Psychotherapy with children and early adolescents from a mentalization perspective

Mémoire Doctoral

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Résumé

Un faible nombre d'études portant spécifiquement sur des interventions basées sur la mentalisation pour les enfants et les adolescents sont actuellement disponibles. Cependant, plusieurs études appuient l'idée qu'un large éventail de psychopathologies sévères chez les enfants et les adolescents est lié à une faible capacité à mentaliser. Cette étude pilote vise donc à identifier, à classer et à conceptualiser les interventions fondées sur la mentalisation et utilisées en thérapie par deux thérapeutes expérimentés. Un enfant et un adolescent ont été suivis au cours de leur première année de psychothérapie afin d'obtenir des informations sur ce type d'interventions. Un total de vingt-huit séances de thérapie ont été sélectionnées et codifiées. Cet étude qualitative inductive/déductive a permis d'identifier vingt-trois techniques de mentalisation utilisées en thérapie. Sept techniques font référence à des catégories déjà préétablies alors que dix-sept techniques ont nouvellement émergé du processus de codification. Par ailleurs, un cadre conceptuel a été élaboré afin d'organiser de manière cohérente toutes les interventions basées sur la mentalisation. Une des principales contributions de cette étude pilote fut l'identification et la description de sept nouvelles techniques ayant émergé de la codification et qui sont utilisées dans la thérapie par le jeu. Nos résultats ont montré que dans cette forme de thérapie, le thérapeute utilise un vaste répertoire d'interventions basées sur la mentalisation. En somme, cette étude vise à enrichir le cadre théorique et pratique des traitements basés sur la mentalisation chez les enfants et les adolescents avec des nouvelles données empiriques.

Abstract

Little has been written about mentalization based interventions in adolescents and children in clinical settings. However, several studies have found that a significant number of the most severe child and adolescent pathologies are related with an inadequate capacity to mentalize. The present pilot study, aimed to identify, categorize and conceptualize the mentalization-based interventions used by two experienced therapists. One child and one adolescent were followed up during the first year of psychotherapy to obtain this explicit information. A total of twenty eight therapy session were selected and coded. This qualitative, inductive/deductive study identified twenty four mentalization based techniques used during therapy. Seven techniques were pre-established categories, and seventeen new techniques emerged from the coding process. In addition, based on the coding process, a conceptual framework was developed and used to coherently organize all observed mentalization based interventions. One of the major findings of this pilot study were eight emerging techniques which described mentalization based interventions used in play therapy.

Even though little literature is currently available on this subject, our findings have shown that in play therapy our therapist utilized an extensive range of mentalization based interventions. This study is an important step, since it contributes to enrich the theoretical and practical MBT framework for children and adolescents, with new empirical based evidence.

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Acknowledgments

Life is a journey with plenty different paths that you take in several direction trying to reach your own destination… but I still continue to ask myself… where my final destination is… what the final destination is … what does it mean?

Today I am writing the final chapter of my “Mémoire Doctorale” and I feel I am reaching one final destination. However, it is easy to say it, when the mountain is on your back, when all those days of incertitude, happiness, pain, hope and struggle are over you. It is easy to forget who was behind of you, in front of you, beside you… particularly, when you were climbing up.

This is the reason I want to take a deep breath… and stay on the summit enjoying the spectacular view, sensing the cool wind on my face, observing the clouds in the sky, but must of all, contemplating the long journey that I have just made…

Remembering all special people that I have just crossed. Those ones that were there on the heavy raining days, when the sky was dark, when there was no path… those days where I was hanging on a cliff. Natalia you were there… nearby … sitting behind and beside me… illuminating my days and my nights… thank you my sweetheart… thank you…

You, but other as well… all my closest friends were there, passing by, coming back, carrying me for a while, laughing at my tiny blisters on my toes and giving me, each in their own way, the courage to follow my journey. Thank you… all of you.

Of course my parents were there, proud and impressed, supporting and trying to understand the complicated route and the countless detours that we psychologist take to reach the next corner. However, I have to admit, that their own desire to explore and take risks in life, is a source of inspiration and motivates me to explore and be part of new adventures… Thank you… Papá, Mama… Gracias… Danke…

Furthermore, having a mentor for this long journey was essential. My advisor was there, being sensible and understanding the importance of supporting my deep desires to be creative and to work on something that actually meant something to me. Karin thank you for letting me spread my wings and fly.

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One final word about all volunteers that were involved in this crazy journey… without their dedicated work, there would be …. literally no trek to walk… thank you.

So… After taking this deep, deep breath… It is time to walk down and choose the next route I am going to take…

I think what I choose is just to walk … Is by taking the risk to get lost that we cross the ones we love and inspire us… is by walking that we experience what it feels to be alive… is by walking that we can feel the warm sunshine, is by walking that we can sense the breeze and is by walking that we can contemplate the stars in the sky…

1. Introduction

Mentalizing as conceptualized by Fonagy and colleagues (Fonagy, Gergely, Jurist, & Target, 2002) can be understood as an imaginative mental activity involved in understanding the behaviors of others in terms of their internal subjective motivations, and seeing oneself and the impact of one's behaviors from the outside. Mentalizing, though falling under the general rubric of social-cognition, and overlapping with concepts like Theory of Mind and emotional understanding, is considered specifically relevant in the context of close attachment relationships where a more nuanced understanding of others, oneself and the impact of one's behaviors on others is likely particularly important for adaptive functioning. Among psychotherapists, there is a rapidly growing interest in mentalization-based treatments (MBT), but also in thinking about how psychotherapy generally, regardless of orientation, addresses and facilitates the capacity to mentalize.

