

Therapeutic Mentoring: Mentalization Training in the Community

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ABSTRACT

This paper describes a therapeutic mentoring program involving 150 children over a period of three years. The program is operated from an outpatient clinic, in this case using psychodynamic supportive therapy delivered in the home as a clinical hub for high-risk families referred by child welfare, juvenile justice, or courts. This program is part of Massachusetts Children's Behavioral Health Initiative (CBHI, 2013). This model of therapeutic mentoring requires all youth be involved with individual or family therapy and that the technique is designed to stabilize aggressive behavior in the community and begin to develop lasting social skills that can be sustainable in the community as a protective factor against poverty, social deviance and violence. The process of mentoring is viewed as an adjunct to therapy and a concrete way to practice mentalizing while learning to engage in a positive community activity. Copyright © 2014 John Wiley & Sons, Ltd.

Key words: therapeutic mentoring program, psychodynamic supportive therapy, high-risk families, mentor, adolescents, therapy

INTRODUCTION

Therapeutic mentoring (TM) is a 12 to 18 month program and is designed to work as an adjunct to longer term, outpatient psychotherapy that is often provided in the home or in the school. The agency approach is clearly a psychoanalytic one that strives to create a secure attachment between the client and the agency via the psychotherapy relationship in tandem with the mentoring, psychiatry, and psychology departments. This approach is firmly anchored in psychodynamic principles.

The TM is an extension of the therapy. The client benefits from the coordinated actions of the therapist and therapeutic mentor who adds an action

component to the therapy. The mentoring is designed to support the psychotherapy and works with the youth's caretaker in structuring activities. The TM may act as a reward for success identified by the therapist.

Israel is a 17-year-old African American male living with his mother, stepfather, younger brother, and two step sisters. Israel has been diagnosed with an Autism Spectrum disorder and post-traumatic stress disorder (PTSD) thus referred to mentoring to improve his social thinking. Israel endured frequent housing transitions uprooting the hard earned peer groups in an inner city school to start fresh at suburban school. Israel struggled to integrate into the new suburban student body while his frustration emerged at home with primary support conflicts and social withdrawal. The initial consult with the therapist outlined this difficulty in transition, along with Israel's inability to establish new peer relationships.

The therapeutic mentor's first session with Israel allowed his mother to express her desire to provide more technical assistance in helping Israel connect with friends. She involved Israel in the Special Olympics, trips to Broadway and museums, in addition to many other social activities. Israel returned home from school to meet his new mentor, and the mentor's first observation was a list of names written on the cover of Israel's agenda. Upon inquiry, Israel read every name on the agenda and described each friend in-depth. The mentor explored his interests to gauge the direction of mentoring and possible venues for peer socialization. Sports such as track, speed skating and especially soccer were highlighted as his favorites.

The mentor developed an intervention enhancing Israel's involvement with the high school varsity soccer team through score keeping, equipment assistance and designated team enthusiast. The first step to integrating Israel involved the mentor contacting the school's athletic director to develop the relationship with the head coach. Israel and the mentor first met the team at practice where the player's introduced themselves to Israel with a handshake and smile. The coach invited Israel and his mentor to join the team for the next game. The mentor identified the team captains and natural leaders to ensure people would not shame or bully Israel. Israel was famous for running around the stretching circle high-fiving the players. Often, Israel would be overwhelmed with excitement sprinting around the circle more than once. The mentor played an important role containing Israel assuring the teams routine was not disrupted, yet enhanced from Israel's wholehearted presence. The team bought into the positivity while periodically kicking a soccer ball to Israel, and involving him in team half-time discussions. The pinnacle of Israel's soccer game experience involved the team huddling together after a victory with their hands raised in order for the final team breakdown chant, which was Israel's name in celebration of his involvement. The mentor connected Israel to as many games as possible to foster budding friendships. Players would greet Israel in the hallway, start conversations in web-design class, and even inquired whether Israel would be apart of the team next year.

