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A TWO-ARTICLE EXAMINATION OF MENTALIZATION BASED TREATMENT FOR CHILDREN WITH ATTENTIONAL DISORDERS

Abstract

ABSTRACT

A TWO-ARTICLE EXAMINATION OF
MENTALIZATION BASED TREATMENT
FOR CHILDREN WITH ATTENTIONAL DISORDERS

Laura J. Acsadi, LCSW-C

Dissertation Chair: Judith Jordan, PhD

This two paper dissertation seeks to explain the theoretical basis for Mentalization Based Treatment (MBT) and its applied treatment with children who have been diagnosed with attentional disorders that include attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD). Children who have been diagnosed with attentional disorders frequently present for mental health treatment with emotional regulation and behavioral concerns. The standard treatment for children diagnosed with attentional disorders are cognitive and/or behavioral treatment modalities. These treatment modalities focus on changing the behaviors of the child and are not oriented to include the parents as a focus in the treatment. Mentalization Based Treatment for Children (MBT-C) is an emerging treatment for children with emotional or behavioral symptomatology. MBT-C is a psychodynamic treatment modality that is informed by attachment theory and focuses on treating the child, the parents, and the relational interactions within the family system.

The first article explores the theoretical underpinnings of MBT by presenting research on early childhood psychological development that includes attachment theory, natural pedagogy theory, and the use of ostensive cues by the caregiver as a specific communication signal to the child. This is followed by research into the development and role of mentalization, the psychological process that allows the child to regulate feelings, understand others, and respond to stimuli in the social environment. Lastly, this article connects the function of the attachment system in developing the capacity within the child to mentalize the self, relationships with others, and how this impacts the child's developing attentional and emotional regulation systems.

The second article provides composite case examples of children who have been diagnosed with attentional disorders and have presented for treatment related to dysfunction with behavioral and emotional regulation. The article outlines the MBT-C treatment model for the composite case and includes assessment as well as interventions with the child, parents, and family system. The article follows the composite case of "Patrick" through the MBT-C treatment process and explains each step from assessment to conclusion of treatment.

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Christopher M. Ciarleglio, PhD

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Mentalization Based Treatment, MBT, natural pedagogy, ostensive cues, emotional regulation, attention deficit disorder

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**A TWO-ARTICLE EXAMINATION OF
MENTALIZATION BASED TREATMENT
FOR CHILDREN WITH ATTENTIONAL DISORDERS**

Laura J. Acsadi, LCSW-C

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work (DSW)

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Judith Jordan, PhD

Dissertation Chair

Christopher M. Ciarleglio, PhD

Dissertation Committee

DEDICATION

This dissertation is dedicated to my favorite teacher, Duane Wirdel. I met Duane, or Mr. W. as we called him, at Prospect Hall in 1978. This was early in his teaching career and he had that youthful swagger that makes you excited as a learner. Mr. W. had the coolest car which he parked right in front of the school so all of his students could drool as they entered the building. Mr. W. was the first teacher who inspired me to think critically and write concisely. More than that, he inspired me to have a life-long desire for learning. He is that once in a lifetime teacher who is able to make learning any topic fun, vibrant, and interesting. He believed in me and helped me to grow into believing in myself. Mr. W. is truly a shining star who has inspired countless students to grow and develop. I for one am truly blessed to have been one of them.

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Lastly, I would like to acknowledge Viktor Frankl. This quote has helped me find my way through many challenging days: “Those who have a ‘why’ to live, can bear with almost any ‘how’. If you find a why, then you can bear the how’.”

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TABLE OF CONTENTS

DEDICATION..... ii

ACKNOWLEDGEMENTS iii

ABSTRACT..... iv

**Article One: Mentalization Based Treatment Theoretical Underpinnings:
Attachment Theory and Natural Pedagogy Theory 1**

Problem Statement..... 1

Purpose of the Study 5

Research Questions 7

Significance of the Study 7

Introduction..... 9

Attachment Theory 10

Natural Pedagogy Theory 14

Epistemic Trust 21

Theoretical Underpinnings of MBT 23

Mentalization Based Treatment (MBT)..... 28

Mentalization Based Treatment for Children (MBT-C)..... 31

The Mentalizing Stance 37

Article Two; Applied MBT-C Treatment for the Composite Case of Patrick 40

Introduction.....	40
MBT-C Treatment Protocols.....	41
The Assessment Phase; Weeks 1-3	43
The Interventions Phase with the Child; Weeks 4-8.....	54
The Interventions Phase with the Parents; Weeks 4-8.....	63
Review Session with Parents and Child: Week 9.....	70
Completing Treatment: Weeks 10-13	72
Conclusion	77
Appendix A	81
Appendix B	85
References	86

**Article One: Mentalization Based Treatment Theoretical Underpinnings:
Attachment Theory and Natural Pedagogy Theory**

Problem Statement

Globally, children's mental health has become a focus for mental health practitioners as the rates of mental health disorders in children have escalated. Kieling (2011) estimates that the worldwide incidence of mental health problems in children and adolescents ranges between 10 – 20% based upon a systemic review of studies that include low to middle income countries. Husky, et al., (2018) found that 22% of children sampled in 8 European countries including Italy, France, Germany, Netherlands, Bulgaria, Romania, and Turkey self-reported at least one mental health disorder with scores ranging between 16.4% in the Netherlands and 27.9% in Bulgaria. In the United States, the Centers for Disease Control and Prevention (Bitsko, et al., 2022) found that between 13-20% of children have at least one mental health disorder in any given year. The study reviewed children's mental health disorders from 1994-2011 and noted that during this time period, the incidents of mental health disorders was increasing. Danielson, et al., (2021) found that one in six children aged 17 and under met the diagnostic criteria for a childhood mental health disorder with anxiety disorders being the most prevalent followed by oppositional defiant disorder (ODD) and then attentional disorders. The impact of shutdowns related to Covid-19 beginning in March of 2020 have further exacerbated children's mental health disorders. According to Breaux, et al.,

(2021) adolescents who were diagnosed with ADHD or emotional regulation disorders experienced an increase in symptoms following the Covid-19 lockdowns which did not remit after the lifting of stay-at-home orders.

Attentional disorders including attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are common childhood disorders that have a prevalence rate of about 8.2% of children aged 6-17 based upon parental rating scales (Larson, et al., 2011). More recently, (Danielson, et al., 2018) found that approximately 10% of children in the United States have been diagnosed with ADHD. According to the American Psychological Association (2013) attentional disorders are characterized by difficulty concentrating, distractibility, forgetfulness, fidgetiness, failure to pay close attention to details, difficulties with following through with tasks, and difficulty sustaining attention. The symptoms of attentional disorders, “often interfere with school performance and social functioning” as well as create stress within the family system (Conway, et al., 2019, p. 213). Additionally, symptoms of ADHD often do not remit in adulthood and research has shown that adaptive functioning for adults with a history of childhood ADHD is poorer than peers without the disorder. For example, Pelham, et al., (2020) found that adults aged 30 with a childhood history of ADHD had, “deficits across almost all financial indicators, including income, savings, employment status, and dependence on parents and other adults” compared to the control group without an ADHD diagnosis (p. 9). Stepp, et al., (2012) found a strong relationship between an attentional disorder diagnosis for girls in childhood and the development of borderline personality disorder later in adolescence. Other challenges that adults with a history of

childhood ADHD face include higher suicide risk, higher rates of incarceration, and other comorbid mental health disorders including anxiety and depression (Conway, et al., 2019).

One prominent treatment modality to provide treatment for children's mental health disorders is cognitive behavioral therapy (CBT). According to Stallard (2005), the function of CBT treatment for children is for the mental health clinician to assist the child with identifying maladaptive thoughts, beliefs, and assumptions and then developing alternative, more adaptive thought patterns. CBT treatment is used to treat childhood disorders including ADHD, depression, and anxiety conditions. Kreuze, et al., (2018) performed a meta-analysis on studies that provided randomized control trials on treatments for childhood anxiety disorders using anxiety-focused CBT. The control group participants were comprised of mostly waitlist or no intervention conditions. The nexus of their analysis was to determine if CBT was effective in treating secondary outcomes such as depression and externalizing behaviors. They analyzed 42 studies with 3239 participants and found that overall anxiety-focused CBT had a small to moderate effect on depression and a small effect on externalizing behaviors.

One of the problems with using CBT with children is that there is no standardized manner to deliver the treatment intervention. In reviewing studies included in the Kreuze, et al., (2018) analysis, there is little homogeneity across studies in terms of the actual treatment intervention. For example, Santucci (2013) noted the treatment interventions included, "psychoeducation, somatic anxiety management, cognitive restructuring, problem solving, graduated exposure ... rewards, and relapse prevention" (p. 442).

However, Kendall (1997) used a combination of CBT and behavioral interventions. Their listed CBT interventions were described as recognizing anxious feelings, clarifying anxious feelings, coping by engaging positive self-talk, and monitoring through a process of self-reinforcement. The behavioral interventions utilized in the study included modeling, exposure, role play, relaxation techniques, and contingent reinforcement. Kendall notes that future studies, “need to be designed specifically to dismantle the treatment (e.g. cognitive training vs. behavioral exposure)” (pp. 377-378). Walkup (2008) operationalized CBT treatment as providing the child training in anxiety management and exposure. Although there is some minimal overlap in treatment approach, there is no defined procedure of what CBT treatment interventions entail across studies. David, et al., (2018) define CBT treatments as, “an umbrella form of empirically supported treatments for clearly defined psychopathologies that are targeted with specific treatment strategies” (p. 1). This would suggest that there is no agreement across clinicians of diagnosis and treatment interventions which is not discussed in the Kreuze, et al., (2018) meta-analysis. It appears that the approach to CBT in research studies is eclectic and subjective to the researchers’ stated protocols. There does not appear to be “standard CBT” treatment. This creates a problem for the mental health clinician because there is no standardization of CBT treatment as there does not appear to be an operational definition of what constitutes the independent variable.

In addition to the non-operationalized nature of what consists of CBT treatment for children, Kreuze, et al., (2018) notes that there is a paucity of research on the impact of the involvement of parents on the outcomes of CBT treatment. They indicate that

parental involvement may be warranted to assist the child in reinforcing coping skills acquired within CBT treatment in whatever form this treatment is delivered. It appears that CBT treatment is focused solely on the intrapsychic processes of the child's mind rather than as a member of a family system that is impacted by others behaviors in the system. Additionally, CBT treatment focuses on the internal process of the child and it does not address symptoms or psychopathology related to family dynamics within the family system. In cases of child neglect or maltreatment, it is the parent's behaviors that are often the causal link of maladaptive behaviors or other psychological dysfunction in the child. Attachment theory posits that the attachment relationship between the parent and child is often a determining factor of impairment in adulthood (Bowlby, 1977).

Purpose of the Study

The first aim of this study is to explore the efficacy of MBT-C for treatment with children that have attentional disorders including ADD and ADHD. MBT hypothesizes that symptoms and behaviors in the client are a function of the individual's underdeveloped capacity to sustain mentalization of the self or with other people such as interactions with the parent or other family members. This study proposes to create a composite of children who meet the diagnostic criteria for ADD or ADHD and evaluate the efficacy of MBT-C treatment. Specifically, this study aims to break down the components of MBT and how these components contribute to the application of treatment with particular focus on child development theories.

The components of MBT-C include the therapeutic role of the therapist in the treatment, the fostering of epistemic trust between the child, therapist and family members, practical interventions designed to increase mentalizing, and generalizing social learning between the child, parent/caregiver system, and the child's greater social system. The study will explore ways that the relationship between the therapist and the child expands the child's capacity to recognize affective states in the self and with others in order to help child regulate their emotions and navigate the social environment. The study will explore the intentional use of ostensive cues such as eye contact, mirroring, tone of voice, and turn-taking and how this assists the child in developing epistemic trust. Further, the study will demonstrate interventions that are designed to increase mentalizing within the child and parents/caregivers in the larger family system.

The second aim of this study is to evaluate the benefit of parental involvement directly in treatment as a way to reduce the child's symptoms and improve adaptive functioning within the child's family system as well as their other social environments. One of the studies hypothesis is that in addition to the child, the parents are a target of the treatment intervention and that the focus on the interactions between the child and the parent are vital. This study seeks to demonstrate that the child's symptoms are not solely located within the child, but rather in the interaction between the child and the parents. Further, the study aims to show how assisting the family unit as a whole develop better mentalizing is the key to ameliorating the symptoms in the child and within the greater family dynamic.

Research Questions

1. Does mentalization based treatment for children (MBT-C) reduce symptoms of ADHD and ADD in children?
2. What role does integrating parents into the active treatment process in MBT-C assist in reducing symptoms within the child and the family system?
3. Does involving parents in the active treatment with MBT-C promote a reinforcement feedback loop of better mentalizing between parent(s) and child generalize to other social environments such as school, peer relationships, and community activities?

Significance of the Study

Worldwide, the prevalence of mental health disorders in children is approximated to range between 10-20% across countries and cultures. This has resulted in a need to find efficacious treatment interventions to decrease symptoms and promote mental health in children. Cognitive behavioral therapy (CBT), a treatment modality that has been demonstrated to work with adults, is being used to treat children's mental health disorders including attentional and anxiety disorders. Developmentally, children are not the same as adults and this impacts how treatment is received. Unlike adults, children always live with parents or caretakers and the interaction between the parent and child often plays a role in both symptoms and treatment. For example, a child may act out behaviorally in order to get the attention from the parents. This same child may demonstrate appropriate behavior in other contexts where adults provide adequate attention and interaction. In this

example, it is important to view the child within the family and social contexts in which he/she lives. CBT treatment is focused on changing the cognitions and behaviors of the child intra-psychically with minimal attention paid to the role of the parents in the etiology of the presenting problem or the delivery of the treatment. Additionally, in the CBT treatment model, the role of the interaction between the therapist and the child is not often considered clinically relevant.