In recent years there has been a proliferation of MBT adaptations for a range of adult psychological difficulties and there is evidence of the efficacy of MBT for adults and adolescents with borderline personality disorders (Bateman & Fonagy, 2012; Fonagy et al., 2014). Furthermore, studies that have attempted to explore mechanisms of change have produced preliminary evidence that both MBT and psychodynamic therapy facilitate mentalizing, which may help to explain the observed improvements in symptoms and personality functioning. For example, there is evidence that MBT for parents with substance dependence develop mentalizing about themselves and their relationships with their children (Suchman, DeCoste, Leigh, & Borelli, 2010) and that psychodynamic treatments, like transference-focused psychotherapy, improves mentalizing about past attachment relationships (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). Although causal links are hard to establish, Allen, Fonagy and Bateman, (2008) suggest that enhancing mentalizing may be a common process factor inherent to all effective treatments. Further empirical investigation is needed, but there is preliminary evidence that promoting mentalizing may be a common feature of both psychodynamic and cognitive behavioral child treatments (Goodman, Midgley, & Schneider, 2015) as well as MBT and play therapy (Goodman, Reed, & Athey-Lloyd, 2015). Furthermore, expanding

evidence regarding the relationship between child and adult psychopathology, social cognition and mentalizing has contributed to the development of cognitive behavioral therapies aimed for example at facilitating emotional understanding in the context of anxiety disorders (Southam-Gerow & Kendall, 2000) or limiting rumination in the context of depression (Hankin, Wetter, Cheely, & Oppenheimer, 2008).

Relative to research on MBT with adults, research on mentalization-based interventions for adolescents and especially children is lagging behind, despite research showing that child and adolescent psychopathology may be associated with difficulties in mentalizing specifically (Ensink, Bégin, Normandin, & Fonagy, 2016; Sharp, Croudace, & Goodyer, 2007; Taubner & Curth, 2013) and social-cognitive deficits more generally. From a developmental perspective, there is evidence that social-cognitive capacities such as Theory of Mind (ToM), emotional understanding, as well as mentalization, develop in the context of attachment relationships with adults interested in their subjective experience, who treat them as someone with a mind, and where they have the opportunity to learn about their own minds and those of others through conversations where mental states and emotional experience is talked about and explained. While there is evidence that even very young children are sensitive to the reactions of others, the ability to articulate their own feelings and consider the internal motivations behind the behaviors of others emerge more slowly as language skills develop (Fonagy & Target, 2000). There is evidence that around the age of eight mentalization takes on a more adult character and children begin to be able to think about themselves, and their relationships with attachment figures (Ensink, Normandin, Target, Fonagy, Sabourin & Berthelot, 2015; Wellman & Lagattuta, 2000).

Some children may have few opportunities to develop mentalizing capacities either because their parents themselves may have difficulties mentalizing, or may not be able because of other difficulties to engage with their children in ways that will help them develop these capacities. As a result some children may experience pervasive mentalization deficits. Subsequently, failures in mentalizing appear to increase vulnerability to developing depressive symptoms and externalizing behavior difficulties

(Ensink, et al., 2016). Alternatively, children who face challenging life events or who have particularly difficult temperaments involving sensitivity and aggressive emotional reactivity, likely require additional help to develop a capacity to mentalize that could enable them to integrate these temperamental factors. For example, mentalization regarding trauma appears to be particularly important for the adaptive functioning for individuals who have experienced childhood abuse and neglect (Berthelot et al., 2015; Ensink et al., 2015). In sum, this emerging evidence is consistent with clinical observations that many children and adolescents need help from therapists to develop mentalization and socio-cognitive capacities.

Since the 1980's Peter Fonagy started elaborating a developmental model where psychopathology is linked to failures in the developing understanding of minds, emotions and others, from infancy onwards (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Subsequently he observed that psychotherapy with children included a dimension of what Anna Freud referred to as development help (Midgley, 2012), a form of psychological support around psychological reactions, much like a good parent might think about the child's reactions and explain by placing this in the context of common human reactions to certain emotion eliciting interpersonal events or intrapersonal conflicts. This type of focus is also present in other psychotherapy approaches, notably Paulina Kernberg's adaptation of the object-relations approach. In addition, child therapy may enhance reflective processes through opportunities to play and through work in the transference (Fonagy & Target, 2000).

Subsequently, Ensink and Normandin (2011) elaborated a mentalization based therapy for sexually abused children and Zevalkink, Verheugt-Pleiter and Fonagy (2012) reinterpreted psychoanalytic psychotherapy from a mentalization perspective. Furthermore, a recent qualitative study using the Child Psychotherapy Q-Set suggests that MBT and psychodynamic play therapy approaches share key features (Goodman et al., 2015). Given that play is a precursor of mentalization (Fonagy & Target, 1996), play therapy may be particularly important for facilitating mentalizing, Fonagy (2000) suggest that the therapist can facilitate mentalizing by commenting on the mental content of the

play characters, the child's behavior or play. The therapist can identify mental states underlying the child's behavior or play, or verbalize the wishes or intentions of the play characters, significant others in the child's life, such as parents, or reflect on the uniqueness of the child's mental world. However, whereas the focus of play therapy is to help the child elaborate their subjective experience and restore healthy self development, and enhancing mentalization may be a by-product, while in MBT the focus may be more explicitly on the latter.

To date there have been few studies that have focused explicitly on identifying techniques used by child therapists that address mentalization. Identifying techniques aimed at developing the capacity to mentalize in child psychotherapy - whether the treatment is mentalization based, cognitive behavioral or psychodynamic - is an important first step to eventually being able to compare the use of such techniques across different kinds of therapies and examine which techniques appear to be the most effective for different types of problems. The aim of this pilot study was therefore to identify, categorize and conceptualize the interventions aimed at promoting mentalization used by psychodynamic child psychotherapists working with children and early adolescents (aged 8-13 years old) using an integration of mentalization based (Ensink & Normandin, 2011) and object relations (Kernberg, Weiner, & Bardenstein, 2000) clinical approaches.