The therapeutic mentor acts as a role model replacing kinship structures such as father, older brother, uncle, or neighborhood cousin. A transference develops between the mentor and his or her mentee offering containment that is used to protect the youth's sense of safety during the activity period in the community. Many of the clients suffer from social isolation or affiliate with gangs because they lack the skill to take part in activities in the community. The therapeutic mentor serves as a container (Bion, 1963) and offers youth the opportunity to take chances and practice social skills. The therapeutic mentor creates a type of positive attachment site and models a mentalized state of mind (Fonagy,

2008; Fonagy, Gyorgy, Jurist & Target, 2002). The mentor promotes self-reflection and offers security and safety during the three-hour experience in the community. This extends the therapy from the home and school and connects the community into the treatment. School violence interventions often require the coordination of signals from the home, school, and community (Twemlow & Sacco, 2012).

This approach to TM within the psychoanalytic frame is designed to work with families that have multiple, high risk, often aggressive or self destructive patterns of behavior exhibited at home, in the community, and at school. Many of the youth involved in TM are struggling to find their own place in the world and feel unsafe. This approach offers a promising alternative to more restrictive responses to high-risk behaviors exhibited by the youth in the community.

This paper illustrates a technique (TM) that is currently being used as an adjunct to psychotherapy for a seriously disabled population of children and families referred primarily from the child welfare, juvenile justice and special education agencies. The mentoring client is primarily referred to what is termed as a "clinical hub," which is in this case is an outpatient mental health clinic providing home-based treatment. The primary diagnostic categories within this patient population include disruptive disorders, conduct disorders, attention deficit disorders, PTSD, and a variety of other childhood disorders which can interfere with a youth's ability to function in every day life activities. Mentoring is funded as a medical ancillary service by Medicaid.

TM has been described elsewhere (Twemlow & Sacco, 2012). Mentors are available for four hours per week to work in building highly specialized social skills and interventions. Strategies designed and directed by a psychotherapist who also provides intensive psychotherapy to the client and family/caregivers. Traditional mentoring has been evaluated; Eby, Allen, Evans, Ng and DuBois (2008) preformed a multi-disciplinary meta-analysis comparing mentored and non-mentored individuals. In this study, three types of mentoring were looked at including workplace, academic and youth. This study concluded that there were gains in mentoring versus non-mentoring but the effects were somewhat small. The least progress was made on youth mentoring. Spencer, Basualdo-Delmonico and Lewis (2011) emphasize the need to involve parents in improving the outcomes in youth mentoring. This study used intensive case studies of 13 families receiving mentoring. This study found that parents favored mentors who offered their child with opportunities they could not. They found this a significantly important variable over race or socio-economic status.

This approach assists the therapist in maintaining motivation in long-term therapy. This is an example of how the psychoanalytic frame can be used to include adjunctive therapies that have as their primary focus maintaining community stability. The mentor and therapist create a safe and secure attachment to the agency as described in Sacco, Twemlow and Fonagy (2007). The overall approach can be called a two dimensional therapy. The population served with TM can be described as serious emotionally disabled (SED), very high risk,

overwhelmingly involving child welfare referrals, and virtually all youth could be rated as having very high ACE scores or Adverse Childhood Experiences. In fact, this CDC (Center for Disease Control and Prevention) study suggests that a score of four or more on this 10-item scale indicates a greater likelihood of developing chronic illness and high-risk behaviors in adulthood. Leslie *et al.* (2010) highlight that youth who are referred from the child welfare system are more likely to engage in risky health behaviors. The value of TM is that it intervenes at critical life stages and offers alternatives to high-risk health behaviors. TM helps the youth discover their identity and models successful achievement. The average ACE score for the 150 youth currently in this clinic is over six.

TWO DIMENSIONAL THERAPY: MENTORING AND HOME-BASED PSYCHOTHERAPY

Two Dimensional Therapy is the use of outpatient psychotherapy delivered in the home and community in close tandem with TM (Twemlow & Sacco, 2012). The goal of the intervention is to use psychotherapy delivered at home, school and the community with disruptive youth to build mentalization skills to strengthen social skills. The therapist and parent or custodian develop goals based on strengths and weaknesses identified in the Children and Adolescent Needs and Strengths (CANS) manual: an information integration tool for children and adolescents with mental health challenges (www.mass.gov/.../child-and-adolescent-needs-and-strength). Both the therapist and the mentor consult weekly to fine tune the plan and keep the therapy and mentoring in sync.

