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A Drama-Based Group Intervention for Adolescents to Improve Mentalization

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by

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Dedication

I dedicate this research project to my former students from Vladimirovtsi, Bulgaria.

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Abstract

This dissertation is an innovative intervention design to improve mentalization in preadolescents. The intervention presented is conducted in a group format and using techniques drawn from drama-based therapy. I have provided a brief literature review on mentalization, and relevant topics in group treatment and drama therapy. I have outlined key concepts from mentalization theory including: (a) the development of the self, (b) its relationship to attachment, (c) psychic equivalence and pretend mode functioning, (d) marked-affect mirroring, (e) the various facets of mentalization, and (f) mentalization treatment with children. After outlining these concepts, I discuss psychodynamic group treatment, mentalization-based group therapy, and the mechanism of change in group treatment from a neurobiologically informed perspective. From there I discuss concepts from play and drama therapy relevant to work with preadolescents. The topics covered in the literature review are used as a basis for an mentalization-based intervention appropriate for preadolescents. The argument is made that drama therapy is an appropriate vehicle through which this age group can be engaged as they are often regarded as too old for the typical toys of play therapy, but not yet ready for an adult approach to group treatment. Following the literature review, an intervention design is proposed. The proposal offers guidance on the structure of the group intervention, approach taken by the therapist, and the format of a typical session. Finally, limitations, future directions, and reflections on conducting this research are discussed.

Keywords: mentalization, group therapy, drama therapy, preadolescence

A Drama-Based Group Intervention for Adolescents to Improve Mentalization

The aim of this dissertation was to propose an innovative group intervention for working with preadolescent children using the concept of mentalization as an organizing principle and dramatic play techniques as the primary vehicle of intervention. Mentalization, or reflective functioning, is the ability to reflect on one's own and others' emotional states. It is a capacity that is refined over the course of healthy development, in the context of attuned relationships, and is needed for effective self-regulation and social interaction (Fonagy et al., 2002). Deficits in mentalizing capacity underlie seemingly disparate interpersonal and intrapersonal difficulties. For example, a middle schooler may be referred for psychological services because they are constantly disruptive in the classroom, while another child may be having frequent disagreements with classmates, and a third frequently becomes tearful and is difficult to soothe. Although the manifest symptoms in each case are quite different, each of the children in question are experiencing a deficit in their ability to mentalize effectively; they are limited in their ability to reflect on (a) their own behavior; (b) the impact their behavior is having on the people around them; and (c) the motivations, desires and intentions of the behaviors of others. As failures to mentalize at an age-appropriate level can be understood as a significant factor influencing a wide variety of challenging behaviors and psychopathologies, intentionally focusing on this capacity is a meaningful target for therapeutic intervention.

While there exist effective treatment approaches using mentalization as a core concept (Allen & Fonagy, 2006), the intervention proposed here is unique in that it was designed to address the specific developmental concerns of middle school-aged children (approximately ages 10-13); and, the intervention is focused on work in groups to be implemented as a stand-alone

treatment or used in conjunction with individual and/or family therapy. The rationale for focusing on an approach that is theoretically grounded in a concept that is therapeutically valuable to wide ranging symptom presentations, and already has an empirical support base as a group treatment (Karterud, 2016), is pragmatic. Many school, community mental health, and inpatient settings lack the financial and human resources to provide treatment focused on specific diagnostic categories, and many patients present with complex diagnostic pictures. Due to these factors, transdiagnostic treatment approaches are increasingly needed.

The review of the literature to follow clarifies the theory and practice of mentalization as an approach to treatment and argues that improved mentalizing ability can be understood as a transdiagnostic and transtheoretical treatment goal. The literature review then proceeds to discuss the benefits of group therapy and its role in treatment to improve mentalization. Finally, the review also explores the aims of arts-based therapies, including drama therapy, through the lens of mentalization, and discusses the particular therapeutic needs of preadolescent children. The aim of this review was to highlight the need and establish the theoretical foundation for a mentalization-based group treatment targeting preadolescent children.

Mentalization

Mentalization and the Self

Mentalization is concerned with the development of both the representational self, the aspects of self inferred from the way our social environment reacts to us—the "me," and the psychological, or agentive, self—the "I" (Fonagy et al., 2002). According to Fonagy et al. (2002) the latter has received far less attention in both the fields of psychoanalytic and cognitive psychology due to the Cartesian assumption that we possess a reliable ability to accurately introspect on intentional states of mind.

> The relative neglect by psychologists and psychoanalysts of the developmental processes that underpin the agentive self may be seen as a residue of the traditionally powerful Cartesian doctrine of first-person authority that claims direct and infallible introspective access to intentional mind states. (Fonagy et al., 2002, p. 3)

The view from this Cartesian perspective has been that our ability to think and introspect is a given, is reliable, and is accurate. When Descartes wrote cogito, ergo sum, *I think, therefore I am*, it meant that the ability to doubt the existence of the self proves its existence. However, embedded in the phrase is an assumption that has had a great influence on many modern theories of mind and the development of the self—that consciousness of the self is an individual act that does not require the existence of other selves. Contemporary research from a wide range of fields, notably in neurobiology and infant development research (Beebe, 2006; Schore, 2003; Trevarthen et al., 2015), are pointing in quite a different direction; namely, we come into existence as psychological selves because early in life others envision us as selves with agency. The roots of this view of self-development can be found in the perspectives of psychoanalysts such as Fairbairn (1952),Winnicott (1964), and Kohut (1977).

In the Cartesian tradition, many developmental theorists have regarded mental agency as an innate modular capacity (Carruthers & Smith, 1996), in a similar vein to Chomsky's *language acquisition device* (Chomsky, 1965; Palmer, 2000). Their argument is that the existence of certain human capabilities, such as language, can be explained as genetically endowed internal capacities that need only be activated by the environment. Mentalization challenges that notion and takes an alternate approach to the development of the psychological self. According to Fonagy et al. (2002), the psychological self" "is not a genetic given. It is a structure that evolves from infancy through childhood, and its development critically depends upon interaction with

more mature minds, who are both benign and reflective in their turn”“ (Fonagy et al., 2002, p. 4). This insight, that the capacity to infer others’ and our own minds is a developmental process, beginning in infancy and continuing throughout the lifespan, has significant implications for the manner in which we approach therapy and its aims.

From the mentalization perspective, and the psychoanalytic theories from which it draws, the birth of the psychological self begins with the recognition and co-regulation of affective states, which occurs through interaction with primary object relationships. Children learn, from birth through 5 months, to represent affect through moment-by-moment nonverbal exchanges with caregivers (Beebe, 2006; Beebe & Lachmann, 2014; Fonagy et al., 2002; Tronick, 2007). The development of self-representations is accompanied by object representations. Self and other representations are associated with feelings and different affective states (Kernberg, 1984) that provide the emotional coloring for the experience of self in interaction with significant others, which, in turn, informs the way we see ourselves in the world. Interactions with caretakers and the environment become a part of the developing personality, long before autobiographical memory comes online. Preverbal experiences of self and other are remembered through bodily sensations, behaviors, and models of interaction (Ogden et al., 2006). The self comes into being through the interaction of neurophysiological processes and interpersonal experience (Fonagy, 1991; Fonagy et al., 2002; Fosha, 2000; Schore, 2003).

Mentalization and Attachment

The theory of mentalization is closely related to and draws heavily from attachment theory (Bowlby, 1969, 1973, 1980, 1988). Bowlby theorized that early attachment increased the likelihood of survival by increasing proximity-seeking behaviors in the infant or young child, while simultaneously stimulating the caregiving behaviors of adults. If the infant experienced the

caregiver as a source of safety, a secure base, they developed a healthy attachment and could confidently explore and learn from the environment (Ainsworth, 1973; Bowlby, 1988). According to Bowlby (1969), the quality of early attachment set the stage for future relationships through the development of internal working models. These models influenced the expression of attachment behaviors (i.e., safety and proximity-seeking behaviors) throughout life (Bowlby, 1969). According to Bowlby (1988), "all of us, from the cradle to the grave, are happiest when life is organised as a series of excursions, long or short, from the secure base provided by our attachment figures" (p. 62). From Bowlby's perspective, attachment served the evolutionary function of increasing the likelihood of survival for the infant, and also made exploration of the environment in childhood and adulthood possible and pleasurable. Mentalization theorists expanded upon the theory of attachment explaining that early attachments are a means to an end—a step in the development of a self that is competent and capable of functioning in a highly social human environment (Fonagy et al., 2002). From the mentalizing perspective, the function of early object relations is to allow the infant to develop a self and sense of the content of other people's minds (Fonagy & Target, 2000).

While attachment is observed in all mammals, mentalization is thought to be uniquely human as no other animal seems to have the quality of awareness to consider another's perspective and infer the intentions behind an action (Asen & Fonagy, 2012). Adults with an ability to continue to mentalize even under stressful conditions, and recover mentalizing capacity quickly when lapses do occur, tend to have secure attachment histories (Fonagy et al., 2002). Individuals with insecure attachment histories exhibit limited capacity to reflect on their thoughts, and infer the minds and motives of others, resulting in deficits in the ability to self-regulate and maintain close relationships (Bateman & Fonagy, 2013). Mentalization and

attachment affect each other in a recursive manner. Secure attachment to primary caregivers, and to intimate partners later in life, creates space for the development of mentalization, and increased mentalizing improves attachment relationships throughout life. Conversely, insecure attachments engender higher levels of emotional dysregulation, resulting in the breakdown of mentalizing capacity which tends to result in less healthy relationships and higher degrees of attachment insecurity (Klassen, 2017).

Psychic Equivalence and Pretend Mode

Fonagy et al. (2002) proposed that infants develop mentalizing capacity on a progression, attaining the ability to mentalize, in typical development, at around 5 years of age. According to Fonagy and Target (1996), prior to the age of 2 or 3, the child,

> generally operates in 'psychic equivalence' mode, where ideas are not felt to be representations, but rather direct replicas of reality, and consequently always true; however, at other times the child uses a 'pretend' mode, in which ideas are felt to be representational but their correspondence with reality is not examined. (p. 219)

Unlike adults, children still operating in psychic equivalence do not regard their psychological states as based upon their beliefs and desires, but consider their psychological states to be objective realities, as real as a chair, table, or chrysanthemum. There is no possibility for others to have different perspectives or psychological states in this mode of functioning because a mental state is regarded as real. There is no distinction between internal representations and the outside world. Muller and Midgley (2020) give the example of a child who imagines there is a monster under the bed and takes the imagined monster to exist in the real world. "There is no space for a sense of pretend, or any gap between what is thought and what is perceived to actually be" (p. 2). This is normal for the young child and becomes problematic later in life when

the fusion of thought and reality impact functioning, most notably in the social sphere.

Typically, between the ages of 2 and 5 a shift occurs from psychic equivalence to pretend mode functioning (Fonagy & Target, 1996). With the shift towards pretend mode the child can begin to play with reality in make believe. “In pretend play, a chair is a tank and yet the child does not expect it to shoot real shells” (Muller & Midgley, 2020, p. 2). Pretend play allows for a gap between mental representations and their referents, and representations can be worked with in a flexible mental space. This developmental achievement makes voluntary intention possible. In pretend play, the chair may come to represent a cave or a ship as the emotional needs of the child shift. In typically developing children, a range of pretend behaviors can be witnessed by 24 months, and expressions of understanding that others are playing or pretending are generally exhibited by 30 months.

