

Mentalization-Based Treatment for Children, Second Edition stands as a compelling articulation of how reflective functioning and mentalization can be cultivated in children whose early relational experiences have disrupted their capacity to make sense of minds—their own and those of others. Grounded in developmental and psychodynamic theory, and animated by careful clinical attention, this volume shows how thoughtfully held therapeutic relationships can restore meaning and emotional coherence, and encourages psychological growth. It is an indispensable work for clinicians committed to igniting children's curiosities about their internal worlds in the service of relationship building and repair.

—**Miriam Steele, PhD**, Alfred J. and Monette C. Marrow Professor in Psychology, New School for Social Research, New York, NY, United States

I very warmly recommend this book to clinicians, and to anyone interested in learning about helping troubled children. It is very clearly written and organized, with reference to the broader background of theory and work with adults, and presents the great progress made in working with children, since the first edition. The authors are international leaders in this field, and this book is a major contribution.

—**Mary Hepworth (formerly Mary Target), PhD**, Professor, Research Department of Clinical, Educational and Health Psychology, University College London, London, United Kingdom

This second edition offers a wonderfully nonstigmatizing and deeply respectful look into the inner worlds of children, especially at a time when COVID's aftereffects and rapid technological change make reflective thinking harder to sustain. The authors bring the model to life through rich case studies and thoughtful attention to cultural context, giving clinicians a clear and robust framework they can trust. It's a timely, humane, and genuinely practical guide for anyone who wants to help children reclaim their capacity to make sense of themselves and others.

—**Francine Conway, PhD**, Distinguished Professor, Rutgers University, New Brunswick, NJ, United States

This inspiring second edition of *Mentalization-Based Treatment for Children* transforms cutting-edge science into a practical, developmentally attuned response to today's urgent child and family mental health needs. It stands out through its vibrant synthesis of developmental theory, attachment research, mentalization-based treatment scholarship, and the realities of everyday clinical work—all held within a flexible and evidence-informed framework. With its focus on the building blocks of mentalizing, the role of parents, and time-limited goals, this manual becomes an indispensable resource for clinicians committed to nurturing children's emotional growth and resilience.

—**Nicole Vliegen, PhD**, clinical psychologist and psychodynamic child psychotherapist; Professor of Clinical Psychology, Leuven University, Leuven, Belgium

This book provides a very clear, well-organized, and integrated presentation of how and why to practice a brief, structured approach of mentalization-based treatment with children. It demonstrates the utility of a developmental approach to therapy and is brought to life with vivid examples. It should be an invaluable resource to any clinician or educator involved in the care of children.

—**Efrain Bleiberg, MD**, Professor of Psychiatry and Child and Adolescent Psychiatry, Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, TX, United States; Educational Consultant, Houston Center for Psychoanalytic Studies

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Introduction

Why We Developed Time-Limited Mentalization-Based Treatment for Children

It has been estimated that, at any one time, almost 15% of children and adolescents around the world are suffering from a mental health disorder (Bruha et al., 2018). Among the most common mental health difficulties in children are conduct problems, antisocial behavior, attention-deficit/hyperactivity disorder, depression, and anxiety—with emotional disorders more common in girls and behavior problems more common in boys. As Hagell and Maughan (2017) pointed out, such mental health problems “have important implications for every aspect of young people’s lives including their ability to engage with education, make and keep friends, engage in constructive family relationships and find their own way in the world” (p. 28). We might add that they therefore have important implications for family members, friends, schools, and wider society.

Although there are now a wide range of evidence-based treatments available for children and families, a significant proportion of children still either drop out of therapy or are not able to make use of the treatments available (Fonagy et al., 2015). Moreover, many of the evidence-based treatments have been developed for very specific populations, making it unrealistic for child therapists to be trained in a vast assortment of treatment models relevant to the extensive array of presenting problems that may bring children to child mental health services. Paradoxically, faced by the many manualized therapies for specific childhood disorders, an increasingly narrow range of approaches are actually made available to children and families, with many child mental health services primarily offering interventions based on a cognitive behavioral therapy (CBT) approach.

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Although CBT has a good evidence base for a range of childhood disorders (Stallard, 2022) and has clearly benefited many children and families, a “one-size-fits-all” approach is always dangerous, especially when the evidence suggests that client choice and preference should be at the heart of all good clinical practice. Moreover, many practitioners have had experiences where parents and children have difficulties using the kind of strategies that may be offered to manage their problems more effectively, often because they do not have the affect regulation skills or capacity to make use of guidance that is a prerequisite for benefiting from such therapeutic approaches (e.g., Scott & Dadds, 2009).

