INTRODUCTION

It has been estimated that at any one time, approximately one in 10 children aged 5 to 16 years suffers from a psychological disorder (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Among the most common mental health difficulties in children are conduct problems, antisocial behavior, attention-deficit/hyperactivity disorder, depression, and anxiety; emotional disorders are more common in girls, and behavioral problems in boys. As Hagell and Maughan (in press) have 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.” We suggest that these problems therefore have important implications for family members, friends, schools, and the wider society.

Although there is now a great variety of evidence-based treatments for children and families, a significant proportion of children still either drop
out of therapy or are unable to make use of the available treatments (Fonagy, Luyten, & Allison, 2015). Moreover, many of the evidence-based treatments have been developed for specific populations, making it unrealistic for child therapists to be trained in numerous treatment models relevant to the diverse presenting problems that may bring children to child mental health services. Paradoxically, faced with the wide array of manualized therapies for specific childhood disorders, an increasingly narrow range of approaches is actually made available to children and families, with many child mental health services primarily offering interventions based on a cognitive behavioral therapy (CBT) approach.

Although CBT has a good evidence base for a variety of childhood disorders (McLaughlin, Holliday, Clarke, & Ilie, 2013), and has clearly benefitted 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 experienced situations in which 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 the capacity to make use of the guidance that is a prerequisite for benefitting from such therapeutic approaches (e.g., Scott & Dadds, 2009). We therefore hope that the approach described in this book fills an important gap by offering a short-term, focused intervention for school-age children that draws on traditional psychodynamic principles but integrates them into attachment theory, the empirical study of mentalization, and features of other evidence-based approaches.

OUR APPROACH

In their preface to the Handbook of Mentalization-Based Treatment, Allen and Fonagy (2006) 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. xix)

Although this statement might be seen as somewhat disingenuous, there is no doubt that much of what has been described as “mentalization-based treatment” (MBT) will be familiar to therapists coming from different backgrounds—perhaps especially those, like ourselves, who have trained in the psychodynamic tradition. At the same time, we believe that some
new ideas have crept in, whether deliberately or accidentally. When running MBT training at the Anna Freud National Centre for Children and Families in London, Dickon Bevington added a typically playful addendum to Allen and Fonagy’s (2006) statement, warning that “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” (Asen et al., 2011).

In this book, we describe an approach to working with children therapeutically in a time-limited way that we hope will be both familiar and commonsensical, while 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 fit to the local contexts in which therapists are working and can be flexible enough to be of use when working with children who present with a range of difficulties.

By focusing on a core capacity that may promote resilience in children with a variety of presenting problems, MBT for children (MBT–C) aims to be a generic therapy that can be adapted to the particular needs of children in middle childhood—roughly ages 5 to 12 years. MBT–C as described in this book is a time-limited, focused intervention that can be easily integrated and used alongside various psychosocial treatments. The overall aim of MBT–C is to promote mentalizing and resilience in such a way that a developmental process is put back on track, and the family and child feel they are better equipped to tackle the problems that first brought them to therapy. Thus, MBT–C aims to both 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). Although some therapists may view short-term and time-limited therapies as a “necessary evil” in the era of managed care (Salyer, 2002), a significant body of research now suggests that short-term interventions in child mental health can be effective (McLaughlin et al., 2013), including short-term psychodynamic interventions (Abbass, Rabung, Leichsenring, Reseth, & Midgley, 2013). Likewise, a meta-analysis of attachment-focused interventions by Bakermans-Kranenburg, van IJzendoorn, and Juffer (2003) showed that most effective interventions used a moderate number of sessions (between five and 16) and tend to be more focused in their aims.

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 great a disruption to their everyday lives. Nevertheless, there are some children for whom a brief intervention may not be indicated (Ramchandani & Jones, 2003). In certain cases in which 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 the pros and cons of additional treatment, and in these cases, the treatment is never open-ended but 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 the child. For both parents and children, this would include opportunities to practice good mentalizing but also to pay attention to the places where mentalizing breaks down or 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 (Ensink, Bégin, Normandin, & Fonagy, 2016; Ensink, Berthelot, Bernazzani, Normandin, & Fonagy, 2014). Targeting such capacities is likely to be of value to children (and their parents) with diverse presenting problems, even if the underlying mental health disorder is not “caused” by a failure of mentalization.

As the preceding 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 his or her difficulties or to develop an understanding of where these 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.

ORIGINS OF TIME-LIMITED MBT–C

Although it is not possible to do justice to the rich history of the clinical thinking that has inspired this book, here we briefly sketch out some of the developments that have contributed to this work, and in particular those ideas that have personally informed the authors of this treatment guide.

In Fonagy’s 1991 paper, which set out a new way of thinking about borderline states of mind in adults, he 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).