When operating in pretend mode, the child maintains a clear distinction between play space and what is real. According to Fonagy and Target (1996), “play has a pivotal role in the development of thinking as well as emotional experience, and particularly in their integration” (p. 220). By maintaining a barrier between play and reality, the child can entertain new ideas that would otherwise be a danger to a cohesive sense of self. Fonagy and Target (1996) suggested that the correspondence between play and reality is threatening to the child and that children will work to exaggerate the distinction between the two. When adults witness children playing and see the child using pretend voices and acting *as if*, we tend to interpret their actions from our own mentalizing perspective and presume a higher level of awareness than is experienced by the child. It can be difficult to understand that a child can only reflect on mental states because they are doing it in the protected space of play. In the pretend mode “the child can differentiate thoughts and fantasies from actual reality, although on his own he can create no useful

connection between this representation and physical reality" (Fonagy et al., 2002, p. 292). If a connection between psychic reality and the real world is made explicit for the child, it is likely that the play will end.

Marked-affect-Mirroring

Pretend mode is developed and expanded through interactions with caregivers' marked interactions, which help the child develop the link between the world of fantasy and that of reality. By the age of 4 or 5, children with appropriately attuned caregivers can independently fuse the two previously attained developmental stages of psychic equivalence and the pretend mode, to arrive at mentalizing (Fonagy et al., 2002; Fonagy & Target, 1996; Muller & Midgley, 2020). As children attain the developmental achievement of mentalizing, they no longer believe that thoughts are the same as reality nor completely dissociated from it: "mental states can be experienced as representations, with inner and outer reality linked" (Muller & Midgley, 2020, p. 3). In the early stages of mentalization, the child will begin to exhibit an ability to discuss play representations in connection to external events and emotions. For example, the child may share that they are feeling angry because they were scolded and are using the tank to feel strong. In this example, the child demonstrates that they understand the tank is not real, but also that it has a relationship to external events. When mentalizing the child can relax the distinction between play and reality observed in pretend mode functioning. Considering the relationship between external and internal reality is less threatening to the inchoate sense-concept and greater self-awareness is apparent.

In the context of the infant–caregiver relationship, mentalization is born out of tens of thousands of moments of accurate mirroring and empathy on the part of the caregiver, which allows the child to apply meaning and organization to his or her various emotional states (Asen

& Fonagy, 2012). For example, if an infant is anxious, the securely attached caregiver will ideally respond with expressions of concern and mirror the child's affective cues. The infant percepts through the mind of her parent the meaning of their internal feeling states. The mirroring provided by the parent, however, is marked by subtle cues that the anxious state is both transient and can be remedied. Fonagy et al. (2002) referred to this externalizing mirroring as *marked-affect mirroring*. It is through this modified mirroring process that the caregiver both teaches the infant how to regulate emotion, and teaches the infant of the distinction between internal and external reality. Through this process of dyadic regulation, in which parents repeatedly help the infants to reestablish self-regulation, children gradually learn to regulate themselves unassisted (Trevarthen et al., 2015). Alternately, if the parent is thoroughly overwhelmed by the infant's anxiety, the infant receives very different messages: first, that this anxious feeling state is unmanageable and terrifying; and second, that a subjective, internally experienced emotional state also exists in the external world (Fonagy et al., 2002). In this case, psychic equivalence has been reinforced and the infant has missed an opportunity to learn that a difference exists between the inside and the outside.

Incongruent responding on the part of the caregiver is also problematic. If a parent responds with glee or terror at the anxiety of her child, the child will not have learned the meaning of their feeling state resulting in confusion and emotional dysregulation. Depending on the degree of inconsistency and incongruity in the caregiver's responses, the infant is likely to have a less secure attachment, and is likely to experience greater deficits in mentalizing capacity later in life. If unprocessed or confusing responses are the norm, then the child will: (a) not feel understood and secure, (b) not develop a healthy attachment, (c) not organize emotional states accurately, (d) not erect a consistent psychological self, and (e) not learn to infer the minds of

others. The child will develop with dual deficits in the ability to regulate emotions and accurately infer the emotional state and intentions of others (Klassen, 2017).

As the caregiver repeatedly provides a regulatory function to the child, through the use of marked-affect mirroring, children learn that their feeling states do not exist out in the world, but yet can be symbolized in the outside world by the parent. The act of mirroring, but not mirroring perfectly, allow children to reintroject symbolic representations of the child's own internal states in a modified form. Through the parent's mirroring and the reintrojection of the parent's representations by the child, "nonmentalizing reality-oriented [psychic equivalence] and mentalizing nonreality-connected mode [pretend mode]" (Fonagy et al., 2002, p. 266) are integrated. The child learns two things through the parent's marked mirroring: (a) a difference exists between the outside and inside, and (b) the outside and inside are connected. Through reintrojecting the representations of the parent, children learn to develop their own representations and begin to think symbolically about their own internal affective experiences. As Fonagy et al. (2002) stated when discussing the development of the psychological self and the child's ability to reflect on internal experience, the child "can ultimately use the parent's representation of his internal reality as the seed for his own symbolic thought, his representation of his own representations" (p. 267). Through this process the child gradually learns to symbolize and regulate emotional states independently of the affect mirroring of the caregiver.

The Components of Mentalization

In outlining Bateman and Fonagy's (2004) explication of the various aspects of mentalization, Choi-Kain and Gunderson (2008) described three dimensions on which mentalization can be broken down.

the first related to two modes of functioning (i.e., implicit and explicit), the second

> related to two objects (i.e., self and other), and the third related to two aspects (i.e., cognitive and affective) of both the content and process of mentalizing. (p. 1128)

Implicit functioning "refers to unconscious, automatic, or procedural operations of an individual's ability to imagine his own and others' mental states" (Choi-Kain & Gunderson, 2008, p. 1128). Implicit mentalizing includes the social conventions we understand and act upon without deliberate consideration. Examples include hand shaking in most western cultures, or the typical pace and reciprocity of conversation. These actions indicate that we are unconsciously reflecting upon another's expectations and desires. The same behaviors can be explicit mentalizing, when, for example, an individual is in a different culture with unfamiliar norms. That individual must deliberately inhibit the desire to offer a hand and alter their typical conversation style as they reflect upon the other's expectations. Another example may be an individual with social anxiety who, due to neurotic preoccupations, is explicitly reflecting upon social expectations and the mind of the other. It is likely that implicit assessment of the environment is evolutionarily less advanced and controlled by subcortical brain regions (Luyten & Fonagy, 2015). Luyten & Fonagy suggest explicit mentalizing likely occurs in the evolutionarily newer brain regions of the cortex, particularly those regions associated with language and symbolic processing. The distinction between implicit and explicit mentalizing is conceptually helpful in order to define the poles of this dimension; however, in reality "individuals can alternate between these two modes and use them simultaneously" (Choi-Kain & Gunderson, 2008, p. 1128).

Each of the objects, self and other, "has a set of *mental states*, including feelings, thoughts, motives, intentions, beliefs, desires, and needs" (Choi-Kain & Gunderson, 2008, p. 1128). These mental states interact and influence each other. The way we interpret our own

emotions influences the way we imagine the mental states of others, and the way we imagine the mental states of others impacts the ways we interpret our own emotions. Through conversation we develop deeper, and generally more accurate views of the mind of the other, and this in turn changes our understanding of our own mind. “Feelings, thoughts, and intentions constantly shift in response to changes in the interpersonal milieu” (Choi-Kain & Gunderson, 2008, p. 1128).

The final dimension outlined by Choi-Kain and Gunderson (2008) is concerned with the cognitive and affective aspects of mentalizing. Both the content and process of mental activity can be focused on cognition and/or affect. Effective mentalizing “requires a panoply of intact cognitive skills that enable individuals to imagine mental states with plausibility, flexibility, and complexity” (p. 1128); however, mentalizing must also attend to affect. For an individual to exhibit good insight, reason and emotion must be effectively integrated. Cognitive-based therapies focus more on developing the cognitive aspects of mentalizing, whereas emotion-focused and psychodynamically oriented therapies tend to focus on developing the affective mentalizing abilities.

The degree to which we are sensitive to a breakdown of mentalizing has major impacts on many aspects of daily functioning. Life is often stressful and the ability to mentalize allows for a degree of control over levels of arousal, allowing us to work through challenges and navigate social interactions without becoming thoroughly overwhelmed by emotion. A tendency towards frequent disruptions in mentalizing is commonly seen in personality disordered individuals, particularly those with BPD. Bateman and Fonagy (2013) described BPD as a disorder in which the individual frequently loses the capacity to mentalize, or envision the minds of self and other. Much of the initial research on mentalization as a therapeutic intervention was conducted with patients with BPD; however, the past three decades have seen an expansion of

the approach to work with other personality disordered individuals, children, families, substance abuse disorders, and eating disorders (Bateman & Fonagy, 2019). Because mentalization as a theory is concerned with the development and regulation of the self, it has relevance to understanding human development and treating psychological disorders in the broadest sense. Its potential as a therapeutic application is not limited to a particular population or diagnostic category (Klassen, 2017).

Mentalization-Based Treatment and Children

Currently, many mental health treatments geared towards children are variations of cognitive behavior therapy (CBT). While CBT has an evidence base for treating childhood disorders (C. McLaughlin et al., 2013), relying on a single treatment approach inevitably means individuals who are not a good fit for that particular model will receive limited benefit. Client preference and tailoring treatments to specific needs of the clients is a key component of sound clinical practice (Midgley et al., 2017).

CBTs, as the name suggests, rely heavily on the ability to use higher order cognitive skills, such as rational inquiry, as a path towards psychological health. Many children who lack the affect regulation and attention skills necessary to support higher-order cognitive functioning first require treatment focused on basic regulatory capacities before they can benefit from treatments highlighting rational analysis of the thoughts and feelings motivating behavior (Midgley et al., 2017). Treatment for younger children tends to be play-based because we understand that play is the primary means by which children process emotional experiences (O'Connor et al., 2015), and there is a general understanding that developmentally advanced cognitive abilities have not yet been attained. Expecting young children to verbally analyze thoughts and emotions would be of limited value. Even in the case of older children, especially

those referred for psychological treatment, delays in both their capacity to regulate and understand emotions are evident. These delays result in a wide range of psychological concerns (Southam-Gerow & Kendall, 2002). As with adults with notably impaired mentalizing capacity, when working with children it is necessary to focus primarily on those affective, right-brained aspects of mentalization which come online at earlier stages of development and are prerequisite skills to higher order left-brained cognitive analysis (Schore, 2019a).

Taking mentalization-based treatment (MBT), an approach designed for work with adults with personality disorders, and applying it wholesale to preadolescents at a far earlier stage in their development would overlook many of the unique issues relevant to this population, likely decreasing the effectiveness of the treatment. However, in light of the developmental nature of mentalization and its importance to healthy functioning across the lifespan, it has received increasing attention in application to children in recent years (Midgley et al., 2017). Midgley et al. pointed out that a child's capacity to accurately read mental and emotional states is related to effective affect regulation and the ability to create and maintain healthy relationships. Children further along in the development of their mentalizing capacity have been shown in empirical studies to be more socially competent and engage in higher levels of social play (K. W. Cassidy et al., 2003; Dunn & Brown, 1994).

Many of the issues which typically result in therapy referrals for children can be explained in terms of mentalizing capacity. For example, a child who constantly calls out in class struggles to envision the experience of their teachers or peers in response to their behavior. Their attempts at participation result in reprimands and alienation. If they are unable to fully recognize why their attempts to belong are having a paradoxical result, then their behaviors will either intensify as they continually try to employ the same ineffective strategies, or they will reactively

deal with their confusion by withdrawing or acting out. Building on this child's ability to mentalize will allow for a more accurate assessment of the interpersonal context and the child will respond more adaptively and flexibly. The ability to mentalize has been likened to having a pause button (Allen & Fonagy, 2006), which can be employed in high stress situations allowing for additional time to self-regulate and consider potential responses and outcomes.

Mentalizing ability tends to progress in a linear fashion in typical development (Midgley et al., 2017). This means treatment providers can assess for lags and regressions in the development of mentalization and intervene as needed. Typically, once a child reaches the age of 6, and has spent a few years in highly social environments during preschool and kindergarten, they will have a basic understanding of what people feel in different situations. Through elementary and middle school, from ages 7 to 12 years old, this basic ability to mentalize will flourish with higher levels of cognitive sophistication.