This study seeks to evaluate mentalization based treatment for children (MBT-C), a psychodynamic attachment informed treatment modality. This treatment modality differs from CBT because the focus of the interventions is to develop the child's capacity to mentalize within their family system and other social systems. Additionally, MBT-C treatment involves addressing any mentalizing problems within the parent or caregiver system and promoting adaptive mentalizing between the child and parents/caregivers. MBT-C focus is on identifying problematic relational interactions and working with the family to change dynamics in order to create functional ways of interacting in order to promote the growth and developmental of both the child and the greater family system.

There is a significant amount of research on MBT for treatment for adults with personality disorders that demonstrates its efficacy in reducing symptoms and promoting adaptive functioning. MBT-C is a recent adaptation of MBT that is used to treat children that have attentional, behavioral, and anxiety diagnosable disorders. There are very few research studies on the effectiveness of applied treatment of MBT-C with children. This dissertation seeks to explain the theory behind the treatment and demonstrate its methodology in treating children with attentional disorders.

Introduction

This article will include the underlying theoretical frameworks for mentalization based treatment (MBT) and mentalization based treatment for children (MBT-C) which include attachment theory and natural pedagogy theory. Attachment theory posits that the quality of attachment relationships between the parent(s) and their child impacts the child's development in key areas including attention control and emotional regulation. Natural pedagogy theory explains how humans beginning in infancy attain knowledge beginning with parents/caregivers and then within the larger social environment.

MBT was first implanted as a treatment modality for adult women who were diagnosed with borderline personality disorder (BPD). This literature review will provide an evaluation of the efficacy of this treatment with BPD and other mental disorders. This will be followed by an overview of the literature on the application of MBT-C with children who are in the foster care or have other clinical diagnosable behavioral disorders. Lastly, this article will examine the role of attachment between parent and child in promoting mentalization and social learning.

Attachment Theory

Attachment theory has been well researched and provides an understanding of the impact of parent/child bonding on the psychological well-being of the developing child. Cassidy, et al., (2013) explored early attachment experiences through the lens of cognitive ‘working models’ and how they integrate within neural and physiological mechanisms and contribute to the development of the child (p. 1415). They cited the early work of John Bowlby and Mary Ainsworth who pioneered research inquiry about the quality of caregiver/infant attachment and how the quality of the attachment relationship manifests in the child through his/her lifespan.

During World War II, Anna Freud and her colleague Dorothy Burlingham performed observational studies of children who experienced separation from parents/caregivers and those who experienced the effects of bombardment during the German “Blitz” in London (Freud & Burlingham, 1973) . At that time, psychoanalysis was mainly concerned with the development of insight within the patient through a process of talk therapy and did not recognize the importance of the external environment upon the psyche of the individual (Fonagy, 2001). Thus, Freud’s observational studies were novel in that they focused on observed behaviors of the children and in some cases their parents within institutional care or similarly situated domiciles in the community.

Freud & Burlingham (1973) found that children who were evacuated from London and separated from their parents faced deeper and more persistent psychological

damage than those who remained with their parents despite being exposed to extreme danger and violence. Freud noted that, “separation from the mother, even if she was not a very competent one, appeared to be far more damaging than living in the unhygienic squalor of bombed out buildings in the London underground” (Jones, 2004, p. 193). Freud & Burlingham also noted that the response of the mother or caregiver to the bombing heavily influenced the child’s response regardless of the severity of the danger. They noted that the, “children’s reactions to air raids related more closely to their mother’s reactions than to the seriousness of the raids” (Jones, 1994, p. 194). Midgely (2007) noted that Freud’s observations explored, “the degree to which a child’s response to air raids was determined by the reaction to his/her parents” and the connectedness of the child to the parent’s reaction to dangerous events (p. 945). Thus, their work began to inform the exploration of the role of parent/child attachment with the psycho-social development of the child as well as the child’s ability to cope or recover from extreme environmental dangers.

Jones (2004) added onto the Freud and Burlingham research about the impact of war experiences on the functioning of children after the war concluded. Jones (2004) conducted a longitudinal study of child survivors from the Bosnian war. She interviewed children who had been living in various parts of the former Yugoslavia and were directly impacted by the war. Like Freud, she noted that children fared better psychologically and adjusted better post-war if they remained with their primary caregivers compared to children who were sent outside of the conflict zone to reside with extended family or other non-biological families. Additionally, she found that, “how parents coped mattered”

in terms of how they responded to the conflict and violence in their environment (p. 219). The children of parents who were able to minimize their own distress due to extreme environmental stressors such as bombings or witnessing violence were less likely to have psychological disturbance in the years following the conflict. Conversely, she found that the children whose parents responded with anxiety to the same or lesser level of conflict stressors were more likely to experience long-term symptoms of psychological disturbance such as PTSD into their early adulthood.

The post-war decades saw many advancements in the field of psychiatry in terms of exploring outside of the traditional insight oriented psychoanalysis treatment model. In Europe, psychiatry began to focus on the psychological impacts that resulted from the many traumas of the war including forced separations and exposure to extreme violence. Midgely (2007) noted that Anna Freud, Winnicott, Bowlby, and others evaluated the, “policy of evacuation [In England] while saving many children from unheard of danger, was creating other consequences that might be equally harmful to children’ the consequences of broken attachments” (p. 948). It is in the post-war period that Bowlby began researching the relationship between the disruption of mother/child separation and later behavioral difficulties when the child became a juvenile. Bowlby performed a retrospective study with 44 male ‘juvenile thieves’ which informed his hypothesis that, “the disruption of the early mother-child relationship should be seen as a key precursor of mental disorder” (Fonagy, 2001, p. 6). Bowlby (1944) found that the difference between the juveniles who committed thievery and those in the general clinic population was that

the former experienced prolonged separation from their parents. Thus began Bowlby's work and theoretical framework into the formulation of attachment theory.

Bowlby (1977) highlighted the significance of the caregiver/infant bonding system as he was developing attachment theory. He stated that, "attachment behavior is conceived as any form of behavior or retaining proximity to some other differentiated and preferred individual" (p. 203). He further stated that the expression of an individual's emotions are correlated with their attachment relationship with their infant/childhood caregiver. Bowlby noted that, "emotions are usually a reflection of the state of a person's affectional bonds, the psychology and psychopathology of emotion is found to be in large part the psychology and psychopathology of affectional bonds" (p. 203). Thus, he hypothesized that there is a relationship between the quality or expression of attachment with psychological health or psychopathology.

Additionally, Bowlby posited that the attachment behavior system is, "underpinned by a set of cognitive mechanisms" which he termed as "internal working models" (Fonagy, 2001, p. 12). According to Bowlby, the child formulates an internal mental representation of the caregiver which he termed the "internal working model". This internal representation is formed through the child's interactions with caregiver. The child experience of self is modeled through the caregiver's treatment of the child. Thus, a child who experiences maltreatment from the caregiver will form a complementary internal working model of self that is seen as unlovable and flawed (Ainsworth, 1978; Fonagy, 2001).

Mary Ainsworth and her colleagues (1973) expanded upon Bowlby's work by creating an experiment, the Strange Situation, in order to identify and evaluate different attachment styles. In the experiment, an infant was left with a stranger and the researchers observed the infant's response when the caregiver returned. From this experiment, they identified three attachment styles; secure, anxious, and avoidant. Shilkret & Shilkret (2016) characterize the secure attachment style as reflecting "the upset infant's welcome of the mother's return and his use of the mother to calm down" (p. 201). They describe the avoidant attachment style as reflecting that the infant "did not protest their mother leaving and ... did not respond immediately to her return" (p. 202). Additionally, they described the ambivalent infant as being "quite upset when their mother's left and seemed to welcome their return, but did not calm down readily" (p.202). Main & Solomon (1990) identified a fourth attachment style, disorganized attachment, which is characterized by an absence of attempts by the infant to cope with anxiety about separation from the mother in the Strange Situation room.

Natural Pedagogy Theory

Natural pedagogy theory posits that there is a communication system between infant/child and adult that allows for the conveyance of knowledge from the adult caregiver to the infant/child (Gergely & Csibra, 2005). Csibra & Gergely (2006) define natural pedagogy as, "explicit manifestation of generalizable knowledge by an individual (the 'teacher'), and ... interpretation of this manifestation in terms of knowledge content

by another individual (the 'learner')” (p. 5). Natural pedagogy differs from social learning in that social learning relies solely on observation for imitation and natural pedagogy involves interactive behaviors between the teacher (parent/caregiver) and the student (infant/child) in order to transmit relevant knowledge.

Natural pedagogy is a learning system that originated in early hominid groups as a way to convey “efficient social learning mechanism that enabled transmission of not just observable behaviors but also unobservable knowledge” (Csibra & Gergely 2006, p. 256). Accordingly, the ability to transmit knowledge and skill sets from adult to child in an efficient manner allowed for further development of the human species. Csibra & Gergely (2006; 2009; 2011) hypothesize that this adaptive social learning communication system has evolved within humans as the conduit for early social learning between the caregiver and infant. Critically, the knowledge that is being transmitted is generalizable to other contexts which allows for rapid learning and adaptive development in the physical and social environment. Thus, the infant/child is able to efficiently learn valuable information in order to fully develop into an adult without a priori safety and skill acquisition through repeated observations (Egyed, et al., 2013; Futó, et al., 2010).

Csibra & Gergely (2009) propose that specific mechanism for natural pedagogical learning is through the use of ostensive cues. They state that infants are neurologically wired to receive information which enables the “fast and efficient social learning of cognitively opaque cultural knowledge that would be hard to acquire relying on purely observational learning mechanisms” (p. 148). The mechanism for the infant/child to recognize that the adult is conveying relevant, meaningful, and generalizable knowledge

is by the caregivers use of ostensive cues. Ostensive cues are activated through the interaction between the adult caregiver and the infant/child in the form of directed attention to the child, motherese, eye contact, turn taking, eyebrow raising, and use of child's name which serve to alert the child that what comes after the cue is relevant to the child (Csibra & Gergely 2006; Gergely, et al., 2007; Csibra & Gergely 2009).

The ostensive cue "motherese" or infant directed speech is delivered to preverbal infants by the caregiver and is defined by Csibra (2010) as having, "higher pitch, broader pitch and amplitude variation, and lower speed than adult-directed speech" (p. 147). He proposes that the function of motherese is that, "it makes manifest that the speech is infant directed" and serves as a mechanism to cue the infant to attend to the mother/caregiver (p. 148). Furthermore, Csibra indicates that additional functions of motherese include capturing the infant's attention, regulating infant affective states, as well as possibly aiding in the infant's language acquisition. He also notes that the response from the infant to the motherese, "just like their responses to eye contact, also have an affective component" which signals the bi-directional affective state communication between mother/caregiver and the infant (p. 148).

One function of the bi-directional affective state communication is for the infant/child to develop the capacity to regulate their emotions. Fonagy & Allison (2014) theorized that, "through the down-regulation of affect triggered by proximity seeking in the distressed infant, attachment not only establishes a lasting bond between child and caregiver, but also opens a channel for information to be used for

knowledge transfer between generations” (p. 374). Additionally, Midgeley, et al., (2017) hypothesize that parent/caregiver mirroring of the infants’ affective states through the use of motherese and other ostensive cues aids in the development of emotional regulation. They stated that, “when parents mirror their infants’ affect at a lower intensity, this is believed to help infants down-regulate their affect until it is regulated” (p. 29). The function of motherese with the affective component seeks to mirror the affective state in the infant/child and allows them to down-regulate negative affective states.

Eye contact serves as another effective ostensive cue between mother/caregiver and the infant. Csibra (2010) notes that, “eye contact triggers enhanced attention to the face in adults, children, and infants” which serves to cue the recipient to attend to the eye gaze (p. 146). The function of eye contact is to capture attention for further directed verbal or non-verbal communication. Specifically, Csibra notes that eye contact, “is a signal that, when it is noticed, unambiguously specifies its target and is ideal for establishing or re-establishing a communicative link between two people” thus the use of infant directed eye contact by the mother/caregiver serves to capture attention in order to promote communication (p. 145).

Another ostensive cue that is designed to signal important communication is turn-taking or contingent response. Csibra (2010) proposes that this signal originates from feeding behaviors between mother/caregiver and the infant. He states that this

occurs when the nursing infant stops feeding and the mother moves the breast to determine the infant's desire to feed or discontinue feeding. The infant may then restart feeding which signals to the mother the infant's interest. This contingent response interaction pattern, "is an essential structural property of normal human conversation" and serves to create a communication pathway within the dyad (p.150). Csibra notes that these contingent response interactions during feeding creates a dialog between mother/caregiver and infant as both parties seek to, "adjust the timing of their own communicative actions to the other's communicative actions" which fosters attunement between mother/caregiver and the infant (p. 150).

In addition to establishing a communicative system between mother/caregiver and infant, Csibra (2010) states that another function of ostensive cues is to "create a shortcut for triggering inferential processes that would interpret accompanying actions of the same source" (p. 142). Csibra further states that this process of marking relevant information to the infant/child is designed to transmit knowledge directly without cognitive processes for interpretation or inference. This process operates efficiently and does not require cognitive processing within the child, of which, the child is not yet capable of forming cognitions to evaluate the truthfulness or usefulness of what is being transmitted. Furthermore, the knowledge transmitted appears to be generalizable rather than idiosyncratic and allows for the infant/child to engage in learning that can be used across multiple contexts.

