## Specific dialectical behaviour therapy (DBT) techniques for working with young people who have self-harmed or are suicidal

This section describes DBT techniques intended for young people who are actively self-harming or suicidal.

Effective delivery of this approach depends on its integration with the knowledge and skills set out in the full description of DBT set out in the competence framework for working with people with personality disorder and in the CBT competence framework (both accessed at (www.ucl.ac.uk/clinical-psychology/CORE/competence-frameworks)

### Knowledge of how DBT conceptualises self-harm and suicide

| | |
|---|---|
| An ability to draw on knowledge that DBT techniques and strategies were developed specifically to help people who self-harm or are suicidal | |
| An ability to draw on knowledge that and self-harm and suicide are viewed as a way of coping with acute emotional suffering when a person is unable to access other (more constructive) coping strategies | |
| An ability to draw on knowledge that these behaviours are viewed as learned responses to emotional suffering (whereby a pattern of escaping from distressing internal or external situations becomes negatively reinforced, and over time emerges as an automatic response) | |
| An ability to draw on knowledge that suicidal behaviours are viewed as a form of 'problem-solving' aimed at relieving intense negative emotional arousal: | |
| | directly, by ending life through loss of consciousness |
| | indirectly, by eliciting help from the environment |
| | through negative reinforcement (e.g. experienced reduction in emotional pain, physiological effect of body's natural painkillers) |
| An ability to draw on knowledge that self-harm and suicidal behaviours are considered to emerge as a consequence of a number of interacting factors: | |
| | a lack of a stable sense of self-identity |
| | a poor capacity to create and maintain stable relationships with others |
| | a poor capacity for emotional regulation, including tolerating and experiencing distress |
| | personal factors (such as relevant demographic and historical factors) and environmental factors (such as recent life changes, family and social contexts) that inhibit the development and deployment of more effective behavioural coping skills |
| An ability to draw on knowledge that DBT directly addresses these issues by: | |
| | skills training, which aims to enhance the capacity for interpersonal effectiveness self-regulation (including emotion regulation) and tolerance of distress |
| | structuring the treatment environment in way that motivates and reinforces the appropriate use of the taught skills component |
| | identifying and 'breaking-up' learned behavioural sequences that precede dysfunctional behaviours, and removing reinforcers for those behaviours by using behavioural and solution analyses |
| | structuring treatment to encourage the generalisation of new skills from therapy to application in everyday life |
| | providing support and regular ongoing consultation for therapists treating young people at high risk of suicide |

**Using DBT techniques in individual work to address the risk of life-threatening behaviours**

| | |
|---|---|
| An ability to track self-harm and suicidal behaviours through the use of diary cards | |
| An ability to maintain a dialectical balance between validation and change in discussions of self-harm and suicidal behaviours | |
| An ability to help the young person develop and apply problem-solving skills through: | |
| | an ability to conduct a behavioural analysis of the self-harm or suicidal behaviour* |
| | an ability to conduct a solution analysis of the self-harm or suicidal behaviour* |
| | an ability to address self-harm or suicidal behaviour using appropriate DBT change procedures (e.g. contingency management*, exposure*, cognitive modification*, interpersonal effectiveness or coaching to make use of targeted application of skills training) |
| An ability for the individual therapist to make use of team consultations in order to maintain a non-judgemental, empathetic and dialectical stance when discussing suicidal behaviours | |

* Described in the full DBT framework

**Using consultation meetings for therapists to help maintain the therapeutic frame**

| | |
|---|---|
| An ability for the therapist to set an agenda for the consultation meeting that is consistent with the DBT hierarchy of targets, and so identifies: | |
| | the therapist's need for consultation around suicidal crises or other life-threatening behaviours |
| | a person's behaviours that interfere with therapy (including absences and dropouts) as well as inadvertent therapist behaviours that might adversely affect the treatment |
| | team behaviours that might adversely affect treatment, and burnout |
| | a person's behaviours that are severe or escalating and interfere with their quality of life |
| | areas where the therapist is working effectively |
| An ability for the therapist to use the consultation team to further their DBT training | |