Middle school aged children are at an interesting age in that the ability to examine emotional experience verbally is beginning to take flight. Southam-Gerow and Kendall (2002), in a review of the research on emotion regulation and understanding, discussed the well supported theory that with increasing development comes a move towards nuanced mentalistic explanations of emotions. Whereas a child in earlier development might say something like, "I am angry because he called me a bad word," an older child is likely to say something like, "I am angry because he wanted to embarrass me in front of my classmates by insulting me." The older child is able to infer the intentions and motives of the one who insulted him and can make assumptions about the responses of peers to hearing the insult. Further, preadolescents are increasingly able to consider self and others in terms of personal qualities and mental states, often with scaffolding from more mature minds (Midgley et al., 2017). As mentalizing becomes

more complex, children come to develop a stronger self-representation and are more able to describe the quality of relationships in addition to an ability to express mixed emotional states and feelings of ambivalence (Southam-Gerow & Kendall, 2002). Self-descriptions become more articulate and nuanced. An increase in self-awareness makes children more sensitive to interpersonal slights, which can affect self-esteem as they come to recognize personal strengths and weaknesses in comparison to peers. Once a child reaches early adolescents, an awareness of the different aspects of self tend to be expressed in different contexts (Midgley et al., 2017).

Midgley et al. (2017) provided a useful list of attributes that can indicate underdeveloped mentalizing in children. This list includes difficulty or inability to: (a) identify their feelings, (b) use awareness of feelings to self-regulate, (c) see themselves from another's perspective, (d) notice their reactions to painful emotions, (e) describe their personalities, (f) narrate the story of their lives, and (g) control rumination. While some confusion regarding identity is developmentally appropriate, when this lack of self-representation is too pronounced it can contribute to difficulties in seeing through the eyes of others and weighing the impact of one's behavior. In addition, a lack of conception about one's own qualities makes it difficult to build on innate strengths (Midgley et al., 2017).

Why Mentalization: A Rationale

A Remark on Manualized Treatment Approaches

Time-limited manualized treatment approaches, primarily CBTs, have been steadily increasing in popularity over the course of the past three decades (Gaudiano, 2008). This is in large part the result of the push towards evidenced-based treatment (EBTs) and the comparative ease of applying randomized control trials (RCTs) to manualized treatments that are implemented using a static progression of steps (Glenn, 2014). While it is no doubt important to

rely on research and scientific principles when choosing interventions, it behooves us as a profession to bear in mind that the method of inquiry shapes the results. As RCTs are increasingly viewed as the gold standard by which psychotherapy treatments are evaluated, many funding sources are now tied to this kind of research and many large hospitals and institutions offer only treatments included in the (American Psychological Association) Division 12 list of empirically validated treatments (Chambless et al., 1997). This focus on RCTs to determine the best types of treatment eschews research on therapy process and common treatment factors (Wampold, 2015). Our current approach to psychological research limits our understanding of what is regarded as scientific and what has value, which, in turn, limits our understanding of growth and mental health.

The EBT movement, alternatively referred to as the evidence supported treatments (ESTs) movement, which for the purposes of this discussion is used interchangeably, posits that different types of disorders are best treated by specific treatment approaches, and the best way to discover which approaches are most effective for which disorders is through randomized controlled trials (RCTs). A second approach, spearheaded by Dr. Bruce Wampold, has focused on identifying the common factors inherent to all effective psychotherapy (Wampold, 2015).

The search for effective treatments using RCTs has not been without controversy. Shedler (2018) highlighted that while the term *evidence-based* is derived from the medical fields attempt to ensure using the best treatments instead of persisting with the status quo, in psychology it has been used as code for manualized treatment instead of a genuine attempt to deepen our understanding of our clients' therapeutic needs. Shedler has argued that any therapy that is not manualized, and based on cognitive-behavioral principles, is now deemed unscientific and inadequate. Interestingly, Shedler pointed out, that the primary study that began the EST

movement, the Treatment of Depression Collaborative Research Program, a 20-year study funded by the National Institute of Mental Health (NIMH) showed statistically significant but functionally negligible benefit from CBTs versus placebo psychopharmacological treatment. What this means is that, based on the findings of the study, a person is going to fair similarly well if they receive CBT treatment as if they take a sugar pill. The principal investigator of this seminal study stated that there was no evidence to support the effectiveness of CBT for depression (Elkin et al., 1989). In a more recent large scale RCT investigating the effectiveness of time-limited CBT for depression, only approximately 23%of patients in the study achieved remission (Driessen et al., 2013).

Shedler (2018) has highlighted a number of methodological concerns with these large scale RCTs. In these studies, control groups are often designed to benefit the aims of the study, for example, using first-year graduate students to administer the control group treatment and experienced therapist to administer the experimental (usually CBT) group. In addition, exclusion and inclusion criteria for the studies are designed to inflate positive results. Shedler concluded that the EST movement is missing the point of evidence-based treatment. Instead of looking at the convergence of scientific evidence, sound clinical judgment, and patient preferences, the EST movement has sought to reduce what constitutes effective treatment to the results of RCTs. This means that important process variables, such as client–therapist relationship, receive comparatively little attention.

Wampold and Bhati (2004) described the history of the EST movement in order to encouraged therapist to be knowledgeable consumers of research and continue to mind the important common factors influencing psychotherapy outcomes. One concern Wampold and Bhati (2004) pointed to was the focus on the treatment approach while ignoring the impact of the

treating therapist. Wampold (2001) has shown that the type of therapy used accounts for approximately 1-percent of the variance in psychotherapy research while the skill and ability of the therapist accounts for, on average, 8-percent of the variance. Between the two factors, the choice of treatment modality is an odd factor to focus so much of our time and resources on considering it makes little difference to treatment outcome for the client. As Wampold (2015) states, “if evidence were taken seriously, one could easily build the case that the attempt to identify particular treatments as privileged is unjustified” (p. 568). This sentiment is supported by researchers concerned with the neurobiological underpinnings of therapeutic change. Both Schore (2020), and Koole and Tschacher (2016) have proposed that psychotherapy research would offer greater insight into the therapeutic change process by focusing on the therapist–client relationship and the inter-brain communication which makes it possible. Focusing on the common factors leading to therapeutic change makes space for therapeutic interventions informed by a holistic understanding of the available evidence, and leaves greater room for clinical judgment as it relates to each unique client.

Hand-in-hand with research focused on psychotherapy process and common factors, there has been increasing interest in transdiagnostic treatment models as a response to the shortcomings of ESTs (Frank & Davidson, 2014). Norcross and Wampold (2019) presented evidence that attending to client characteristics, such as cultural background, spiritual identity, and treatment preferences and expectations, impact treatment outcomes as least as much, and likely more so, than attempting to match treatment to diagnosis. It is becoming increasingly clear from the research that there are underlying common factors involved in the change process in a wide range of treatment orientations, and that treating diagnoses is far less important than treating individuals.

Mentalization as a Common Factor

Taking a common factors approach, Goodman et al. (2016) sought to understand whether reflective functioning (RF), the operationalized counterpart of mentalization, was a common process factor in two approaches to working with children: CBT and psychodynamic therapy (PDT). RF measures mentalizing ability using the Adult Attachment Interview (AAI; Main & Goldwyn, 1990). The AAI was originally developed to measure attachment through parent interviews. While the AAI does include a measure of metacognitive ability (Katznelson, 2014), Fonagy et al. (1991) developed the RF coding system for the AAI to better capture the broader dimensions of mentalization including "(1) an awareness of the nature of mental states (2) the explicit effort to tease out mental states underlying behaviour (3) the recognition of developmental aspects of mental states and (4) mental states in relation to the interviewer" (Katznelson, 2014, p. 108). Goodman et al.'s (2016) research used a Q-methodology, often referred to as a Q-sort, in which 10 expert child CBT clinicians and 12 expert child PDT clinicians were asked to categorize 100 statements relevant to child therapy in general. Experts were in agreement regarding the factors of a prototypical process in their respective treatment approaches. In addition, nine experts in RF coded the same 100 items based on their view of an ideal session based on mentalizing principles. While the CBT and psychodynamic therapy responses had a low correlation, both groups had a moderate to high correlation with the responses of the RF experts. This suggests that mentalizing, or RF, is a common factor in at least these two approaches to child therapy. An additional Q-sort study found that in the treatment of borderline personality disorder (BPD; Goodman, 2013), two effective treatment approaches, transference-focused therapy and dialectical behavior therapy (DBT) were not correlated with each other, but both were significantly correlated with RF principles.

Furthermore, similarities have been noted between the primary focus of DBT and MBT. The aim of DBT is to decrease the tendency towards ineffective behavior by addressing emotional dysregulation. This is achieved through teaching patients to recognize and regulate their emotional responses to life events (Chapman, 2006). MBT shares this goal although the method of achieving it is different. While a secure attachment relationship is considered necessary for therapeutic change in both treatment approaches, in MBT the therapist uses marked and contingent mirroring to facilitate the evolution of dynamic views of self and other, while in DBT problem-solving and skills training are the primary means of intervention (Swenson & Choi-Kain, 2015). Further, DBT draws its theory of change from behaviorism and mindfulness, as compared to MBT, which is rooted in attachment, developmental theory, and affective neuroscience (Swenson & Choi-Kain, 2015). Despite these differences in interventions and theoretical foundation, a number of authors have argued that DBT is an effective treatment because skills training, when undertaken in the context of the therapeutic relationship, serves to increase the ability of clients to mentalize by facilitating the use of metacognitive skills (Goodman, 2013; Montgomery-Graham, 2016; Swenson & Choi-Kain, 2015). The research cited above supports the argument that the concept of mentalization is a core component of psychological functioning and is a shared focus, whether or not it is explicitly stated, of many commonly used treatment approaches. Due to its central role in healthy psychological functioning and its transtheoretical relevance, improving mentalization is an important target for therapeutic intervention and is the aim of the intervention outlined here. .

Focusing on Group Treatment

Work in groups has been validated as an important component of treatments geared at improving mentalizing capacity. Group treatment is essential to MBT (Bateman & Fonagy,

2016) and DBT (Linehan, 1993), both of which have been shown to target facets of reflective functioning (Swenson & Choi-Kain, 2015). A 2019 meta-analysis of RCTs for BPD (S. McLaughlin et al., 2019) demonstrated a large positive effect size for the reduction of BPD symptoms when comparing group therapy to therapy as usual (defined in the study as a heterogeneous group of community-based treatments). More broadly, group therapy has been shown in metanalysis to be an effective treatment modality for approximately three quarters of patients (Burlingame et al., 2003). In addition to its effectiveness, group therapy is more cost-effective than individual treatment. In a climate of limited funding for mental health treatment, it is likely to become utilized with greater frequency (Taylor et al., 2001). Much of the intervention outlined below draws from techniques utilized in mentalization-based group therapy (MBT-G; Karterud, 2016; Klassen, 2017). In this section, relevant concepts from the MBT-G and psychodynamically oriented group therapy literature are discussed.

Mentalization-Based Group Therapy

According to Karterud (2016), in outlining the principles of MBT-G, group therapy offers a number of advantages when working with individuals with pronounced interpersonal issues. As interpersonal conflicts inevitably arise in group therapy, failures in mentalizing can be named and addressed in the here-and-now. Through entering into and processing enactments, the group can be used as a training ground for effective mentalization.