The mentor can spend about 2–4 hours per week in activities designed to create increased activity in the community and build socialization skills by practicing these skills 1:1 with the mentor. The youth receives one positive signal from home, school, and community. The mentor is further charged to break down the socialization skills into achievable steps. This action curriculum is a shadowing experience. The youth has a chance to model the mentor's skills in engaging activities ranging from the Boys and Girls Club to the Anime Club at a local library. The therapeutic mentor reports back to the therapist who can in turn use it to fine-tune the psychotherapy and medication if needed.

Manuel is a 17-year-old Caucasian male living with his mother, stepfather, and two younger brothers. Manuel was referred to therapy for insomnia, PTSD, panic attacks and social withdrawal. Rarely leaving his room constantly playing video games Manuel was digitally entrapped throughout the day and night. Manuel has been engaged in psychotherapy, yet a therapeutic alliance was not established due to the therapist's surmounting frustration with Manuel's inability to put down the video game controller. The subsequent therapist utilized TM to increase community involvement and socialization. The mentor was able to build an initial connection through playing a multiplayer combat video game. The mentors experience with video games challenged Manuel's gaming skills while earning his respect. Simultaneously, Manuel was talkative and open. A few months into treatment Manuel would respond and engage the mentor more than

the therapist. The mentor introduced mountain climbing, yoga, martial arts and zen painting. Manuel identified the mountaintop view as one of the best moments in his life. The creation of peak experiences functions as a powerful motivator in therapy. In consultation with the therapist, Manuel began to work through his trauma in therapy, and began to discuss other possible methods to help regulate sleep like medication and neurofeedback.

The psychotherapy relationship in an outpatient clinic offers the youth and family instant access to psychiatry and psychological evaluations with 24 hour, seven day per week client support and emergency phone access. These are useful in cases with child welfare, juvenile justice and courts. The typical involvement is 6–18 months depending on the progress.

This style of therapy and TM is useful in cases where young people are aggressive or seriously withdrawn and have difficulty making friends. They often display problems at home, school, and do not have active after-school lives. Isolated and regressed youth can become trapped in cyberspace, thus distancing themselves from healthy community activity and self-care. Mentors pierce the cyber wall and extract the youth from self-imposed exile and creates realistic bridges for him/her to walk into the community.

PSYCHOTHERAPY AND TM BUILDING SOCIAL SKILLS

TM offers a way for a psychotherapist to team up with a mentor and address specific problems that exist at home, in school, and in the community. Most of the children have serious difficulties maintaining a productive life at school and tremendous social isolation because of a lack of involvement in key community activities. These youths tend to be aggressive or withdrawn and will not have the ability to join what is readily available within most communities. The lack of initiative and social skills of these children and their families are the main engine for creating and maintaining isolation and withdrawal. When a child is unable to pursue a passion and interest and engage in community activities, this creates predictable risk of delinquency especially during a high-risk period specifically between 3 p.m. and 7 p.m. (Office of Juvenile Justice, Delinquency, Prevention, 2012). This is a critical time for adolescents to begin engaging in prosocial activities, rather than joining in destructive peer and self activities such as smoking tobacco and drug use.

Home-based psychotherapy (Clark, Zalis & Sacco, 1982) allows the therapist to enter into the family's world and begin to identify barriers to making progress in therapy. When a young person under 21 lives in a family struggling with multiple stressors, it becomes increasingly more difficult to help the family when so many unmet needs remain unmet because of the limitations of a psychotherapy hour. The therapist can make the proper diagnosis, refer for medication, learn more about a situation through psychological testing, and make recommendations for participation in a wide range of activities available in the community. If a young person does not have the skills necessary to join in one of these activities, these recommendations are nothing but words on a

medical record or in the ears of a parent paralyzed by lack of resources, other children, and maybe suffering from some type of mental impairment or chronic medical condition.