2. Theoretical framework

2.1. What is mentalization and how we develop this capacity

Bateman and Fonagy, (2012) affirm that mentalization is a form of social cognition that enables us to perceive and interpret human behavior in terms of intentional mental states (needs, desires, beliefs, goals, purposes, and reasons). The failure of mentalization is marked by a tendency to misread minds, one's own and those of others: "Individuals with this difficulty perform dramatically badly in social context, not only upsetting people whom they wish to befriend but also showing deficit in social problem solving" (Bateman & Fonagy, 2012, p. 10). When mentalization fails, non mentalized modes of organized subjectivity emerge, disorganizing interpersonal relationships and destroying the coherence of the experience of self. Therefore, for several authors a key developmental question is how children's mentalization capacities develop. It is a vital question, since this process underpins how an individual comes to understand the feelings and intentions of others, as well as themselves, and how that understanding is integrated over the course of development into their feelings for and expectations of others (Ensink & Mayes, 2010).

Based on the research of Wellman and Bartsch (1988), we can say that conceptual thinking emerges at around age 4. However, it starts with a basic mentalization capacity of understanding of desires at 2 years of age, followed by references to thinking at 3 years of age This leads to a belief-desire understanding that emerges progressively until it is established at the age of 4. In this way, children learn from their parents to attribute mental states to themselves and to others, and also that others have similar feelings and thoughts (Ensink & Mayes, 2010). However, data collected by Wellman and Lagattuta, (2002) indicates that it is only during the primary school years that children develop a more general ability to know when others are thinking, as well as imagine what could be their mental states. At the end of the primary school period, children develop a more complex understanding of the behavior and thoughts of others as individuals, based on personal characteristics that are stable over time, like knowledge, experience, tastes, and personalities. At the same time, children who start to be able to understand others in terms of mental states are also beginning to display the capacity to talk about their own thoughts

and, increasingly, to think about them in terms of mental states (Wellman & Lagattuta, 2002).

Finally, Ensink and Mayes (2010) published findings indicating that children's capacity to think about themselves and others in terms of mental states is starting to be well established at the aged of 8 and continues to develop until the age of 12, where the main developmental milestones of mentalization are consolidated. These results coincide with the greater capacity for abstraction and symbolization that children start to acquire at this age.

After this stage of consolidation, the child is prepared to enter a new period where he will face new developmental challenges (adolescence) and where he will have to use his newly acquired capacity to mentalize. However, when children struggle to develop their mentalization capacity they will be less able to withstand the developmental challenge of adolescence, and will be more vulnerable to develop mental health disorders. Bateman and Fonagy (2012) argue that the most severe pathologies are related with an inadequate capacity to mentalize. Some of these children and adolescents may function too much in the psychic equivalent mode, whereas others function mainly in the pretend mode, and some operate alternately in one or the other of these modes without being able to integrate them. Often, these children and adolescents have suffered for too long while developing complex mental health problems and are deeply invested in using nonmentalizing strategies to relief the psychological pain caused by the mental health disorder. These children and adolescents may benefit from a longer term approach like the Mentalization Based treatment (MBT) or other psychotherapeutic approach that enhance the mentalization capacity (Bateman & Fonagy, 2012; Verheugt-Pleiter & Zevalkink, 2008).

2.2. What is Mentalization-Based Treatment (MBT)

MBT simultaneously stimulates the patient's attachment and involvement with treatment and helps him to maintain mentalization: "A more or less exclusive focus on the patient's current mental state while activating the attachment relationship is expected to enhance

the patient's mentalizing capacities without generating iatrogenic effects as it inevitably activates the attachment system" (Bateman & Fonagy, 2012, p. 39).

MBT aims to maximize the patient's ability to consider thoughts and feelings in different contexts. But to achieve this Bateman and Fonagy, (2012) affirms that the therapist has to; intervene in a simple and easy way, - be affect focused, - actively engage the patient, be focused on the patient's mind rather than on his behavior, and make use of the therapist's mind as a model (i.e by talking to the patient about how the therapist anticipates that he or she might react in the situation being discussed). In addition, it is very important that the therapist is able to adjust complexity and emotional intensity in the interventions based on the intensity of the patient's emotional arousal. For Bateman and Fonagy, (2012) the key aim of this therapy is to promote curiosity about the way mental states motivate and explain the actions of self and others. Therapists can achieve this through a systematically attitude of curiosity and questioning what the patients says: "Highlighting their own interest in the mental states underpinning behavior, qualifying their own understanding and inferences, and showing how such information can help the patient to make sense of his experience" (Bateman & Fonagy, 2012, p. 40). However, MBT for children and early adolescents has to consider some special issues, as they traverse important developmental milestones. Therefore, one of the main objectives of MBT for children and adolescents is to facilitate the emergence of a coherent self. The aim is that at the end of therapy they are able to manifest a sense of internal coherence, self-organization and affect-regulation by the capacity to tell coherent autobiographical stories, and by the ability to mentalize and ensure the capacity to postpone, modulate and regulate emotional reactions. In summary, the overall objective is to enable the child and adolescent to mentalize and ensure that he is capable of interpretative self-regulation (Bateman & Fonagy, 2012; Verheugt-Pleiter & Zevalkink, 2008).