We hope that the approach described in this book therefore fills an important gap by offering a short-term, focused intervention for school-age children (roughly age 5–12), which not only draws on traditional psychodynamic principles but also integrates them with the findings from attachment theory, the empirical study of mentalization, as well as features of other evidence-based approaches.

In the remainder of this introductory chapter, we define and conceptualize mentalization, explain how mentalization-based treatment (MBT) was developed and adapted for children, and present an overview of this book.

DEFINING MENTALIZATION

The term *mentalization* has emerged as a key concept in the world of psychotherapy since being used in an article written by Peter Fonagy (1991), which sets out a new way of thinking about borderline states of mind in adults. Fonagy referred to “the achievement of a representation of mental events,” which he noted had been referred to in the psychoanalytic literature as the “capacity for symbolization.” This term, he suggested, had become “over-burdened with meanings, particularly in psychoanalysis” (p. 641). So, he proposed: “For the sake of brevity I would like to label the capacity to conceive of conscious and unconscious mental states in oneself and others as the capacity to *mentalize*” (p. 641, italics in original).

In other words, *mentalization* refers to the ability to “make sense of” and interpret the meaning of others’ behavior by considering their underlying mental states and intentions. In addition, it involves the capacity to understand our own emotional reactions and their impact on others (Bateman et al., 2023). In simpler language, mentalizing is about understanding oneself and others on the basis of what is going on inside us; it involves seeing oneself from the outside and others from the inside. Mentalizing is particularly important because it facilitates interpersonal interactions and supports self and emotional regulation.

Indeed, when we are mentalizing well, we are likely to be able to

- have an awareness of what we are feeling as well as a sense of our personalities or qualities as people, which helps us have a sense of how we “look from the outside” to others, so that it is, in turn, easier to understand their reactions to us;

- have a solid ability to consider the emotions and motivations of others and see their reactions and behaviors from this perspective;
- have some awareness of the limits of our ability to know what is in the minds of others;
- have curiosity about how the world looks from other people's perspectives and how our own perspective may influence what we do or color how we see someone else's behavior; and
- be mindful that we might get it wrong when we try to understand why others behave in the way they do and that trying to make sense of these misunderstandings can enrich our interpersonal relationships.

When we are able to make sense of the behaviors of others (and ourselves), the interpersonal world becomes a more predictable, safe, and meaningful place. But when we misread the intentions of others, or struggle to make sense of our own internal states, this can lead to confusion, misunderstanding, and difficulties in interpersonal relating, contributing to escalating conflict or bottled up anger and fear. How we interpret why people are behaving in the way they do has a huge impact on the way we think and behave.

We see how, as Fonagy et al. (2002) put it, mentalization is central to the sense of self and emotion regulation. Being able to mentalize, even in a fairly stressful situation, helps a person to stay emotionally regulated. It helps them make sense of a stressful situation, so they can see it in perspective and remain focused on the priorities. J. G. Allen and Fonagy (2006) described this function of mentalizing as like having a pause button, which can be used to help regulate our emotional reactions. As Fonagy and Allison (2014) noted, the stakes are highest in close interpersonal relationships, especially attachment relationships in which general emotional understanding is not enough and a more nuanced understanding of others, as well as of our own feelings and personalities and the impact of this on others, can have important implications for the quality of these relationships.

THE DEVELOPMENT OF MENTALIZATION-BASED TREATMENT

What began in 1991 as a term used for “the sake of brevity” has taken off in a spectacular fashion in the years since those words were written. In a 2013 review article about MBT (Bateman & Fonagy, 2013), the authors note with evident pride that the use of the term “mentalizing” in titles and abstracts of scientific papers on the Web of Science increased from 10 in 1991 to 2,750 in 2011, with a whole range of authors now using the term, “from psychoanalysts to neuroscientists, from child development researchers to geneticists, from existential philosophers to phenomenologists” (Bateman & Fonagy, 2013, p. 595). Although the figures since 2013 are not available, it is likely that the number has continued to rise exponentially.