As mentalization has its roots in psychodynamic thought, the core principles of MBT-G are drawn from relational psychodynamic group principles (Karterud, 2016; Klassen, 2017). A key concept from the group literature is that of *enactments*. Enactments are unprocessed interactions that occur between client and therapist in which both parties' interpersonal dynamics come to recapitulate core relational themes from the life of the client (Wright, 2004). From the

relational perspective, enactments are not seen as therapeutic problems, but as opportunities, and arguably the primary vehicle through which change and growth occur. Successful therapy allows the client to gain perspective on enactments or regressions because the therapist is situated as both participant and observer. By noticing enactments as they occur, the astute therapist can guide the client towards an increased capacity for curious observation. From the relational perspective, issues of transference and countertransference are not viewed as manifestations of distorted or pathological thinking (Aron, 2016). Rather, transferential dynamics are viewed from a postmodern point of view. There are many plausible ways to interpret reality and one reaction cannot be said to be objectively wrong or right. The goal in therapy is to understand the etiology of the perspective being taken and determine whether that perspective is serving the client adaptively. All people attempt to pull others into enactments in order to obtain a response that "matches preconceived wishes, expectations, and needs" (Wright, 2004, p. 241). These wishes, expectations, and needs come from our pasts and the images of relationships we have internalized from infancy. As described by Schore (2020), enactments are mutual regressions wherein dissociated affects, often related to early attachment trauma, can be processed and integrated into the self structure. In order for relational dynamics to be exposed, the therapist must be willing to participate in enactments with intention (Aron, 2016). When enactments can be noticed and processed, what was once an unconscious reaction to a particular type of interpersonal circumstance can be explored consciously, resulting in both new insights and corrective emotional experiences. Psychotherapy is a process of moving from one enactment to the next as the unconscious is gradually revealed (Davies, 1997).

Brain Lateralization. Psychoanalytically-based treatments are experiencing a resurgence of interest in clinical spheres due to a wealth of empirical support drawn from the fields of

neurobiology and affective neuroscience (Kaplan-Solms & Solms, 2018; Schore, 2003, 2019b). Schore (2020), with the aim of providing an explanation of the change process in group psychotherapy, highlighted recent findings regarding the role of brain lateralization in therapeutic enactments. The differences in the functions of the right and left hemispheres are profound and create disparate, and often competing interpretations of reality (McGilchrist, 2012). The rational, linguistic, left brain is often at odds with the social, emotional, right brain. “These neurobiological structural dualities are psychologically mirrored in conscious and unconscious minds, and in explicit and implicit self systems” (Schore, 2020, pp. 30–31). Schore’s research over the past three decades has shown that the right brain, shaped in the context of early attachment relationships, is the seat of the human unconscious, originally proposed by Freud (Schore, 2019b, 2019a). Unlike the original Freudian view of the unconscious as “a static, deeply buried storehouse of ancient memories buried and silenced in ‘infantile amnesia’” (Schore, 2020, p. 32), contemporary psychoanalytic views, supported by neuroscientific research, argue for a relational unconscious which communicates with the unconscious of other minds.

Due to the introduction of brain scan technology, the neurobiological changes during infant–caregiver and client–therapist dyads can be measured in real time (Schore, 2003). This advance in technology has allowed for studies that make visible right brain to right brain unconscious communication. According to Schore (2020), the “right-lateralized unconscious system plays a central role in the recognition, expression, communication, and regulation of positive and negative emotions” (p. 33). The synchrony of unconscious communication is a key component underlying the growth of the self in early development and change in psychotherapy, regardless of theoretical orientation (Schore, 2019a). Koole and Tschacher (2016) argued that the interpersonal synchrony between therapist and client allow for the creation of a therapeutic

alliance. In the context of group psychotherapy this synchrony is the neurobiological underpinning of group cohesion (Schore, 2020).

Over time, synchrony between patient and client can lead to an increased capacity for emotion regulation, much in the same way growth occurs within the infant–caregiver dyad. "Psychotherapeutic synchronized and interactively regulated right-lateralized communications facilitate neuroplastic structural changes in the patient's right-brain regulatory systems, which in turn allow for optimal treatment outcomes in symptom-reducing and especially growth-promoting psychotherapy" (Schore, 2020, p. 39). The interpersonal underpinnings of the emotional right brain and the importance of brain synchronicity as a vehicle for therapeutic change are especially relevant for group therapy, which involve synchrony between many brains and is interpersonal by design (Schore, 2020).

Mutual Regression. Extending the concept of enactments to account for a current understanding of neurobiological functioning, Schore (2019a) has emphasized the importance of mutual regression in the process of psychotherapeutic growth. In speaking about mutual regressions, Schore refers to a shift in dominance from the later developing left brain to the earlier developing right brain. In groups, members and therapist shift from the reliance on the verbal, cognitive, conscious functions of the left brain, to the emotional, implicit functions of the unconscious right brain. The concept of regression in the service of growth has a long tradition in the psychoanalytic literature (Kris, 1952). Through regression clients can revisit primitive defenses, and dissociated experiences and affects, offering opportunity to amend aspects of the self born out of harmful early life experiences. Adaptive regression in psychotherapy is "the only means of directly encountering dissociated aspects of the patient" (Schore, 2020, p. 68) and reenacting, and processing, early relational trauma and attachment shortcomings. When shared

regressions occur, the attuned therapist can nonverbally co-regulate strong affect making way for dissociated feelings to be integrated into the right-brain subjective self (Avdi & Seikkula, 2019). In the group context, multiple right-brain connections develop to other individuals in the group, and also to the group as a whole, which allow for the mutual regulation of a wide range of positive and negative emotional states (Schore, 2020).

Thought of in terms of mentalizing processes, enactments and mutual regressions are opportunities for the therapist to increase the use of symbolic thinking and decrease dissociative processes by integrating more primitive modes of thinking (i.e., psychic equivalence and pretend mode). According to Schore (2020), by encouraging group regression and a "shift from conscious cognition into unconscious bodily based unconscious affect" (Schore, 2020, p. 57), two different avenues towards change—the conscious, *intentional*, and the unconscious, *implicit*—can be leveraged.

Schore (2020) highlighted that groups, as with individuals, will work hard to avoid threatening affective experiences. Even groups with good relational skills will seek to remain in the comparatively safe and controlled left-brain mode of functioning. The left brain will unconsciously suppress strong affect and the group, left to its own devices, is likely to function at an emotionally superficial level. By facilitating regressive enactments, strong affective states that pull for avoidant reactions can be worked with therapeutically.

Due to the many unconscious communications occurring in group therapy, there is greater risk for iatrogenic effects. These negative therapeutic effects become more likely when working with groups of individuals that are sensitive to loss of mentalizing due to early attachment failures. Bateman and Fonagy (2016) proposed that historically-based interpretations of transference reactions are most likely to negatively impact already fragile self structures and

prompt defensive and explosive reactions. Despite the potential challenges of group treatment with individuals with delayed mentalizing capacity, when the focus is aimed at mentalizing affective communications in the here-and-now, as opposed to focusing on early life trauma, and a frame with clearly defined goals is established, group therapy is considered an essential component of treatment aimed at improving mentalization (Fonagy et al., 2017; Karterud, 2016).

In the process of right-brain to right-brain communication, Schore (2019a, 2020) highlights the importance of play and creativity to move in and out of emotionally-salient enactments. The next section of this literature review discusses play and its role in development with a focus on the development of mentalization. Dramatic play as an approach to therapy will be reviewed and the many similarities in the theory and practice of MBTs and drama therapy highlighted with the aim of further establishing a rationale for combining the two modalities when targeting improvement of mentalization in preadolescents.

Play

Play is central to the development of emotional, social, and cognitive abilities. Through play children explore emotions and develop strategies of self-regulation; they advance their understanding of social roles and the culture in which they are situated; and they learn to interact with and manipulate their environment. Play and its many functions have captured the interest of researchers from wide-ranging academic disciplines including (a) psychology, (b) psychoanalysis, (c) child development, (d) anthropology, (e) ethology, (f) linguistics, and (g) education, to name but a few. Each discipline has approached play with its own focus, goals, and methods of inquiry (Ariel, 2002). Many designations have been used to describe the type of play referenced in this dissertation. They include imaginative play, fantasy play, make-believe play, sociodramatic play, pretend play, and representational play (Ariel, 2002). I use the term *dramatic*

play throughout this text to highlight the use of drama techniques, in the sense of theatrical acting, to facilitate the development of mentalizing capacities.

Play is especially important in the lives of children and is integral to healthy development. Play allows children to try on different roles, develop physical prowess, and learn about social skills and interactions (Lillard et al., 2013). In relation to mentalization, it is likely that make-believe play facilitates learning about mental states, and experimenting with different affects and empathy (Midgley et al., 2017; Slade & Wolf, 1999). Play, as a therapeutic medium, has a long history and research has demonstrated its effectiveness with a wide range of psychological disorders (Russ, 2004), and a variety of play-based treatments exist for working with specific disorders (O'Connor et al., 2015; Stagnitti & Cooper, 2009). In work with children the types of interventions that are often regarded as classically psychoanalytic can be counter-therapeutic. Interpretations aimed at uncovering the unconscious latent meaning behind manifest content can impede the therapy by preventing the emotional process from unfolding. Therefore, working in the world of make believe is widely regarded as good practice (Hoffman, 2015).

Drama and Therapy

Role-playing and imaginative play typically develop as children reach school age. It is common for children to begin improvising dramatic scenarios with peers and family members from the age of 5. Playing pretend promotes the development of social communication and provides opportunities to co-create meaning through interaction with others. The ability to partake in dramatic play influences the quality of interpersonal relationships, social acumen, and expressions of positive emotions later in life (Harvey, 2015). "Dramatic play provides a natural stage in which children find ways to negotiate their emotional experiences in response to and

with others" (Harvey, 2015, p. 289). Drama can be particularly useful in work with children as their ability to communicate verbally is in the process of developing.

> According to the North American Drama Therapy Association (2014),
>
> Drama Therapy is an active, experiential approach to facilitating change. Through storytelling, projective play, purposeful improvisation, and performance, participants are invited to rehearse desired behaviors, practice being in relationship, expand and find flexibility between life roles, and perform the change they wish to be and see in the world.

The roots of drama therapy can be found in a range of traditions including psychoanalytic approaches such as Jungian psychology and Winnicott's theories on human development (S. Cassidy et al., 2014).

While the literature on drama therapy is rich with case examples and advisement on technique, there has been little empirical qualitative and quantitative research published. That said, some recent studies offer promising evidence that using drama and acting-inspired interventions can improve social functioning. Corbett et al. (2016) conducted a study using a theatre intervention to improve social competence in children diagnosed with ASD. The intervention included theatre games, role-play exercises, improvisation, and character development to explore and practice social interactions (Corbett et al., 2014, 2016). The study (Corbett et al., 2016) showed medium to large effect sizes in a variety of facets of social functioning.

In order to address the lack of research on change factors in drama therapy, S. Cassidy et al. (2014) conducted a systematic review of published clinical drama therapy cases in order to distill the key processes of change and key theoretical underpinnings of treatment. The review

used a grounded theory approach to draw conclusions regarding the most important elements of change in the practice of drama therapy. S. Cassidy et al. (2014) noted that a common theme throughout the papers they reviewed was a focus on the here-and-now. The authors, however, offer little definition of what this phrase means in the context of drama therapy. Further examination of the case examples used in their review make it evident that by working in the here-and-now, S. Cassidy et al. (2014) were referring to a primary focus on affect. In the majority of the case examples described, clinicians sought out moments of heightened emotion and then deepened and clarified the emotional experience through the use of drama techniques. Many of the cases described used enactments to both contain and expand the strong emotions of participants.

The idea of enactments in drama therapy seem to closely mirror the idea as understood by Schore's (2020) description of enacted mutual regression. It seems that in both Schore's neurobiological understanding of the change process in group psychotherapy and the change process described by S. Cassidy et al. (2014), the role of the therapist is to maintain right brain to right brain attunement and together with the client enter into a right-brain affective mode of communication. Furthermore, S. Cassidy et al. described the importance of the therapist working alongside the client and resisting the pull towards quick interpretation. This is again in a similar vein to Schore's (2020) depiction of the therapist's role as entering into the enactment with the client instead of staying in the left-brain analytic mode of functioning.