The theory of natural pedagogy extends to the psychological development of the child including the infant's recognition of self and the development of the emotional regulation system. Fonagy & Allison (2014) state that contingent and marked affect mirroring which is delivered through ostensive cues initiate the psychological development of the infant. They note that parents mirroring of affect that is accurate and congruent, and marked in a way to that allows the infant to distinguish between parent and themselves. This in turn provides for the infant's development of the intrapsychic experience of self, the recognition of parent as separate from self and creates the pathway for secure attachment. Furthermore, through repetition of marked, mirrored interactions within the infant/caregiver dyad, the infant/toddler/young child begins to regulate their emotional responses to internal or external stimuli. Winnicott (1967) noted that the mirroring process between infant/child fosters the development of the mental representation of feelings within the child. Fonagy & Target (2002) proposed that the emerging awareness in the child of self-mental states develops with the early attachment relationship between caregiver/infant. Thus, in addition to the transfer of knowledge, the ostensive cue communication system provides for the emerging psychological development of the infant/child

The role of ostensive cues as a communicative instrument has been demonstrated in the research literature. Csibra & Gergely (2009) found that 6 month old infants followed the adults gaze when preceded by ostensive cues of direct gaze by the adult to the infant as well as infant directed speech. Conversely, they found that the infants did not follow the adult gaze when ostensive cues were not introduced. Senju, et al., (2008)

found that 9 month old infants directed their gaze jointly with the adult towards objects when an ostensive cue of direct eye contact preceded the action. They state that the “preceding period of eye contact is crucial for the longer looking time for object-congruent gaze stimuli” which indicates the importance of directing the attention of the infant through the use of the ostensive cue direct eye contact towards the stimuli presented (p. 314). Okumura, et al., (2020) expanded on the infant directed eye gaze ostensive cue experiments by comparing the directed eye gaze to attention grabbing cues e.g. shivering, beep, and mouth moving beep. They found that while both conditions affected infant gaze, it was only the infant directed speech ostensive cue that “facilitated their referential objective learning” (p.1). Wu, et al., (2014) found that ostensive cues were more successful for generalizable learning than interesting non-ostensive cues that preceded stimuli event.

The therapeutic use of ostensive cues in clinical practice has been documented in the research literature. Fisher, et al., (2021) states that ostensive cues are useful when providing telehealth therapy sessions in a variety of treatment modalities in order to promote epistemic trust between the therapist and client. Previously, Fonagy & Allison (2014) noted the relationship between ostensive cues and creating epistemic trust. They stated that, “ostensive cues from the caregiver trigger epistemic trust at the same time as increasing the chance of child-parent attachment”(p. 374). Thus, the use of ostensive cues in therapy sessions serve to replicate the innate communication system that existed in early childhood in order to promote epistemic trust and generalizable learning.

Fisher, et al., (2021) specifically identified ostensive cues which include, “facial expressions like raising eyebrows or showing marked surprise; body gestures and mannerisms like sitting straight and leaning forward; maintaining eye contact continuously; exaggerating voice intonation or making marked changes in tone; and being meticulous in turn taking by waiting for the patient to finish speaking and pause before beginning to speak” as mechanisms for establishing the connection between therapist and client (p. 510). They also stated that the therapeutic use of ostensive cues with psychotherapy with children in a telehealth environment, “can be used playfully and in an exaggerated manner to signal to children that their subjective experience has been identified by the therapist” (p. 519). Furthermore, Fonagy & Allison (2014) noted that these cues serve to promote attachment security which is, “rooted in a history of feeling recognized [and] appears to increase the likelihood of trust in a source of communication when it is reasonably credible” (p. 374).

Epistemic Trust

Epistemic trust is defined as the capacity to trust knowledge that is being conveyed from the caregiver(s) to the infant/child and thus allows the child to integrate the information being conveyed as relevant and meaningful (Sperber, et al., 2010; Bateman & Fonagy, 2016). Further, epistemic trust allows for the infant to trust knowledge being transmitted without the cognitive processes of assessing the validity of the information that is being presented. Asen & Fonagy (2021) theorize that infants are

born with epistemic vigilance or a general, “self-protective suspicion toward potentially damaging, deceptive, or inaccurate information” (p. 129). Additionally, Mazzarella & Pouscoulus (2021) posited that, “epistemic vigilance is linked to the source of information” which indicates that the infant/child is able to discern both how the information is communicated and also who is communicating with them (p. 356). In the context of a therapeutic relationship, it is vital for the therapist to intentionally cultivate a system of epistemic trust between themselves and the client or client system. Fonagy & Allison (2014) stated that, “establishing epistemic trust in the creation of a collaborative between patient and therapist through the explicit effort of seeing the world from the patients’ standpoint serves to open the patient’s mind to the therapist’s communication” (p. 375). Thus, epistemic trust allows the client to glean relevant knowledge from the therapist with the goal of generalizing this knowledge in the client’s intrapsychic self and externally in the social environment.

The function of ostensive cues is to counteract epistemic vigilance and alert the infant/child that the information conveyed is relevant. Therefore, ostensive cues operate within an interactive system between infant/child and caregiver to provide a pathway for the development of epistemic trust within the infant (Bateman & Fonagy, 2016). Furthermore, they state that ostensive cues are specifically sensitive to the quality of the attachment system between the parent/caregiver and infant/child. A parent that is sensitive to the child’s proximate needs and provides ostensive cues through mirroring, child directed speech, and “motherese” will likely generate a secure attachment. Thus, the quality of the attachment in conjunction with the use of ostensive cues between the

caregiver/infant may determine the receptivity of the infant to the formation of epistemic trust. Fonagy & Allison (2014) stated, “ostensive cues from the caregiver trigger epistemic trust at the same time as increasing the chance of a secure child-parent attachment” (p. 7). They argue that a secure attachment between the infant/child and its caregiver(s) is the foundation that allows for the child to reliably trust the information being conveyed. Furthermore, Fonagy, et al., (2015) noted that caregiver contingent mirroring between the caregiver and infant, “creates the foundation for the infant to acquire further knowledge from that individual” (p. 15). Thus, the development of epistemic trust and the attachment system between the caregiver/infant are reinforcing; the better the quality of attachment between the caregiver and infant through the use of ostensive cues spurs greater epistemic trust which then results in stronger, secure attachment.

Theoretical Underpinnings of MBT

Mentalizing is a psychological process that allows the individual to "understand actions by other people and the oneself in terms of thoughts, feelings, wishes and desires" (Bateman & Fonagy, 2016 p. 3). Allen, et al., (2008) suggest that, "mentalizing is the most fundamental common factor among psychotherapeutic treatments" and posit that as such, mental health professionals will benefit from incorporating mentalizing in treatment applications (p.1). Bateman and Fonagy (2019) note that MBT treatment has been expanded from its original use in partial hospitalization programs in Europe into a

broader worldwide context which includes outpatient clinics, schools, prisons and with a variety of client systems including children, adolescents, adults, couples, and families. They further state that as MBT has evolved, it is now being used as a treatment modality for a range of clinical diagnosis including eating disorders, conduct disorder, personality disorders, depression, substance abuse and psychosis.

The development of mentalization begins in early infancy within the attachment system between mother/caregiver and the infant (Bateman & Fonagy, 2016). It is within the context of the attachment system that the child develops the capacity to mentalize their 'self' as a separate self from the caregiver and others in the social environment. Specifically, Csibra & Gergely (2009) found that ostensive cue interaction systems between the caregiver/infant dyad are the key components in the developing self of the infant. They noted that ostensive cues in the form of, "motherese, eye contact, turn taking, and special tone of voice" work to develop epistemic trust within the child. Epistemic trust allows the child to consider and believe the information the caregiver is conveying is relevant and meaningful. Fonagy & Allison (2014) further state that contingent and marked affect mirroring by the caregiver initiates the psychological development of the infant. They noted that this mirroring of affect initiates the emotional regulation system within the infant and provides a pathway for secure attachment.

Mentalization is a complex psychological process that involves multiple aspects that work in concert with each other in order to form the psychological self which interacts within the social environment. According to Lieberman (2007), there are four dimensions of mentalizing that operate together with each other in order to form the

operation of organized internal mental states. These dimensions include automatic versus controlled, 'self' versus 'other', cognitive versus affective, and internal versus external. When these dimensions are in balance with each other, the mentalization system is robust and functional intra-psychically as well as with interactions between the individual and his/her social environment. Bateman & Fonagy (2016) theorize that imbalance in any of the four domains of mentalizing may result in dysfunction or psychopathological symptoms. They further state that, "different types of psychopathology can be distinguished on the basis of different combinations of impairments along the four [mentalizing] dimensions" thus they suggest that the imbalance of one or more of these domains contribute to the symptomatology of mental health disorders (p. 8).

According to Bateman & Fonagy (2016) automatic mentalizing is characterized by, "faster processing, tends to be reflexive, and requires little or no attention, awareness, intention, or effort" (p. 8). This type of mentalizing is used in every day interactions that require basic communication such as social greetings, requests, or providing or receiving information. Controlled mentalizing which is on the opposite dimension, is slower and "demands reflection, attention, awareness, intention, and effort" (p. 8). Examples of controlled mentalizing include reflexive thinking, understanding, formulating opinions or ideas, and considering alternative perspectives. Typically, individuals who experience situations where they need to more deeply evaluate either themselves or an interaction with other(s) are able to easily shift from the automatic to the controlled form of mentalizing in order to understand or make judgements about the stimuli presented. Bateman & Fonagy (2016) hypothesize that individuals who are unable to shift to

controlled mentalizing often misread or misinterpret their own self or other(s) affective or cognitive communications. In doing so, the meaning of what is being expressed can be misunderstood or not identified.

Mentalizing the self is the ability to be aware of mental states within the self of both cognitive and affective forms. Mentalizing the other is the ability to consider the mind states of others; to consider others thoughts, feelings, wishes and desires in order to understand their motives, intentions and behaviors (Bateman & Fonagy, (2016). They further theorize that the quality of the individual's attachment will impact their ability to recognize and differentiate between their own internal states and those of the other person. An individual with a secure attachment profile who has adequate nurturance from the "good enough mother" in terms of marked mirroring and the creation of self will tend to have balanced mentalizing in the domain of 'self' versus 'other.' Alternatively, individuals who have attachment profiles such as anxious, avoidant, or disorganized, may have impairments in the development of self and will reflect imbalanced mentalizing in this domain. The absence of an organized, cohesive sense of self will often result in symptoms such as anxiety and depression as well as difficulties in relationships with others.

Bateman & Fonagy (2016) explain the dimension of cognitive versus affective mentalizing as the balance between and the recognition of emotions and cognitions. They state that, "cognitive mentalizing involves the ability to name, recognize, and reason about mental states (in both oneself and others), whereas affective mentalizing involves the ability to understand the feeling of such states in self and other" (p. 13). They further

hypothesize that the imbalance of this dimension with either an individual whose psychological experience is weighted towards affective states or conversely weighted by cognitive states are the underlying factors in the development and expression of personality disorders and other forms of psychopathology.

Internal mentalizing is the ability to evaluate one's own internal mental states including thinking about one's internal experience both affective and cognitions. External mentalizing is to evaluate and make judgements about others mental states based on non-verbal communications, expressed verbal content, and affective presentation. Non-verbal communication includes body language, facial expressions, sounds, and body posturing. Balanced mentalizing in this domain requires internal evaluation of the others presentation before making rapid judgments about motives, desires, wishes, emotions, or thoughts (Bateman & Fonagy, 2016).

When there is an imbalance in any one or combination of mentalizing domains, individuals often regress to a developmental age before developing mentalizing capabilities. Bateman & Fonagy (2016; 2019) identify these regressive pre-mentalizing states as "non-mentalizing modes". They identified three distinct non-mentalizing modes which include psychic equivalence mode, pretend mode, and teleological mode. Psychic equivalence is defined as the perception of external reality is distorted because the focus is solely on the individual's internal states. This results in the individual believing what they feel on the inside is absolutely true in the external world. The pretend mode is defined as when the internal mental world is decoupled from reality and is experienced as more real than reality. Pretend mode is characterized by seemingly endless non-

consequential talk about thoughts and feelings but without any connection to the external reality. It may feel to the listener as inauthentic and not a real representation of the individual's true internal states. The teleological mode is defined as a conviction that mental states can be solved by means of physical action or solely evaluated by external evidence. Thus, individuals who are in the teleological mode may assign meaning to mental states (self/other) that are determined to be real or valid based solely on external observations. As an example, an individual operating in the teleological mode may believe that the only way to be certain that their partner loves them is to receive physical contact from their partner.

Mentalization Based Treatment (MBT)

Mentalization Based Treatment (MBT) was originally designed as a treatment model for women with a diagnosis of borderline personality disorder who were in a partial hospitalization program (Bateman & Fonagy, 2009). According to Bateman & Fonagy (2016), "mentalizing is a fundamental psychological process that has a role to play in all major mental disorders" which suggest that non-mentalizing modes play a significant role in psychopathology and maladaptive behaviors (p. 3). MBT treatment was designed to increase the mentalizing capacity within the individual in order to increase social cognition, regulate emotions, and develop an integrative sense of self. Bateman & Fonagy (1999) first implemented an emerging form of MBT which they called psychoanalytic treatment within a partial hospitalization setting for adult women

diagnosed with borderline personality disorder. They found that psychoanalytic treatment implemented in the partial day hospitalization program resulted in decreased suicidal acts, self-injury, lower inpatient hospitalizations, and better social and interpersonal interactions compared to the TAU protocols. Bateman & Fonagy (2008) further evaluated these results between the emerging form of MBT and TAU protocols by evaluating treatment outcomes from their (Bateman & Fonagy, 1999) study five years after initial treatment. They found that the partial hospitalization group who received MBT compared to the TAU group had significantly lower diagnostic status (23% versus 74%), outpatient service use (13% versus 87%), and medication use (.02 months versus 1.9 years with 3 or more psychotropic medications). The MBT group had increased vocational (work or school) status with 3.2 years versus 1.2 years with the TAU group. Bales, et al., (2012) performed a follow-up study to the Bateman & Fonagy (1999) partial hospitalization study with adult women diagnosed with severe borderline personality disorder and replicated their results. They found that the partial hospitalization group who received MBT treatment had decreased symptom distress, increased social and interpersonal functioning, and decreased pathology with very large effect sizes compared to the TAU group. They also found that the MBT partial hospitalization treatment group had a significant decrease in suicidal acts, self-harm, additional treatments, and psychiatric hospitalizations compared to the TAU group.