**Using consultation to help young people interact with their environment effectively**

| |
|---|
| An ability to identify problematic aspects of the environment that might increase the risk of repeated self-harm or suicidal behaviour |
| An ability to provide consultation to a young person to enable them to interact with their environment more effectively (e.g. learning to communicate more effectively with family members, carers, friends and professionals) |
| An ability to use clinical judgement to decide when it is more appropriate to intervene in the environment to prevent substantial harm to the young person (e.g. when they lack the abilities they need to learn and the situation is acute and potentially life-threatening) |

## Application of DBT strategies when working with young people and their families and carers

| |
|---|
| An ability to draw on knowledge of adolescent development |
| An ability to draw on knowledge of the distinction between age-appropriate and problematic behaviours |

## Knowledge of relevant difficulties in parenting and family styles

| | |
|---|---|
| An ability to draw on knowledge of factors that can make it harder for parents and carers of young people to offer consistent or positive parenting: | |
| | background factors such as mental health problems (particularly substance misuse), a history of loss, abuse, social adversity or negative experiences of parenting |
| | unhelpful responses to self-harm and suicidal behaviours (e.g. a fear of making too many demands on a young person, attempting to deal with the effects of behavioural dysregulation though excessive control, becoming desensitised to problematic behaviours) |
| An ability to draw on knowledge of problematic parenting styles that DBT identifies (and so focuses on), for example, moving between: | |
| | being excessively lenient versus being inappropriately controlling |
| | normalising unhelpful behaviours versus pathologising behaviours that are normal for young people |
| | forcing their child to be unhelpfully autonomous versus fostering dependence |

## Knowledge of common parenting targets/aims that inform treatment

| | |
|---|---|
| An ability to draw on knowledge that DBT for young people who have self-harmed and/or are suicidal usually includes giving a young person and their parents or carers skills that increase: | |
| | a young person's capacity for self-discipline and decrease excessive permissiveness or lack of appropriate self-discipline |
| | a young person's capacity self-determination and decrease excessive parental control |
| | parental recognition of behaviours that are developmentally normal |
| | parental recognition of developmentally pathological/abnormal behaviours |
| | a young person's capacity for self-direction and decrease inappropriate dependence |
| | a young person's capacity to make use of support from others appropriately |

## Including families and carers in the intervention

## Knowledge of key barriers to engagement for families and carers

| | |
|---|---|
| An ability to draw on knowledge that DBT assumes that families and carers of young people who have self-harmed or are suicidal will commonly: | |
| | experience intense feelings of shame and failure |
| | have intense fears for the safety of their children |
| | feel guilty about their role in the young person's difficulties |
| | have had experiences of past treatment failures |
| | have had experiences of being blamed by professionals |

| | |
|---|---|
| An ability to make use of DBT principles to adopt a helpful stance towards young people and their families and carers by assuming that they: | |
| | are doing the best they can |
| | want things to improve |
| | may not have caused all their own problems, but have to solve them anyway |
| | experience life as it is currently being lived as unbearable |
| | must learn new behaviours in all relevant contexts |

**Family therapy sessions**

| | |
|---|---|
| An ability to draw on knowledge of ways in which family sessions (that include the young person) can be used, including: | |
| | intensive coaching and support for both parties (e.g. where there is a major ongoing conflict between them, or the responses of families and carers at home is inadvertently reinforcing dysfunctional behaviour or punishing helpful behaviour) |
| | assistance with a sudden crisis in the family or care arrangements |
| | supporting individual work with the young person by sharing education and information about specific treatment targets and skills |
| An ability to draw on knowledge that the aims of family treatment sessions are to: | |
| | decrease family/carer interactions that contribute to the young person's life-threatening behaviours |
| | reduce unhelpful family, parental or carer behaviours that interfere with the treatment (e.g. refusing to provide necessary transport to appointments) |
| | improve the family's quality of life by improving their capacity for communication and emotional regulation |
| | increase the family's or carers' behavioural skills by enhancing their parenting skills and interpersonal effectiveness |
| An ability to manage complex issues of confidentiality in a transparent way with the young person and their family or carers | |
| An ability to prepare young people for family sessions by anticipating difficulties and identifying skills they can use to manage these | |
| An ability to involve all family members and carers in a behavioural analysis:* | |
| | orienting the family and carers to the procedure of chain analysis and its purpose |
| | examining the events leading up to a young person's targeted behaviour and eliciting moment-to-moment, thoughts, feelings and behaviours from all family members and carers |
| | drawing attention to the ways in which interactions between the young person and family members and carers are reciprocal and play a role in the events in a chain |
| | helping the family or carers consider the ways in which their responses to the target behaviour may shape it (either helpfully or unhelpfully) |
| An ability to conduct a solution analysis* in order to help the family or carers identify potential solutions that may reduce the target behaviours | |
| An ability to collaboratively construct a crisis plan with the family or carers that identifies key DBT skills and helpful responses when the young person is in distress | |