S. Cassidy et al. (2014) determined three areas in which clients change through their participation in drama therapy which included (a) increased ability to engage in drama activities; (b) increased insight into self, other, and relationships; and (c) increased ability to socialize and maintain healthy relationships outside of therapy. The second and third areas of change targeted

by drama therapists are similar to the goals of MBT (Bateman & Fonagy, 2013). The first goal, the ability to engage in the drama activities, implies an improved ability to maintain attention and regulate disquieting reactions, both of which are components of mentalization (Fonagy et al., 2002).

S. Cassidy (2014) highlighted Winnicott's potential space and writings on the development of the self (Winnicott, 1964, 1971) as important theoretical foundations of drama therapy. According to S. Cassidy,

> it is important that the client feels that the therapist is attuned to their needs and is close by to provide support to establish safety. The child then goes through a transition to develop an increased recognition of self and sense of others, before moving into relative independence where they can develop a sense of self that can be presented to the world. (p. 363)

This Winnicottian view underlies the mentalizing conception of self-development and is part of the theoretical foundation of mentalization (Fonagy et al., 2002). Drama therapy, relationally oriented group psychotherapy, and MBT share many theoretical and technical similarities, and share many of the same therapeutic goals.

Distancing. A core concept in drama therapy is that of distancing (Landy, 1983, 1994). Landy describes distancing as the act of regulating the balance between closeness and separation to others and to one's various self states and internal representations. According to Landy (1983),

> The distance can be physical, as in maintaining a space of so many feet from another in a face-to-face conversation; or it can be emotional, as in choosing whether or not to empathize with another's personal dilemma; or the distance can be intellectual, as in choosing to analyze rather than empathize with another's problem. (p. 175)

In drama therapy the relationship between self, role, and identity is especially relevant as participants are continuously determining, both consciously and unconsciously, to what degree they will identify with the roles they are playing.

Distancing is a concept used in a number of disciplines including theatre, sociology and psychology. In theatre, aesthetic distancing refers to the spectator's level of affective involvement in the drama. The drama can feel so real that the viewer begins to experience themselves as a participant, as if it is they who are playing the part of the protagonist. Alternatively, it can be experienced as alienating, and the viewer feels like an outsider, analyzing the unfolding drama from a safe distance (Landy, 1983). Aesthetic distancing in theatre is most associated with the work of Bertold Brecht. In his *epic theatre*, the spectator was "encouraged to face a certain situation and make a decision, rather than become involved in a situation and luxuriate in it" (Landy, 1983, p. 176). The spectator was engaged more at a cognitive level than an emotional one, and was invited to analyze instead of feel. From Brecht's perspective, through overdistancing the spectator was liberated to evaluate rationally instead of confined by emotional responding (Landy, 1983).

The sociologist Thomas Scheff used the concept of distancing to understand the use of emotion in psychotherapy (Landy, 1983; Scheff, 1981). Scheff's theory is based on the idea of repression, which he likens to overdistancing. Underdistancing in therapy can be seen when a patient is completely overwhelmed by emotion. Aesthetic distance is achieved when the patient is able to feel the emotion and observe the process of feeling it.

Dramatic Play and Mentalization. Scheff's (1981) conception of distancing bears a close similarity to that of psychic equivalence, pretend mode, and mentalizing in mentalization theory. In psychic equivalence there is no space between internal feeling states and reality

(underdistancing), while in pretend mode the two are kept completely separate (overdistancing). The goal in Scheff's model and in MBT is to become both participant in emotions and observer of them.

In Scheff's view repressed emotion can be addressed through manipulating distance. By moving in and out of feeling the full force of an overpowering emotion, shifting between the feeler and observer roles, repressed or dissociated emotions can be brought into consciousness and addressed. Similarly, in treatments geared towards improving mentalization the therapist is seeking to both have the patient embody emotion in the here-and-now, and to distance themselves from those emotions in order to analyze them rationally. Through this process a connection between an experience and affective responses is established thereby expanding the patients ability to regulate their emotions (Bateman & Fonagy, 2004).

Although MBTs are generally described as traditional talk therapies, Asen and Fonagy (2012) have endorsed the use of dramatic play interventions when working with children and families. Asen and Fonagy proposed a variety of activities for helping families improve the ability to reflect upon emotions and take perspective. An example of these activities includes inverting roles (child plays parent role, and parent plays child role). An activity like this encourages perspective taking and emotion identification, and does it in a manner that is appropriate for children who are limited in their ability to verbally express affective states.

Mentalizing and imaginative play are influenced by and reflect early attachment security, or lack thereof. According to Fonagy et al. (2002), playful interactions in the context of a trusting relationship with caregivers is the process by which psychic equivalence and pretend mode are integrated and mentalization develops. Dramatic and imaginative play can be seen as both a training ground and indication for the child's ability to mentalize. As with MBT, the goal of

dramatic play interventions is to help clients develop interpersonal skill and affect regulation (Weber & Haen, 2005). The many similarities in both the theory and practice of drama therapy and MBTs suggest the two can be usefully combined therapeutically to improve mentalizing capacity. In combining these two modalities for the purposes of this dissertation, however, it is necessary to consider the specific developmental abilities and needs of the target population, preadolescents.

Therapy with Preadolescents

In comparison to work with young children and teens, the literature pertaining to work with preadolescents is sparse. Determining the best therapeutic approach for this age group can be a challenge because of the variability in their attainment of formal operational thinking (Piaget, 1970; Vernon, 2007). While preadolescents are in the process of developing abstract reasoning skills, many do not have the ability to verbalize their feelings and thoughts, and they tend to be limited in the degree to which they can apply problem-solving skills to themselves and their emotions (Vernon, 2007).

Problems deriving from early attachment shortcomings, such as misattuned or unmarked mirroring by caregivers, can come to the fore as children transition to adolescence. When a caregiver does not reflect an accurate representation of the child's internal state, the child will introject the caregiver's actual state into the self structure (Fonagy & Target, 2000; Winnicott, 1967). Fonagy and Target (2000) used the concept of the *alien self*, to refer to these foreign introjects. According to Fonagy et al. (2002), "the infant is forced to internalize the representation of the object's state of mind as a core part of himself. But in such cases the internalized other remains alien and unconnected to the structures of the constitutional self" (p. 11). As development progresses, and the child begins to mentalize, projective identification is

used as a mechanism to externalize the alien parts of the self.

As children transition into adolescence, and become increasingly separated from caregivers, it becomes more difficult to maintain a sense of internal coherence through the externalization of alien parts of the self into caregivers. Further, as children approach adolescence, "both the appreciation and the expression of affect take on a new dimension and thus many new meanings…adolescents start to contemplate adultlike scripts for emotions" (Fonagy et al., 2002, p. 322). Fonagy et al. (2002) argued that the increasing cognitive sophistication, with the entrance into the formal operational mode of thinking, coupled with the developmental achievement of increased separation from caregivers, "can reveal developmental failures or weaknesses that were established much earlier in life, but which it may have been possible to conceal at this earlier stage" (p. 318). The alien self is relevant to all people, not only those who exhibit psychopathology. Minor instances of neglect and misattunement are a part of normal parenting. It is when neglect is severe, or interpersonal trauma causes a child to identify with the aggressor that the alien self becomes destructive and its externalization takes on great priority and mentalizing is sacrificed.

The alien self can be repaired through the enactments of effective treatment. The therapist replaces the marked mirroring function of early caregivers, but does in a manner that is contingent upon the true expression of the patient. Through the play of enactments and marked mirroring, alien parts of the self are brought to light and can be acknowledged and rejected by the patient (Stortelder & Ploegmakers-Burg, 2010). Working with children approaching adolescence requires an appreciation of their increasing use of formal operational modes of thinking, and an awareness that psychological vulnerabilities stemming from early attachment failings can be exasperated by increased separation from caregivers. These considerations are

addressed in the intervention outlined below.

Objectives

According to Fonagy et al. (2002), psychotherapy with individuals with an underdeveloped ability to mentalize "should be focused on helping them to build this interpersonal interpretive capacity" (p. 14). Expanding the ability to mentalize is a primary goal of psychotherapy across many modalities. It is a concept that is both transtheoretical and transdiagnostic. From a psychoanalytic perspective the best way to improve mentalization is to work with emotion and transference reactions in the here-and-now of treatment. This intervention attempts to do that for middle school-aged children through group treatment using imaginative dramatic play as the primary vehicle through which these lagging capacities can be obtained. Work in groups is not only pragmatic in terms of resource utilization, but also, due to the many varied opportunities for transferences to develop and enactments to play out, an ideal environment in which to improve mentalizing.

The majority of the interventions currently employed with school-aged children take a CBT or skills training approach. These approaches are most likely to be effective for individuals who are able to identify their difficulties and are motivated to address them. They are least likely to benefit individuals who lack basic affect regulation. Cognitive interventions presuppose that clients have already attained many of the component parts of mentalization; however, many preadolescent clients, particularly those most likely to be referred for psychological services have not developed an age-appropriate ability to regulate their emotions, or think about the emotions of others.

Dramatic play techniques are proposed as the primary vehicle through which to promote mentalization with this age group. While there is little research in the effectiveness of drama

therapies, and arts therapies more broadly, I expect it is an area that will gain increasing attention in the coming years as the pendulum in the field of mental health gradually swings towards an increased focus on emotional processes and shifts away from a primary focus on left-brained, cognitive analysis of mental states and representations. In my view, using drama techniques as a therapeutic intervention is well suited to middle school aged children because it (a) is not experienced as childish in the same manner as playing with toys, (b) cuts through defensiveness through the use of externalization, (c) uses pretend play to externalize feelings, and (d) provides an opportunity to integrate pretend with reality.

This intervention focuses on various aspects of group process and presents a set of principles important to working with the target population. All the principles presented will be aimed at the central goal of promoting increased mentalization. As with other mentalizing-based treatment approaches (cf. Karterud, 2016; Midgley et al., 2017), the goal of the intervention is not increased insight or an exploration of the root cause of emotional and behavioral challenges. The aim is to help child clients increase their capacity to mentalize so they can better manage emotions and take advantage of opportunities for emotional learning through interaction with healthy individuals in their lives.

Methodology

In order to develop the proposal presented here, I have taken several steps to deepen my understanding of mentalization, its theoretical underpinnings, and its application to working with preadolescents in a group format. I have explored the research in the areas of mentalization and attachment, MBT, MBT-G, mentalization-based treatment for children (MBT-C), drama therapy, the neurobiology of therapeutic change, and issues related to working with middle school aged children. In the area of mentalization theory and practice, the writings and research of Peter

Fonagy, Mary Target, and Anthony Bateman, have been invaluable (i.e., Bateman & Fonagy, 2004; Fonagy et al., 2002; Fonagy & Target, 1996, 2006). The writings of Karterud (2016) and Midgley et al. (2017) have been primary sources of guidance to applying mentalization principles to work with groups and children respectively. Much of the recent research in the arenas of infant development, neurobiology, affective neuroscience, and neuropsychoanalysis, (e.g., Beebe, 2006; Beebe & Lachmann, 2014; Kaplan-Solms & Solms, 2018; Schore, 2003, 2019a; Trevarthen et al., 2015; Tronick, 2007) has helped me to deepen my understanding of the biological and developmental empirical support for the theory of mentalization.

Journals that have been of particular usefulness in designing this intervention have been *The Journal of Infant, Child and Adolescent Psychotherapy*, *Psychoanalytic Dialogues*, and *Psychoanalytic Inquiry*, all of which have a number of published articles covering topics relevant to mentalization and working with children from a mentalizing perspective.