TM often begins with a slow engagement until an alliance is built; the client is engaged and eventually the mentor motivates him to clean his room, then move out of the room, and eventually move into the community once the youth and mentor found an interest activity at a local library. This was a step-by-step process that was reinforced at home through the psychotherapy as well as reflected upon by both the mentor and the psychotherapist in weekly consultations. Both mentor and therapist strive to widen the youth's positive experiences in the community and to help balance the bullying at school and the unending stressors at home.

This process is somewhat similar to helping an agoraphobic take their first step outside of their home. It is the anticipatory anxiety that cripples the agoraphobic. With many of the disruptive youth receiving TM there is a similar restriction of their motivation to try new experiences. Somehow the repetitive nature of their withdrawal and isolation provides a soothing interface with the world that they experience as threatening and unpredictable. A therapeutic mentor offers a "safe person" to begin a voyage of exploration within the community. The therapeutic mentor is offering a moving role model that also can serve as a containing figure (Bion, 1963).

Sharing

Youth in TM do not know how to share any resource or to participate in group activities because they need to be the center of attention. Therapeutic mentors work systematically at all age levels (up to age 21) to build the ability to play cooperatively. The coordinated efforts of the therapist and mentor work to build an inroad into the community for these children and adolescents who would otherwise not be able to simply walk in and try something new and learn how to be cooperative and play in a friendly fashion.

With the younger children it is often a matter of building a skill base for the foundation in an area of life that is either strong or needs further expansion. The best example of this involves a young person who is interested in athletics. This is a young person who has the best chance of finding an activity in the community that is affordable, reachable and sustainable. There are also youth that are not athletic and still need to find something positive to do in the community. Mentoring can offer opportunities to create unusual excitement and life enhancing experiences. The following is an example of how a chance mentoring opportunity led to a real ego boost for a 10 year old.

Larry is a 10-year-old male with Asperger and living in a motor home with extended family. He is frequently bullied at school and has few friends because of his oddities and peculiar obsessions. One of his obsessions involved dancing like Michael Jackson. A mentoring session was scheduled as a reward for school behavior at a large auditorium with

several thousand people and a videotron with a wandering camera. Larry got into the spirit and began to dance. The mentor encouraged him and the camera caught him twice letting loose with a rendition of Michael Jackson complete with 360 twirl. The crowd cheered both times and Larry could not stop talking about it.

There are a host of activities within many communities that are easily accessible with the proper adult support. This is a primary goal of the TM program. The ideal objective of the TM intervention is to both find a significant interest as well as build a realistic pattern of behavior for the client in his or her family to sustain the community activity to everybody's benefit. These younger children can be brought by the mentor to a Boys and Girls Club and with the one-on-one assistance can learn to shoot a basketball, pass a soccer ball, or take turns on a computer in a game room. These are all activities that require some modeling and some trial and error. Frequently, mentors report back to the therapist if they have had significant difficulties with temper, self control, anti-authority, or report any fear and anxiety reactions observed by the mentor during the community activity. This is a common aspect of the communication between the therapeutic mentor and the therapist. Strategies are co-developed both in the therapeutic mentor's supervision as well as in the psychotherapist's supervision to help discover ways of creating activities or developing strategies for young people to use in situations of conflict as reported from the field.

Sharing is a skill that all therapeutic mentors report as a basic social skill needed for young people to join a community group. The Boys and Girls Club or YMCA is an excellent example. Young people must learn how to keep their own identification, access available public transportation, and participate in a controlled way in group activities where people take turns and use exercise equipment and participate in activities. It requires an acute level of awareness and consideration of others while in the weight room or shooting hoops in an overcrowded community gymnasium with six basketball hoops. These skills come from practice and the therapeutic mentor is the coach who assists with this process in the one-on-one relationship. The mentor steps back as the young person gains confidence and skill while still being in eyesight of the mentor and provide a quick escape if a difficulty arises. This experience is reported to the therapist who promotes reflection within psychotherapy.