* Described in the full DBT framework

- An ability to help families and carers make use of DBT skills and principles to prevent a crisis from occurring by helping them to:
  - understand and empathise with the young person's difficulties in emotion regulation
  - decrease judgemental reactions that might escalate the situation
  - validate their own distress and concerns whilst reinforcing their ability to get through the crisis
  - improve communication between the young person and family members or carers
  - increase parental responsiveness during periods where there is no crisis
  - respond to and reinforce helpful coping, and decrease reinforcement of unhelpful coping by the young person
  - develop a detailed plan to keep the young person safe that can be followed in a time of crisis

**Family/carer involvement in skills training**

- An ability to conduct and where required adapt skills training for young people and their parents/carers, for example by:
  - providing a rationale for family or carer involvement (e.g. to help them coach their young person and learn skills that may benefit them in their own right)
  - discussing topics that might raise guilt or defensiveness in families or carers (e.g. the concept of the invalidating environment, confidentiality)
  - teaching skills in an experiential way that will engage young people (e.g. use of playful mindfulness exercises, bringing in props to demonstrate self-soothing)
  - anticipating and problem-solving barriers to practising skills in both young people and parents/carers
  - addressing common therapy-interfering behaviours of parents or carers and young people when in a group (e.g. arriving late, cross-talking, doodling, interrupting)

* Described in the full DBT framework

**Using phone/digital consultation with young people and their families and carers**

- An ability to draw on knowledge that the aim of ad hoc coaching (usually by telephone or email) is to help young people and their families or carers generalise the skills taught in face to face sessions to situations in everyday life
- An ability to draw on knowledge of problems that can arise when providing consultation, such as:
  - unintended violations of confidentiality
  - threats to therapeutic trust (particularly the young person's trust in the therapist)
  - the complication of occupying a dual role in relation to both the young person and their parents
- An ability to manage the potential problems by, for example:
  - having separate contacts for the young person and for family members or carers
    - where a single clinician acts as the sole contact, establishing clear ground rules about transparency (e.g. that the young person will be informed if a family member or carer calls the therapist)
  - setting out clear expectations about information sharing with all parties
- An ability to establish the therapist's and the young person's and their family's or carers' expectations of how and when to use between-session consultations
- An ability to respond to a suicidal act by:
  - assessing the lethality of the act

| | |
|---|---|
| | ensuring that the young person receives medical attention if this is required |
| | ensuring the family or carer is informed and involved in keeping the young person safe |
| | aiming to help the family or carer respond to the suicidal behaviour but not to reinforce it |
| An ability to respond to imminent self-harming or suicidal behaviour by: | |
| | determining the immediate risk of self-harm or suicide |
| | identifying how to remove access to means |
| | empathically reinforcing the idea that self-harm and suicide are not the solution |
| | generating hopeful statements and alternative solutions |
| | assessing whether the behaviour is a direct response to overwhelming negative emotional arousal or an indirect response that may function to elicit help from others |
| | helping a young person to communicate their need for help to their family or carers |
| | helping a young person and their family or carers make use of the skills in their safety plan and find helpful alternatives to self-harm or suicide |
| An ability to respond to a young person in crisis in a manner that is consistent with the principles of DBT, for example: | |
| | focusing on the current emotion rather than the content of the crisis |
| | identifying triggers to the crisis and arriving at a formulation of its development |
| | helping them to problem solve and identifying skills they are using |
| | reducing any high-risk factors in the environment |
| | reducing any high-risk behaviours |
| | developing a collaborative plan of action |
| | assessing the potential for suicide throughout and at the end of the interaction |
| | anticipating crisis recurrence and keeping in touch |
| An ability to help parents/carers to respond to a young person in crisis in a manner that is consistent with the principles of DBT, for example: | |
| | helping them to assess the potential for suicide and act accordingly |
| | addressing their distress and helping them to regulate their emotions (so they can respond more effectively to a young person effectively) |
| | helping them to implement a prearranged collaborative safety plan |
| | anticipating crisis recurrence and taking steps to monitor a young person |