In order to further my understanding of arts-based therapeutic approaches, and drama therapies in particular, I have focused on the official journal of the North American Drama Therapy Association (NADTA), *Drama Therapy Review*; the official journal of the British Association of Dramatherapists, *Dramatherapy*; and, *The Arts in Psychotherapy*. All three of these journals are peer-reviewed and contain articles with case examples, dramatic play techniques, and theorizing on the mechanisms of change from an arts-based therapy perspective.

In addition to further deepening my knowledge of theories and approaches pertinent to work with this population from a mentalization perspective, I have paid close attention to case studies using MBTs. Case studies are a valuable bridge between theory and practice and have provided me with insight into the ways other practitioners have adapted the ideas of mentalization to therapy practice. A number of training videos for using dramatic techniques,

working with school-aged children, and applying mentalization in practice are available online, some publicly available, others, specific to mentalization, offered through the Anna Freud National Centre for Children and Families (Anna Freud Centre, 2020). Watching videos from various disciplines (e.g., play therapy, drama therapy, etc.) has helped me to become more attuned to subtle differences in the ways that practitioners apply interventions which either explicitly or implicitly target mentalizing ability.

Finally, I have reviewed my own work with groups and school-aged children to further inform the development of this intervention. Over the course of my training, I spent an academic year providing group therapy at a school employing a range of approaches including CBT, drama therapy, and play therapy. Further, I spent a year working on an adolescent inpatient unit running DBT groups and psychodynamically oriented process groups. While the population on this unit was a few years older than the group targeted with this intervention, many of the skills needed to engage group members, the targets of treatment, and the developmental considerations are similar. In addition, working on the inpatient unit has helped me to understand the ways that early attachment trauma can come to the fore as children approach adolescence and begin to apply increasingly complex thinking to their lives and relationships.

These practical experiences have helped me to consider the similarities and differences between treatment orientations and explore the ingredients that make different approaches effective. As a whole, these training opportunities have shaped my views on effective treatment with children and adolescents, and reviewing my clinical notes has helped me to organize my thoughts around the role of mentalizing in group therapy from a range of theoretical orientations.

Proposed Intervention

The group intervention presented here is based in the theory and research on

mentalization, group therapy, and drama therapy presented in the literature review, as well as my own experiences running groups with children and adolescents. The remainder of this proposal will shift from a primary focus on the theoretical underpinnings and rationale for the proposal to a pragmatic guide to implementing a mentalization-based drama therapy intervention.

One of the defining differences between process-oriented therapies, such as relational psychodynamic approaches and manualized treatments, is that process-oriented treatments guide the clinician to focus on a class of growth-promoting interventions which are generally unstructured and rely heavily on the clinician's ability to use good clinical judgement. Manualized CBTs are more directive as to which techniques the therapist should use and what the therapist should do in each session of therapy. The intervention proposed here falls somewhere in between these two approaches to treatment. It offers both general guiding principles, and suggests a format for a session and an overview of the progression of treatment. In my experience, group therapy for children tends to be time-limited, usually bounded by the academic calendar. Therefore, with this proposal I envision an intervention that is time-limited and closed, beginning and ending with the same group of children. The intervention can be administered in as short as 10 sessions or proceed for the 30 to 40 weeks of a typical academic school year. Developing mentalizing skill is a lifelong pursuit for all of us, and I therefore see no downside to an extended treatment as long as the participants are engaged and the work continues to be productive. I have found that 90–120 minutes is an appropriate amount of time for each session. I have attempted to use the session format proposed below in less than 90 minutes, but the sessions have felt rushed and the quality of the processing of interpersonal events suffered as a result.

Any activities I suggested here are ones that worked for me in the settings in which I was

situated. Part of the joy of conducting an experiential play-based intervention is that the group leader has ample opportunity to engage creatively in both the design and implementation of each session. There is no predetermined set of dramatic activities that will work best for every group of children. Therapists should endeavor to design their own activities based on the needs of the setting and clients.

Structure of the Group

While MBT is a psychodynamic approach, it differs from a traditional psychodynamic approach in that it presupposes a higher degree of structure. MBT was developed with patients with severe psychopathology in mind and therefore better anticipates the tendency of groups of individuals with limited mentalizing capacity to become chaotic when clearly defined boundaries are lacking (Karterud, 2016). Whereas neurotic patients may benefit from the openness of the psychoanalytic approach, borderline patients struggle to maintain an internal sense of structure and boundaries. Speaking about borderline groups without sufficient structure, Karterud (2016) noted, "the space for thoughtful reflections on mental states will be undermined and a lot of the therapist's time and attention will be spent on 'putting out fires'" (p.43). In order to provide an appropriate level of structure within the group, Karterud proposes that the group leader take control of the group and intentionally and explicitly uses the group as a *training ground for mentalizing*. Unlike a traditional psychodynamic group where free association is the norm and expectations are not explicitly laid out, in a mentalizing group the leader highlights and outlines the importance of exploring interpersonal events between group members. The group leader formats the group in a way that makes time for exploration of group interactions, and the group leader is explicit in using interventions that encourage mentalizing. I believe these insights into work with borderline patients are also relevant to work with children. Without structure

play-based interventions can become chaotic or devolve into pretend mode, losing any link to reality. In my experience running groups with children, balancing structure to reign in playfulness with the need to create an open atmosphere in which emotions can be expressed freely is a constant challenge and requires ongoing consideration from the therapist.

Structure also allows for the development of a therapeutic frame in which a productive therapeutic alliance can form. Common factors research (Wampold, 2001, 2015) demonstrates that a strong therapeutic alliance is the element which is most predictive of successful outcomes in psychotherapy. The alliance can be broken down into three component parts including: (a) the goals of therapy, (b) the tasks of therapy, and (c) the therapeutic bond.

Goals

Along the lines of Karterud's (2016) advisement for adult patients participating in MBT-G, when conducting a mentalization-based intervention with preadolescents it is important to explain the purpose of the treatment. In a mentalizing group, the goal of the treatment is to improve the ability to think about one's own feelings and that of others. Compared to young children, preadolescent patients often come to therapy with some awareness of their social deficits. While their difficulty mentalizing means they struggle to make sense of their own emotions, they are generally aware of being socially isolated, having volatile relationships, or being reprimanded for their failures to participate in the manner expected. Much of the first session of group should be dedicated to highlighting the difficulties participants might be experiencing and providing a simple explanation of the ways their challenges are related to mentalization. Often, preadolescents coming to treatment do not know why they have been referred, or they disagree with the reason for referral. It can be helpful to highlight that interpersonal difficulties, whether with teachers, bosses, friends, or significant others, are

experienced by everyone throughout life. Those with the happiest relationships are those that put time into understanding their own feelings and expectations. It this way, group participation can be framed as a growth activity instead of a sign of pathology.

Tasks

A second aspect of the therapeutic alliance is agreement on tasks. I have generally found this component of the alliance easier to establish than broader goals. While it is common that young people participating in group will be defensive about the behavior that has resulted in their referral, and therefore hesitant to acknowledge that targeting the goal of deepening mentalization could be of benefit, it is rare that I have met resistance regarding the manner in which we will approach these goals. Children on the cusp of entering adolescence are at a point in development where play and adult behavior are contending pulls. Many authors on play therapy with preadolescents have commented that this group tend to find the typical toys of play therapy to be childish; however, due to their degree of cognitive development, they are not yet ready to participate in standard talk therapy (Bratton & Ferebee, 1999). Preadolescents still enjoy childlike playfulness, but also feel a draw towards acting more adult and not seeming childlike. Participants tend to be excited about the prospect of acting as it is neither child's play nor sitting around talking about feelings.

The most common adverse response to the tasks of therapy is that some participants may feel shy about acting in front of peers. In my experience, it is helpful to state from the beginning that no one will be required to act. For those participants that opt out, I invite them to be part of the audience, and offer gentle encouragement to join in each session. I have never had a group member sit out for more than three sessions as the enthusiasm and excitement of their peers tend to outweigh their hesitation.

It is important to explain to participants that in addition to acting, we will be discussing our experience following each acting activity. The therapist should inform participants that they are expected to take part in discussions about their own emotions in relation to the characters in the scenes they perform, and about their experience in response to watching peers. The basic goal of treatment is to increase the curiosity of participants about the thoughts and feelings of themselves and others (Bateman & Fonagy, 2006). To avoid confusion, this should be explained to the group at the start of treatment. As many preadolescents are motivated to act, but less enthusiastic about talking about feelings, I explain that the key to any good acting is understanding the emotional experience of the character. I inform the participants that by learning this skill in order to be better actors, we will also become better at applying it to ourselves. Through making explicit the group goals and expectations it is easier to notice and highlight for the group when they are participating in the work of the group and when they have devolved into basic assumption functioning (Bion, 1961). I have found it helpful to post the expectations on the wall so they can be referred to as needed. Periodically, throughout the course of the group, it is helpful to reestablish the group frame by bringing attention to expectations and inviting discussion as to how well we are doing in our work together.

Cohesion

In group work the therapy bond is closely related to the concept of group cohesion. Over the past 25 years, group cohesion has been one of the most robust and consistently researched findings in the group psychotherapy literature on group therapy outcomes (Burlingame & Jensen, 2017). A meta-analysis of cohesion in group therapy examining 40 studies published up until 2009 (Burlingame et al., 2011) found a medium effect size between cohesion and individual outcomes. This is similar to the effect size between therapeutic relationship and individual

outcomes in individual therapy (Norcross & Wampold, 2019). Further, Yalom and Lescz (2005), in their seminal work on group psychotherapy, highlighted group cohesion as a necessary ingredient for the group to be productively therapeutic.

As discussed in the literature review, Schore (2020), made the comparison between cohesion in group therapy and the therapeutic relationship in individual therapy, stating that both have their neurobiological substrates in right-brain to right-brain synchronicity. “Synchrony, associated with physiological linkage, affective reciprocal exchange, emotion transmission, and coregulation occurs not only in dyadic right brain-to-right brain contexts, but also in group multibrain contexts of multiple relational patterns of unconscious right brain-to-right brain communications” (Schore, 2020, p. 43). The role of the group therapist is to build cohesion through facilitating the types of affective interactions that build the kind of synchrony needed for cohesive growth enhancing relationships within the group.

In acknowledgement of the importance of group cohesiveness to the success of group treatments, when conducting the drama-based intervention proposed here, the therapist should target group cohesion early in treatment. There are many books, as well as free resources, available online, on the topics of establishing cohesion in groups. I have found activities specific to theatre to be most helpful. Early in treatment I commonly use a get-to-know-you activity, in which participants stand in a circle and play catch with 2–4 balls simultaneously. When doing this activity, I highlight that the activity is not competitive, but the goal is to work together to keep the balls in the air. I also tell participants that they must say the name of the person to whom they wish to throw the ball and make eye contact before they throw.

While this is a simple activity that requires little preparation, it highlights some important principles I like to keep in mind when targeting group cohesion. First, I never make the activities

competitive. I make sure to inform participants that they are working together to make the game proceed smoothly. If individuals in the group attempt to make the activity competitive by drawing comparisons between participants abilities, I respond by encouraging *striving with* instead of *striving against*. I highlight that the metric for success in the activity is not being better than others but improving as a group as the activity progresses. Second, activities should be engaging and ideally involve movement. This will help clients become comfortable with the idea that group will be an active experience. Third, the activity should encourage mentalizing in some form. In this example, by having the participants seek eye contact before throwing the ball, they must take the perspective of the recipient in order to gauge whether they are ready to catch. While there is no limit to the number of activities a creative leader can devise, it is important that the leader choose activities with intention and consider how the activity promotes group cohesion and mentalizing.