Reading Social Cues: A Key Mentalizing Skill

Mentalization as described by Fonagy (2008) involves the development of a capacity to read social cues in various environments. Mentalization is the process of self-reflecting and results from feeling secure and safe. When this sense of well-being is established, a person can then, in a relaxed and focused way scan their environment looking within themselves to respond appropriately to the social cue. When mentalization is disrupted for whatever reason, the ability to read the social cues is impaired. When this impairment settles into a disruptive symptom pattern, the therapeutic mentor enters to assist in helping the young person anticipate and acknowledge social cues. Brief educational conversations

are had about what people mean. This offers help in accurately reading social cues. Winner (2007) refers to a model in Social Thinking, which uses this approach in helping youth on the autism spectrum. She refers to the objective as creating “perspective.” These issues are discussed again in consultation with the therapist.

Alex is a 19-year-old male who lives his social life through 13 different Facebook profiles role-playing socialization as multiple Anime characters. The therapeutic mentor immersed Alex in a weekly Anime club at the local library, yet the social skill deficits were quite apparent. Skills needing improvement included introductions, eye contact, asking questions about peers, appropriate dialogue and controlling the verbalization of disturbing fantasies. The lack of exposure to social situations created Alex's inability to carryout a conversation. Instead, Alex would interject dark and sadistic elaborations of group conversation while unable to read the social cues to stop. The mentor would intervene to stop the escalating fantasies, and shape the conversation back to the group before things became completely disrupted or disturbed. The mentor on the ride back to Alex's home would exercise mentalization by identifying the social cues in relation to his comments, and provide alternative actions or responses for that moment. The car ride to the next social activity provided an opportunity to express expectations and behaviors to be aware of.

THE MENTOR–THERAPIST FEEDBACK LOOP

Everything the mentor does is communicated to the therapist creating a feedback loop in a way to continue the therapy not only in language but action. This loop forms a type of observing ego guiding the quality of the person's life. The therapist can remain in his or her role and use the experiences of the mentor to further explore ways of improving self-regulation and other socialization skills. The therapist is responsible for directly communicating with the client and or family, and the mentor is responsible for creating structured activities that practice specific behavioral skills. The mentor uses active listening to help understand what the youth's interests are. Like a good analyst, the mentor looks for the passion or interest expressed by the youth. The mentor does not impose a direction or try to sell the client on a direction. The mentor and therapist work together to keep the focus on what the youth is expressing.

The mentor engages in interaction with the entire family but does not engage the family in psychotherapy. The mentor communicates in supervision his/her impulses to directly solve a problem, give advice, offer an interpretation or engage in any of the psychotherapy techniques. The mentor learns how to be positive, strength-focused in all the interactions with the family and youth. This allows for the two helpers (therapist and mentor) to work with families who exhibit primitive pathologies including splitting, projective identification, and denial to infect the therapeutic process. This loop ensures the therapeutic message stays in harmony between mentor and therapist.

This feedback loop creates a way to generate real-life experiences by the mentor who directly observes family conflict in action while picking up or dropping off a youth. The mentor is trained not to engage in conflict unless it is a matter of personal safety. The mentor learns to de-escalate an ongoing conflict in a general way and try to leave the youth at home in a positive way. The mentor models self-regulation, a key aspect of mentalizing. The mentor does not attempt family therapy, give advice, confront, or in any way try to start a psychotherapeutic revolution. A common theme in consultation between the mentor and therapist involves the mentor's discussing times when they feel the need to directly confront a problem or gratify a need. The mentor is aware of the countertransference forces and the TM supervisor maintains this boundary in supervision and the therapist and mentor are free to focus on the client's needs. Countertransference pulls the mentor into the pathology of the family. The therapist works with the family and the youth on specific goals and actively attends to the client and family's experiences with the mentor.

Jonathan is a 13-year-old Hispanic male living with his second foster mother in an inner city neighborhood. Jonathan experienced the death of his mother at a young age and his father battled addiction with periodic incarceration. Jonathan's first foster home was traumatic. Jonathan was punished by being stripped of his clothing, thrown into his bed and told not to move. His new intensive foster home has provided excellent structure for Jonathan and has been key in the stabilization of impulsive and aggressive outbursts. The introduction of a therapeutic mentor was undertaken as a way to stabilize Jonathan in the community rather than have him bounce through foster homes. In response to a consultation with the therapist, the mentor suggested a trip to the local animal shelter. The therapist was aware of Jonathan's early childhood experiences with dogs. The therapist-mentor loop allowed for the discovery of Jonathan's interest based on his early childhood experiences reported in the therapy.

