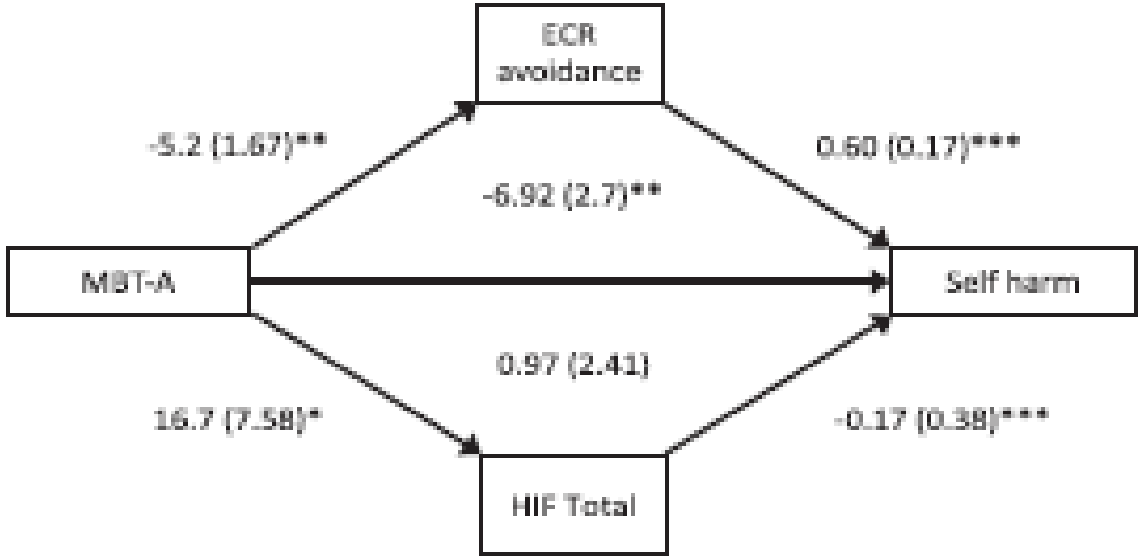
Group differential rate of change: β=1.49, 95% CI: 0, 2.98, t(159)=1.99, p<0.049, d=0.32

Attachment avoidance scores from Experiences in Close Relationships Questionnaire for treatment groups



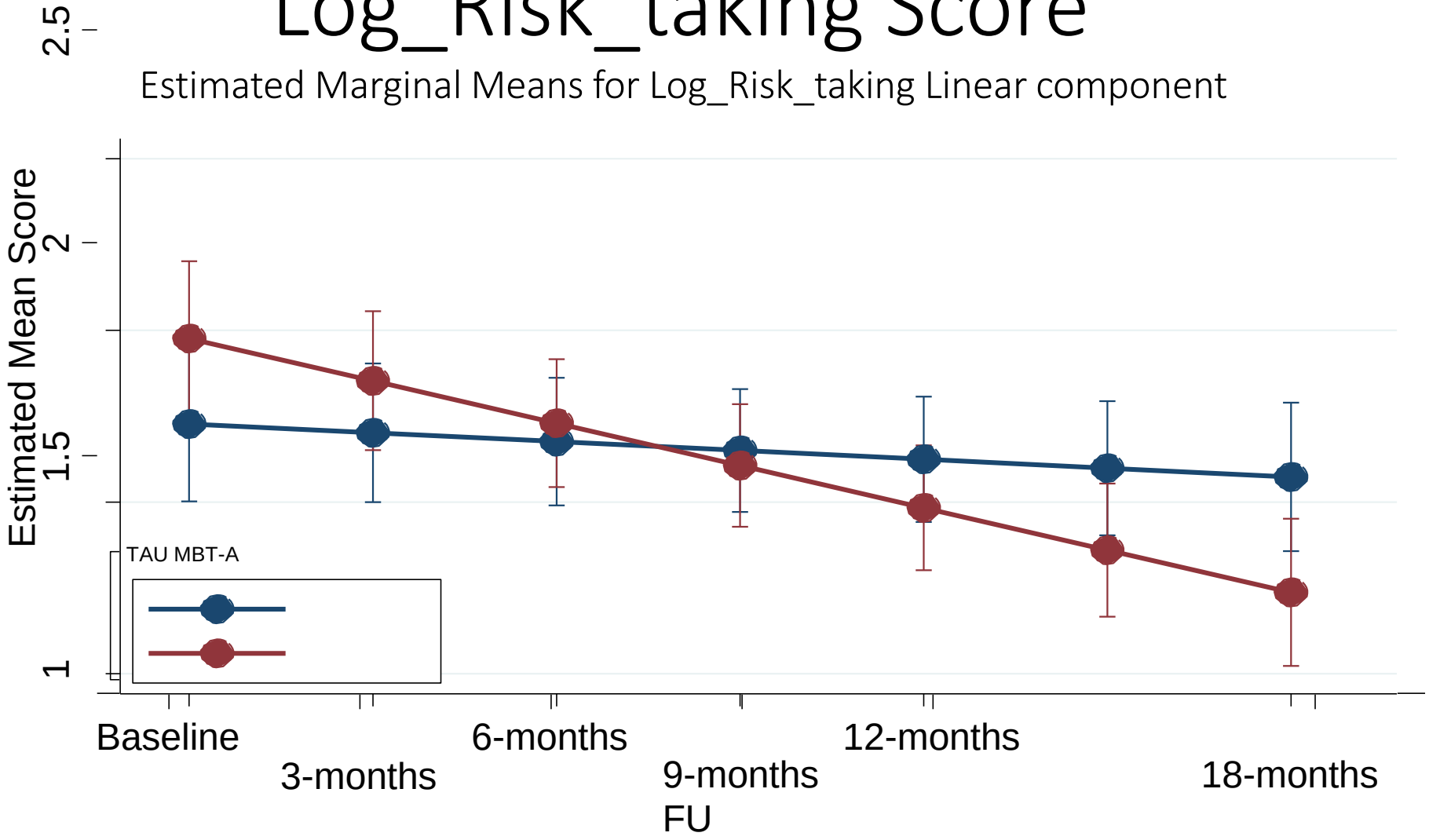
Group differential rate of change: β=-0.696, 95% CI: -1.48, 0.08, t(159)=-1.75, p<0.081, d=0.28