# Mentalisation-based treatment (MBT) for young people who self-harm and their families and carers[1]

This section is in two parts, the first describing the application of MBT, and the second the extension of MBT to a family context.

## Knowledge

### Knowledge of the developmental model underpinning MBT

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|---|
| An ability to draw on knowledge that a mentalisation based approach is grounded in neurobiology and attachment theory |
| An ability to draw on knowledge of mentalisation as a generic psychological process |
| An ability to draw on knowledge that the MBT model formulates the mental vulnerabilities associated with self-harm as arising from the loss of a capacity for mentalisation in the context of attachment relationships |
| An ability to draw on knowledge of the developmental factors and experiences that are typically associated with a vulnerability to loss of mentalisation (e.g. a history of abusive relationships) |
| An ability to draw on knowledge that vulnerability to losing a capacity for mentalisation makes it likely that a young person's internal reality will rest on modes of experiencing associated with early phases of development, and this will undermine the coherence of self-experience |

### Knowledge of the aims and focus of the intervention

| |
|---|
| An ability to draw on knowledge that MBT aims to increase people's capacity to mentalise at points when it would otherwise be lost |
| An ability to draw on knowledge of indicators that signal 'good' and 'poor' mentalising (e.g. a capacity to distinguish between appearance and reality, to monitor and reflect on own thoughts, feelings and language to infer meaning, and to reason from a basis of knowledge about self or others) |
| An ability to draw on knowledge that the therapy aims to support the recovery of mentalisation, not the acquisition of insight into unconscious dynamics |
| An ability to draw on knowledge that the treatment systematically focuses on: |
| a person's state of mind, not on their behaviour |
| a person's affects in the here-and-now of the session or recent past, not on the interpretation of unconscious or events that occurred a long time ago |

[1] Sources: Bateman A, Fonagy P. Mentalisation-based Treatment for Borderline Personality Disorder. Oxford: Oxford University Press; 2006; Roussouw, T. MBT-A Manual. Unpublished manuscript; 2018.

## Knowledge of the intervention strategy

| |
|---|
| An ability to draw on knowledge of the ways in which MBT can be delivered (individually or in mentalisation-based family therapy, in the context of either day hospital provision or intensive outpatient treatment with psychiatric support) |
| An ability to draw on knowledge that the three main phases of the treatment have distinct aims targeting particular processes: |
| an initial phase that aims to engage a young person and their family or carers in treatment using the formulation |
| a middle phase that focuses on enhancing mentalising capacity in a young person and their family or carers by developing their ability to become more aware of mental states in themselves and others |
| a final phase that focuses on helping a young person to prepare for ending treatment |
| An ability to draw on knowledge that the intervention makes active use of the young person-therapist relationship to explore failures of mentalisation and their consequences |

## Therapeutic stance

| |
|---|
| An ability to establish and maintain a supportive, reassuring and empathic relationship with a young person and their family or carers |
| An ability to adopt a stance of 'not knowing', which communicates a genuine attempt to find out about the mental experience of a young person and their family or carers |
| An ability to sustain an active, non-judgemental mentalising stance that prioritises the joint exploration of a young person's mental states: |
| an ability to communicate genuine curiosity about the mental states of a young person and their family or carers by actively enquiring about interpersonal processes and their connection with all the participants' mental states |
| An ability to sustain a positive, supportive stance without undermining a young person's autonomy: |
| an ability to make use of supportive interventions judiciously, which may involve taking concrete action while maintaining therapeutic boundaries (e.g. endorsing a young person's decision to disclose an intention to self-harm, or agreeing to negotiate a brief hospital admission on a young person's behalf, if needed in an emergency) |
| An ability to communicate a non-judgemental and non-blaming stance to the family or carers to help them engage with treatment and work towards remoralisation (from a position of demoralisation) |
| An ability to reflect critically on when and how to self-disclose, and to do so selectively in the service of fostering a young person's mentalising |
| an ability for the therapist to communicate their own way of thinking about a young person's experiences (disclosing the therapist's emotional reactions and thoughts in response to the relational context described by a young person) |
| an ability for the therapist to show an openness to reflecting on their own 'non-mentalising errors' and how these may have impacted on the young person (e.g. by discussion, through relevant questions and observations) |
| an ability to model honesty by acknowledging the therapist's own errors |