Current research has yielded additional evidence for the efficacy of MBT treatment with patients diagnosed with borderline personality disorder. Volkert, et al., (2019) systemic review of 14 published clinical trials using MBT for the period of 2015-

2018 found evidence that suggests MBT is effective for treating borderline personality disorder and other personality disorders. Their review cited studies RCT studies that compared MBT with TAU or SCM protocols. The results across studies noted that MBT provided reduction in psychiatric symptoms, lower treatment drop-out rates, reduction of suicide attempts, reduction of self-harm behaviors, and decreased depressive symptoms.

MBT has been evaluated for use with patients diagnosed with depression. Fischer-Kern & Tmej (2019) performed a meta-analysis using 15 studies that examined relationship between mentalization deficits and severe, chronic and treatment resistant depression. They found that psychodynamic therapy approaches with a focus on mentalization are a mediating and moderating variable (p. 162). In a pilot study which included 24 adult participants with a diagnosis of major depressive disorder (MDD), Bressi, et al., (2017) measured the effect of using Short-Term Psychodynamic Psychotherapy with Mentalization Based Techniques (STMBP) in conjunction with SSRI or SNRI medications in reducing depressive symptoms. They found that STMBP combined with medications reduced depressive and alexithymia scores. Furthermore, they performed repeated measures and noted that the reduction of scores was maintained one year post treatment (p. 308). Taubner, et al., (2011) studied the impact of mentalization psychodynamic treatment with 20 patients who had a primary diagnosis of depression and were categorized as being chronically depressed with clinical levels of depression for at least two years. They found the mentalization treatment provided significant effect sizes on the Beck Depression Inventory (BDI) and the General Severity

Index (GSI) between baseline measurements and 15 months post-treatment measurements.

Mentalization Based Treatment for Children (MBT-C)

Mentalization based treatment for children (MBT-C) is predicated upon the same underlying theories of mentalization based treatment for adults (MBT) but has some adaptations specific to working with children and was developed as a time limited approach. The overall goals of mentalization based therapy are to develop and strengthen secure relationships, stabilize the self-structure through internal representations, and develop the ability to identify and appropriately express emotions (Bateman, 2006). These goals are extended to working with children that experience psychiatric symptoms by providing MBT-C treatment within their larger family system which includes the parent(s). Fearon, et al., (2006) conceptualize that dysfunction in the child or adolescent is related to the greater family system problems with mentalizing. These difficulties with mentalizing are then exacerbated by stress and heightened arousal and results in interactions that are unsupportive and further drive symptoms within the child and larger family system. Thus, they suggest that targeting increasing mentalizing in the family system will ameliorate symptomology in the child. MBT-C provides targeted treatment for the child and incorporates the parents/caregivers in the treatment with the stated goal of increasing mentalizing within the family system as a whole.

Midgely, et al., (2017) stated that MBT-C evolved as a specific treatment model for children and “may be suitable primarily for children with affective or anxiety disorders, mild or moderate behavior problems, adjustment reactions such as parental divorce or bereavement, or trauma or attachment issues” (p. 65). They state the time limited approach is designed to clarify the presenting problem within the family context in order to provide treatment for both parents and children and for this work to continue within the family system post-treatment. The stated aim of MBT-C is to, “provide mentalizing resilience in such a way that developmental process is put back on track” (p. 64) which reflects the hypothesis that the symptoms of childhood disorders are related to difficulties in mentalizing within the child, the parents, and the child-parent interactive system. The specific aim for the child is to, “strengthen and deepens the child’s ability to form and maintain relationships (p. 69). The specific aim for the parents is to, “strengthen their parental reflective functioning” by considering the child’s internal psychological experience, focusing on the child’s mind, viewing the child as a separate agent with his/her own thoughts and feelings, and developing a curious stance about the child’s mind in order to facilitate a greater understanding the of child’s behaviors (p. 69). The secondary aim of MBT-C for parents is to “develop the capacity to see their own affects and behaviors from the perspective of the child” (p. 70). In this way, MBT-C proposes that increasing the mentalizing capabilities within the child and parents will allow each agent to come to a better understanding of each other in order to promote communication and decrease symptomologies.

Verheugh-Pleiter (2008) identified four key elements of focus for providing mentalizing treatment with children. First, the emphasis is to work within the ‘here and now’. This may seem counter-intuitive to parents who present their child for treatment with a list of problems to review and work on in therapy. However, in mentalizing treatment, the emphasis is to develop the capacity to mentalize as a process rather than to redress past events. Secondly, the treatment provides that therapist meet the child on the child’s level of mental functioning. Third, the focus in the treatment is to use play to experience reality through fantasy. Thus, the child is able to expand their capacity to explore alternative options, allows for the expression of feelings, and to do so in a safe environment. Lastly, the work with the child is focused on process over content. The goal is for the child to develop internal representations, connected with the development of the sense of self in order to attain affect and attentional regulation.

Midgely, et al., (2017) put forth that the components of MBT-C treatment contains three phases; assessment, middle, and endings. In the assessment phase which is comprised of the first 3-4 weeks of treatment, the clinician interviews the parents and the child, and develops a written case formulation which is created and shared with the family (including the child). The formulation contains the presenting problem(s) and an indication of how the MBT treatment is tailored to ameliorate the symptoms. Furthermore, the clinician(s) will assess the capacity of the children and parents to mentalize in an informal format, i.e. by observing the child and parents communication and behavior patterns.

In the beginning phase of treatment, the assessment phase, the child meets separately with the therapist and the parents meet separately with the therapist without the child. The purpose of the beginning phase for the child sessions is to establish the therapeutic relationship as well as display curiosity about the child's mind and internal world through the use of play materials. The purpose of the parent sessions in the initial phase is to promote reflective parenting and develop, "empathetic attunement with the parents' experience even if the therapist has different views" (p. 72).

The middle phase of treatment, weeks 4-8, the child sessions are designed to increase the child's capacity to mentalize through the use of specific interventions. The parent sessions are designed to focus on reflective parenting and shifting perspectives from the parent to the child especially when mentalizing has broken down. Following the middle phase of treatment, the treatment team which includes the therapist(s) for the child and parents meet with the family to review progress and to determine if additional treatment sessions are required.

The ending phase, weeks 9 – 13, focuses on revisiting the formulation and marking changes within the child and family dynamic. The therapist and family system mutually decided if the treatment needs highlighted in the case formulation have been sufficiently addressed or significantly ameliorated. If there is a consensus, treatment is concluded and after-care needs are formulated to prepare the child/family for transitioning out of the therapeutic context. The parents are provided with the option of booster or check-in sessions in the 3-12 months after treatment concludes. However, if the therapist and family system decide that there are ongoing difficulties that have not

been addressed by treatment, they may decide to continue with another 13 week increment of MBT-C treatment.

Though promising, there is a paucity of research on the efficacy of MBT-C treatment (Byrne, et al., 2020; Midgely, et al., 2021). Oehlman-Forbes, et al., (2021) reviewed 18 studies that utilized some form of mentalization treatment for children who had experienced trauma. These studies included quasi-experimental, cross sectional, naturalistic, case-control, and a single case study and noted that, “all studies reviewed supported the hypothesis that improvements in mentalization were associated with various measures of symptom reduction and improved functioning” (p. 50). Byrne, et al., (2020) performed a review on studies that provided mentalization treatment that, “directly targets mentalizing – operationalized as reflective functioning and impact on psychological symptom” for a variety of parent, child, or family based treatment. They noted that there were only two studies for mentalization treatment for children, Halfon & Bulut (2019) and Ramires, et al., 2012).

Halfon & Bulut (2019) study focused on the associations between adherence to mentalization based practice in play therapy and increase in affect regulation in children with behavior problems. There were 48 participants in the study, equally proportioned between males and females, aged between 4 and 10 with a mean number of treatment sessions 34 across participants. The treatment for the child consisted of weekly 50 minute psychodynamic oriented play therapy using mentalization informed practices. The treatment with the parent(s) consisted of monthly psychotherapy session with the parent(s) with a focus on increasing parental reflective functioning. They found that there

was an association between therapy delivered with a high adherence to mentalization practices and increased affect regulation in the child.

Ramires, et al., (2012) is a single case study performed in Brazil. The subject participant was a 7 year old male child living in an institutional setting. His mother placed him in the shelter because she could not afford to care for him and he had little contact with his father who was incarcerated. He received 6 months of individual mentalization focused psychotherapy with stated goals of developing a sense of self within the child and a reduction of depressive symptoms. In post-treatment evaluation, they found a significant reduction in depressive symptoms and some movement towards development of self.

Though not a research study, Conway, et al., (2019) cites the benefits of using a mentalization informed psychodynamic psychotherapy approach in working with children that have a diagnosis of ADHD compared to behavior therapy. They cited research that indicates there is little evidence that stand alone behavior therapy for children with ADHD is effective (p. 213). The article cites case examples of treatment using a mentalization informed approach with children diagnosed with ADHD whose symptoms have either substantially remitted or the child is able to function significantly better in school and home environments. They noted that, “the difficulties children with ADHD present often evoke frustration and anger from caregivers, teachers, and peers, which further alienate them and can exacerbate symptoms” (p. 213). It is for this reason that they stress the importance of involvement of caregivers including teachers in the mentalization-informed treatment. Specifically, they hypothesize that children with

ADHD have a lower capacity to mentalize or that their mentalization breaks down in emotionally charged circumstances and this makes it difficult for them to engage in reflective thinking and learning. They suggest that mentalization-informed treatment promotes creating “a supportive, authentic relationship with the child which allows for the development of epistemic trust and helps the child to develop the ability to mentalize” which allows for social and behavioral learning (p. 215). Furthermore, they stress the importance of providing mentalization-informed treatment to other adults in the child’s environment to increase bi-directional mentalizing between the child and caregiver, teachers, or other adult figures. Accordingly, they state that the focus of mentalizing informed treatment with the adults in the child’s life is to encourage, “an empathetic, holistic understanding of children with ADHD rather than focusing on their limitations and difficulties” (p. 217).

The Mentalizing Stance

At the heart of MBT is the mentalizing stance that the therapist assumes with the client or client system. Midgely, et al., (2017) stated that “the therapist’s stance in MBT ... is at the core of what MBT is and how it works” (p. 84). According to Bateman & Fonagy (2016), the mentalizing stance, “is an attempt to capture a sense that mental states are opaque, and that the clinicians can have no more idea of what is in the patient’s mind than the patient himself ... and in fact will have a lot less” (p. 185). Midgely, et al., (2017) characterizing the mentalizing stance as recognizing that understanding the self

and others, “is not a straightforward process” because “we always have to work to try to understand the experience of others” (p. 92). Allen, et al., (2008) characterized the mentalizing stance as acknowledging, “the opaqueness of the patient’s mental states, as contrasted by making unwarranted assumptions and interpretations” (p. 349).

In working with children and families, Keaveny, et al., (2012) characterized the mentalizing stance as encompassing, “enquiries which are respectful, curious, tentative, and emphasizes the importance that the therapist places on trying to understand the feelings and perspectives of others” (p. 102). The primary goal of the mentalizing stance is to encourage clients to consider their own and other’s mental states with flexibility in order to try to understand their own and others thoughts, feelings, wishes, and desires. Midgely, et al., (2017) stress the importance of the mentalizing stance because, “we are trying to help the families we work with to develop the capacity to mentalize but also the means through which we can achieve this aim by trying to model this stance ourselves” (p. 84). Thus, a secondary aim of the therapist’s mentalizing stance is to model this posture to clients and related client systems so that they can recognize and further develop mentalizing with themselves and in relationships with others.

The MBT therapist will approach the client with curiosity about the mental states of the patient and invoke curiosity within the client about the therapist’s mind. Pearlman & Saakvitne (1995) stated of the therapist’s role in psychotherapy, “we are the tools of our trade” (p. 149). The use of the therapist as self is paramount with the MBT treatment model. In working with children, it is noted that bringing self into the relational space enables the therapist to connect with the child. Keaveny, et al., (2012) expressed the

importance of the therapist use of self because, “speaking openly about oneself can often help engage children, especially in the early stages of therapy, and can help create a sense that the therapist is friendly, interested, and non-critical” (p. 86). Furthermore, they noted that the therapist’s self-disclosure may provide the child with a sense of, “being with an adult who is genuine, non-judgmental, and empathetic” (p. 87).

The mentalizing stance is also a key component in working with parents and family systems. Slade (2008) noted that the function of the mentalizing stance with parents is to evoke reflective thinking about their child. She further indicated the importance of modeling the mentalizing stance to parents in order to be curious about their child’s mental states in order to link the child’s feelings with behaviors. Specifically she noted the importance of modeling mentalizing to parents in order to help them connect their child’s mental states with their behaviors, to understand that their child’s feelings will change over time, and also to have a curiosity and flexibility about their child’s mental states (p. 208).

Article Two; Applied MBT-C Treatment for the Composite Case of Patrick

Introduction

The second article will consist of examples of MBT-C that will encompass each stage of treatment for both the child sessions, the parent sessions, and the joint parent/child sessions. The examples that will be used are a composite of children and parents with case specific information changed to protect their identities. The children that were used in the composite include males, females, and non-binary with an age range of 7-10 which is consistent with MBT-C's target age population. The definition of "parents" includes married parents, single parents with or without co-parenting non-parents (e.g. step parents or other partners), and grandparents who are primary custodians. The inclusion criteria for the composite case is a diagnosis of ADHD with a presentation of behavior problems, anxiety, or both presentations. Exclusion criteria includes children below age 7 or above age 10, diagnosis of autism spectrum disorder(s), and children who are in any form of non-custodial or institutionalized care.

The composite child for this paper consisted of five children between the ages of 7-10 who presented for treatment for symptoms of ADHD. These symptoms included impulsivity, poor frustration tolerance, deficits in attention control, and frequent meltdowns. These symptoms occurred at home, in the school setting, and community environments. The parents in the composite included married couples and single parents

aged between 35-47 and are homeowners who reside in the greater Baltimore, Maryland area.