As with any activity, it is important that the group process the affective interaction in order to facilitate the type of right-brain communication described by Schore (2020). In the case of the catch activity described here, I will pause the game between rounds and invite discussion about emotional exchanges that occurred during the game. I may point out a moment of frustration, or a period when the group seemed to be working very efficiently. By introducing here-and-now conversation concerning the emotional aspects of interactions from the start of group, participants are encouraged through modeling to focus on affective elements of experience. Over time, they will anticipate the group leaders' queries and will begin to share spontaneously.

In my experience, this catch game can become chaotic as participants become excited. They begin to throw the ball before peers are ready, throw it with unneeded force, and try to

move the ball along as quickly as they can. By slowing the activity down, the therapist acts as the pause button, a vital function of mentalizing (Allen & Fonagy, 2006). By highlighting the emotional process of participants in the here-and-now, but not becoming chaotic themselves, therapists provide the marked-affect mirroring function described by Fonagy et al. (2002). Providing this function is the fundamental task of the therapist in MBTs (Bateman & Fonagy, 2016).

Once I feel confident that the group is becoming comfortable with each other and the types of emotionally focused discussions essential to deepening mentalization, I will introduce activities that tend to pull for increased emotionality. Examples of more advanced activities that encourage cohesion are pair mirroring and the human machine. In pair mirroring, two individuals face each other and attempt to move in unison. As Fonagy and Bateman (2010) stressed, emotion identification is the first task of improving mentalizing. The mirroring task facilitates focusing on and identifying the body-based substrates of affective experience. In the human machine, one group member goes up and stage and begins making a repetitive movement of their choosing. One by one the remaining participants go up on stage and add to the machine by doing their own movement. With this activity, I highlight the importance of moving as one machine even though each individual is doing a different movement. As with the catch activity, it is the mentalizing therapist's role to pause the activity and reflect the affective interaction occurring between group members and of the group as a whole. Further, I find it helpful to invite participants to share what they believe the function of the machine was after the activity is completed. This discussion can serve as an introduction to perspective-taking, a component of mentalizing, as each participant has a different viewpoint from which to observe the machine. The discussion also reveals much about participants' attitudes about the group and its purpose.

Approach of the Therapist

The approach of the therapist in the intervention proposed here is drawn primarily from MBT. Bateman and Fonagy (2013) focused on the key aspects of the therapist's stance: (a) the therapist should approach the group with "humility deriving from a sense of not-knowing" (p. 600); (b) the therapist should approach ideas and perspectives patiently with an attitude of acceptance; (c) the therapist should seek to understand the experiences of the patients by asking for clarifying details; and lastly, (d) the therapist should model comfort with ambiguity instead of hurrying to offer explanations or interpretations. The therapist should also be prepared to acknowledge and take responsibility for misunderstandings. By doing so, the therapist demonstrates how to work with and correct the assumptions leading to misinterpretations. All of these guiding principles teach through modeling. Clients see the therapist working to mentalize effectively and, over time, will begin to do the same. Bateman and Fonagy (2013), explained that through identification with the mentalizing therapist, patients come to approach their own thoughts and those of others with greater curiosity and willingness to reappraise their assumptions.

> Thinking about oneself and others develops, in part, through a process of identification: The therapist's ability to use his mind and to demonstrate a change of mind when presented with alternative views is internalized by the patient. Gradually, the patient becomes more curious about his own and others' minds, and is consequently better able to reappraise himself and his understandings of others. (Bateman & Fonagy, 2013, p. 601)

The Not-Knowing Stance

Bateman and Fonagy (2013) describe the not-knowing stance as a perspective needed to

maintain curiosity about transference and countertransference feelings, while also keeping in mind that the experiences of both the client and the therapist are only an impression of what is occurring. This postmodern view of experience serves as a reminder to the therapist to remain humble. Therapists do not have objective knowledge regarding what is occurring in the dynamics of the therapeutic relationship. Karterud (2016) likened the not-knowing stance to an approach to therapy where client and therapist are "companions on a journey" (p. 138). In my experience, young people appreciate and respond well to this sort of approach. Many preadolescents referred for group therapy have extensive experience of being told or made to feel that their behavior or feelings are wrong. They often come to therapy expecting the adult in the room to act as the expert. It is therefore important for the therapist to establish a collaborative attitude and avoid drawing conclusions about the experiences of participants.

Bateman and Fonagy (2013) warned against a knowing stance, noting that borderline patients will quickly take on the mental state of the therapist and enter into pretend mode, a mode where they are dissociated from their own reactions to reality. "This circumscribes their exploration of their own mental processes, and prevents them from discovering exactly what they do feel" (p. 602). To foster openness and curiosity, Bateman and Fonagy (2013) advised using open-ended questions to explore the clients mental state instead of closed-ended statements (e.g., It sounds like you are feeling…). As with borderline patients, preadolescent children have a limited ability to mentalize and easily slip into less developed modes of functioning. A child may take the statement of empathy from the therapist as fact and resign their independent mentalizing to the therapist.

Schore (2020), in his discussion of neurobiologically-based psychoanalytic group therapy, echoes this warning against a knowing or interpretive stance. A stance of openness and

curiosity is necessary for enactments and mutual regression to occur, which allows for the integration of dissociated aspects of the self. Relying too heavily on left-brain analysis, which could be termed a *knowing stance*, the therapist is unable to engage emotionally in the therapeutic process. “An over-reliance on thinking may lead to knowing, which can foreclose access to this more primitive developmental world” (Price, 2018, p. 7).

Epistemic Trust

Midgley et al. (2017) highlighted the importance of the therapist taking a stance that engenders epistemic trust. According to Fonagy and Alison (2014) epistemic trust is “trust in the authenticity and personal relevance of interpersonally transmitted information” (p. 372). Without faith in the motives and value of the remarks of the therapist, the patient will remain vigilant and will not be open to change. Kamphuis and Finn (2019) discussed the concept of epistemic trust in terms of Kohut’s (1984) work on disintegration. Kohut (1984) proposed that individuals with a fragile sense of self are prone to disintegration, an experience of overwhelming emotional distress and disorientation. These experiences occur when a central belief about the self is challenged and cannot be adequately refuted. Kohut theorized that through the process of empathic immersion, or attunement, the therapist can take the perspective of the patient and respond in accordance with transference needs stemming from early developmental shortcomings (Kohut, 1971, 1977). For epistemic trust to be established, attunement is essential. In a context of epistemic trust, rooted in empathic attunement, patients can relax their vigilance against challenges to self-concept and are more likely to be open to corrective experiences and therapeutic growth.

Midgley et al. (2017) pointed out the similarities between the stance of the mentalizing therapist and the person-centered approach propounded by Carl Rogers (1957). From the

person-centered approach congruence, empathy, and unconditional positive regard must be expressed by the therapist as prerequisites to therapeutic growth. It is in a context of a safe and trusting relationship that the client is able to engage with reduced defensiveness and can learn from mentalizing individuals in the social environment (Fonagy & Allison, 2014).

Working with Emotions

Bateman and Fonagy (2013) highlighted that the first task of therapy is to stabilize the client's expression of emotion and increase the ability to regulate affect. According the Bateman and Fonagy (2013) only after affect is brought under increased control and impulsivity reduced "is it possible to focus on internal representations and to strengthen the patient's sense of self" (p. 599).

Therapists should target much of the early work of group to emotion identification and expression. Early in treatment most of the activities employed should be focused primarily on activities that teach clients to notice their feeling states. I have found that participants are generally excited to begin acting out scenes immediately at the start of therapy. I often find it necessary to temper the eagerness of the group by explaining that before we can act well, we must consider what an actor pays attention to in order to convey their character in a manner that is believable to the audience.

I have found the description of the building blocks of present moment experience outlined in sensorimotor psychotherapy particularly useful in breaking down here-and-now experience during group (Ogden, 2015; Ogden et al., 2006). Ogden described the present moment as made up of cognitions, emotions, sensory perceptions, bodily sensations, motor movements and impulses. I use Ogden's formulation as a basis on which to design activities for increased emotional awareness. Early in treatment, again drawing on the work of Ogden (2015),

I find it helpful to play with posture and encourage participants to speak about the various aspects of the present moment they are noticing as they stand in various stances (e.g., shoulders curved in and chin tucked into the chest; shoulder blades squeezed together and chest and chin pointing up). This helps participants begin to tune into their bodies' cues and facilitates a shift to right-brain emotional functioning. I use Ogden's model throughout treatment to teach participants to notice what they are feeling and how it is informing their understanding of their characters and their selves. Throughout acting activities, I periodically pause the scene and invite actors to use Ogden's five building blocks to help us understand the experience of the role they are in. This carries over into discussion portions of the session where I will invite participants to use the building blocks to describe experience in the here-and-now. Using the building blocks to guide conversations about emotion adds a level of structure to the group. It offers a helpful guide to young people who are not experienced at noticing or discussing their feeling states.

Working with the Relational Environment

The theory of self-development presented throughout this proposal argues, based on evidence from the fields of neurobiology and infant development (e.g., Beebe, 2006; Schore, 2003; Trevarthen et al., 2015), that the self comes to exist through interactions with others. The ability of those with whom we interact to mentalize dictates the quality of these interactions, which has far reaching impacts on emotion regulation and interpersonal functioning. The self and the ability to mentalize continues to be influenced by interactions with developmental objects throughout childhood and adolescents (Midgley et al., 2017).

In a program targeting preschoolers in London, Malberg et al. (2012) focused on parents and teachers to help them better mentalize the experiences of child participants. Drawing on the work of Anna Freud (1949), Malberg et al. (2012) emphasized that "by guiding and supporting

parents and teachers ability to reflect on children's behavioral manifestations from a developmental perspective we can improve the quality of the relational environment in which emotional development takes place" (p. 191). Considering the limited time children spend with mental health specialist, it is important to recruit other stakeholders to form a supportive team which will facilitate the healthy development of the child. In the case of the study conducted by Malberg et al. (2012), parents and teachers were taught a developmental/psychological perspective on the challenging behaviors they observed. The overarching aim of the program was to shift the school/home system towards taking a reflective, collaborative approach instead of a primary focus on behavior management (Malberg et al., 2012). The study showed promising results at post-intervention, with children demonstrating better social functioning, decreased behavioral concerns, fewer conduct problems, and less reported distress.

In my own experience completing training at a school where I conducted a mentalization-inspired experiential group, I was struck by what seemed to be a high correlation between the attitudes of the classroom teachers and the outcomes of group participation. Those teachers who were more enthusiastic about the group and amenable to discussing my observations regarding the students' challenges in developmental terms, reported better social functioning and fewer behavioral challenges in the classroom. I suspect those teachers who were more prepared and willing to mentalize their students through a psychological/developmental lens altered, through the quality of their interactions with the students, the way those students experienced and mentalized themselves. Working with the "relational environment" (Malberg et al., 2012) of the group participants was at least as important as any work that occurred during the group itself.

While the Malberg et al. (2012) program was a large-scale grant-funded study, its

implications are relevant to any therapist implementing children's groups. It is essential to find time, either formally through planned meetings or informally through brief conversations in passing, to speak with other stakeholders in the participants' treatment. In my experience, these interactions serve two primary purposes. First, they serve the aim of increasing the understanding of the rationale for a play-based experiential intervention, which can look rather chaotic from the perspective of classroom teachers or therapists accustomed to skills training approaches. Second, these conversations encourage others with influential roles in the participants' lives to envision behavior in terms of psychological and developmental influences. As demonstrated by the program conducted by Malberg et al., shifting the response to challenging behaviors towards a reflective/mentalizing orientation instead of a punitive/compliance orientation is vital to healthy development.

