

MBT-C Adherence Scale (MBT-CAS)

As of October 17, 2020

How to Use the Scale:

The MBT-C Adherence Scale was developed as a tool for assessment and reflection. It can be used to consider adherence in direct work in MBT-C with children. This scale can be completed by an independent rater, clinician, observer or supervisor.

The terms 'adherence', 'fidelity', 'competence' etc. have different, but related meanings. For the purposes of this Scale, the term 'adherence' is used not only to describe the use of specific techniques, but also the capacity to hold the core 'mentalizing stance' and the quality of the way in which the model is delivered. A central feature of MBT-C is the development of the child's sense of self. And as clinicians, we too have our own "selves" with different temperaments and styles, and the children we work with have different needs. Thus, while the MBT-CAS sets out core principles and techniques that are expected to be present in an MBT-C session that is "on-model," these may look different for each child-therapist dyad, at different points in time.

This scale will serve as a guide to help clinicians focus on areas of strength and areas for growth, during supervision, training, and self-reflection. The goal is for clinicians to learn to apply MBT-C stance and techniques with fidelity in practice.

When used as an evaluation tool for research or demonstrating capacity to work 'on model', the scale can check adherence to the model and serve to identify aspects of treatment associated with positive change in the child. *When being used by therapists or supervisors as an aide to developing fidelity to the MBT-C approach, it is recommended that clinicians spend 5-10 minutes after each MBT-C session with a child, reviewing this scale and assessing the presence and skill level the clinician was at in the session.*

Similar to MBT-C treatment, the focus of this scale is not on what the clinician did "right or wrong," but rather a process of reflecting on the work with each child in which clinicians and supervisors do the following: 1) make the implicit explicit, in terms of what you did or did not do, and 2) attend to and explore the thoughts, feelings and intentions that were underlying your behaviour as a clinician, and those that may have been underlying the behaviour of the child in the session.

We are all prone to slip into non-mentalizing modes when working with children who are emotionally dysregulated and not mentalizing. Therefore, it may be useful to use the scale in supervision, as a function of the supervisory relationship is to restore and facilitate your own mentalization. By practicing restoring our mentalizing functions in the context of supervision, we become better able to restore our mentalization when we are in the room with children and to help them to develop or restore their mentalizing capacities.

Assessment of Skill Level

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

<u>MBT-C Stance and Core Principles</u>	<u>Presence</u>	<u>Skill</u>
1) Adaptation to child’s developmental level	<input type="checkbox"/>	
2) Non-judgmental stance	<input type="checkbox"/>	
3) Not-knowing, mentalizing stance	<input type="checkbox"/>	
4) Playful stance	<input type="checkbox"/>	
5) Making implicit, explicit	<input type="checkbox"/>	
6) Use of Self	<input type="checkbox"/>	

<u>MBT-C Techniques</u>	<u>Presence</u>	<u>Skill</u>
Attention Control Interventions		
Create joint attention – rhythm, structure and feeling of being together	<input type="checkbox"/>	
Assume responsibility for structure and holding	<input type="checkbox"/>	
Name and describe what child is doing/what is happening in the here and now	<input type="checkbox"/>	
Look for/be curious about mental states (including in play)	<input type="checkbox"/>	
Other characteristic attention control interventions:	<input type="checkbox"/>	
Emotion Regulation Interventions		
Awareness and curiosity about perception and feelings	<input type="checkbox"/>	
Identify bumpy roads or triggers	<input type="checkbox"/>	
Regulation of Arousal	<input type="checkbox"/>	
Play with regulation and limits	<input type="checkbox"/>	
Offer support and empathy in face of mentalizing breakdowns	<input type="checkbox"/>	
Other characteristic emotion regulation interventions:	<input type="checkbox"/>	
Explicit Mentalizing Interventions		
Link mental states to behavior	<input type="checkbox"/>	
Play with perspective	<input type="checkbox"/>	
Mentalize the relationship	<input type="checkbox"/>	
Other characteristic explicit mentalizing interventions:	<input type="checkbox"/>	

Introduction to the scale:

Each item listed on this scale requires the rater to indicate if the stance or technique was **Present**, and then *if the stance or technique was present*, assign a rating for **Skill Level**, which refers to the clinician's demonstration of:

- Expertise, competence and commitment, willingness to take well-judged relational risks
- Appropriate timing and pace of intervention
- Adapting to the fluctuating mentalizing state of the child/ parents
- Responding to where the child /parents are at specific times

A definition will be given for each item defining: Poor (1) adequate (3) and very good (5) skills. Skill level is not the same as effectiveness of intervention. A clinician may make an intervention which has a high level of skill, but it may not have an immediately observable effect for a number of reasons. When rating a session, it is most helpful to assume that the clinician is 'adequate' until proven otherwise. The assessor should then be able to define why a clinician moves below or above this 'good enough' level of skill.

Skill level of each item encompasses 1) **frequency** (the number of discrete times the clinician engages the intervention), 2) **extensiveness** (the depth or detail with which the clinician covers any given intervention) and 3) **appropriateness** (the degree to which the intervention is adapted to the right level for the given context). A highly skilful clinician makes interventions with the frequency and extensiveness that is appropriate to the given situation. When interventions are made too infrequently/not frequently enough or too minimally/inappropriately extensive, they should be rated lower in skilfulness as a result.

Criteria for the Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

- 1 Poor The clinician handled this in an unacceptable manner.
- 2 Less than adequate The clinician handled this skill poorly e.g. demonstrating lack of expertise, poor timing, unclear language, lack of understanding, in a less than average manner.
- 3 Adequate The clinician handled this in a manner of an average 'good enough' clinician.
- 4 Good The clinician handled this in a skilled manner that was better than average.
- 5 Very good The clinician handled this in an extremely skilled and thoughtful way.

Behavioural Descriptors will be added to each item to aid assessor in assessing the appropriate skill level.

An intervention is any audible behaviour/utterance of the clinician (for audio recordings or observable for video recordings or live supervision). This may be a single statement or a series of statements developing an interaction between the child and the clinician.

Though frequency, extensiveness and appropriateness of interventions are not rated separately, these aspects of an intervention should be considered when assessing skilfulness. For example, a highly skilful mentalizing intervention may be done only once in a session but with depth (extensiveness) and appropriately. In contrast, frequent mentalizing interventions done in depth and at wrong timing might be overwhelming to the child and therefore rated lower in skill.

EMPLOYING MBT-C STANCE AND BASIC PRINCIPLES

1. Adaptation to child's developmental level

The clinician has an understanding that different children have different developmental capacities, and this is not necessarily tied to chronological age. The clinician adapts his/her way of working to the child's developmental level and that enables to build a relationship with the child. The clinician also seems to adapt to the fluctuating mentalizing capacity of the child. The interventions are for the most part short, concise and easily understood by the child.

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- The clinician shows little or no evidence of adapting to the child's developmental level. Clinician's ways of speaking, relating and expectations are too difficult for the child to understand. Clinician may name affect too abruptly to a child who does not have the cognitive emotional capacity to understand. The clinician does not adapt to the child's fluctuating mentalizing capacities present in the session e.g. asking questions that may be difficult to understand / too difficult to answer and lead to disengagement which is then not repaired.

Adequate- For most part, clinician seems to adapt to the developmental level and the fluctuating mentalizing capacities of the child. The clinician is able to keep the child engaged and involved at own pace. The clinician's interventions are short, concise and can generally be understood. Clinician at times may make comments/assumptions that are not fully adapted to the child's developmental level and mentalizing capacity.

Very Good- The clinician demonstrates exceptional skill in adapting to the child's developmental level and mentalizing capacity. The clinician is well-aware of the child's developmental level and that it could be different among children with the same chronological age. Clinician is able to build a relationship with the child and adapt ways of speaking, relating and expectations to the child's developmental capacities. The clinician skilfully attunes interventions to the appropriate level for the child, which are short, concise and easily understood by the child.

2. Non-judgmental stance

The clinician appears genuinely warm and interested, making comments to communicate a positive and non-judgmental attitude throughout the session. The clinician is respectful and accepting of the child's experience, emotions, feelings and thoughts.