During the car ride to the animal shelter Jonathan reflected with the mentor on his dog that was sold by his father for drug money. The mentor did not explore the memory, but utilized empathetic listening and added a positive perspective and a set of upbeat expectations for the upcoming activity of visiting animals in a shelter. Jonathan was able to connect with animals more than peers. The process of adoption with the animals was symbolic of Jonathan's experience. He would feed the dogs a handful of treats. The front of each cage had a description of the dog's personality and voice to potential adopters. The mentor encouraged Jonathan to read the descriptions with him; "I am an Independent natured dog. I have a lot of learning to do and classes would be a great start. I want to learn how to be the best canine dog for my new family. I am in need of an adopter that has previous experience with strong powerful breeds like me." Jonathan had to explore every inch of the animal shelter and even inquired about possible volunteer positions. Eventually, he began to take photographs with the mentor and post them on the animal shelter's adoption page.

PSYCHOTHERAPIST'S PERSPECTIVE ON TM

The feedback loop can also be used as a tag team in accomplishing therapeutic objectives. The therapist and the mentor work together to create behavioral strategies that fulfill the therapeutic treatment plan. Sporting events like AHL

hockey, minor league baseball games or developmental league basketball games can be rewards for school completions. The therapist designs the approach and supervises the process of engaging the youth and family using this strategy. The mentor always spends more time with the youth and has the opportunity to actively do things that are designed to be fun. This creates an excess of positive transference, which can be transferred to the therapist by the mentor by modeling a cooperative and collaborative relationship between the therapist and the mentor. The mentor builds a type of transference equity that is shared with the therapist to assist in overcoming resistances to progress in traditional psychotherapy even when it is provided in the home or community. Simply stated: youth prefer to play rather than talk. This process helps maintain motivation in therapy, especially for disruptive youth.

A mentor directed by the client's therapist can coach a client where he or she lives in order to help them be successful. The following is an example of how the mentoring was used by the therapist.

Jose is a 19-year-old African American male. Jose has a history of trauma, and is diagnosed with PTSD and Bipolar I Disorder, Jose has been abused physically and sexually. Jose has been separated from his mother on numerous occasions because of being hospitalized for aggressive, angry outbursts; he was last hospitalized four years ago for attacking someone with a kitchen knife. The police came to the scene and brought the client to the emergency room. He went to the psychiatric hospital where he received inpatient treatment intermittently for two years with short stays. The client was abused as a child, and witnessed domestic violence on many occasions (his mother being abused by his father and later her boyfriend). He has borderline intellectual functioning, and is emotionally immature; his reading level is below fifth grade.

He came into my care for treatment two years ago, in that time the client has become homeless and has been assaulted by his brother twice. Even with these psychosocial stressors, the client has made progress in improving his self-regulation and in particular controlling his anger. It is clear that the client does not have adequate attachment ego function. He stopped going to school because he does not want to leave his mother. He is afraid that something bad will happen to her. And he has no belief in himself that he can manage relationships with other people. There is no question that with individual therapy alone, he would have been re-admitted to the psychiatric hospital. Mentoring in conjunction with therapy has helped him become more flexible and replace rigid defenses with more adaptive functioning skills.

A partial process recording will be used to illustrate how mentoring has helped the psychotherapy from the therapist's point of view.

Jose: I don't like my mentor anymore, he's the same as my grandparents.

Therapist: Really? What happened?

Jose: He hates video games just like my grandparents, he told me I can play video games all day long and that I can't play them during mentoring. Just like my grandfather, he

doesn't have any faith in me, he (my grandfather) told me I'm a loser cause all I do is play video games. He thinks video games are just a waste of time. Frank is the same as my grandfather, I'm not going to mentoring tomorrow.

Therapist: Oh, it sounds like it really hurt you when your (grandfather) called you a loser.