## Assessment

### General

| |
|---|
| An ability to assess a young person's overall functioning (and in particular coexisting 'Axis I' and 'Axis II' disorders) |
| An ability to assess level of risk to self and others and to create a detailed crisis plan for use by a young person and their family or carers from the start of treatment |
| An ability to assess a young person's cognitive and executive functioning, where there are indications that this may be relevant |

### Model-specific areas of assessment

| | | |
|---|---|---|
| An ability to assess a young person's ability to regulate their own emotions, independently of any mental health problem | | |
| An ability to assess mentalisation in the interactions of family members or carers | | |
| An ability to distinguish mentalisation from: | | |
| | pseudo-mentalisation or 'pretend mode' (where a young person, family member or carer appears to mentalise, but in a way that is not stable over time, inconsistent with other thoughts about the self, and not linked to appropriate affect, and where discussion of their thoughts and feelings may lead to rapid agreement, without reflection or scrutiny) | |
| | concrete thinking (psychic equivalence): a prementalising mode of thinking in which reality is equated with mental states, and the sense of representation of mental states is absent | |
| | misuse of mentalisation (using an understanding of another's mental state to exert power over them, rather than to communicate and foster understanding) | |
| An ability to assess a young person's capacity to mentalise, and the factors that undermine this capacity, by exploring their current and past interpersonal context: | | |
| | an ability to elicit a detailed picture of a young person's significant relationships and their connection with presenting problem behaviours | |
| | an ability to elicit interpersonal narratives by asking questions that invite a young person and their family or carers to elaborate and reflect on their own mental states and those of others | |
| An ability to assess the quality of a young person's current and past interpersonal functioning, including: | | |
| | whether their pattern of relationships is characterised by hyper-activating or deactivating strategies: | |
| | | hyperactivating strategies (e.g. vulnerability for self-other confusion) |
| | | deactivating strategies (e.g. avoidance of relationships in the service of maintaining stability, or strong approach-avoidance conflicts) |
| | the quality of communication between a young person and others, particularly family members or carers | |

## Engagement

| |
|---|
| An ability to communicate with a young person and their family or carers in a direct, authentic, transparent manner, using simple and unambiguous statements so as to minimise negative interactions and the risk of over-arousing them by over-estimating their capacity to mentalise |
| An ability to share a summary of the difficulties with a young person and their family or carers in an open, collaborative manner that encourages them to reflect on what this means for them in the context of their experience and reported difficulties |
| An ability to introduce a young person and their family or carers to the core concepts of MBT by providing psychoeducation indicating that: |
| behaviour has meaning |
| feelings arise in a relational context |
| people have a powerful emotional impact on each other |
| An ability to pitch the level of explanation according to an assessment of a young person's capacity to take in new information (which in turn will depend on their developmental stage and capacity to mentalise at that moment) |
| An ability to personalise the introduction of the model by linking it to a young person's own history and current experiences |
| An ability to introduce a young person and their family or carers to the treatment rationale and goals, through psychoeducation and making use of the live process in the session (e.g. by highlighting examples of their mentalising strengths and vulnerabilities as they describe themselves and their relationships) |
| An ability to introduce a young person and their family or carers to the contract and ground rules that protect the treatment boundary, and to provide a rationale for them in the context of the mentalising focus of the treatment: |
| an ability to engage a young person and their family or carers in exploring their reaction to the ground rules |