FIGURE 2 Mediation of effect of mentalization-based treatment for self-harm in adolescents (MBT-A) on self-harm scores at the end of treatment. Note: Path coefficients (SE) are shown with the association of MBT-A on self-harm. The coefficient for the path controlling for specific indirect effect of Experience of Close Relationships Inventory (ECR) avoidance and How I Feel Questionnaire (HIF) change is shown in italics. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.



18 month follow-up data

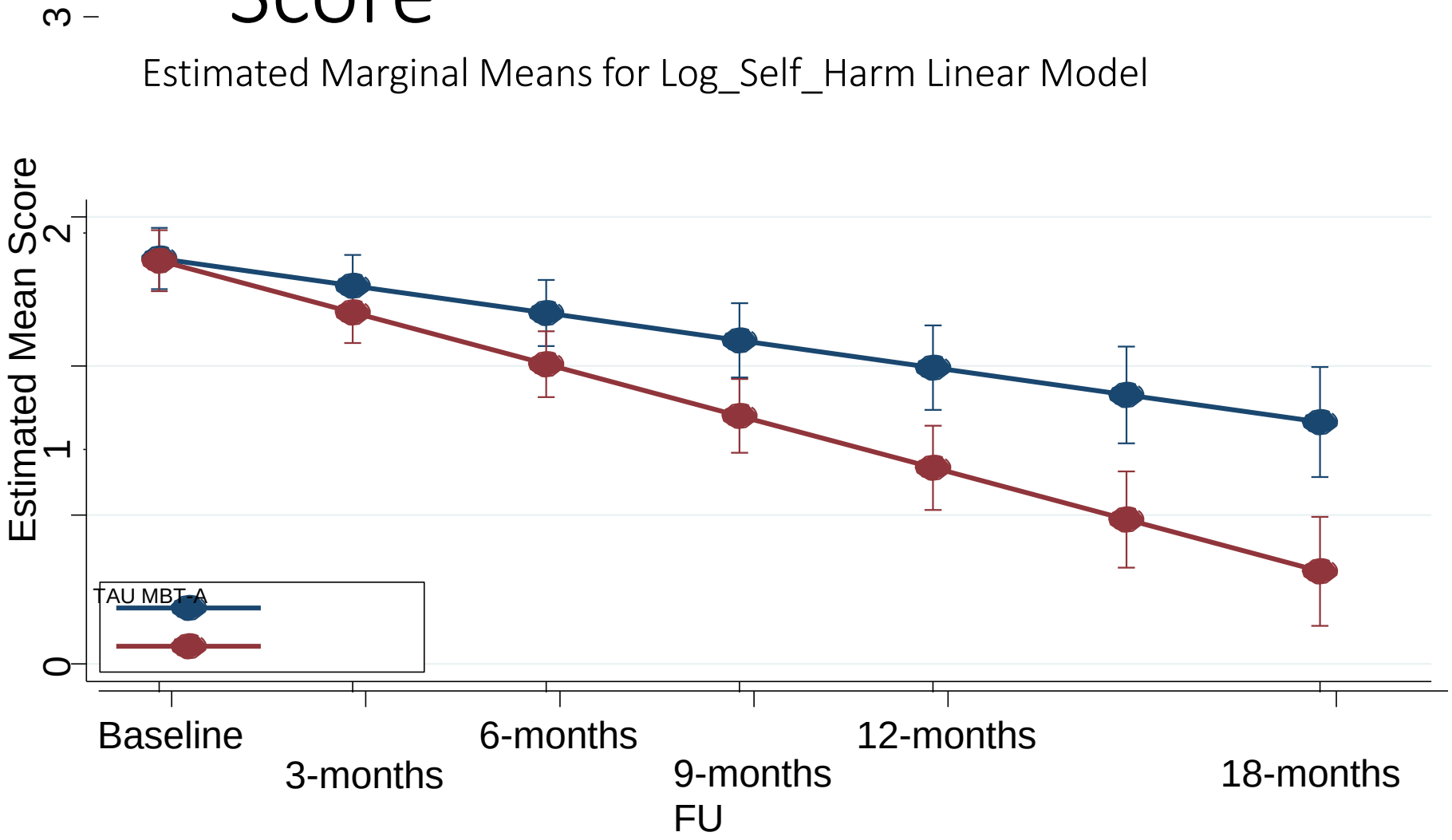
RTSHs analysis: Log_Risk_taking Score



Adjusted for Age: Random Slope .

Group differential rate of change: Beta=-0.098, 95% CI: -0.17, -0.03, t(437)=-2.64, p<0.0041, d=0.25