What began 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 paper about MBT (Bateman & Fonagy, 2013), the authors noted 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 numerous authors now using the term, “from psychoanalysts to neuroscientists, from child development researchers to geneticists, from existential philosophers to phenomenologists” (p. 595).

Fonagy’s 1991 paper 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, Steele, Steele, Moran, & Higgitt, 1991). But first and foremost, it was a development in the clinical sphere and, in particular, in 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, 2010). 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 propose a new model of therapy for adults with BPD: MBT (Bateman & Fonagy, 2004).

Although MBT was originally developed as a treatment for adults with BPD, in recent years, MBT has been modified for work with children and families (Midgley & Vrouva, 2012). One of the first such developments was short-term mentalization and relational therapy (SMART; Fearon et al., 2006), a family-based intervention later renamed MBT–F (Asen & Fonagy, 2012a, 2012b), which preliminary evaluation has suggested can be helpful for children with a broad range of presenting problems, both internalizing and externalizing (Keaveny et al., 2012). In terms of individual therapy with children, Fonagy and Target’s (1996a) model of psychodynamic developmental therapy was perhaps the first treatment approach to be explicitly influenced by emerging ideas about mentalization. A decade later, Verheugt-Pleiter, Zevalkink, and Schmeets (2008) reinterpreted Anne Hurry’s (1998) model of psychoanalytic developmental psychotherapy from a mentalization perspective, setting out a model of open-ended therapy that they later described as mentalization-informed child psychoanalytic psychotherapy (Zevalkink, Verheugt-Pleiter, & Fonagy, 2012). As in the work presented here, this approach moves beyond the traditional psychoanalytic approach based on interpretation and developing insight and recognizes that the child therapist is not only a “transference object” but also a “development object”
(A. Freud, 1965), helping to foster new capacities, including improved affect regulation and reflective functioning. Likewise, Ensink and Normandin (2011) elaborated an MBT for sexually abused children, incorporating child psychotherapy techniques developed by Paulina Kernberg (e.g., Kernberg & Chazan, 1991; Kernberg, Weiner, & Bardenstein, 2000), and similar models have been described in case studies by Ramires, Schwan, and Midgley (2012) and Perepletchikova and Goodman (2014). All of these approaches have been 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.

Developments in MBT have also taken place for both younger and older children. A number of teams have developed mentalization-based interventions with parents and infants (e.g., Etezady & Davis, 2012; Ordway et al., 2014; Slade, Sadler, et al., 2005) and adolescents (e.g., Bleiberg, 2013; Fuggle et al., 2015; Malberg & Fonagy, 2012; Rossouw & Fonagy, 2012; Sharp et al., 2009). Studies have demonstrated the value of mentalization-promoting interventions in school settings (Twemlow, Fonagy, & Sacco, 2005) and school-based psychoeducation programs (Bak, 2012; Bak, Midgley, Zhu, Wistoft, & Obel, 2015). 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 and CBT with children, as well as play therapy (Goodman, Midgley, & Schneider, 2016; Goodman, Reed, & Athey-Lloyd, 2015; Muñoz Specht, Ensink, Normandin, & Midgley, 2016). Given the links among attachment, trauma, and mentalizing (see Chapter 2, this volume), 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 (e.g., Bammens, Adkins, & Badger, 2015; Jacobsen, Ha, & Sharp, 2015; Midgley et al., 2017; Muller, Gerits, & Sieckler, 2012; Taylor, 2012).

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 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 manner were influenced by the Norwegian work on time-limited developmental therapy (e.g., Gydal & Knudtzon, 2002; Haugvik & Johns, 2006, 2008; Johns, 2008; Svendsen, Tanum Johns, Brautaset, & Egebjerg, 2012). At the same time, we have been influenced by the sea change that has taken place in the attitude to working with parents; no longer seen as simply an adjunct to the child’s therapy, parent work has rightly come to be seen as
central to therapeutic change. As the title of Novick and Novick’s (2005) seminal book puts it, “Working with parents makes therapy work.” So when the American Psychological Association offered us an opportunity to write a book about MBT with 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 and that is applicable to work in a variety of settings with diverse children and parents.