The 1991 article situates the development of the concept of mentalizing at the interface of a number of domains, including research on theory of mind (Premack & Woodruff, 1978) and attachment and reflective functioning (Fonagy et al., 1991). But it is perhaps best known as a development in the clinical sphere and, in particular, a way of approaching the treatment of borderline personality disorder (BPD), which Fonagy and Bateman came to reconceptualize as “a disorder of mentalizing” (Bateman & Fonagy, 2004). From the early 1990s, Bateman and Fonagy began to describe certain modifications to the technique of psychodynamic therapy that would follow from a focus on the capacity to mentalize, leading them to finally propose a new model of therapy for adults with BPD: MBT (Bateman & Fonagy, 2004). Since this key article on MBT was published, the approach has come to be seen primarily as a model of treatment for adults with BPD, which, in its development, was strongly influenced by research in the fields of attachment, social cognition, and (to a lesser extent) neuroscience. But in recent years, modifications of MBT for work with children and families have also taken place (Midgley & Vrouva, 2012; Volkert et al., 2022). Many of the early approaches focused on open-ended or longer term interventions, often targeted at children with severe histories of neglect and maltreatment and explicitly integrating mentalizing approaches with psychodynamic child therapy (A. J. E. Verheugt-Pleiter et al., 2008). Developments in MBT have also taken place for both younger and older children, including mentalization-based interventions for parents and infants, adolescents, and families (Byrne et al., 2020) as well as in schools and children’s social care settings (Midgley, Sprecher, & Sleed, 2021). Empirical studies examining what therapists actually do in the consulting room (looking beyond the brand name of therapy) have demonstrated how promoting mentalizing is a feature of psychodynamic therapy, CBT with children, and play therapy (Goodman et al., 2015, 2016). Given the links between attachment, trauma, and mentalizing (see Chapter 2), it is not surprising that a number of interesting developments have also taken place exploring how ideas about mentalizing can helpfully inform work with children in the context of fostering and adoption (for a review, see Midgley, Sprecher, & Sleed, 2021).

Although seen as an adaptation of MBT work with adults, clinical work with children can also be viewed as having played an important role in the development of MBT and should not be considered as only an “adaptation” of MBT to a new clinical field (Midgley, 2024). As early as 1966, Anna Freud herself recognized that using traditional child analytic techniques for treating children with “developmental disturbances” was likely to be unsuccessful, and she called for new developments in the technique of child analysis (Freud, 1966). She gave her clinical staff at the Hampstead Child Therapy Clinic (renamed the Anna Freud Centre after her death) considerable freedom to experiment with different ways of working with these complex cases, resulting in the groundbreaking papers on technique with borderline children written by her colleagues Rosenfeld and Sprince in the early 1960s (Rosenfeld & Sprince, 1965). Following Anna Freud’s death in 1982, Fonagy, Moran, Bleiberg, Target, and others continued this strand

of work, demonstrating how the lack of a fully formed theory of mind can underlie the kind of developmental disturbances that are so common in referrals to child mental health services, and they offered the outlines of a clinical approach to child treatment under the umbrella term of “psychodynamic developmental therapy” (Fonagy & Target, 1996).

In their 1998 article on the changing aims of child analysis, Fonagy and Target focus on three elements in particular that they suggest are of particular importance in psychodynamic developmental therapy: a capacity for playfulness, a focus on enhancing reflective functioning, and the need to work in the transference. All three of these elements are elaborated on in the book edited by Anne Hurry in 1998, *Psychoanalysis and Developmental Therapy*, which along with Stanley Greenspan’s work on developmentally based psychotherapy (Greenspan, 1997) is perhaps the most complete early articulation of what a mentalization-based, psychoanalytic, developmental child therapy could look like. This led to the important work by A. J. E. Verheugt-Pleiter et al. (2008; A. Verheugt-Pleiter & Zevalkink, 2021), *Mentalizing in Child Therapy*, which systematically explored how a mentalizing approach could be seen as central to the process of long-term psychodynamic psychotherapy with children. These were all elements that significantly influenced the model of time-limited mentalization-based treatment for children (MBT-C) set out in this book. (For a more detailed account of the relationship between child analysis and MBT, see Midgley, 2024.)

TIME-LIMITED MENTALIZATION-BASED TREATMENT FOR CHILDREN

The idea for developing a time-limited model of MBT for school-age children originated at a meeting in London in 2011, which brought together a range of clinicians who were interested in thinking about clinical developments of MBT for children and families. Several members of that group met again in London in the following year and for a third time in Stockholm in 2013. Working closely with colleagues in this group was the impetus for developing our thinking about MBT-C. In particular, our ideas about working in a time-limited way were influenced by the Norwegian work on time-limited developmental therapy (e.g., Haugvik & Johns, 2008; Svendsen et al., 2012). So, when the American Psychological Association offered us an opportunity to write a book about MBT for children, five members of the original working group came together, drawing on our experience in a number of clinical settings and in close collaboration with each of our clinical teams, to develop and describe a model of time-limited MBT-C in a form that we hope can speak to child therapists from a range of clinical and conceptual backgrounds, applicable to work in a range of settings with a wide variety of children and parents.