2.2.1. Framework of our psychotherapy approach

The psychotherapeutic approach of our treatment unit for children and adolescents at the *Psychology Consultation Service Center - Laval University*, is based on an integration of a mentalization approach (Ensink & Normandin, 2011) and contemporary psychoanalytic

object relations theory as developed by Otto Kernberg (2006; 1993) and Paulina Kernberg et al., (2000). Both are modern psychodynamic approaches that are largely overlapping at both a theoretical and clinical level. The aim of the therapeutic process is to help the child and adolescent to gain better behavioral control, increase affect regulation, develop more intimate and gratifying relationships with family, peers, or close friends, and engage in a productive life as well as investing in school and future goals (Normandin, Ensink, Yeomans, & Kernberg, 2014). The fundamental premise of the Kernberg approach is that psychodynamic treatment has to contribute to the development of integrated representations of self and others, which closely links up with Fonagy's notion that the aim of therapy is to increase mentalization about self and other. Kernberg adds to this the modification of primitive defensive operations, the resolution of identity issues that participates in the fragmentation of the patient's internal world, and recognizing and facilitating every attempt made by the child and the adolescent to face normal developmental challenges. However these can be seen from Fonagy's perspective as a result that would follow naturally from increasing mentalization.

Essentially, a number of mentalization-base interventions have been integrated into the contemporary psychoanalytic object relations approach used in daily therapy practice. This MBT adaptation is based on vast empirical data relating to psychodynamic and cognitive-behavior treatments, as well as on research and theory of attachment, effects of trauma, dissociation, constitution and developmental psychopathology. More precisely, our strategies and therapeutic interventions are based on developmental psychopathology and the development of the socio emotional understanding of children and adolescents (Ensink & Normandin, 2011). The role of the therapist is to ease the mentalization process since the main objective of therapy is to develop the capacity of the child and adolescent to think, in terms of mental states, about itself, his emotional reactions, his relationships and the stressful and traumatic experiences. Ensink and Normandin (2011) affirm, that this role resembles that of a mother who has good capacity to show interest in the internal world and mind of his child (mind-mindedness), but with the difference that the objective is to use the precious time of therapy to help the child to develop his capacities to mentalize: "The therapist takes up this challenge following very closely the experience of

the child in the immediacy of what he speaks in session or of what he stages in his game, or in the way he behaves with the therapist" (Ensink & Normandin, 2011, p. 418). Through this process, we give the child and adolescent the basic tools to develop his own skills of mentalization. However, Ensink and Normandin (2011) emphasize that this approach is flexible and also integrates the parent –child therapy and psychoeducation.

Furthermore, after describing the fundamental premises of our psychodynamic treatment, it is important to specify that, even though the treatment framework is the same, children and adolescents are treated with two main different techniques. Children receive a psychodynamic play therapy treatment while adolescents receive the dialectical psychodynamic therapy.

2.2.2. Play Therapy for children

This psychodynamic play therapy is delivered in individual sessions ideally once a week, in a playroom where the child can be introduced to the play situation. This play therapy is nondirective thus the therapist makes little effort to control or guide the child's behavior.

Basic techniques and strategies of this modality can be described as; introducing the child to the play situation, allowing him a chance to explore it as he wishes, and talking while playing. In time, the child will develop a routine of activity, whether to start with a drama play, which he might continue from session to session, building Lego pieces, whatever. The therapist will elaborate on the play throughout, picking up themes to query and deepen, or he/she may choose to remain silent, depending on the child's reactions to the interpretation (O'Connor & Braverman, 2009). Indeed, the therapist role is to actively reflect the child's thoughts and feelings, believing that when a child's feeling is expressed, identified and accepted, the child can accept them and then is free to deal with this feeling (Landreth, 2012).

2.2.3. Psychodynamic psychotherapy for adolescents

Our psychodynamic treatment for adolescents is delivered in individual sessions ideally once or twice a week but not less than one. Four main intervention techniques are used:

interpretation, transference analysis, technical neutrality, and countertransference analysis. These treatment techniques are the therapist's tools to address what is happening in the here and now with the aim to accomplish the overall strategy of integration (Normandin et al., 2014). Furthermore, this treatment addresses emotional regulation, mentalization, but also the capacity to support normal development while addressing and changing the path of personality development through addressing extreme affects and split-off self and object representations: "The effective integration of the adolescent's self-concept and his concept of significant others, that is, the development of a normal ego identity corresponding to a normal adolescent developmental stage, will facilitate the adolescent's resumption of normal psychological growth" (Normandin et al. 2014, p. 353). Indeed, this psychotherapy aims to establish the adolescent's internal freedom to enrich his internal experience and develop creative relationships in school, work, love, friendship family, and social life (Normandin et al., 2014).

2.3. Developmental milestones in middle childhood and early adolescence

2.3.1. Middle childhood Period

Middle childhood (4-12 year-old) has been described as the latency period: "Latency refers to the subsiding of the turbulent passion of the oedipal phase and the dormant period of those passions. The implied process of disengagement from parents is called the cathexis" (Bateman & Fonagy, 2012, p. 131). The ability to successfully accomplish this period depends to some extent on the possibility to be able to explore freely and creatively the social world that is beginning to open up to the child beyond his or her primary caregivers. It's the chance to engage the world playfully and diligently, learning new skills and amassing information. However, for a child who is under constant physical threat, this exploration could be loaded with intense anxieties. Such a child may use rigid patterns of defense to control anxiety, which may make the child appear timid, scared, aggressive or obsessional (Bateman & Fonagy, 2012).

When the child starts to explore the world beyond his parents this does not mean that the importance of the relationship with them will be reduced. What changes, is the quality of the child's relationship with the primary caregivers. Bowlby (1982) explains that during this stage the specific attachment behavior to the attachment figures (e.g., crying) starts to decline and instead the attachment behavior begin to be determinate by a wider range of conditions. At this stage the child starts to have access to a mental representation of the caregivers that changes the goal of the attachment system, rather than searching only a physical proximity, the infant realizes that even if the caregiver leaves (e.g., to work, a travel etc) they will return. Therefore, the attachment goal begins be more focused on; open communication; parent responsiveness to the child's needs, and potential rather than literal proximity. That means that the child's expectations and beliefs toward the attachment figures becomes a good indicator to measure the quality of attachment (Bateman & Fonagy, 2012).