In accordance with MBT-C treatment protocols, the composite family which included the parent(s) and the child met together and individually with the therapist for 3-4 weeks of treatment for assessment purposes. During the assessment phase, the therapist worked with the family to create a case formulation which is a written document that highlights areas of concern for both parents and the child. The therapist performed a biopsychosocial assessment with specific focus on parent/child attachment systems. A specific intervention “what’s on my mind” which included a drawing board and coloring materials was used to assess the child. A detail of the intervention is included in this paper.

MBT-C Treatment Protocols

Time limited MBT-C has a specified treatment protocol of 13 weeks with options for additional sessions if the treatment team (including the family) deems it is warranted. The initial three weeks are devoted to the assessment phase of the child, the parents without the child, and the family unit as a whole. The main focus in the initial sessions are the assessment of the parents and the child’s mentalizing capacities as well as for the therapist to build rapport with the family. The therapist introduces play materials to the child and engages in directed play activities with the child. The therapist provides ostensive cues with the child including matched, marked mirroring, contingent response,

and a soft tone of voice similar to motherese. In the parent sessions, the therapist provides psychosocial information about the symptoms of ADHD and the challenges the child and/or parents may experience with mentalizing breakdowns.

The middle phase of MBT-C treatment, weeks 4-8, the therapist introduces specific mentalizing treatment interventions. These interventions may include purposeful walking, boxing, and baking sessions. A primary focus for the therapist is on using ostensive cues with the child in order to engender epistemic trust so that learning can occur. Specifically, these interventions are designed to help the child develop a sense of agency and to recognize self-internal affective states. Furthermore, the therapist works with the child in order to master areas that cause frustration such as the need to slow down to absorb instructions and listening to verbal directions. The therapist uses a curious, not knowing stance in order to elicit mentalizing with the child. In the parent sessions, the therapist provides parents with examples of positive mentalizing within themselves and their child as well as ways to reinitiate mentalizing if there is a breakdown.

The ending phase of treatment for the child, weeks 9-13, focuses on reviewing past learning in sessions. Parents will join the child for the final 2-3 sessions and the parent/child dyads will perform the treatment interventions in the middle phase together. The therapist will role model the intervention for the parents, review the case formulation with family, and note areas of relative strengths and weaknesses. The therapist will specifically engage the family in mentalizing their relationship with each other in the here and now and reflect on learning during treatment. Lastly, the therapist will offer after-

care options that include booster sessions for the family and referrals for additional psychotherapy as warranted.

The Assessment Phase; Weeks 1-3

The first three weeks in MBT-C treatment are devoted to assessment of the child and family systems. Midgely, et al., (2017) stated that the aim for assessment phase in MBT-C, “is to develop a mentalizing profile of the child and the parents or family and to explore what links this might have with the difficulties that brought the child to treatment “ as well as to, “help reach an agreed focus for the work and set goals” (p. 106). The manner in which the focus on treatment and goal setting is promulgated occurs by the collaborative creation of the case formulation between the therapist, the child, and the family system. The case formulation includes a summary of the reasons that the family is seeking treatment for the child, the ways in which the challenging behaviors impair the child, parents, and family as a whole, the mentalizing capacities for the child and attachment figures, attachment patterns and triggers between the child and attachment figures, and goals for treatment for the child and family system. See Appendix (A). The assessment phase is typically structured by having the initial meeting with the parents and the child followed by individual session(s) with the parents, individual session(s) with the child, and then a joint session with the child and parents to clarify reasons for treatment, set goals for treatment, and collaboratively create the case formulation.

The initial session with the parents and the child is designed to initially assess the family members' mentalizing capacities and how their mentalizing interacts with the problem or challenges the child and/or family is facing. At the onset of the session, the therapist works to build rapport with the child and family members and create a pathway for new learning through the use of ostensive cues. Fonagy, et al., (2015) observed that ostensive cues, "open a channel of information exchange" that serves to "transmit and assist in receiving knowledge about the social and personally relevant world" that extends beyond the individual's subjective experience (p. 14). Thus, the therapist will intentionally use ostensive cues by making direct eye contact, using the person's preferred name, engaging in marked mirroring of affective expressions or behaviors, and through the use of turn taking.

The therapist will make eye contact with the family members and intentionally use their preferred name(s). Additionally, the therapist will look for ways that he/she can contingently mirror each family member's affects, mannerisms or actions. For example, if the parent sighs and verbally expresses frustration, the therapist will mirror the affect and behavioral expression and mark it by either body language or other verbal expression. The ostensive cue of turn taking is intentionally utilized as a way to activate attachment between the therapist and the individual members of the family as well as the family as a whole. Furthermore, the therapist works to provide equal time for each family members' turn as a way to signal to the family system that each member has a voice and is given the time to express themselves.

The session will begin with family member introductions. The therapist may suggest that family members introduce each other, e.g. the mother introduce the child and specify the child's positive qualities. During introductions, the therapist will have the first opportunity to assess the mentalizing capabilities of the family members. Midgely, et al., (2017) states that the function of the family introductions in the first session is to assess how the family members describe each other, "in terms of personal qualities, mental states, and how they relate, or are their descriptions more concrete, focusing primarily on behavior?" (p. 109). Another area of assessment is the emotional descriptions that each family member presents about each other, "are they negative, overly idealized, or nuanced?" which will provide information about how each family member mentalizes affects both with oneself and with the other (p.110). Lastly, the therapist will assess how the each family member responds to the how they have been described.

After the family member introductions, the therapist will pivot to discussing the reason that the parents presented the child for treatment. Midgely, et al., (2017) suggests that the initial focus of assessing the presenting problem is identifying the history and context of the difficulties. Specifically, they state that the focus is on learning the nature and development of the problems, the contexts with which they typically present, and how the parents and the child understand them. The therapist will explore the effects that the problem(s) have on the family members and other related systems (community, peers, school relationships) and ways that the family and/or child has sought help to ameliorate the problems. Furthermore, the therapist will explore if family members have different

ideas about the problem(s), the etiology of the problem(s), and other factors related to causation (p. 110).

The second session in the assessment phase is with the parent(s) without the child present. The goals of this session are twofold, the first being to assess the mentalizing capacities of the parents and the second is to clarify the parent's concerns about the child. In assessing the parent's capacity to mentalize, Midgely, et al., (2017) puts forth the ideal parental mentalizing stance with their child which includes the following:

An interest in the child's mind and being emotionally available to assist the child with understanding his/her own actions, [having a] focus on child's mind/mental states rather than behaviors to figure out what the child is trying to communicate, [having the] capacity to engage in imaginative play and humor/joking, [being] motivated to consider the child's feelings/thoughts and to make sense of them, [being] available to assist the child with creating a self-narrative about feelings, [having] an understanding the the child's experiences are different than the parents and seek to view child's perspective, [the] parents have the ability/self-awareness of own mentalizing thoughts and feelings to regulate parent's own aggression, and [having an] understanding that parent's own feelings and mood will have an impact on their child (Midgely, et al., 2017, p. 24).

In the composite case of Patrick, one of the important aims of the assessment of the parents without the child is to evaluate the quality of their parental mentalizing with their son. This is significant in the case of children who have behavioral difficulties in conjunction with an ADHD diagnosis because the presenting problem is often linked to

emotional regulation challenges. Ensink, et al., (2016) noted the importance of parental mentalizing in providing a developmental pathway for the development of the emotional regulation system in the child. They stated that, “the parent’s capacity to understand the child’s behavior as communication and respond sensitively and with marked mirroring when the child is distressed ... are considered central for early self-regulation” which recognizes the importance for the parents to focus on what the behavior is communicating rather than to operationalize a reward/punishment system in order to assist the child in developing self-regulation. (p. 364). Luyten, et al., (2017) also emphasized the importance of the parent mentalizing the child’s mental states in order to understand the child’s behavioral expressions as a form of communication. Additionally, they recognized the importance of the parents’ capacity to recognize their own mental states and how this may influence their feelings towards their child (p. 174).

It is noted in the case formulation for “Patrick” that both of his parents struggle with mentalizing their sons’ negative affective states. The relationship pattern between Patrick and his father has been identified as either avoidant – both Patrick and his father avoid each other especially during times of conflict or his father reverts to behavioral consequences when Patrick becomes dysregulated. Ensink, et al., (2016) noted that if the parent responds, “as if his [the child’s] aggression and opposition is intentional provocation and assumes the child can simply control their behavior and resorts to threats and punishment, this is likely to contribute further to the child’s distress and dysregulation” (p. 365). It is noted in the formulation that Patrick’s father focuses on the behavior rather than the underlying mental states that occur before the behavior. The

behavioral strategy has not helped Patrick develop self-regulation and has resulted in increased behavioral outbursts both at home and in the school environment.

Conversely, Ensink, et al., (2016) noted that parents who respond to the child's oppositional and aggressive behaviors by considering the child's mental states, "communicate to the child that his/her reactions can be understood, and help them understand and articulate why they might be distressed or angry" (p. 364). In the case formulation for Patrick, his mother attempts to co-regulate his affective states when he becomes dysregulated. However, she struggles with his intense proximity seeking and also as the sole parent who Patrick seeks when he is experiencing emotional dysregulation or behavioral outbursts. Identifying these relational patterns between the child and his/her parents is vital for providing treatment interventions. Furthermore, this shifts the treatment from the child as being "the problem" and looks at the interactional patterns between the child and his/her parents and how these interactions contribute to the emotional regulation or dysregulation states.

The second week in the assessment phase also includes an individual session with the child without the parents present. According to Midgley, et al., (2017), the aim of the child assessment is to, "develop a profile of the functioning and abilities [of the child], assess personality and interacting with others, assess child's mentalizing capacity and how it may be linked to the presenting problem" (p. 113). Additionally, they noted that an important part of MBT-C is, "making an assessment of the child's basic capacity for attention control and self-regulation" (p. 115). This is particularly relevant in working with children who have a diagnosis of ADHD. In order to meet the diagnostic criteria for

ADHD, there must be deficits in attention and/or self-regulation (APA, 2013). Lastly, in addition to assessing for deficits in the child, Winnicott (1971) urges to look for the “vital spark” in the child as a way to bring the child’s inherent strengths into the overall assessment picture.

Assessment for attention control and self-regulation is performed by observing and interacting with the child. Midgely, et al., (2017) suggest that the therapist look specific features related to attention control which include: assessing the ability and quality of the child’s capacity for attention, observing the child’s ability to “live in their body”, observing the child’s sensorimotor regulation for sound, light, touch, temperature, and movement in space, observing the child’s gross and fine motor skills, and assessing the child’s level of hypervigilance in the session (p. 116). Furthermore, they note that it is important for the clinician to intentionally use ostensive cues with the child in the session in order to increase rapport with the therapist and decrease arousal. Rapport building and lower arousal will allow the therapist to better assess the child in their natural state.

Assessment for mentalizing in children seeks to appraise their capacity for affect regulation. Midgely, et al., (2017) suggest that the therapist evaluate the following factors that are involved with different aspects of the child’s affect regulation capacities: what emotions does the child show organically in the session, does the child engage in imaginative play and if so how connected are they with emotions, what emotions does the child recognize or name, are there any emotions that the child is uncomfortable or unwilling to express, how does the child manage difficult emotions or negative affects in the session, how well can the child accept limits, does the child have the capacity to ask

for help, and how can the child be comforted if distressed (p. 117). As the therapist is evaluating for affective regulation in the child, it is incumbent that the therapist engage in the ostensive cue of marked mirroring the child's affective states. This will assist the therapist in assessing the child's previous experiences with mirroring from the parent/caregiver or other trusted adult. If it appears that mirroring is somewhat novel to the child, this will prompt the therapist to further observe the interaction between the parent and the child in future sessions. Additionally, marked mirroring is an ostensive cue that reduces hypervigilance and increases epistemic trust thus allows the therapist to build rapport with the child (Bateman & Fonagy, 2019).

The third week in the assessment phase will bring the parents and the child together to meet with the therapist. The goal of this session is for the therapist, parents, and child to write the case formulation collaboratively to identify relational patterns and goals for the treatment. The case formulation will include an assessment of the attachment relationship between the child and parents, the mentalizing strengths of the child and the family as a whole, areas where the mentalizing breaks down with the child individually and with interactions with parents or other relationships in the community e.g. school, church groups, peer clubs, and the presenting problem that brought the child to treatment (Midgely, et al., 2017, p. 126). Lastly, the case formulation, informed by the collaborative work with the child, parents, and therapist, will set goals for the treatment. Midgely, et al., (2017) suggest that the therapist consider the following when conceptualizing the case formulation with the family: identify the, "nature and severity of the [presenting] problem, key causal factors, maintaining factors, understanding of the

child and parents mentalizing strengths and weaknesses, central issue[s] to focus on, and treatment goals” (p.131).

In the composite case formulation of Patrick (see [Appendix A](#)), the case formulation follows the guidelines set forth by Midgely, et al., (2017). The case formulation was written with collaboration between the therapist, child, and the parents. The beginning of the formulation starts with a narrative about the background of Patrick and the reasons he presented for treatment. Specifically, in this case formulation, Patrick’s statements about himself are included in the formulation. As the treatment is for and about the child, it is important for the child’s voice be included in the case formulation. This formulation is shared with the family and it gives the therapist an opportunity to highlight or mark areas in the child’s life that may contribute to the child’s behaviors. For example, Patrick identified that he is afraid of his father and that he believes that his father does not care about him. He does not seek his father for comfort when he is distressed. This type of information is helpful to present to parents in terms of understanding the child’s internal mental states and his/or motivations. In this composite case, Patrick’s father expressed that he did not feel close to his son and did not understand the underlying reasons. This allowed the therapist to encourage Patrick’s father to mentalize or consider his son’s internal states in order to understand or explain his behavior. Furthermore, the case formulation process provides the therapist an opportunity to provide psychosocial education to the parents/child about mentalizing and to begin the shift from focusing on behaviors to trying to understand and have curiosity about the child’s mind.