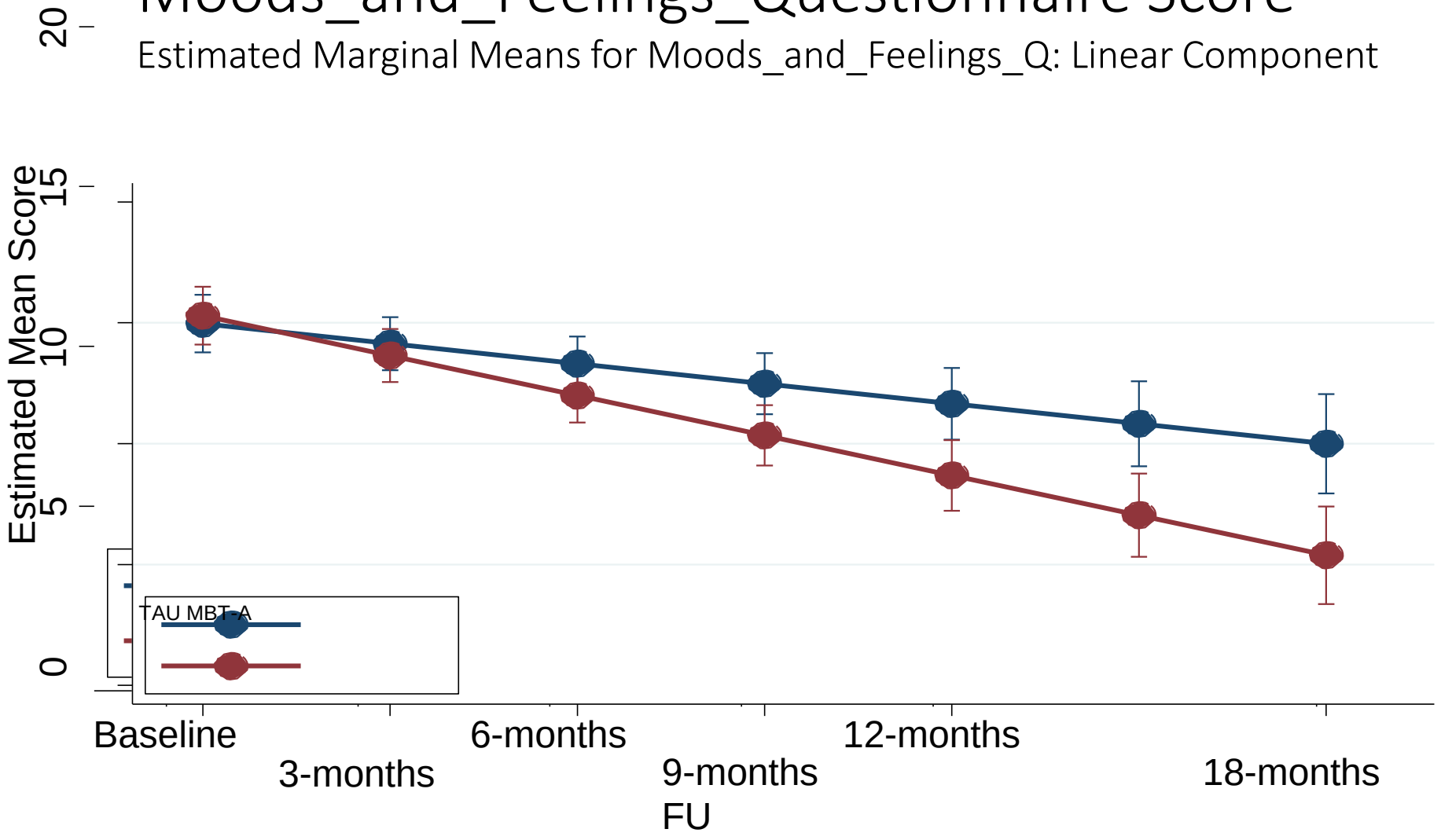
RTSHs analysis: Log_Self_Harm Score



Adjusted for Age: Random Slope .

Group differential rate of change: Beta=-0.165, 95% CI: -0.26, -0.08, t(437)=-3.51, p<0.0002, d=0.34

RTSHs analysis:
Moods_and_Feelings_Questionnaire Score



Adjusted for Age: Random Slope

Group differential rate of change: Beta=-0.824, 95% CI: -1.45, -0.21, t(437)=-2.61, p<0.0045, d=0.25

MBT-A

Structure of MBT-A

- Out patient program
  - Combination of individual MBT-A and MBTF
- Inpatient/daypatient program
  - Combination of individual MBT-A and MBTF and MBT Group

Structure

Assessment phase

Individual and family assessment, Psychometrics
Mentalizing formulation
Crisis plan

Bulk of therapeutic program

Increase mentalization

- Improve impulse control
- Reflect and repair

Termination

- Quite a bit of work on consolidating gains
- Relapse prevention

Formulation

Background Information

When you were referred to this service you reported a two year history of feeling depressed and harming yourself.

At times you have felt so depressed that life did not feel worth living.

You thought your parent's divorce three years ago, your mother's subsequent depression, your father's drinking and his recent violent relationship with his girlfriend all played a role to make you depressed.

You spoke about feeling guilty as if it was your fault.

Before you came to us for help you entered into a relationship in which you allowed someone to treat you in a disrespectful manner, almost as if you were being punished. All of this made you feel terrible about yourself.

Personality Style:

You are a very brave young person who has coped with a lot in your life.

You were also very brave to speak to me about your feelings and stuff that happened in your life. You are kind and caring to others and you have been a very reliable friend to your friends.

It is sad to notice how you cannot see your own beautiful qualities and how you constantly expect people to dislike you.

This can make you feel so anxious in social situations that you tend to withdraw yourself, but the problem with this way of coping is that it does not allow others to be close to you and in that way it reinforces you view that they do not like you.

You also told me that in your relationships things can be up and down at times. You explained that you have a desire to be close to people but as soon as you are close to them, you feel ripped apart by anxieties that they will let you down or reject you. This, you said, can make you feel so anxious that you can feel as if you are on a rollercoaster emotionally with large mood swings. From our discussions I had the impression that sometimes when you have strong feelings inside you, you cope with it by either cutting yourself or by switching your emotions off until you feel empty. Is that what happens to you?

When we spoke about you switching your emotions off, I thought about it afterwards and I thought that although I can see that it feels as if this coping style helps you at the time, I did wonder whether it does not also make you feel disconnected from what you or other people feel and whether it is then not difficult to understand what is going and I wondered if it may be at times like this that you feel action is the only thing available to you – and whether it may be at these times that you have a tendency to harm yourself. What do you think about that?