During middle childhood the child is expected to be less dependent on external figures and to start successfully replacing them by stable and secure internal representations of the attachment figures. Bateman and Fonagy (2012) affirms that: "Individual or episodic experience of self with another aggregates into a higher-order generalization of the way self normally interacts with specific other, which in turn creates a generalized representation of the self" (p. 132). At this stage the concept of mentalization starts to be important. The emerging of the capacity to understand oneself and others as agents in the environment is the first steps to consolidate a coherent self, different of others. Achieving this awareness is one of the main milestones that children in middle childhood have to consolidate and is a good indicator of whether the child is ready to face the next developmental challenge: early adolescence.

2.3.2. Early Adolescence Period

Normandin et al., (2014) affirms that from a neurobiological and socio-emotional perspective, adolescence is considered to be one of the most important, but at the same time vulnerable periods for the development of cognition, especially of higher order thinking, reasoning, problem solving, and risk taking. Over the period of adolescence,

important brain changes take place in the frontal lobe regions that observe reasoning, problem solving, decision making, affect regulation and higher order reasoning (Reyna, Chapman, Dougherty, & Confrey, 2012; Steinberg, 2008).

Kroger (2006) affirms that early adolescence can be defined in terms of both chronological age and psychosocial tasks – the time from 11 to 14 years, during which they are likely to experience many new events: "The biological changes in puberty, the move to more complex ways of thinking, redefining the self within the family, developing new forms of relationships with peers, and adapting to the more complex demands of a junior high or middle school system- all raise important identity consideration for the young adolescent" (Kroger, 2006, p. 32). The reason for using a dual terminology lies in the fact that "puberty" describes the physiological and morphological changes that come with sexual maturation, while the term "adolescence" encompasses the sum total of those psychological changes that are attributable, directly or indirectly, to the onset of puberty (Blos, 1970).

Blos (1970) affirms that when the child is entering early adolescence some of the most significant identity issues are associated with the biological changes of puberty and their reverberation in psychological process and societal expectations and reactions. During this period the child suffers a complex sequence of biological changes whereby he becomes a sexually mature adult, capable of reproducing and assuming the height, weight, body contours, and increased strength and tolerance for physical activity of adulthood (Kroger, 2006). However, it is important to appreciate the interaction among the biological, psychological and societal spheres and how the identity of the adolescent has to be readjusted to integrate all these changes caused by interactions of the different spheres. Kroger (2006) explains that identity-related difficulties during this period are related with the process of multiple simultaneous transitions within different areas of development that will described in section below.

2.3.2..1. Biological Process:

The onset of puberty, generally experienced in early adolescence, is not marked by a sudden eruption of biological change but rather by a steady process of changing hormonal

activity: "This process eventually results in mature reproductive capacity, the development of secondary sex characteristics, and the assumption of adult height and body proportions" (Kroger, 2006, p. 33). This enormous physical transformation of early adolescence has a direct impact on their identity and as a consequence they have to develop a new sense of self that integrates the new body proportions and sex characteristics (Kroger, 2006)

2.3.2..2. Psychological Issues:

This sudden eruption of biological changes is the transition into early adolescence and the beginning of the end of childhood. The relative continuity of middle childhood start to be undermined. Kroger (2006) affirms that the rapidity of body growth as well as increasing of genital maturity brings new questions of identity at the time of early adolescence. It's a new integration process where the young adolescent has to integrate elements from the past (childhood) to the present.

During this period the relationship with peers starts to be an important psychological issue, being accepted or left behind others, is a prevalent concern among many early adolescents. It's a period when the attachment with main caregivers is already established and the new main goal is to succeed in new social spheres where the parents do not have control. Additionally, beginning to differentiate one's parents and significant others is an initial undertaking, that is vital to build his own identity and to achieve new social challenges: "Integrating newfound body changes and sexual desires into a sense of personal identity, different from but related to all previous identification, is a further challenge. And beginning to channel these new capacities into socially available outlets using culturally appropriate forms of expression is yet a further demand required across cultures"(Kroger, 2006, pp. 38–39).

2.3.2..3. Social influences:

Kroger (2006) explains that for young adolescents, social expectations across various social spheres begin to take place. Families, friends, schools, providers of jobs, places of worship, facilities for recreation and community services generally start to have informal

expectations of an early adolescent different to the expectations that they have for children. Tolerance for egocentric modes of reasoning and behaving, without formal responsibilities during middle childhood are gradually replaced with societal expectations of cooperation and coordinating one`s viewpoint and activities with those of other people's: "Institutional and relational responses to an early adolescent`s changing biology, appearance, psychological needs, and cognitive capacities play a vital role in helping to answer the questions of who he is and who he can become in the rapidly approaching world of adult life" (Kroger, 2006, p. 42).

The description of the main milestones that children in middle childhood and early adolescents pass through give us some grounding to understand the relationship between psychopathology and development, but also the type of intervention strategies that therapists can use. However, a short review of the main psychopathologies in middle childhood and early adolescents is indispensable to characterize the subset of children and adolescents who will participate in this study.

2.4. Psychopathology

A growing body of research demonstrates that maltreatment impairs the development of reflective function, thus undermining children's and adolescent's capacity to experience themselves as mindful, self-regulating agents who can relate to other person who they now have minds of their own (Bleiberg, 2001). Schneider-Rosen and Cicchetti, (1991) report that abused children show less capacity to recognize themselves in a mirror- and less positive affect on recognizing their own reflection. Beeghly and Cicchetti, (1994) documented the deficit of maltreated children in using words to describe internal states – and the concrete, context dependent nature of their language. Bleiberg (2001) affirms that those factors of vulnerability can lead the child to replace the reflective function with coercive and non-reflective models. Reaching adolescence they are unable to achieve real competence and effectiveness, intensifying their tendency to omnipotence and coerciveness, and thrusting them into an even more extreme grandiosity and a variety of desperate defensive maneuvers directed at protecting a precarious self-esteem and an illusory sense of control. In contrast, children who had a secure attachment and developed

a good capacity to mentalize are children that in adolescence are able to build an ideal self by selectively using their own memories, fantasies, parental models, and new extra familial objects of their expanding world. They are able to construct an internal ideal that matches their talents and characteristics, and the realities of their physical and social world. They can build a reflective –symbolic mental model of an achievable future, and they can take steps to approximate their ideal, resulting in greater competence, self-esteem, and adaptation (Bleiberg, 2001). In the section below, middle childhood and early adolescent psychopathologies will be separately discussed to provide detailed descriptions of different pathology types found in each developmental stage.