In their foreword to the 2006 publication of the *Handbook of Mentalization-Based Treatment*, Allen and Fonagy wrote,

In advocating mentalization-based treatment we claim no innovation. On the contrary, mentalization-based treatment is the least novel therapeutic approach

imaginable: it addresses the bedrock human capacity to apprehend mind as such. Holding mind in mind is as ancient as human relatedness and self-awareness. (p. ix)

Although this statement might be seen as somewhat disingenuous, there is no doubt that much of what has been described as MBT will be familiar to therapists coming from a range of different backgrounds—perhaps especially those, like us, who have trained in the psychodynamic tradition. At the same time, we do believe that some new ideas have crept in, whether deliberately or accidentally. When running MBT training at the Anna Freud Centre in London, Dickon Bevington added a typically playful addendum to Allen and Fonagy’s statement, warning: “This product may contain traces of originality. These are only trace contaminants, occurring as part of the production process, and should not spoil your enjoyment of the product.”

In this book, we describe an approach to working therapeutically in a time-limited way with children, which we hope will be both familiar and common-sensical while at the same time offering clinicians a few “traces” of originality that we hope will add something of value to the child therapist’s toolbox. We describe the work as a “treatment guide” because we set out a particular model of treatment, but one that can be adapted and fitted to the local contexts in which therapists are working and which can be flexible enough to be of use when working with children presenting with a range of difficulties.

By focusing on a core capacity that may promote resilience in a wide range of children, with a variety of presenting problems, MBT-C aims to be a generic therapy that can be adapted to the particular needs of a range of children in middle childhood—roughly between the ages of 5 and 12. MBT-C as described in this book is a time-limited, focused intervention that draws on fundamental psychodynamic and attachment principles but which can be easily integrated and used alongside a range of psychosocial treatments. The overall aim of MBT-C is to promote mentalizing and resilience in such a way that the family and child are better equipped to tackle the problems that first brought them to therapy. In doing this, MBT-C aims to increase the child’s capacity for emotional regulation and support parents to best meet the emotional needs of their children.

The basic MBT-C time-limited model is 12 individual sessions, with separate meetings for the parent(s) offered alongside it. Although some therapists may view short-term and time-limited therapies as a “necessary evil” in the era of managed care, a significant body of research has suggested that short-term interventions in child mental health can be effective (McLaughlin et al., 2013), including short-term psychodynamic interventions (Midgley, Mortimer, et al., 2021). Time-limited work, when effective, is clearly in the interests of children and families because it allows children to return to their daily lives without too much disruption. Nevertheless, there are some children for whom a brief intervention may not be indicated. In certain cases, where a longer-term intervention is appropriate (e.g., for those children whose early relational trauma or attachment insecurity makes trusting an adult a real challenge), it is

possible to offer up to three “blocks” of 12 MBT-C sessions (i.e., up to a maximum of 36 sessions). These additional blocks of treatment are based on a review process that weighs up the pros and cons of additional treatment. In these cases, the treatment is never open-ended but rather continues to be time limited, with a clear focus and aims.

Like all mentalization-based interventions, the fundamental aim of MBT-C is to enhance skills in mentalizing, both in the parent and in the child. For both parents and children, this would include opportunities not only to practice good mentalizing but also to pay attention to the places where mentalizing breaks down or to work on areas where there are deficits in the capacity to mentalize. Such a focus is justified by the fact that research is increasingly demonstrating that the capacity to mentalize contributes to a positive sense of self, healthy relationships, and better emotional regulation (Kumpasoğlu et al., 2025). Targeting such capacities is likely to be of value to children (and their parents) with a range of presenting problems, even if the underlying mental health disorder is not “caused” by a failure of mentalization.

As the above description implies, the focus of MBT-C is more on process than on content: The aim is not primarily for either parent or child to gain insight into their difficulties or to develop an understanding of where their difficulties may have come from; rather, it is to enhance their capacity to use their mentalizing capacity to manage emotions and relationships and to increase the child’s capacity to make use of relationships for emotional learning. As such, the ultimate aim of MBT-C is to help the child to make better use of helping relationships after the therapy has ended and for the parents to be better equipped to support their child’s development outside and beyond therapy.