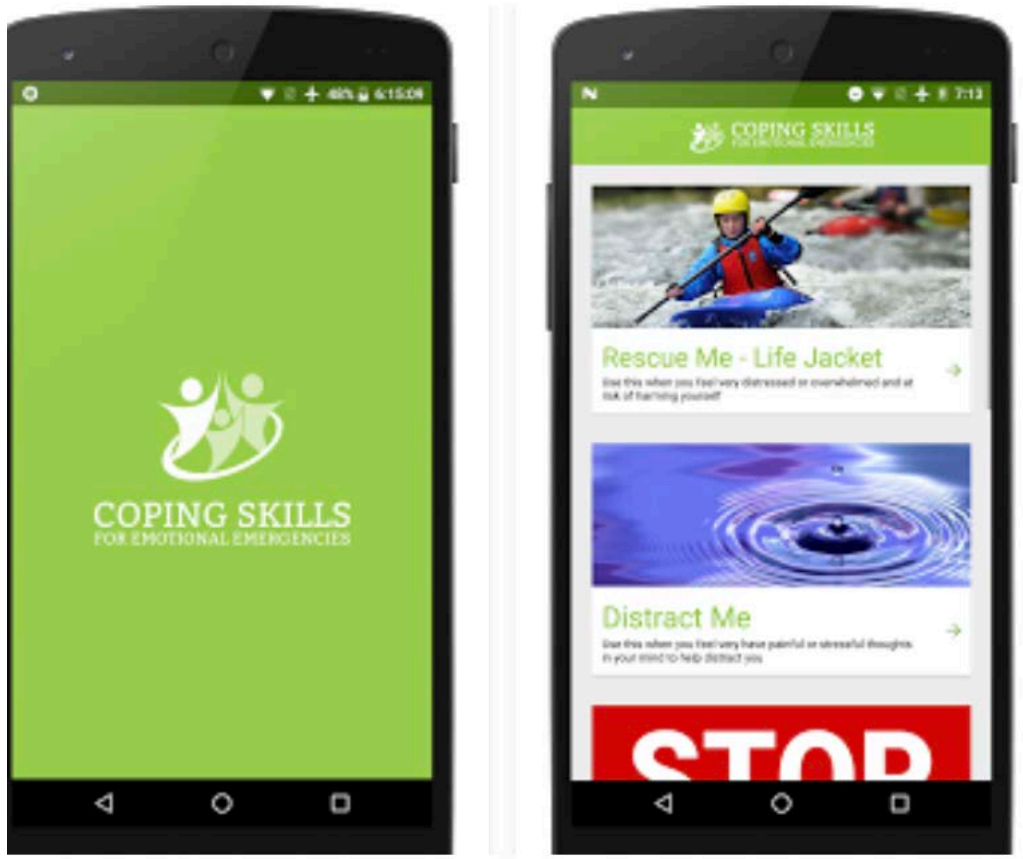
In listening to the way you spoke about yourself, I felt myself feeling very sad about the constant negative ways in which you see yourself.
I was also struck by how you seem to relate to other people in a self sacrificing manner and how at times you allow them to take advantage of you. Perhaps in therapy we can work on all these aspects and help you to develop a desire to look after yourself and to allow others to look after you rather than hurt you.
You are a lovely person and you deserve more than what you currently allow yourself to have.

Treatment Plan:

Crisis Plan:

Trigger factors that you and I identified are times when you feel rejected,
humiliated or bad about yourself. As we have discussed , these feelings do not just arrive out of the blue, they are likely to have been
triggered in a close relationship. When you have those feelings you tend to rush into an action to take the feelings away.
When you feel like that again, I would like you to use the COPING SKILLS APP. STOP AND PAUSE. Try focussing on your breathing or on one of your senses. Then try and reflect – what are you feeling? What happened before you had the feeling? Did something happen between you and someone else? Can you try and pause before you make an assumption about what they are feeling and thinking. Remember we cannot see into someone else's mind and we can make mistakes when we make assumptions about what they feel. Sometimes we are so overwhelmed with our own feelings, we assume others feel it to.