Jose: Yeah, he doesn't understand me. He doesn't know that I can't help it. There is nothing wrong with video games, they help me not think about bad stuff and my grandfather doesn't get that. He wants me to get a job, like him (grandfather) and I want to get a job too, but he doesn't know that it's hard for me.

Therapist: It sounds like even though you are understandably angry with your grandfather, part of you wishes you could please him?

Jose: Yeah, but I can't he just hates video games, just like Frank. I know Frank is the same as my grandfather. He hates video games like my grandfather.

Therapist: I wonder if you thought of your grandfather when Frank asked you to put away your video game? And- Even though Frank is different than your grandfather, sometimes you're reminded of painful things your grandfather said to you.

Jose: Yeah. Frank is the same as my grandfather.

Therapist: Did you tell Frank that when he asked you to put away the (portable video game) you thought about your grandfather? And that you felt angry after thinking about what your grandfather said?

Jose: No. But I might tomorrow, I know I said I wasn't going to mentoring, but I changed my mind, I'm still going to go.

Therapist: Yeah, I know Frank looks forward to seeing you.

Jose: Yeah, after this I'm going to the (drop in program) because that's our goal for me to go to the center twice a week, cause Frank wants me to go and I want to give my mom a break from me.

This is an example of how a client can act out transference with a mentor and process it with his therapist. Through working in a holding environment in the community with a mentor who sensitively coached the client to use good social skills, by asking the client to put away the portable video game so he could engage with others in the community center. The therapist helped the client gain insight to differentiate between the client's internal world (transference) and what was happening in the community at the time. So the client can take more control of his emotions and thus better regulate them.

In addition, the therapist informed the mentor about the transference that the client was experiencing so the mentor could help him work through it in the community. The insight helped the mentor provide a corrective experience with the client. In another mentoring session (about two weeks later) the mentor brought the client to a veterans home for the client to volunteer to help veterans. In this mentoring session the mentor offered to help the client fill out the application. Jose told the mentor that he could not do it without his mother's help. The mentor who was trying to help Jose achieve some autonomy, encouraged him to complete the application in the moment with the mentors help rather than wait and depend on his mother to help him. Jose got very upset (because differentiating from his mother is very scary for him) and stormed off.

The mentor caught up to him and asked him if he was angry. Jose said “Yes I am angry.” The mentor then apologized that he did not mean to offend him, and praised Jose for expressing his anger appropriately with words.

The mentor let the therapist know about the mentoring session. The therapist waited one whole session and about 15 minutes and Jose did not bring up the mentoring session to him. So the therapist brought it up.

Therapist: So, Frank told me that you did a really good job in mentoring the other week.

Jose: He did, what did I do?

Therapist: He told me about what happened at the veterans home.

Jose: Yeah, I got mad cause I wanted my mom to help me, I know that Frank could help me, but I got mad and I started to walk away. But he didn't go away. Most people let me go away when I get mad.

Therapist: “Were you afraid that Frank might go away? Or that he might not like you or something if you told him you were mad?”

Jose: Yeah [bashfully], but he listened, nobody else listens to me.

Therapist: Yeah, he was really happy that you told him how you felt.

Jose: Really? I trust him more after that happened cause he listened.

Therapist: That was really mature that you told him you were angry, and it took courage because I know you were scared he might go away if you told him that, but you did it anyway, and now you have a better relationship because of it.

Jose: Yeah, everyone else would have just let me walk away. He listened.

Therapist: Did you let him know how important it is to you that he's a good listener?

Jose: No, but I might when I see him if I remember.

This was a really therapeutic mentoring/therapy session. Without the mentor taking the client out into the community and informing the therapist about the sessions, the therapist would not have had this opportunity to help client identify his fear of abandonment. Jose is often being told by his mother that he is going to stress her out and she will die of a heart attack. So in a sense, he is given the message that his anger will cause him to lose his mother. In this case, he had a corrective reparative experience with the mentor who accepted his anger, validated it and positively reinforced him expressing it in a peaceful way. He then gained insight in therapy. Since client has been working with a therapist and mentor in tandem he has not been hospitalized, nor has he been sanctioned by the legal system.

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