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- No evidence of non-judgmental stance demonstrated by the clinician in the session. The clinician appears to be authoritative to the child and may give critical comments or overuse praise/evaluative comments. The clinician may also set limits for the child without giving any explanations in challenging contexts.

Adequate- Clinician seems reasonably non-judgmental, and may give positive comments communicating a positive attitude throughout the session. The clinician shows respect and empathy to the child, but at times may make critical comments /set limits to the child without giving explanations.

Very Good- Clinician approaches the child in a non-judgmental way and demonstrates a capacity to maintain empathy and engagement even when the context may make this challenging. Clinician conveys their warmth and interest and offers empathy in a skilled and well-timed way, which enables the child to feel deeply understood and share more powerful thoughts and feelings. Clinician may also adapt interventions in a respectful way that are effective and individualized for the child. The clinician makes comments that communicate positive attitude even under challenging situations.

3. Not-knowing, mentalizing stance

The clinician communicates a genuine curiosity and poses appropriate questions designed to promote exploration of mental states of the child. The clinician takes a 'not-knowing' position, which does not mean that the clinician has no thoughts or ideas but recognises that there are ideas and knowledge to be shared in the room. Rather than taking an expert position and offering advice immediately, the clinician demonstrates the capacity to focus on the child's psychological experience. Under non-mentalizing moments, the clinician is able to identify what triggers the child and reconstruct the mentalizing stance.

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- The clinician does not ask questions, offers advice rather than taking a '*not knowing*' stance. Clinician appears disinterested, or does not notice they are overwhelming the child. The clinician may also elicit the child to think about possible solution without understanding the child's experience.

Adequate- The clinician demonstrates the capacity to share thoughts and ideas in the room, and asks appropriate questions to promote exploration and provokes curiosity. Throughout the session, the clinician mostly takes a genuine 'not knowing' stance by being really interested in finding out more about the child and his/her internal world, although at times s/he may assume to 'know' what the child is thinking or be quick to empathize or problem solve rather than explore.

Very good- The clinician conveys curiosity by asking questions in a well-timed and well-paced way. The clinician also demonstrates the capacity to take a 'not-knowing' stance, asking questions that prompt mentalizing and enable the child to take different perspectives and increase relational understanding in the session. Even under non-mentalizing moments, the clinician recognises moments of non-mentalizing and is curious about what triggers the child and makes efforts to repair with openness from a stance of collaborative exploration, and reconstruct what went wrong.

4. Playful stance

The clinician adopts a playful, open stance. This does not necessarily mean that the clinician has to literally play with the child, but rather to show playfulness and creativity through verbal and non-verbal tone. The clinician also has the capacity to play with ideas, perspectives and the temperature in the room. Flexibility is demonstrated by bringing reality in the play (e.g. using information and real-life examples) when it is needed. Play does not have to be a central part of the session.

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- No evidence of playfulness or play seems artificial. Clinician may be cold, rigid or overly serious. Play may seem meaningless to both the clinician and the child, with the clinician following closely the child but not making any sense of the play.

Adequate- Clinician seems reasonably and consistently playful throughout the session, though may show some moments of rigidity or constriction. The clinician displays openness to be playful and use the opportunities in play to explore mental states of the child.

Very good- Clinician conveys playfulness both verbally and nonverbally, by being authentic and flexible in the moment, as well as showing a sense of humour, creativity and openness. Play is not limited to be funny, but clinician is also playing with perspectives, ideas and tension. The clinician's level of playfulness is well attuned to the child. Clinician may also bring in reality in play by using information from parents/child adequately when it is needed. The clinician demonstrates the skill to use all opportunities to actively intervene and explore the affects and mental states of the child.

5. Making the implicit, explicit

Across all three levels – attention, affect and mentalization – the clinician’s interventions aim to make the implicit explicit by naming and describing nonverbal behaviours, emotions, or interpersonal patterns. The clinician demonstrates transparency (open-mindedness) by thinking explicitly.

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- The clinician fails to observe, describe and label the child’s internal experiences or behaviour.

Adequate-The clinician is somewhat consistent in making the implicit explicit, though they may miss some opportunities to make describe their observations.