## Formulation and planning

| |
|---|
| An ability to arrive at a written formulation that can be shared with a young person and their family or carers, setting out relevant issues related to their vulnerability to loss of mentalising clearly and explicitly, and illustrated with examples drawn from the assessment: |
| introducing and discussing the formulation with a young person while monitoring the impact it has on them, and responding sensitively to indicators of emotional arousal |
| modifying the formulation according to new understandings that emerge |
| An ability to work collaboratively with a young person and their family or carers to agree short- and long-term goals, and to identify what a young person and their family or carers can do for themselves in a crisis and how they will access help if necessary |
| An ability to identify a young person's main subjective concerns as well as problematic behaviours (such as self-harm) and develop a formulation that links these areas and indicates a pathway for change |
| An ability to engage a young person and their family or carers in collaboratively identifying how they will access help when in crisis |

## Intervention

### Knowledge

| |
|---|
| An ability to draw on knowledge that interventions are aimed primarily at helping a young person discover what they feel and to develop meaning, and not to interpret what a young person may be feeling and why they may be feeling it |

### General characteristics

#### a) Content of interventions

| | |
|---|---|
| An ability to make interventions that are: | |
| | focused on thoughts and feelings, not on behaviour |
| | focused on affect (primarily in relation to the here-and-now of the session) |
| | related to current event(s) and to near-conscious or conscious content |
| | simple, short and unambiguous |
| | qualified/tentative, so as to model managing uncertainty in relation to the mental states of others (e.g. 'I am not sure if…') |
| An ability to accurately and succinctly restate and spell out the assumptions behind a young person's thoughts and feelings about an issue, neither oversimplifying nor overcomplicating their experience | |

#### b) Process of intervention

| |
|---|
| An ability to respond to a young person's requests for clarification in a direct and clear manner that models a self-reflective stance that is open to correction |
| An ability to follow shifts and changes in a young person's understanding of their own and other people's thoughts and feelings |
| An ability to become aware of, and respond sensitively to, sudden and dramatic failures of mentalisation |
| An ability to make use of the here-and-now relationship with the therapist to help a young person identify failures of mentalisation and explore their consequences |
| An ability to consider the timing and the type of interventions in the context of an assessment of a young person's current emotional state, so as to maintain their level of arousal at an optimal level that supports (and does not disrupt) mentalising |

## Ability to explore mentalising

### Knowledge

| |
|---|
| An ability to draw on knowledge that basic mentalising interventions are introduced in a gradual, staged manner in which a young person's state of emotional arousal is closely monitored so as to ensure that they can mentalise (and therefore make use of) the therapy relationship |

## Ability to explore mentalising

| |
|---|
| An ability to use clarification and elaboration to gather a detailed picture of the feelings associated with a specific behavioural sequence |
| An ability to clearly restate and elaborate an understanding of the thoughts, feelings, beliefs and other mental states described by a young person, and to do so in a way that opens up discourse about these (rather than closing it off) |
| An ability to help a young person make connections between actions and feelings |
| An ability to help a young person develop curiosity about their motivations |
| An ability to help a young person identify instances when they failed to 'read minds', and the consequences of this failure |
| An ability to share the therapist's perspective so as to help a young person consider an alternative experience of the same event |
| An ability to maintain or to redirect the focus of exploration to a young person's felt experience, motivations and current state of mind, pointing out instances of 'non-mentalising fillers' (e.g. rationalisations and dismissive statements) |
| An ability to help a young person shift the focus from non-mentalising interaction with the therapist towards an exploration of current feelings and thoughts relating to the young person-therapist interaction, or recent experiences outside the therapy room |
| An ability to praise a young person judiciously when they use mentalising with a positive outcome, so as to encourage and support change |

## Ability to re-establish mentalising

| |
|---|
| An ability to identify breaches in mentalising, as they occur in a young person, the therapist or both, so as to redirect the focus on understanding the rupture or impasse and re-establish mentalising |
| An ability to draw attention to the rupture or impasse, exploring what has happened by focusing on a young person's felt experience |
| An ability to challenge a young person's perspective while exploring their underlying emotional state |
| An ability to communicate to a young person the affective process that inhibits the capacity to mentalise |
| An ability to sensitively, yet firmly, persist with exploring a young person's state of mind in the face of a difficulty in reinstating mentalising |