2.4.1. Middle Childhood:

There is a large range of psychopathologies that children can develop during middle childhood, but Bateman and Fonagy (2012) consider that the severest pathologies are related with an inadequate capacity to mentalize. In general, children who have had developmental problems from a very young age may be unable to mentalize in a particular area. However, it seems to be more common in children who have had traumatic experiences or suffered home violence or sexual abuse. There is evidence to suggest that more developmental spheres are disturbed when these traumatic experiences perturb the attachment system: "These children develop disorders that involve entire modes of mental function, so psychic process of fantasy, feeling, thinking, and wishing can be impaired. These children deal with their affect in a primitive manner and make frequent use of projective identification and splitting" (Bateman & Fonagy, 2012, p. 133).

Bateman and Fonagy (2012) explain that exposure to negligence and invalidation in early attachment relationships may lead to disturbed mentalizing capacities in attachment context that discourage a coherent internal discourse concerning mental states. This difficulty to mentalize, and a disorganized attachment in infancy are linked to affect dysregulation and weak capacity to represent internal mental states: "The childhood markers of this vulnerability include oppositional, controlling, coercive behavior toward attachment figures; a hostile or suspicious view of the world; a proneness to outbursts of inappropriate and intense anger; impulsivity; and poor defined sense of self" (Bateman &

Fonagy, 2012, p. 474). Children, who suffered abuse and negligence, are therefore more propitious to enter into the devastating vicious cycle described by Bateman and Fonagy (2012): trauma activates the attachment system and the desire to have proximity, reciprocity, and protection. However, caregivers with low sensibility or who feel overwhelmed by this situation will not be able to response assertively to the demands of the child. This type of ambivalent or disorganized attachment activates intense distress, in both children and their caregivers, and this escalating distress, intensifies the activation of attachment. The result is an impossibility to contain the affects of the then highly distressed child who is both unable to mentalize his internal mental state and understand the cause. Leading to hyper activation of the malfunctioning attachment system, and finally the child reacting to the affects in non-mentalizing manner. As a consequence, some of these children will function too much in the psychic mode, in which the seriousness of the external world is overwhelming for the child, or will function mainly in the pretend mode, in which internal experiences fail to link with external reality. Some may alternate between these modes without being able to integrate them: "feeling at liberty to contemplate any kinds of perspectives in relation to beliefs, desires, and affects but the suddenly experiencing these as physically real and immediately feeling terrorized by the compelling quality of the experience" (Bateman & Fonagy, 2012, p. 135). From a diagnostic standpoint, these children may have a heterogeneous group of symptoms and diagnostics, nevertheless, based on a developmental perspective we can regroup the different psychopathologies by the common developmental problem associated with the mental process of social cognition. Verheugt-Pleiter and Zevalkink (2008) define these children as having a mental process disorder secondary to a maladaptive attachment process, characterized by great difficulty in regulating their anxiety and anger and becoming overwhelmed by internal or external reality.

2.4.2. Early adolescents.

Bateman and Fonagy (2012) state that children reaching adolescence with a disturbed capacity to mentalize in the context of attachment are less able to face the developmental challenges of adolescence. They are less able to integrate their changed body image, to deal with increased sexuality and affective intensity and to manage a greater capacity for

abstraction and symbolization in a self who is being reorganized. They are also challenged by the pressures of increased peer interaction and new social norms. Finally, they have to deal with the psychosocial demands of achieving autonomy and separation, and the assumption of distinct adult roles: “The adolescence is the point at which early developmental difficulties join hands with neurodevelopmental changes, weakening mentalizing and mental pressures that place greater demands on the capacity to represent the self and regulate affect, creating the condition for serious mental disorders”(Bateman & Fonagy, 2012, p. 474).

Numerous authors affirm that young adolescents with these characteristics are at greater risk of developing several features associated with serious mental disorders such as borderline personality disorder (BPD). The new handbook of mentalizing in mental health practice (Bateman & Fonagy, 2012) provides an excellent summary of the main features that adolescents can develop when they suffer serious mental disorders. These six core features will be described below.

The first feature is a vulnerability to dissociation, which is triggered by stress, loss, rejection, or the failure of interactive patterns to “match” the youngster’s state of mind: “These triggers evoke an overwhelming state of hyperarousal, subjective dyscontrol, and a sense of fragmentation that is unbearably painful” (Bateman & Fonagy, 2012, p. 477).

Secondly, they begin to anticipate this vulnerability to dissociation with active defensive effort to dissociate, with a variety of non mentalized strategies that help them to be distracted. Addictive-like patterns such as deliberate self-harm, purging, drug use, promiscuity, or escape into the world of the internet or video games are some of the main defensive strategies.

Thirdly, while these dissociative efforts provide relief and sense of control, they are illusory and only intensify the disconnection between their subjectivity, sense of intentionality and self – directedness: “They find themselves falling into a dark despair, in which their experience resist naming or comprehension and their behavior “happens”

to them, compelled by powerful forces of raw affect to enact rigid patterns of response not amenable to interpretation" (Bateman & Fonagy, 2012, p. 478).