Helpful apps



Crisis plan for parents:

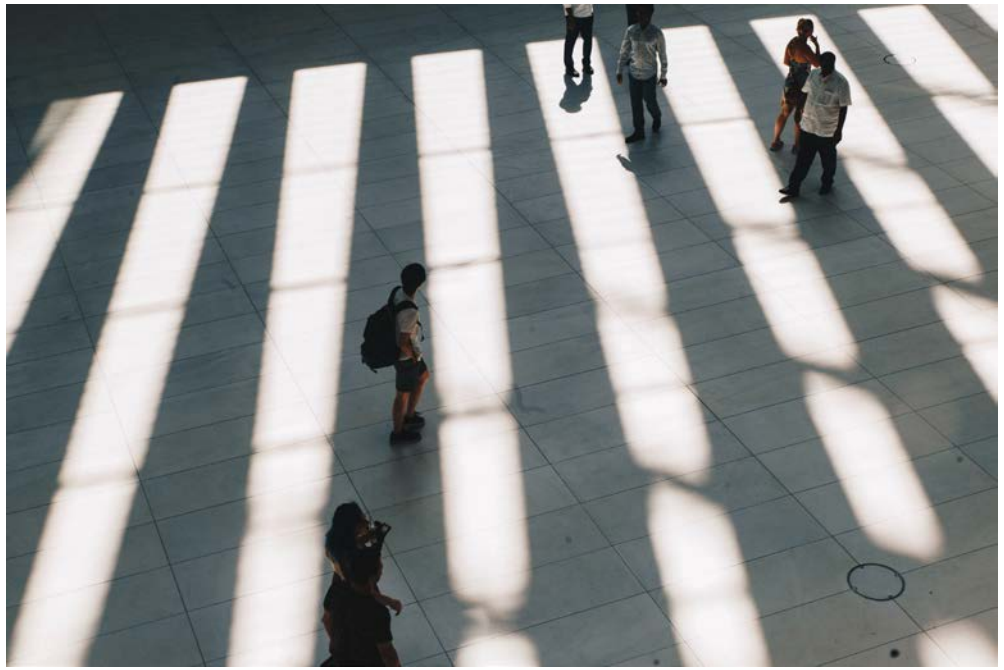
As we spoke, X's self harm is often in the context of very strong feelings that she finds hard to manage. Here are 3 do's and 3 don't's which may help you at times of risk:

Do's:

- Listen
- Understand
- Help to mentalise

Don't's:

- Panic
- Blame
- Punish



Don’t blame her and don’t blame yourself. Just try and understand what she felt before she wanted to harm herself and help her to speak about the feelings and the events leading up to the feelings. If the events involved you, listen and try and understand *her* perspective without becoming defensive. You don’t have to hold the same perspective, but it is important that you validate her perspective. If there was a misunderstanding between you which you contributed to, own up to it. You are not here to win battles but to restore the connection between you.

If she is very aroused, speaking too much is not helpful. Just be kind and supportive and say things like: “ I am not angry with you, I am here to help you and keep you safe. Something has made you so upset. I don’t know what it is and if it is something I have done, I am sorry. I really want to understand. Talk when you are ready, but until then, I will just be with you to keep you safe.”

If she wants to hurt herself, you could say: “ I really don’t want you to hurt yourself. You deserve so much more. Let’s try one of the alternatives. I will help you, shall we get a bowl of ice?”

If she is suicidal, you could say: “ Killing yourself is not an option. I love you and do not want you to kill yourself. You are not alone.

We will get through this together. I am going to stay here with you to keep you safe. Let’s try and think of something that will help right now. Will distraction help such as going for a walk or watching TV?”

If all else fails, call the clinic or if it is after hours, you may have to take her to the emergency department.

Basic MBT principles

- Therapeutic stance
  - These youngsters have no sense of their own worth, skills or talents. Under the force of the alien self they relate to themselves in dehumanised ways with no sense of compassion.
  - It is crucial for the MBT therapist to embody humanisation, warmth and compassion
  - Validation, support and empathy
  - Curiosity in mental states
  - Focus on the here and now

Additionally ...

- Build humanising scaffolding
    - What is crucial is these patients need to feel that we are interested in them
    - What they feel is important to us
    - Often presenting one's own humanity by being explicit about our motives, thoughts or feelings
- Form an alliance
- Help to re-engage in life tasks that they are fearful of and avoiding, such as going to school

- Aim is to increase the young person and their families' ability to mentalise
- Ie. To help all to be more accurate at representing the mind of the other

Thank you for listening