## Ability to mentalise the therapy relationship

### Knowledge

| |
|---|
| An ability to draw on knowledge that MBT focuses on encouraging people to reflect on what is happening *currently* in the therapeutic relationship |
| An ability to draw on knowledge of the treatment rationale for focusing on the therapeutic relationship (i.e. helping a young person consider alternative perspectives on the same event, not to provide insight) |
| An ability to draw on knowledge that mentalising the therapy relationship is only indicated when a young person is considered able to reflect on their own mental states and those of the therapist in the context of heightened affect |

### Application

| | |
|---|---|
| An ability to help a young person gradually progress (over the course of treatment) from the least intensely felt reflection to the more intensely felt reflection, by staging interventions in the following sequence: | |
| | exploration of emotional experience in current external relationships |
| | exploration of emotional experience in relation to interpersonal themes as they emerge in relation to the treatment |
| | exploration of the therapy relationship |
| An ability to work collaboratively with a young person towards an understanding of the therapy relationship by encouraging them to be curious about what has happened in the room: | |
| | an ability to use clarification and elaboration to elicit a detailed picture of what has transpired between a young person and a therapist and develop a shared alternative perspective |
| An ability for the therapist to monitor their feelings and to convey these openly to a young person in the service of enhancing the mentalising process (e.g. to regain a reflective stance after an enactment) | |
| An ability to acknowledge and explore openly with a young person an enactment on the part of the therapist: | |
| | an ability to communicate the therapist's perspective about the impasse or rupture, focusing on the failure of mentalisation, not on giving insight into underlying unconscious factors |
| An ability to monitor and engage with a young person's response to a therapist's attempts to mentalise the relationship | |

**Working with young people and their families and carers: mentalisation-based family therapy (MBFT)**

## Knowledge

| |
|---|
| An ability to draw on knowledge that the aim of MBFT is to enhance mentalisation in family relations and to reduce impulsive enactments, coercion, non-mentalising interactions and escalation in affect |
| An ability to draw on knowledge of the basic principles of MBFT: |
| maintaining an inquisitive stance |
| holding a balance between observation of the natural family interaction and the need to bring about change |
| intervening to terminate non-mentalising interactions |
| highlighting and reinforcing positive mentalising |

## Application

| |
|---|
| An ability to help families and carers to notice and name repetitive non-mentalising interactions |
| An ability to include all family members and carers in the process of identifying and discussing common problematic patterns of interaction |
| An ability to help families and carers to generalise from examples identified in sessions and plan how they might approach these differently in the future |
| An ability to identify when an individual coaching session for a family member or carer may be necessary in order to help them with mentalising their own feelings |
| An ability to make use of mentalising ‘games’ (e.g. role play, a ‘feelings bubble’) to help families and carers to become aware of each other as individuals with different feelings and who are affected by those around them |
| An ability to apply the core aims and strategies of a mentalising approach to a group and a systemic context, including a young person’s family system and the system within which services are provided |
| An ability to monitor the family’s or carer’s ability to mentalise over the course of treatment and take appropriate action (such as providing additional coaching sessions) if one of them becomes ‘stuck’ in a position of conflict |

## Ending the intervention

| |
|---|
| An ability to address the ending of treatment in the context of the therapy relationship, and the potential for a young person's experience of loss and abandonment to undermine their sense of self-coherence |
| An ability to increase a young person's independence and responsibility by consolidating areas of greater stability and sense of mastery in a young person and their family or carers |
| An ability to help a young person end therapy by: |
| addressing their concerns and those of their family or carers about endings by discussing the issue early in treatment |
| negotiating a clear ending date and identifying arrangements for follow-up (balancing a sense of agency and personal responsibility with management of attachment loss) |
| building up community resources and contacts (so that a young person has opportunities to meet others and live a 'life worth living' in terms of personal constructive activity) |
| working jointly with a young person and their family or carers to identify areas where they show a good capacity for mentalising, and considering how this capacity can be drawn on in areas where they remain vulnerable to a loss of mentalising |
| revisiting the formulation and discussing long-term goals |
| providing a written summary of treatment sessions as an aide memoire for the future |
| creating a coping plan detailing the way difficulties will be managed if these re-emerge in the future |
| tapering sessions towards the end of treatment and offering a follow-up session |