Fourthly, dissociation also compromises access to other people's internal, subjective experiences and leads to an even greater sense of aloneness. Additionally, their mentalization skills are already very disturbed and their capacity to understand others in terms of mental states is very limited. This increases the difficulty to interact with peers and caregivers and augments their feeling of loneliness caused by the dissociation.

Fifthly, aloneness intensifies distress and hyperactivates the attachment system. However, with a disturbed attachment system the adolescent searches for this desired proximity coercively, through physical, nonmentalistic, and manipulative behavior, "matching" responses from others, including parents.

Lastly, coercion, this manipulative behavior leads parents to feel increasingly scared, unable to control the situation, immobilized, and unable to mentalize themselves. As parents become more anxious, enraged, and helpless, they try more desperately to control their children, or in contrast, they accept the manipulative behavior, which reinforces and exacerbates the adolescent's nonmentalistics strategies: "These responses lead to a self-perpetuating and self-reinforcing vicious coercive cycles of nonmentalizing. Such coercive cycles reinforce the adolescents' path to persistent maladjustment" (Bateman & Fonagy, 2012, p. 478).

In summary, adolescents with severe personality disorders fail to construct an ideal self that approximates their talents and opportunities. Bleiberg (2001) affirms that they feel persistent failures, lacking a realistic road map to adulthood. They denigrate their parents for their inability to live up to ideal standards, yet they cannot truly separate from them because they are convinced that their family will collapse if they do. They enviously watch their peers move on, propelled by a passion and a search for love and intimacy. But closeness only brings anxiety, leaving these adolescents feeling worn out and tired, longing to get away, or choked by dependency: "In the end, the crowning achievement of adolescence, the capacity of love and intimacy, eludes their grasp" (Bleiberg, 2001, p. 74).

To conclude this section, it is important to understand the complexity of mentalization problems, which are reflected differently in each psychopathology. Our conception is based on a taxonomy used by Midgley and Vrouva (2013), which allows the regrouping of mentalization problems in different categories. For example: no mentalizing, under mentalizing, hyper mentalizing, pseudo mentalizing and distorted mentalizing. The collective research discussed in this section clearly establishes mentalizing as an important issue to be targeted in treatment, thereby providing a clear justification for the treatment approach described in this document.

Secondly, it illuminates how different aspects of mentalizing are reflected in the heterogeneity of child and early adolescents disorders: "Mentalizing is not all of one piece, but represent an uneven distribution of capacities depending of three factors: the developmental phase of the child and adolescent; the characteristics of the disorder; and the particular mentalizing capacity being studied" (Midgley & Vrouva, 2013, p. 46).

Children and early adolescents with disturbed attachment systems, low capacity to mentalize, and a poor defined sense of self can develop serious mental disorders leading to long periods of intense suffering. It is therefore important to consider the prevalence of mental health problems in children and adolescents, the consequences of this prevalence and the reasons that justify an early intervention.

2.5. Prevalence and early intervention

In the United States, mental illness is now the leading cause of disability for all persons 5 years of age and older (Bratton, Ray, Rhine, & Jones, 2005). The American Surgeon General's report (US Department of Health and Human Services [HSS], 2000) on mental health described the shortage of appropriate services for children as a major health crisis and estimated that, although at least 1 in 10 of all children suffer from emotional and behavioral problems severe enough to impair normal functioning, less than half receive any treatment. Furthermore, in England Scott, Knapp, Henderson, and Maughan (2001) conducted a follow up study of antisocial children into adulthood to find out the financial cost of social exclusion. They found that by age 28, costs for individuals with a conduct

disorder were 10 times higher than for those with no problems and 3.5 times higher than for those with conduct problems. Concluding therefore that antisocial behavior in childhood is a major predictor of how much an individual will cost society. They also affirm that few agencies contribute to prevention, which could be cost effective. Despite this recommendation and the seriousness of the metal health crisis, recent evidence compiled by the World Health Organization (WHO, 2002) indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent internationally, to become one of the five most common causes of morbidity, mortality, and disability among children: “These childhood mental disorders impose enormous burdens and can have intergenerational consequences. They reduce the quality of children’s lives and diminish their productivity later in life. No other illnesses damage so many children so seriously” (Hoagwood & Olin, 2002, p. 1). It is important to indicate that several reviews of research have consistently concluded that child therapy is effective. Moreover, the magnitude of this effect, when treatment is compared to no treatment, is significant. Thus, children who receive therapy are much better off than are those who do not (Kazdin, 2002). Therefore, identifying proven interventions that are responsive to the distinct needs of children and their families is critical, not only to diminish unnecessary suffering but to prevent the development of more serious impairment across the life span and the resulting cost to society.

2.6. Next step for mentalize-based interventions

In recent years, several therapists have found the MBT treatment is particularly effective to treat seriously disturbed children and adolescents (Ensink & Normandin, 2011; Ramires, Schwan, & Midgley, 2012; Rossouw & Fonagy, 2012; Terradas & Achim, 2013). Consequently, some clinicians have started to conduct research related to this subject. One of the leading groups is the Verheugt-Pleiter & Zevalkink, (2008) group in the Netherlands. In 2008, based on a systematic research process they published a manual of mentalization-informed child psychoanalytic psychotherapy, integrating psychoanalytic and mentalization concepts. In addition the Fonagy et al., (2014) group recently started to develop a first MBT manual for adolescents (MBT-A). Indeed, Rossouw & Fonagy, (2012) carried out a first RCT of this MBT-A intervention in a sample

of adolescents with self-harm. A reduction was seen in both BPD diagnosis and BPD traits in the MBT-A group at the end of treatment, suggesting that the outpatient MBT-A intervention may be useful for adolescents with and without BPD.

Our literature review has indicated significant documentation both on the subjects of; attachment and mentalization in children and adolescents post trauma, and on the mechanisms of mentalization in children and adolescents in nonclinical settings (Bartsch & Wellman, 1995; Butterworth, Lewis, & Mitchell, 1994; Wellman, Cross, & Watson, 2001).