WHAT IS NEW IN THIS EDITION?

The first edition of this book was published in 2017 and drew its inspiration from a number of different settings and contexts, building on work being done by the authors in clinics in the United Kingdom, Europe, Scandinavia, and North America. What we shared was a background and training in psychodynamic therapy with children, and all had been influenced by the development of MBT work that has taken place at the Anna Freud Centre in London and elsewhere in the United States and Europe. But the contexts in which we had developed our ideas were somewhat different, and the approach described in this book tried to provide a synthesis of what we (and the teams that we had each been part of) had learned.

This second edition builds on the original work in a number of ways. We have updated and integrated new developments in both MBT theory and research, including greater attention to the role of epistemic trust and how cultural differences can be thought about in time-limited MBT-C. We have included a number of new assessment tools that we hope will be of benefit to practitioners, and we have expanded (and split into two chapters) the section on

direct work with children to reflect emerging thinking about this core aspect of the model. This includes more explicit attention to how MBT-C therapists can work with the “building blocks” of mentalizing: attention control and emotion regulation. We are also delighted to be able to add a new chapter on the empirical evidence for MBT with school-age children. Although still a new field, this is an area that has developed significantly since the first edition was published, and it is exciting to be able to share the findings of the first clinical trial of time-limited MBT-C for children with emotional and behavioral difficulties.

In working on a second edition of the book, we drew not only on the exponential increase in research about mentalizing, early development, and psychotherapy that has been published in the past 10 years but also on the experience we have gained in running training for practitioners based on the time-limited MBT-C model, including in parts of the world such as East Asia and South America, which have expanded our understanding of MBT in different cultural contexts. In presenting this updated account of MBT-C, we acknowledge the vital input we have had from colleagues working in each of our teams, and around the world, in developing and sharpening our thinking.

AN OUTLINE OF THIS BOOK

This book is divided into two parts: the first primarily theoretical and empirical, the second mostly clinical. Readers who are already familiar with the concept of mentalization and the empirical and developmental research around it may wish to skip the first part of the book. However, even for those whose interest is purely clinical, we would encourage you to engage with the theoretical section first. After all, MBT is based on the idea that learning a set of behaviors (e.g., mentalization-promoting therapeutic techniques) is not sufficient in itself; rather, what is important is the intentions that inform those behaviors—intentions that ultimately depend on a way of thinking about the world—in other words, theory. For this reason, Chapter 1 provides an overview of the concept of mentalizing, specifically focusing on mentalization in children and what we might expect to see during middle childhood. In Chapter 2, we describe the situations in which a child’s mentalizing might be underdeveloped, or how to recognize when mentalizing has broken down. We offer some thoughts on the links between these mentalizing difficulties and the kind of clinical problems that often bring children and families to seek help. Chapter 3 summarizes the empirical support for MBT. These first three chapters are intended to offer a conceptual background to the model of time-limited MBT-C that is described in the remaining parts of the book.

The second part of the book presents clinical guidance for providing MBT-C. Chapter 4 provides a general introduction to time-limited MBT-C, setting out the basic model and the framework and outlining who may be suitable for this way of working. Chapter 5 presents the “mentalizing stance” as a foundation for all

the clinical work in MBT-C, whether in working with children or their parents. Chapter 6 describes the process of assessment of children in MBT-C, discussing aspects especially relevant to assessment from a mentalizing perspective as well as the practicalities of the assessment of both child and parents. Chapters 7 and 8 describe the therapeutic interventions used in the direct work with children, including interventions focused on supporting the “building blocks” of mentalization (Chapter 7) and interventions focused more on explicit mentalizing and breakdowns in mentalizing (Chapter 8). Chapter 9 describes clinical work with parents from an MBT-C perspective. Chapter 10 explains how to work toward ending treatment, and Chapter 11 presents a case study illustrating a complete case in time-limited MBT-C. The concluding chapter provides some final thoughts on possible future developments for MBT-C.

This book is a guide for clinicians rather than a full treatment manual, and it is intended to be used flexibly according to the setting and contexts in which the reader may work. Throughout the book, we make use of clinical vignettes, which we hope will help the reader to get a sense of how the MBT-C model looks in practice. These vignettes are based on composite cases, which draw on our clinical experience but which do not describe actual children or families. Although using such fictionalized cases always comes with the risk that the work can be presented in an idealized form and that the messy reality of clinical practice can be airbrushed out, we have made an effort not to present these as examples of “perfect” therapy but rather to portray usual clinical practice with all its imperfections and improvisations.