The Format of a Session

Starting the Session

With the exception of the first group, where much of the session is dedicated to establishing the groups structure and making clear the expectations for group participation, each group session begins with a brief check-in. In the spirit of drama and playfulness, I suggest using an activity that involves movement. An activity I often use is to invite each participant to either make a movement or take a posture that is representative of how they are feeling in the moment. The remaining group members are then asked to mirror that posture or movement. As with the cohesion activities described above, a check-in activity facilitates conscious identification of affective components of mentalizing (Bateman & Fonagy, 2004). By doing so, this activity sets the tone for the work to come.

Following the check-in, the previous session should be reviewed by the group leaders.

Karterud (2016) referred to this part of the group with the slogan "*the therapist is minding the group*" (p.48). It is the therapist's job to ensure continuity and remind the group of shared goals by highlighting salient themes and content from the previous session. Karterud proposed that reviewing the previous session, and mentioning each participants contribution by name, improves group cohesion, encourages a sense of belonging, and reminds participants of the group's purpose. In addition, by focusing on emotional processes when minding the group, the therapist is modeling mentalizing by approaching affective experiences with curiosity and reflection.

Dramatic Play

For the purposes of the intervention proposed here, the goal is somewhat narrower and more clearly defined than in other approaches to drama therapy. With the stated aim of increasing the ability to mentalize through a shift from pretend mode functioning to a mentalizing stance, the primary focus of dramatic play activities is to work with emotion and create events that can be mentalized as a group. Our goal in this group is not increased insight into past events influencing present experience; it is an increased ability to think about thinking in an interpersonal context. The goal of treatment influences the ways in which dramatic play and its processing is approached.

Working with Pretend Mode. In adults, reverting to a pretend mode of functioning can occur under stressful circumstances. When this occurs in therapy, the therapist seeks to re-couple psychic and external reality, often through bringing attention to the here-and-now. With school age children, where mentalizing is a newly attained developmental achievement, shifts between different modes of functioning are common and developmentally appropriate. Part of the therapist's role is continually assessing when the child has reentered pretend mode and has lost

the capacity to mentalize (Midgley et al., 2017; Muller & Midgley, 2020). The therapist's goal in mentalizing-based treatment with children is to expand upon the child's developing capacity to maintain mentalizing under stressful and emotionally salient moments. When working with preadolescent children, the therapist is likely to see a range of mentalizing, as participants will be at varying developmental stages. It is generally clear early on in treatment which group members have a relatively advanced ability to maintain a mentalizing stance even while engaging in emotionally charged dramatic acting activities. The degree to which participants are able to maintain mentalizing is influenced by the content of the scenes being played out. Some group participants are likely to deteriorate if themes addressed in the dramatic play are closely related to their real lives. These participants are likely to insist on a high degree of fantasy in the play in order to maintain a clear distinction from their lives outside of therapy. It is these children who are most sensitive to regressing to pretend mode.

Challenging Pretend Mode. When speaking about working with children who seem stuck in pretend mode, Muller and Midgely (2020) provide a case example in which the therapist invites the client to reconnect with the body "as a way of bringing (the client) back in touch with something more real" (p. 5). Bringing attention to the body to teach awareness of emotions and connect the dramatic play with emotional experience is an important component of the proposed intervention. In addition to the body focused warm up exercise employed at the start of each session, it is important to use body awareness when participants seem to have lost sight of the purpose of group participation and have regressed to pretend mode functioning.

While this drama intervention relies on play as a medium with which therapeutic growth can occur, it is necessary for the therapist to differentiate between pretend mode play and healthy play. Muller and Midgley (2020), point out that pretend mode play is often rigid, humorless, and

lacking in emotional resonance. In my experience doing drama activities with school-aged children, it also tends to become chaotically giddy. The child is no longer able to reflect on their own, the characters, or their co-actors' experiences.

Dramatic Reality and Distancing. A useful concept in drama therapy is that of dramatic reality (Berger, 2019; Pendzik, 2006). "Dramatic reality involves a departure from ordinary life into a world that is both actual and hypothetical" (Pendzik, 2006, p. 272). It is not pretend play, in the sense of pretend mode, but it is step removed from reality. It is a space to experiment with new emotional states and ways of thinking. This group intervention uses dramatic reality as a place to take on roles that participants might not take on in real life. It is the therapist job to use dramatic roles to control the degree of distancing (Landy, 1983, 1994). Landy (1983), in discussion of the work of Scheff (1981), outlines various ways the therapist can modulate distance. The therapist can center dramatic scenes on

> present time events vs. past time events; fictional or fantasy events vs. reality events; a rapid reviewing of past events vs. a detailed recollection of the past; and the enactment of positive emotions vs. the enactment of negative or unpleasant ones." (Landy, 1983, p. 178)

The therapist should gradually, over the course of therapy, narrow the distance between the content of dramatic scenes and the actual interpersonal struggles participants experience in their lives. I will generally choose drama activities early in therapy that are comfortably distanced from real life. For example, I often use fables that the group members are familiar with early in treatment. These fables (e.g., The Tortoise and the Hare, The Lion and the Mouse) provide interpersonal events which can then be explored from a mentalizing perspective. This entails the therapist inviting discussion of both the feelings and thoughts of the imaginary roles, and the

thoughts and feelings of the actors. Through these discussions, participants practice using their minds to make sense of mental states (Bateman & Fonagy, 2006). Later in therapy, I will prepare scenes which have some semblance to the real lives of participants, but are not *their* lives, and therefore are more easily discussed without defensiveness. Towards the end of the course of therapy, when group members are familiar with the process of our work and have demonstrated some improvement in their ability to mentalize, I will have participants write scenes based on real-life events.

Processing

The processing portion of each session most closely mirrors adult group therapy. Participants sit in a circle and discuss what occurred during the dramatic play portion of the session. During the first few sessions with a new group it is often helpful to review the expectations in order to provide structure for group members. Processing usually lasts approximately 30 minutes. Within preadolescence, there is a range of ages and maturity levels which will impact the amount of time the group can continue to process effectively without losing focus. For some groups, 30 minutes may feel too long a time period, and with groups that seem to have a more developed mentalizing process, the time may need to be extended in order to give all group members an opportunity to share.

Karterud (2016) advised encouraging turn taking. A typical psychodynamic group format which would eschew turn taking so the interpersonal functioning of group members had an opportunity to arise in the group dynamic. For example, in a psychodynamic group it can be helpful to see who speaks excessively and who attempts to disappear. According to Karterud (2016), in MBT-G, turn taking allows for a more in depth examination of interpersonal events as it prevents group members from taking over the discussion. In MBT-G the person who brings up

an event has ownership over it, and the focus remains on that individual until the experience has been worked through. Working through the experience through the lens of mentalizing means both focusing the client's attention on their state of mind and putting forth the therapist own observations about the mental state of the client. According to Bateman and Fonagy (2006) this entails "a joint process of contrasting states of mind, taking interest in detail, puzzling over difference and nuance, and thereby maintaining the mentalizing focus" (p. 234).

As with MBT-G groups, I have found that turn taking is of particular importance when working with children. In addition to providing structure, it ensures that each child will be heard, and the group will not be dominated by one or two members. Turn taking also provides structure and scaffolding by encouraging participants to inhibit impulsive responding. As with adult groups, turn taking should not be rigid. It is not necessary for each participant to speak an equal amount at each session, but the group leader should be sure to give each group member an opportunity to share if desired.

Karterud (2016) highlighted the importance of working on discrete events in MBT-G. It is important that the events explored in MBT-G have a protagonist, the one telling the story, and the story has a beginning, middle, and end. That is not to say that for the purposes of MBT-G all participants must be skilled storytellers, but simply that they are expected to share events that can be worked with through a mentalizing lens. A participant might state that they have felt anxious all week; however, from the MBT-G perspective, this would not qualify as an event because it does not provide interpersonal material that can be examined for moments of successful and unsuccessful mentalizing.

In the drama intervention proposed here, interpersonal events are initially provided by the scenes acted out by the group. Participants may speak about the experience of the character, or

their own experiences acting in that role. Distancing is relevant here as the group leader will notice that some participants are more or less comfortable speaking about their own experiences versus those of their character. Gradually over the course of group the therapist should encourage a shift towards more discussion about the experiences of the participants when taking on different roles. Often group members will bring in material from their own lives that they have associated to the content of the dramatic play. This is rare during early sessions of the group, when the content of scenes is limited to fantasy and fables. However, later in therapy, when it is clear that participants understand the work of the group and are demonstrating mentalizing during sessions, the introduction of life events should be encouraged.

As with MBT-G, interpersonal events are also drawn from the here-and-now interactions in the group. In my experience running drama-based groups in the past, I have found that some of the richest explorations of mentalizing have come from asking group members what made the activity go well and what made it challenging. When introducing here-and-now conversations with children, it is important to tread lightly as these conversations have the potential of devolving into accusations between group members. However, successful here-and-now conversation creates the opportunity for group members to explore the emotions evoked by various roles and discuss what may be making it difficult to participate in the work of the group.

Discussion

Limitations and Future Directions

The state of research in the field of mentalization and its clinical applications is still in its infancy. Mentalization remains a broad concept, likely with many component parts. As mentalization is better understood, it is likely that the cognitive and emotional components needed for effective mentalization will be better understood and explicated. As we gain a deeper

understanding of the many components of mentalization we are likely to learn that different approaches to therapy improve different aspects of mentalizing (Choi-Kain & Gunderson, 2008). This may lead to better assessment tools, which allow us to make sense of the type of deficits our clients are experiencing, and the type of treatment that will be of most value. The intervention proposal presented here will shift as our understanding of the role of mentalizing in the therapeutic change process is better understood.

Next steps in further refining this proposal will include creating a more structured and detailed outline of what the intervention entails. Such an outline will differentiate the intervention from other drama-based and mentalizing treatments, and will provide clinicians with a clear guide to its implementation. In addition, putting this intervention to the test by conducting both qualitative and quantitative research will better clarify the process of change and determine its effectiveness. Using a case study approach, the treatment intervention proposed here can be tried in real life circumstances, and further hypotheses about the effects of this drama-based intervention on the development of mentalizing can be generated. The intervention can be refined accordingly. In addition, preliminary quantitative research using empirically validated measures of mentalization can provide data on whether this intervention effects mentalizing ability, and to what extent.

This intervention should be viewed as a work in progress. It is my best effort to pair two approaches to mental health treatment, MBT and drama therapy. The literature in both of these fields is rich, and there is always more to learn which can add to the completeness of this intervention's design. As a doctoral student, my experiences running groups and working with mentalization and drama in therapy have been limited. As I continue my career as a psychologist, deepening my knowledge of both theory and practice, I have no doubt that the manner in which I

implement this intervention will become more nuanced and better informed. Further, as research in mentalizing treatments with children continue to expand, I am sure to gain insights which will inform the approach proposed here. Despite these limitations, I believe the techniques and theory of mentalization and the engaging techniques of the drama therapists complement each other well. Continuing to refine this intervention will provide a powerful tool for mental health practitioners seeking a creative approach grounded in the science of infant development, attachment, and affective neuroscience.

Researcher Reflections

While I believe in the therapeutic value of drama-inspired techniques to bring about therapeutic change, I am not a drama therapist, nor have I received formal theatre training. I have drawn on literature from the field of drama therapy to design the proposed intervention; however, the majority of my research and theoretical grounding comes from mentalization and the theories on which it is based. In the course of writing this dissertation, my limited experience and training with drama became evident, and I came to appreciate the rich history and theorizing in this field. Working on this dissertation highlighted the many points of similarity between psychodynamic and drama-based approaches to therapy. Many of the similarities are born out of the shared prizing of emotion over cognition in understanding the way people grow and change. Having completed this dissertation, it is evident to me that taking on roles in one form or another, is implicit in most approaches to therapy, and the concepts from the field of drama therapy can be helpful to clinicians across theoretical orientations. As therapists, we are constantly inviting our clients to consider new ways of being in the world. We ask them to play in fantasy, to try on roles, and to consider different ways of thinking every time we suggest an alternative view of some life event.

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