Very good- Clinician consistently makes the implicit explicit, whether working at the level of attention, affect regulation or mentalization. Clinician demonstrates the capacity to ‘open their mind’ for the child to see what they are thinking. Clinician names the intention behind the behaviour explicitly, giving extra information to the child to make the space safer. When setting limits, the clinician also gives clues and explanations to the child.

6. Use of self

The clinician is authentic and genuine in their interactions with the child. The clinician's interventions appear natural and the clinician displays a level of comfort with being themselves and bringing attention to their own thoughts, feelings and presence in the interaction. The personal qualities of the clinician are reflected in the intervention, as a means of establishing epistemic trust with the child. It may also involve some direct use of self (e.g., the practice of judicious self-disclosure).

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Examples:

Poor- The clinician appears distanced, inauthentic or pretentious. No use of self is observed. Clinician may disclose or over-share irrelevant information about self to the child. It may be evidenced that the clinician becomes overly involved and entangled in the situation.

Adequate-The clinician seems reasonably genuine. There is evidence that the clinician engages in the interaction with personal qualities of being accepting and empathic.

Very good- The clinician shows a high level of use of self. Appropriate use of judicious self-disclosure is observed.

USE OF MBT-C TECHNIQUES

Attention Control Interventions

The clinician appropriately used interventions aimed at regulating attention.

Please check which of the following interventions were used:

- Mirroring/attunement
- Create joint attention – create rhythm, structure, feeling of being together
- Assume responsibility for structure and holding.
- Name and describe what the child is doing here and now
- Looking for/being curious about/reflecting on mental states, such as thoughts, feelings, wishes and intentions in stories and play

Other characteristic attention control interventions:

- Become aware of bodily experiences/ signals
- Stop and stand, while staying in contact – create safe room
- Validation of the unique style of the child - Accept, meet and match the child's own way of being. Tune in to the child's rhythm and regulation.
- Regulate impulsivity and arousal by trying to slow down – or speed up- interactions.
- Work with the basis for intentional behavior by linking the child's actions to the consequences in the outer world. "You hit hard, it sounded loud!"
- Create feeling of being "side by side"

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Emotion Regulating Interventions

The clinician appropriately uses interventions aimed at identifying and regulating emotions.

Please check which of the following interventions were used in the session:

- Awareness and curiosity about perception and feelings - Sometimes speak directly to/about the child, sometimes more generally, or about oneself / figures in play
- Identify 'bumpy roads' or triggers
- Regulation of arousal– taking an active role in keeping the arousal level of the child at a helpful level (not too high so that people lose their capacity to mentalize but not too low so that the session becomes affectively flat), may use simmering down or warming up techniques to support this process.
- Play with regulation and limits– little/a lot, use force/be careful, fast/slow. Focus on the here and now, slow down or speed up
- Offering support and empathy in the face of dysregulation and/or mentalizing breakdowns, notice breakdowns in mentalizing and stop, rewind and explore

Other characteristic emotion regulation interventions:

- Validate feelings in the room - Validate explicit (verbally) and implicit (posture, tone, expression, sounds)
- Make affective states real by taking them seriously
- Naming feelings states
- Identify 'bumpy roads' or triggers
- Connect behavior and feelings
- Help the child to express his feelings
- Stimulate fantasy and play
- Mentalization-enhancement activities (guessing)
- Offer holding and responsibility

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good

Explicit Mentalization Interventions

The clinician appropriately uses interventions aimed at mentalizing. Focus may be on self, other or relationship.

Please check which of the following interventions were used in the session:

- Link to mental states to behavior – self-awareness (when do I feel this and what do I do?)
- Play with perspective - You – me – others – different family members – different figures in play; Now – then (“do you remember”, looking back); On one hand – on the other hand (ambivalence)
- Mentalize the relationship – talk about “us” and what we have together

Other characteristic explicit mentalizing interventions:

- Verbalize mental states
- Enhancing perspective-taking and differentiations between self and others by mentalizing relationships, inside and outside therapy

Assessment of Skill Level:

1	2	3	4	5
Poor	Less than adequate	Adequate	Good	Very good