The intervention used in the assessment of the composite case of Patrick is designed to elicit representations from the child and the parents. This assessment was performed during the sessions with the parents without Patrick and the session with Patrick and his parents were not present. The therapist presented Patrick in his session and the parents in their session with a dry erase board. The therapist prompted Patrick and the parents to use marker to draw a picture or write words to indicate what was on their mind. In the instance of Patrick, he drew representations of himself and of his parents. Similar to a comic book, Patrick drew bubbles from the people and wrote dialog between himself and his parents. The therapist asked Patrick to explain the representations on the dry erase board. As this is an assessment tool, the therapist was looking to evaluate Patrick's capacity to mentalize his thoughts and affective states and his ability to shift perspectives to mentalize his parent's thoughts and feelings. In this representation, Patrick drew a picture of a time of conflict between him and his father. His mother was present comforting him. The therapist asked him to explain the conflict and intentionally used the ostensive cue of turn taking. The therapist assessed his ability to stay on task and to regulate his emotions in what he described as a highly aroused affective state. The therapist also assessed his capacity to engage in controlled mentalizing; being able to tell the story and reflect about different aspects of the people in his drawing.

Similarly, the therapist used the same intervention with Patrick's parents. The therapist invited the parents to use a dry erase board to draw or write things that were on their mind. The therapist was mindful to use ostensive cues with the parents. The

therapist called each parent by their preferred name. The therapist used a soft tone of voice, mimicking “motherese”. The therapist encouraged the parents to take turns speaking and explaining themselves. The therapist provided empathic validation to each of the parents as they expressed their feelings about Patrick and his challenging behaviors.

Patrick’s father wrote sentences rather than drawing representations. He stated that he is angry because Patrick is always getting in trouble at school and he is always getting phone calls at work. The therapist probed the father to consider Patrick’s mental states by asking, “I wonder why Patrick was so upset that he hit another student. What do you think was in Patrick’s mind? What do you think may have triggered this response?”. The therapist is assessing Patrick’s father’s capacity to mentalize himself and his son. Specifically, the therapist is considering how the father is able to express and regulate his own emotions, his ability to engage in controlled mentalizing to retell the story, and his ability to reflect on Patrick’s state of mind.

In this intervention, Patrick’s mother drew a picture of a heart and a representation of herself. She also drew a picture of her husband with an angry affect. As with the father, the therapist is assessing the mother’s capacity to mentalize herself and her son as well as her ability to express and regulate her emotions. In this case example, the mother stated that she loved Patrick and expressed appropriate affect. She explained that she is worried about Patrick’s self-esteem because her husband is often angry with him. The therapist invited the mother to shift perspectives from herself to her husband

and to Patrick. The therapist is assessing the mother's capacity to mentalize affective states in herself and her family members.

The Interventions Phase with the Child; Weeks 4-8

The goal of the assessment phase is designed to identify areas of strengths and weaknesses in terms of mentalizing capacities in order to target interventions that promote the growth of mentalizing within the child, parents, and family as a whole. During the intervention phase, the child is seen for individual therapy sessions without the parents. The parents meet with therapist in separate sessions in combination with telephone contact and other forms of communication. The aim of the intervention phase is to create an environment for the child and his/her parents that they can understand, notice, and practice their mentalization skills individually as well as in the relational space.

The foundation of working with the child in individual therapy sessions is to create an environment predicated upon by play which includes having visual as well as physical access to play items in the session room. Fonagy & Target (1998) state that, "the capacity to take a playful stance may be a critical step in the development of mentalizing" (p. 108). Halfon, et al., (2017) state that children experience their own internal world through imagining the inner world of play characters. Thus, the recognition of the role that play has in working with the child must be considered and intentional.

The therapist stance of playfulness in the session also serves to create an environment of play and as a safe place for the child to express themselves. Midgely, et al., (2017) suggest that the therapist stance of playfulness is an important component in working with the child to development mentalization skills particularly in a relational interaction such as between the child and the therapist. They state, “playfulness is an inner disposition to being open and experiencing freedom of thinking, feeling, and imagining” and that, “playfulness makes it possible to approach a topic or a problem from different perspectives and make contact with a child in a different way” (p. 139). Play is vital for the psychological development of the child in a myriad of ways. Midgely et al., (2017) detail the value of play which includes:

“play regulates negative affects and diminishes stress, play helps metabolize life events, play integrates new information affectively and cognitively, play offers a place to experiment with new behaviors and new solutions, play stimulates fantasy and fosters creativity, play stimulates the development of empathy, and play stimulates the development of mentalizing” (p. 134).

The physical space that the therapy session is held should be geared towards representations of play and creativity. Items such as stuffed animals, blocks, art supplies, and other toys should be displayed to allow the child to visualize that the therapy space is a place to engage in play and other creative tasks. The child should be introduced to play items to determine likes and dislikes as well as to explore their proximate space. The therapist stance with the child is one of curiosity and joining. The therapist invites the child to touch, choose or investigate play materials.

In addition to creating an environment of playfulness in terms of the physical space and the therapist stance, the goal of the intervention phase is to stimulate mentalizing within the child. Midgely, et al., (2017) highlight ways to stimulate mentalizing with the child that include:

“stimulating contact by working on attunement and joint attention, mirroring and contingent coordination, enhancing attention control and self-awareness by naming and describing what is happening in the here and now, promoting intentionality by linking behavior to effects in the external world, regulating affects by exaggerating or slowing down, regulating attention and affects by setting and playing with limits, clarifying and naming feeling states, and using games and activities” (p. 144).

In the composite case of Patrick, the therapist considered how to elevate play in the environment of the session room. The therapy room had multiple items designed for play that were reachable and visible to Patrick. These items include castle building blocks, Lego sets, popular super hero figures, stuffed animals, and art supplies. The session room had evidence of the play of other children on display in the room which included drawings, staged play scenes with action figures, and an opened, furnished doll house with dolls in different parts of the house.

One of the goals of the first intervention session is for the therapist to establish rapport through the use of ostensive cues. The therapist invoked ostensive cues by calling Patrick by his name, using a soft tone of voice, and encouraging him to look at the play materials. Patrick easily separated from his parents and investigated the play materials.

Patrick selected a box of blocks and dumped them on the floor. He began building a structure which toppled over and he became visibly upset. Patrick started crying and throwing blocks around the floor. The therapist employed the ostensive cue of matched mirroring and started crying and throwing blocks around the floor. In this moment, the therapist joined Patrick in his temper tantrum which then resulted in the co-regulation of Patrick's emotions. Patrick stopped throwing blocks and asked the therapist why she was throwing blocks. The therapist asked Patrick why he was throwing blocks. He said that they fall and the therapist repeated his response. The therapist provided an empathy statement about how annoying it is for him when the blocks fall down. Patrick and the therapist began piling blocks together and knocking them down. This exercise was intentional by the therapist in order to mirror the child's affects and behaviors.

Midgely, et al., (2017) noted that it is important for the therapist to monitor the arousal state of the child in order to, "ensure that her interventions meet the child at the right level" (p. 142). Verheugt-Pleiterelal (2008) also emphasizes the importance of recognizing the child's capacity to mentalize and to meet them at their level. In this case composite example, the therapist, using the ostensive cue of matched mirroring, brought herself to the child's level in terms of behavioral and affective states. This allowed for the child to down regulate and re-engage in the play activity. Landreth (2012) noted the importance of providing support and empathy in order to lower arousal states within the child. In this case example, the therapist validated the child's frustration and provided support for his emotions. Midgely, et al., (2017) noted that, "when children are easily affectively dysregulated ... it can be therapeutic to focus on building these foundations

that support mentalizing by working on capacities for basic self-regulation, attention control, and affect regulation” (p. 144). In Patrick’s case formulation, it was noted that he struggles with frustration tolerance. The therapist worked with Patrick with joint attention to the task in order to begin to build the foundation of affect regulation through co-regulation with the therapist. At the end of the session, the therapist and Patrick reflected on the high and low points of the session. Patrick stated that he got angry and threw things like he always does. The therapist reflected he did get angry and that he was able to return to play and manage his emotions in the session. This is an example of the therapist engaging in explicit mentalizing by inviting the child to name affective states and by validating the child’s affective state.

It is important for the therapist to consider the child’s capacity to mentalize and to tailor interventions designed to meet them at their level. Morris & Midgely (2020) stated that when children are unable to engage in symbolic, a stimulating activity that uses the body may be helpful in promoting mentalizing. Conway, et al., (2019) provided a case example of “John” and how the therapist used body movement to stimulate mentalizing. John was diagnosed with ADHD and experienced, “tremendous difficulty sustaining attention in class ... [and] when bored in class he would become noticeably dysregulated and leave the room without permission” (p. 215). The therapist recognized that John had a limited capacity to mentalize and engage in reflective thinking. She shifted the focus to playing basketball with John in order to promote his mentalizing. As treatment progressed, John was able to recognize his body and connect his actions to internal states. He developed a curiosity of his own internal states as well as a desire to understand the

therapist's internal states. At the conclusion of the 12 week MBT-C informed treatment, John ceased leaving the classroom without permission, focused on classwork with sustained attention, and stopped engaging in aggressive behaviors with peers.

In the case composite of Patrick, the therapist invited him to engage in a physical activity designed to incorporate ostensive cues and mentalizing. The activity that the therapist chose was boxing, an exercise that involves joint attention and mirroring. In discussing parent/infant interactions, Beebe, et al., (2013) stated that, "facial mirroring, the expectation of matching and being matched" and "providing each partner with a behavioral basis for entering into the other's feeling state and generating experiences that contribute to feeling "known", [and] attuned to" which helps the infant develop attachment security and the capacity for intimacy (p. 105-106). The aim of the boxing exercise is to intentionally promote attention and mirroring in order to develop attunement between the child and the therapist.

The therapist offered Patrick the option to engage in boxing with the therapist. Boxing provides a good opportunity to engage in matched mirroring as the therapist and the child can mimic each other's actions. Furthermore, the format of boxing naturally involves turn-taking and the use of eye contact. The focus of boxing is to throw a punch that lands on the other person without hurting them. This requires sustained attention of self and other. Boxing is also a highly physical activity that expends a lot of energy.

Patrick was enthusiastic about joining the therapist in the boxing activity. The therapist provided him with child sized boxing gloves. She had adult sized boxing gloves.

The therapist taught Patrick different boxing punch styles including jabs, flurry jabs, upper cuts, and hooks. The therapist also taught Patrick the boxing stance in terms of body position. Patrick and the therapist engaged in the boxing activity for about 20 minutes. The therapist led off the boxing exercise with jabs and invited Patrick to mirror her. Patrick and therapist practiced different kinds of punching styles in a matched mirroring posture. Patrick was able to maintain eye contact with the therapist throughout the exercise. Patrick and the therapist agreed to stop boxing when they both became tired. This involved the therapist and Patrick checking in with each other about their desire to continue.

At the conclusion of the boxing exercise, the therapist invited Patrick to engage in reflective thinking. He stated that he enjoyed this activity and wanted to do this again in his therapy sessions. The therapist, using the curious stance, invited Patrick to reflect on what he noticed about himself and the therapist while boxing. Patrick stated that he did not want to hurt the therapist and he was careful where he punched. He also recognized that the therapist was careful not to hurt him. He stated that he enjoyed the flurry punches the most because he expended the most energy and it was fun. He explained that he felt this was a good way for him to get his anger out without hurting anyone or himself. The therapist engaged in reflective thinking of her own with Patrick. She employed explicit mentalizing by naming things that she noticed that Patrick did well. For example, she noted that he maintained eye contact with her throughout the course of the boxing exercise. She also noted that he was careful not to hurt her and praised him for his

sustained attention in this task. The therapist and Patrick gave each other high fives to recognize each other's efforts in the boxing exercise.

Another key component in the intervention stage is to recognize times when the mentalizing of the child or the therapist breaks down. According to Morris & Midgely (2020), the therapist needs to offer support and empathy to the child if they become dysregulated in the session. Furthermore, once the child has regained regulation, the therapist will engage in a stop and rewind exercise in order to have a joint understanding of the emotional context of where the mentalization broke down. Coming to a joint understanding will allow the therapist and the child to repair their relationship and develop ways to resolve conflicts.

In the composite case of Patrick, the therapist introduced a new intervention with him that involved preparing a dessert in the session room to take home to bake at the child's home. Patrick chose to make a chocolate cheesecake from scratch because that is his Dad's favorite dessert. The therapist prepared for the session by laying out all of the ingredients on the session table for Patrick to view when he entered the room. Patrick became activated by the sight of all of the ingredients and he wanted to open the containers and taste each ingredient. The therapist became irritated and used a harsher tone of voice. Patrick immediately became dysregulated and he started throwing items from the table onto the floor. He said that the therapist hated him and used the mean voice. The therapist realized that her own mentalizing had broken down as she had become overly affective and she intentionally worked to re-regulate herself. She agreed with Patrick that she had used a harsh voice and apologized. Patrick recovered quickly

and was able to talk about what upset him. The therapist engaged in the stop and rewind strategy proposed by Morris & Midgely (2020) and worked with Patrick to understand his point of view and invited Patrick to understand the therapist's point of view. Patrick agreed to try to ask the therapist before touching items and the therapist agreed to try not to use the mean voice. The language in their agreement is flexible because they both discussed that sometimes they might forget or make a mistake.