The work described in this book thus draws its inspiration from a number of settings and contexts, in clinics across the United Kingdom, Europe, and North America. Nicole Muller is a child and family psychotherapist based at the De Jutters Centre for Child and Youth Mental Health in The Hague, Netherlands, where she and her team have extensive experience offering time-limited MBT to children and families with attachment disorders, trauma, or emerging personality disorder. As well as running introductory and advanced MBT–C trainings, Muller has written several articles about MBT for children and families and has a particular interest in work with fostered and adopted children (Muller, 2011; Muller, Gerits, & Siecker, 2012). Both Norka Malberg and Nick Midgley trained as psychodynamic child psychotherapists and worked at the Anna Freud Centre in London; they have been members of the clinical team there that developed a model of MBT for families (MBT–F; Asen & Fonagy, 2012a, 2012b; Keaveny et al., 2012). Nick Midgley has continued to develop this work with a particular focus on MBT for looked-after and adopted children (Midgley et al., 2017), including a mentalization-based model of psychoeducation, the Reflective Fostering Programme. After moving to the United States, Norka Malberg continued to develop her thinking about MBT with children in private practice, as well as during her 2-year tenure as clinical director of the Home Visiting Early Intervention Project in Connecticut. One of her particular areas of interest is in working with parents in the child therapy context (Malberg, 2015). Karin Ensink, now a professor of child and adolescent psychology at Université Laval in Québec, Canada, also worked as a clinician and researcher at the Anna Freud Centre and did her doctorate work on the development of children’s mentalizing capacities with Peter Fonagy and Mary Target. Her focus is on mentalization, trauma, and psychopathology in children, adolescents, and parents. As part of her work in Québec, she has contributed to elaborating a model of MBT for children and parents with histories of trauma and personality difficulties (Ensink & Normandin, 2011). Karin Lindqvist is a clinical psychologist working with children and adolescents in foster care, as well as their parents and foster parents. She also holds a part-time research assistant position at the Erica Foundation in Stockholm, Sweden, where she trained in mentalization-based
work with children and parents. The Erica Foundation offers professional training at the university level and also psychodynamic and mentalization-based mental health services to children, adolescents, and families; it developed one of the first intensive trainings for child psychotherapists seeking to use an MBT approach with children. The Erica Foundation has been a pioneer in evaluating the effectiveness of a short-term psychodynamic–MBT model for children and adolescents (Thorén, Pertoft Nemirovski, & Lindqvist, 2016).

As our backgrounds indicate, we share interest and training in psychodynamic therapy with children and have all been influenced by the development of MBT that has taken place at the Anna Freud Centre in London, as well as elsewhere in the United States and Europe. However, the contexts in which we have developed our ideas have been somewhat different, and the approach described in this book tries to provide a synthesis of what we (and the teams that we have each been a part of) have learned. In presenting this shared model, we acknowledge the vital input we have received from colleagues working on each of our teams in developing and describing this approach to time-limited MBT–C.

What should be made clear, however, is that the specific model described in this book has not yet been subjected to systematic evaluation, beyond an initial naturalistic outcome study at the Erica Foundation (Thorén, Pertoft Nemirovski, & Lindqvist, 2016), and as such it remains a clinical guide for an approach to treatment that is not yet evidence based. Many of the components of the model are explicitly rooted in empirical findings, and as mentioned earlier, MBTs have shown themselves to be effective with different clinical populations, including adults with BPD (Bateman & Fonagy, 2009), adolescents who self-harm (Rossouw & Fonagy, 2012), and parents and at-risk infants (Slade, Sadler, et al., 2005). The particular model of MBT set out in this book, however, with its focus on time-limited work for children in middle childhood, will need to be systematically evaluated before we can say with more certainty what works, for whom, under what circumstances, and in what conditions.

AN OUTLINE OF THIS BOOK

This book is divided into two parts—the first primarily theoretical, 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; but 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;
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, the first chapter 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 the second chapter, 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 provisional thoughts on the links between these mentalizing difficulties and the kind of clinical problems that often bring children and families to seek help. These first two chapters are intended to offer a conceptual background for the model of time-limited MBT–C that is described in the remaining parts of the book.

The second part of the book begins with a general introduction to time-limited MBT–C, setting out the basic model and the framework, then outlining who may be suitable for this way of working. Because we consider the mentalizing stance a foundation for all the clinical work in MBT–C, whether in working with children or their parents, this is the focus of Chapter 4 and is deliberately presented before we go into details about MBT techniques. Chapter 5 describes the process of assessment of children in MBT–C, discussing aspects that are especially relevant to assessment from a mentalizing perspective as well as the practicalities of the assessment of both child and parents. We then go on to describe the therapeutic interventions used in the direct work with children in Chapter 6, followed by a description of clinical work with parents from an MBT–C perspective in Chapter 7. Following a chapter on working toward ending treatment, the book ends with a case study that provides an example of what a complete case might look like in time-limited MBT–C, followed by some reflections on potential future developments and final thoughts on future developments for MBT–C. The Appendix lists some of the measures that clinicians can use to assess reflective functioning in children and their parents.

This book is a guide for clinicians rather than a full treatment manual and 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 gain 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 do not describe actual children or families. Although such fictionalized cases always face 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 to portray usual clinical practice, with all its imperfections and improvisation.