The function of the baking session is to engage in a joint attention to task which stimulates mentalizing. Patrick followed the prompts of the therapist to mix the ingredients together. The therapist invited Patrick to touch and taste all of the ingredients as they went along. Patrick was able to maintain eye contact with the therapist when she was giving instructions. He used a large spoon to stir the ingredients and counted how many times the spoon went around. Patrick used sprinkles to make a design on the top of the cheesecake which spelled "Dad". He stated that he wanted his Dad to know that he made this for him. During this exercise, the therapist marked and named his ability to engage in sustained attention. At the conclusion of the exercise, the therapist and Patrick reviewed how the baking session unfolded. Patrick was able to name his feelings of frustration when he thought the therapist was mad at him because of her tone of voice. He also named feelings of happiness and joy in making a dessert that he hoped his Dad would enjoy. The therapist invited him to name things about the exercise that he did and did not enjoy. Patrick stated that he loved tasting everything but he thought that it took too long to stir the batter. He enjoyed decorating the top of the cheesecake but he did not enjoy cleaning the mixing bowl when he was finished. The function of the review is to

encourage Patrick to mentalize his affects and connect them with his likes and dislikes. Furthermore, Patrick was able to sustain attention and remember the process when prompted to engage in reflective thinking. This is an important goal of mentalizing – the ability to review situations and consider different points of view.

The Interventions Phase with the Parents; Weeks 4-8

Direct parent involvement in treatment is an important component of MBT-C which differentiates this treatment modality to behavioral therapies. MBT-C treatment recognizes that the child resides with their family and the interactions between the child and the parents/caregivers are often part of the symptomatology as well as the potential for growth for the child and their parents. Midgely, et al., (2017) stated that, “regular meetings with the parents or caregivers are always scheduled alongside the direct work with children as a part of time limited MBT-C” as they highlighted the role of parents in MBT-C treatment (p. 164). There is a recognition in the MBT-C treatment model focuses on the role the parents plays in the child’s symptoms and treatment. Thus, Midgely, et al., (2017) noted that “helping parents improve mentalizing capacities under relational stress supports the development of mentalizing capacities in children” (p. 165).

In working with parents, it is vital that the therapist also employ the use of ostensive cues within the sessions. As with direct work with children, ostensive cues serve to regulate the emotions of the parents, signal the parents when important information is being conveyed, and generates an environment of epistemic trust. The

ostensive cues of mirroring, using a soft tone of voice if the parent's arousal state elevates, calling them by their preferred name at different times in the session, and engaging in turn-taking are indicated in work with parents. Furthermore, the therapist will purposefully use controlled mentalizing in order to slow down the pace and regulate emotions.

In the composite case of Patrick, the therapist greeted the parents with open body language and inquired about their name preference. She intentionally used their preferred names in the session when addressing them in order to bring their attention to important content. She also engaged in mirroring of body language and affects with both parents, shifting the mirroring to the parent who was being engaged. Another important ostensive cue that the therapist employed was turn-taking. The therapist noted that Patrick's Dad wanted his wife to speak on his behalf instead of expressing his concerns. The therapist invited him to speak and provided empathetic statements about his voiced distress. Although he expressed that he did not want to participate, the therapist turned to him at regular intervals and invited him to provide his perspective. Though Patrick's Dad was initially reluctant to discuss his concerns in the session, after several prompts from the therapist, he opened up and shared freely. The therapist intentionally monitored the time each person had to speak in order to equalize their time. The therapist noted at the end of the first parent meeting that Patrick's parent's emotional arousal was lower and they seemed more relaxed.

In addition to establishing a safe environment with the parents by the use of ostensive cues and empathic validation, the goals of the parent work involve

psychoeducation, perspective shifting, and considering the parent's own capacities to mentalize. Midgely, et al., (2017) outlined the framework for individual work with the parents and the child not present as thus:

General aim of working with parents [includes] helping them develop or regain the capacity to look past the child's behavior to his or her experience and mind; becoming aware of their own affects and behavior, especially in contexts of conflict when they may lose their mentalizing capacities, which may in turn undermine their child's self-regulation and mentalizing; and encouraging parent-child interactions in which the child feels secure and understood and that facilitate[s] motivation, self-regulation, self-knowledge, and mentalizing. (Midgely, et al., 2017, p. 164).

The first aim, helping parents look past behavior and focus on the child's mind, is approached through psychoeducation about the particulars of the child's diagnosis and how this interacts with the child and families capacity to mentalize and the resulting behaviors. Nijssens, et al., (2012) stated that the interventions used in working with parents, "are focused on mental states rather than on behaviour and are related to current activities or interpersonal parental interactions" (p. 90). Thus, the therapist will ask the parents to provide an example of the child's behavior and then invite the parents to collaboratively speculate on what was in the child's mind before the behavior. When discussing the child's behavior, it is important for the therapist to be mindful that parents may feel vulnerable and judged which may make it harder for them to be curious about the child's mind (Morris & Midgely, 2020). In discussing the child's behavior(s) with the parents, they suggest that the therapist works to emphasize the parents strengths and

empathize with their weaknesses in order to decrease parental defensiveness and increase understanding.

In the composite case of Patrick, the therapist invited the parents to share an example of the child's behavior that caused them conflict and distress. Patrick's father stated that his son would leave the classroom and hide in the school. He expressed frustration that he had told Patrick to stay in the classroom and was upset that Patrick did not follow his instructions. He also stated that it was embarrassing to him to receive calls at work from the school about this repeated behavior. He felt that the school was judging him as a bad parent because Patrick continued to leave the classroom even after multiple prompts. The therapist validated his feelings of frustration and upset due to Patrick's behavior. The therapist recognized his vulnerability and praised him for sharing his experiences including feeling judged by the school personnel.

The therapist invited both parents to consider what was on Patrick's mind before he left the classroom. In other words, what is happening inside of Patrick that provokes him to leave the environment. This query shifted the focus from Patrick's behavior to Patrick's mind. The therapist explained the relevance of looking at Patrick's mind when she was providing psychoeducation. She then used Patrick's leaving the classroom as a here and now example that helped illustrate the importance of looking at what happened before the behavior. Patrick's Dad stated that his son was lazy and he wanted to get out of doing work. Patrick's mother stated that her son may have been scared by something that happened in the classroom. The therapist wrote down these answers to review with Patrick in the entire family session scheduled in week 9. The therapist also asked the

parents to actively consider what may be in Patrick's mind before the behaviors. She marked this request by calling the parents by their preferred name in order to inform them of the importance of the request.

The second aim of the work with the parents is to explore their own affects and behavior particularly in times of conflict with the child. It is important for the therapist to provide empathetic validation to the parents when they are discussing their affective states and behaviors. Nijssens, et al., (2012) emphasize the importance of, "experiencing these current emotions, labeling, differentiating and representing them, and placing them within a present context" because they are, "important keys to change" within the family system (p. 91). They note that parents may solely discuss their child's affective states and omit their own. However, the interaction between the parent(s) and the child impacts the child's capacity to regulate affects, engage in attention control, and form adaptive social-cognitive skills.

In the composite case of Patrick, the therapist brought out the case formulation which highlighted the parent's relational patterns with the child. The therapist approached the parents with the "not knowing stance" which Bateman & Fonagy (2016) characterizes as the curious, tentative, and with an understanding that others minds are opaque. This stance is particularly important when working with emotionally latent content which may be uncovered when asking parents to reflect on their own behaviors and affects. The therapist asked Patrick's mother to describe her own internal affective experience when Patrick becomes dysregulated. In using the "not knowing stance", the therapist framed the questions such as "I am wondering what it was like for you when Patrick has big

feelings” or “Can you tell me what you felt inside when Patrick was upset”? She stated that she feels overwhelmed because his emotions are intense and she does not know how to help him calm down. She described an incident when Patrick became so dysregulated after he was corrected by his Dad that he started hitting himself in the head. The therapist validated the mother’s feelings and worked with her to name them. Patrick’s mother stated that she feels helpless when Patrick is upset and this sometimes results in her leaving the room. She stated that she walks on eggshells around Patrick because his emotions are unpredictable and she does not always understand the trigger for meltdowns.

The therapist shifted to Patrick’s Dad and stayed in the “now knowing stance”. She asked his Dad about his interactions with Patrick when he becomes dysregulated. The therapist framed the questions such as “what did you notice in yourself when Patrick became so upset”? Patrick’s Dad stated that he becomes angry when his son becomes upset. He believes that his son has no reason to be upset because he has been provided everything he needs to grow up. He stated that he believes that Patrick is intentionally “bad” and trying to embarrass him. He also cannot tolerate being present with Patrick when he himself is upset.

The therapist probed about Dad’s experience growing up, and using the curious, “not knowing stance”, asked him what it was like when he was a child. Patrick’s Dad demonstrated no affect and he stated succinctly that his father was an out of work alcoholic who beat him and his mother. He stated that he was not allowed to show emotions in his home and that his father would bully him if he expressed any emotions.

Subsequently, he felt the need to protect his mother and he sought employment to support the family beginning at age 12. The therapist directed her gaze to him and made eye contact and expressed sadness about his difficult childhood. Patrick's father began to show some affect and the therapist asked him to name his emotion which he identified as sadness. In this example, the therapist used ostensive cues to foster attunement and allow space for the parent to feel that the therapist connected with his internal, affective experience.

The therapist then turned the focus to Patrick. She used the "not knowing stance" and inquired with each parent what they thought Patrick may experience when his parents feel overwhelmed or angry. His mother tried to consider Patrick's mental states but she was unsure about how he might be feeling. His father stated that he would not get angry at his son if his son followed the rules and did the right thing.

The therapist noted several examples of non-mentalizing modes with each of the parents. Patrick's mother is generally able to mentalize her son and consider his mental states except when he becomes overly affective. This triggers her own intense affective states and her capacity to mentalize him and herself goes off-line. Patrick's Dad experiences significant rigidity when there is conflict involving Patrick or when Patrick becomes overwhelmed by negative affective states. His Dad's mentalizing goes off-line and he goes into the non-mentalizing mode of psychic equivalence. This is reflected by his certainty about Patrick's intentions and his difficulties in regulating his own affective states.

As this case composite demonstrates, working with parents uncovers ways in which the interactions between the parent and child may contribute to the child's dysregulation and conversely, could contribute to re-regulation. Both of Patrick's parents are engaged in a relational patterns with him that aggravates rather than helps regulate Patrick's affective states. This is typical in children with ADHD as they often need additional support from attachment figures to help them regulate their affective states. Conway, et al., (2019) discussed a similar case of "Adam" where the parent's reactions to the child's behaviors further served to dysregulate the child. They noted that the therapist helped the parents understand how their response to the child's dysregulation, "fed into a non-mentalizing, emotionally and behaviorally disinhibited cycle" (p. 216). This allowed the focus to shift from solely the behaviors of the child to how their mental states and behaviors interacted with the child and resulted in acting out behaviors in the child.

Review Session with Parents and Child: Week 9

Following the interventions phase and individual work with the child and the parents, the next step in the process is to bring the family together to review the progress in treatment. Midgely, et al., (2017) stated that, "the central aim of the review session is to provide an opportunity to discuss the progress of the work to date and clarify the aims of the remainder of the intervention" (p. 194). They further elaborate that the focal points of the review session will include re-evaluating the treatment goals within the context of current functioning, provide an opportunity for the child and parents to express their own

perspectives, promote a sense of ownership about the child and parents about their work in therapy, and to practice communication about problems in an effective way. The review session will also provide the therapist an opportunity to recognize the child and parents for their work in therapy. Lastly, there is a discussion in the review session about finishing treatment at the 13 week interval or extending the treatment for additional sessions. This decision is made collaboratively with the child, parents, and the therapist.

In the composite case of Patrick, the therapist met with the family to review the treatment goals and decide if additional treatment sessions were warranted. The therapist approached the family with the curious, not-knowing stance and invited them to share their perspectives about progress towards the treatment goals. Patrick's mother stated that Patrick had not engaged in any aggressive behaviors in school and that he had not received a referral from the school in over a month. Patrick stated that he felt safer in the classroom because he felt the teachers were being nicer to him. The parents felt that Patrick had made progress in school but they still noted that he has frequent meltdowns at home. Patrick's mother stated that she believes he saves up all his emotions from the school day and then becomes emotionally dysregulated in the home environment. She stated that she is not really sure how to manage Patrick's "big emotions" and is still feeling frustrated. Patrick's Dad stated that he would like to feel closer to his son but he was not sure how to do this. The therapist and the family agreed to use the concluding 4 weeks to do family therapy with Patrick. The therapist suggested doing individual work with Patrick and each parent to address their individual concerns.

Completing Treatment: Weeks 10-13

The final weeks of treatment are devoted to addressing outstanding issues discussed in the review session and preparing for the end of treatment. Midgely, et al., (2017) suggest that the framework for the last few sessions be guided by creating a, “developmental experience of a meaningful good-bye” as well as, “thinking about gains and how to follow up and consolidate what has been learned in the context of treatment” (p. 196). As the final sessions are devoted to working with the family as a whole to solidify gains from the treatment, Midgely, et al., (2017), suggests that the therapist create, “a balanced (strengths and weaknesses) profile of the parents, their child, and their relationship” in order to “communicate to the parents a belief that they can be the “experts” going forward” (p. 196). While it is important for the therapist to create an attachment oriented treatment environment for the child and his/her parents in order to promote change, it is vital for the family to be able to separate from the therapist “attachment figure” and feel a sense of competency within the family system so that they can function on their own. Midgely, et al., (2017) notes the importance for the therapist to work with the family to create, “a narrative of the process of treatment” emphasizing the growth within the child and family system and that this narrative, “can prove an extremely powerful motivation for further change” (p. 196).

In the composite case of Patrick, the therapist scheduled an appointment with Patrick and his father without his mother present in the session. Collaboratively, the therapist, Patrick and his father agreed that the focus of this session was for them to get to know each other better by doing a joint activity, boxing. The therapist invited Patrick to

share his knowledge from a previous session about the boxing activity. Patrick then became the “expert” in explaining the boxing activity to his Dad.

Patrick and his Dad donned boxing gloves and tentatively moved closer to each other continually making eye contact. The therapist prompted Patrick to start by throwing a jab in the direction of his father. He gingerly moved towards his Dad and threw a jab. The therapist invited his Dad to mirror Patrick and return the jab. His Dad gingerly moved towards Patrick and threw a jab in his direction. The therapist prompted Patrick to demonstrate other boxing moves such as hooks, upper cuts, and flurry punches. Patrick and his Dad engaged in a sparring match with each other for about 15 minutes. They both maintained sustained eye contact with each other throughout the course of the exercise. Patrick and his Dad were also closely attending to their body movements in order to not hurt each other. They also gave each other encouragement and mirrored non-verbal grunts. After the exercise was completed, the therapist used the balance of the session time to engage in reflective thinking with Patrick and his father. They shared with each other what was on their own minds and what they were guessing was on each other’s minds. They each reflected on their feelings about the exercise in terms of affective states with Patrick describing feelings of closeness and warmth and his Dad feeling connected. This is an example of mentalizing in the four domains; explicit mentalizing, balanced self and other, balanced cognitive and affective mentalizing, and controlled mentalizing.

In the following session, the therapist scheduled a family session with Patrick and his mother. The focus of the session was to explore ways that Patrick and his mother could work together to downregulate his intense affective states or “meltdowns”. The

therapist, Patrick and his mother played a card game together, similar to Uno, with themes about anger management. The therapist designed this activity to invoke ostensive cues between herself, Patrick and his mother. Specifically, card games involve turn-taking, eye contact, joint attention, and the possibility of mirroring.

The cards have questions about the emotion anger, triggers for angry feelings, and ways to experience anger without becoming dysregulated. Each participant received seven cards and the stated goal of the game was to discard all cards before the other players. The cards have questions such as: “Name 2 things that make you feel angry”, “Who made you angry this week?”, “Share a story about a time when you were able to stop anger in its tracks.”, and “What do your friends do when you are feeling angry?” (*Mad Dragon: An Anger Control Game*, 2016). (See [Appendix B](#))

This card game activity directly targets a focal point of Patrick’s presenting problem; managing strong affective states. The goal of this exercise is to stimulate mentalizing between Patrick and his mother in a low arousal type activity. The questions are posed to each person in the game which allows Patrick to learn how adults recognize and manage emotions. The questions evoke mentalizing an affective state, anger, and considers how to use cognitions to mediate angry feelings. This is a way to stimulate balanced mentalizing between affective and cognitive poles. Additionally, the cards inquire about how other people respond to the individual’s anger. This portends to evoke mentalizing the self and other and to shift perspectives. The format of the game is controlled mentalizing; the questions call for specific examples of negative affective states. In order to state the answer, the player must organize a memory and restate the

details. Lastly, this game specifically calls for explicit mentalizing; the questions on the playing cards ask the player to name affective states, describe them, and consider alternatives.

Patrick and his mother shared joint attention in the card game. They sometimes made silly faces with each other, joked about some examples of misunderstandings, mirrored each other's affects, and provided each other support when a question was more emotionally charged. When the game was finished, the therapist invited Patrick and his mother to reflect on their experience of playing the game. Patrick stated that he learned that his mother also gets angry and ways that she manages her emotions. Patrick's mother stated that she learned some of Patrick's triggers for angry feelings. The therapist reflected that she noticed that they were able to communicate their feelings with each other without becoming upset or activated. In addition to the focal point of the game, discussing angry feelings, the therapist noted that the act of playing the game together lowered arousal and promoted attunement between Patrick and his mother.

The final two sessions in the treatment of the composite case of Patrick focused on reviewing the case formulation goals and saying goodbyes. Midgely, et al., (2017) noted that children demonstrate different reactions to concluding therapy. They stated that some child respond by feeling a sense of accomplishment while other children may become avoidant particularly if they have previous experience with attachment figure loss. Although the child may not respond positively to the end of treatment, the therapist needs to recognize the child's feeling states and validate them.

In the composite case of Patrick, he expressed mixed feelings of happiness because he completed treatment and also sadness that he would no longer be seeing the therapist. The therapist, Patrick, and his parents reviewed the case formulation. Patrick stated that he felt more understood in both his school environment and at home. He reflected that he had learned some ways to manage his strong emotions including understanding things that trigger him, spending time with his Dad, and playing with his toys to calm down. Patrick's mother reflected that she felt more confident in being able to help Patrick regulate his emotions because she learned to shift her focus on his mental states rather than his behavior. Patrick's father reflected that he felt closer to his son and he wanted to spend more time with him. He also stated that he learned about how his son's ADHD made it harder for him to manage his emotions and that he could do things to help Patrick regulate.

Lastly, Miggely, et al., (2017) discussed the importance of calling attention to the parent's need for self-care for themselves as parenting a child with ADHD can often be challenging. They suggest that the therapist and the parents brainstorm ideas about how they can ask for help from their support network. Furthermore, they recommend that the therapist offer to schedule a follow-up session within the next 3-12 months to review continued progress. They suggest that this is beneficial to the child and family system because, "knowing that there is another meeting planned when the family and therapists will see each other again to talk about progress or to identify ongoing or new difficulties can contribute to a continued feeling of being kept in the mind" (p. 198).

In the composite case of Patrick, the parents identified caregivers that Patrick and his sister could stay with overnight or for a long weekend so that they could have some “kid free” time with each other. Patrick’s father stated that he had decided to seek therapy for himself to work through his own childhood experiences. The therapist invited the parents to contact her if they felt that they needed additional support.

Conclusion

Childhood mental health disorders are increasing both in the United States and throughout the world. It is estimated that approximately 10% of children in the United States meet the diagnostic criteria for an attentional disorder (ADD or ADHD). Currently, the predominate form of treatment in the US is CBT or behaviorally focused therapies. These treatments primarily focus on changing the intrapsychic process of the child in order to remediate symptoms related to their attentional disorder. These symptoms include distractibility, lack of concentration, hyperactive movements, and inability to stay focused. The research literature has demonstrated that children with attentional disorders have poorer outcomes later in life such as higher rates of other mental health disorders, dependency on caregivers, increased risk for suicide, and incarceration.

The research literature on the effectiveness of CBT treatments across studies have demonstrated moderate or small effect sizes. These studies also are short term and do not represent treatment gains over time. One significant limitation of CBT or behavioral treatments is that they typically do not involve the parents in the treatment. If the parents

are involved, it is to reinforce learning rather than recognizing how the relational interactions with parents can either antagonize or reduce the symptoms in the child.

Mentalization Based Treatment (MBT) is a psychodynamic oriented treatment modality originally implemented with adult women who were diagnosed with borderline personality disorder (BPD). Unlike behavioral treatments, the focus of MBT treatment is on the mental states before the behavior. MBT recognizes that mentalizing, a form of personal and interpersonal cognitions, impacts how a person responds to internal or external stimuli. The goal in MBT treatment is to encourage balanced mentalizing across four domains in order to promote understanding of the motives, wishes, and intentions of the self and others. MBT recognizes the role that attachment plays in the development of the sense of self, the capacity to mentalize with self and others, and emotional regulation.

The MBT treatment modality was modified to work with children (MBT-C). MBT-C has been used to treat childhood disorders including behavioral concerns, attentional disorders, and children who have been placed in institutional care. The premise of MBT-C is that children develop within a family system, either biological or other form of caregiving, and as such, the treatment must focus on the family as a whole rather than solely the intrapsychic process of the child.

Furthermore, like MBT treatment, MBT-C is informed by natural pedagogy and attachment theory. Natural pedagogy theory posits that human infants are neurologically wired to receive signals, “ostensive cues”, from their parents which direct them to attend to the knowledge conveyed from their parents. This allows for the development of

epistemic trust which is the infant's ability to trust that the knowledge transferred from the parent is relevant and generalizable. Attachment theory posits that children develop a sense of self through the mirroring of their parents as well as a sense of safety. Furthermore, sensitive parenting promotes trust and allows the infant to seek the parent(s) to regulate emotions. Together, natural pedagogy and attachment theory explain how infants develop a sense of self, learn emotional regulation, and are able to attain a wide gamut of knowledge before acquiring cognitive abilities. Additionally, as the infant develops, he/she develops the capacity to mentalize.

Significantly, Freud & Burlington (1973) noted that children under extreme stress, such as the bombings in London during WW2, coped better remaining with their mothers compared to children who were sent to safer physical environments. She also noted that children mirrored their mother's response to stressors. She found that the child mirrored the anxious mother and conversely, the child mirrored the adaptive coping of the mother during the bombing incidents. Jones (2004) studied children who experienced the war in Bosnia and found similar results. Children who remained with their mothers coped better during the war and had less psychological disturbances and better functioning as adults. Thus, the power of positive attachment may be helpful in other contexts such as children who experience attentional disorder symptoms as a consequence of neurological deficiencies.

MBT-C treatment differs significantly from behavioral treatment modalities as it focuses on the parent/child relationship and views the presenting problem in a holistic manner. Additionally, the therapist stance, "not knowing" or curious, is central in

providing the treatment. Rather than focusing on behaviors, MBT-C focuses on the child and parent's capacity to mentalize as well as their state of mind. The goal in MBT-C is to assist the child and his/her family to better mentalize individually and within the family system.

In the second article of this dissertation, the application of MBT-C treatment is explained using a composite case of "Patrick". Patrick is a compilation of children that were diagnosed with an attentional disorder and presented for treatment to ameliorate behavioral symptoms. In the case composite of Patrick, the MBT-C model detailed every step of the 13 week treatment process as well as examples of assessment/treatment interventions.

The composite case of Patrick illustrates how to implement specific interventions to increase epistemic trust and foster mentalizing. The therapist used ostensive cues in order to create an attachment oriented relationship with both the child and the parents. She then worked with the child, the parents, and the family as a whole in order to shift the focus from the behaviors of the child to the mental states of the child and the parents. The child progressed in treatment and his symptoms remitted or were significantly improved. Furthermore, the therapist worked with the parents to apply mentalization strategies with their child outside of the consultation room. Lastly, the therapist collaborated with the family to develop an after-care plan and a follow-up session to review progress and address any outstanding concerns.

Appendix A

Case Formulation Patrick

Background/Reason for Referral

Patrick is an 8 year old white, male child who resides in Baltimore City with his biological parents. He has an older sister, Susan, aged 10. Patrick attends Harriet Tubman Elementary School, a public charter school in his neighborhood. Academically, Patrick is operating at or above grade level. He has friends that he socializes with in his neighborhood who attend other schools and he maintains a few friends from school. Patrick has a history significant for being diagnosed with ADHD-combined type at age 6. He is currently taking 20mg of Concerta to manage his ADHD symptoms and his medication management is supervised by a child psychiatrist.

Patrick's parents reported that they have concerns about his behavior at home and in the school environment. They stated that Patrick has frequent temper tantrums for no reason and is prone to emotional meltdowns when he does not get his way. Patrick's school reported that resorts to aggressive behaviors such as hitting, kicking, or spitting at school staff or other students when he has to transition from one environment to another, e.g. from recess back to the classroom, from the classroom to after care. Patrick stated that he has "anger issues" and he doesn't know where they come from. He also stated that he knows "everyone is against me" and that is why he does not like being in school.

Attachment patterns with parents

Patrick prefers to seek comfort from his mother when he is under stress or experiencing elevated arousal. He engages in proximity seeking behavior of a much younger child towards his mother which includes sitting on her lap, following her closely, and insisting on sleeping with her most nights. He fears separation from her and believes that “my mom is the only one who can help me”. His mother is exhausted by her perception of his “neediness” and with helping him regulate his emotions. She is frustrated that he struggles to separate from her and his demands that she sleep with him most nights.

Patrick does not seek his father for comfort. He stated that he is afraid of his father because “he yells at me and he doesn’t care if I die”. Patrick’s father reported that he has had minimal contact with his children because he is frequently out of town on business trips and because it is his wife’s responsibility to raise the children.

Attachment related triggers

Patrick becomes emotionally reactive when he is corrected by authority figures. He often responds with fight or flight responses, e.g. running away or engaging in aggressive behaviors towards individuals he perceives as threats. He experiences a loss of self when he is unable to be in proximity to his mother “when she is not here, I don’t know who I am or what I am supposed to do”.

Mentalizing strengths and weaknesses:

Patrick has the capacity for empathy for younger children. He is able to shift perspectives from himself to others in terms of appreciating their needs, e.g. “the little boy looks hungry, I will share my snack”, “the little girl is crying, she is sad, I want to give her a hug”.

Patrick is intelligent and has higher than age level problem solving and using cognitions to understand his environment.

Patrick struggles with mentalizing self/affective states. When he is triggered, he goes into the non-mentalizing psychic equivalent mode. This is characterized by black and white, rigid thinking, e.g. “everyone hates me”, “I am not good at anything because I am bad”. When Patrick is feeling strong emotions such as when he is corrected by an adult, he often falls into a shame spiral and lashes out with angry words or aggressions.

Patrick’s mother attempts to understand his mental states in order to explain his behavior but she struggles when he becomes highly activated. She reports feeling emotionally flooded when he has meltdowns. She tries to re-regulate his affective state(s) by bribing him, e.g. “if you stop crying I will get you an ice cream”. She is afraid something bad will happen to him when he is upset but she is unable to name what she is afraid will happen. She has difficulty tolerating his negative affective states and sometimes leaves the room when he has having a tantrum.

Patrick’s father is able to reason and problem solve with cognitions. He has limited awareness of his own internal affective states. Patrick’s father has difficulty attending to

his son's dysregulated affective states and tends to either leave the situation or threaten behavioral consequences, e.g. "if you don't stop kicking your sister I will send you to your room for the rest of the night". He also has difficulty with engaging in reflective thinking with Patrick and reverts to the non-mentalizing mode of psychic equivalence, "your bad behavior is the reason I am angry with you".

Goals for treatment

Patrick stated that he would like to learn how to manage his emotions so he can make more friends and get into less trouble at school and with his father.

Patrick's parents both expressed a desire to have a greater understanding of Patrick's mental states and how they influence his behaviors. They would like to learn how to help Patrick de-escalate before he has a meltdown. His mother stated that she wants Patrick to be able to self-soothe at bedtime and for him to be able to separate from her without distress. Patrick's father stated that he wants his son to learn coping strategies to manage his anger.

Appendix B

(Mad Dragon: An Anger Control Game, 2016)



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