However little has been written about mentalization based interventions in children and adolescents in clinical contexts, including only a limited number of books and articles. (Ingley-Cook & Dobel-Ober, 2013; Laurenssen et al., 2014; Lindqvist, 2013; Ensink &Normandin, 2011; Ramires et al., 2012; Rossouw & Fonagy, 2012; Terradas & Achim, 2013; Verheugt-Pleiter & Zevalkink, 2008; Fonagy et al. 2014; Midgley & Vrouva 2013).

Since mentalization-based interventions are fundamental to all forms of therapy, it is key that attention is given to the methods in which therapist are using this interventions with children and adolescents. Therefore, we believe that further categorization and conceptualization of mentalization-based interventions will contribute to the development of new treatment manuals for children and adolescents, integrating both mentalization and psychodynamic concepts. Moreover, we believe that new clinical research exploring mentalization based interventions for children and adolescents will enrich theoretical and practical frameworks, ultimately contributing to new empirically based clinical guidelines.

3. Objectives

3.1. General objective:

Identify and categorize the mentalization strategies used during psychodynamic therapy sessions with children and early adolescents from 10 to 14 years old.

3.2. Specific objectives:

- Identify and categorize the main mentalization based interventions used in two psychodynamic therapy cases (one child and one adolescent), during the first year of therapy.
- Through the completion of a literature review, define the main mentalization base interventions currently in use with children and adolescents in clinical settings.

4. Method

In view of the nature and objectives of this pilot study, a relatively new qualitative methodology called the “Framework approach” developed by Ritchie and Spencer (2002) was used to collect and analyze the data. The “Framework” approach reflects the original accounts and observations of the people studied (therefore remaining both “grounded” and inductive), but starting deductively from pre-set aims and objectives. Data collection methods are more structured than would be the norm for many other qualitative research studies and the analytical process tends to be more explicit and more strongly informed by a priori reasoning (Pope, Ziebland, & Mays, 2000). This approach, described by Ritchie and Spencer (2002) has five main stages of data analysis that we followed: 1. *Familiarisation* - immersion in the raw data *2. Identifying a thematic framework*— recognize all the key issues, concepts, and themes by which the data can be examined and referenced. 3. *Indexing*—applying the thematic framework or index systematically to all the data in textual form by annotating the transcripts with numerical codes from the index. 4. *Charting*—rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts. 5. *Mapping and interpretation*— using the charts to define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings.

4.1. Recrutement and participants

The participation of two experienced psychodynamic psychotherapists of the child and adolescents treatment unit (*Psychology Consultation Service Center of Laval University*) was solicited, one offering psychodynamic play therapy to a younger child, and the second a more psychodynamic “talk-based” therapy with an older child. The therapists were asked to select work with an individual child or young adolescent patient aged 8-13, where patients and their parents agreed to study participation.

The patients were a ten year old boy and a thirteen old boy. The type of psychopathology was not specified by the researchers, but both of the patients met criteria for oppositional

defiant disorder. The ten year old boy had co-morbid encopresis and attention-deficit hyperactivity disorder (ADHD), as well as symptoms of self-harm. He had a history of trauma, having witnessed his father's death when aged 4. He was placed in a government child care center (*Foyer de Groupe*) during treatment, partly because his mother was depressed and was not able to deal with his child violent behavior. The 13 year old boy had aggressive outburst at school and was at risk of being expelled. He also had violent outburst with his mother, once threatening her with a knife, and oscillating with resentful silent withdrawal and refusal to participate in family interaction, suggesting the presence of some personality issues.

4.2. Procedure

4.2.1. Literature review of the main mentalization based intervention

A literature review using PsycNET and EBSCOhost was done to identify the main mentalization based interventions currently used with children and adolescents in clinical settings. A total of 11 pertinent manuals, chapters and published articles were identified that focused on mentalization based intervention for children and adolescents (Ensink & Normandin, 2011; Fonagy et al., 2014; Ingley-Cook & Dobel-Ober, 2013; Laurenssen et al., 2014; Lindqvist, 2013; N. Midgley & Vrouva, 2013; Ramires et al., 2012; Rossouw & Fonagy, 2012; Terradas & Achim, 2013; Verheugt-Pleiter & Zevalkink, 2008). Two potential references, including one manual (Verheugt-Pleiter & Zevalkink, 2008) and one book chapter (Fonagy et al., 2014) were selected as they appeared to describe mentalization based techniques with children and adolescents in a clinical context. However, in order to be used as a reference for the coding process, the techniques had to be clearly delineated and described so that these descriptions could be used to identify the phenomena. Based on this criteria the manual (Verheugt-Pleiter & Zevalkink, 2008) was discarded since it was difficult to distinguish the psychoanalytical techniques from the mentalization-based interventions described in their handbook.

Finally, only the book chapter "Mentalization-based treatment for adolescents with borderline traits" (Fonagy et al., 2014) was selected to guide the codification process of the study, since it was the only reference that clearly delineated and described

mentalization based techniques in a clinical context with in sufficient detail so that it could be used for coding purposes.

Furthermore, aiming to be coherent with the MBT adult theoretical framework, the research team decided to include the MBT manual for adults: "*Mentalizing in clinical practice"* (Allen et al., 2008) as a second source to guide the codification process.

Subsequently, with the aim to define the main categories and facilitate the coding of therapy sessions, discussions were held with the mentalization expert to agree on the pertinence of the different techniques described in both selected document. In total, seven main MBT techniques were selected and organized under one theme, four main categories and three sub categories: Mentalizing Stance Principle, 1) Supportive and empathic interventions, 2) Clarification and elaboration technique, 3) Mentalizing the transference technique and 4) Basic mentalizing techniques: a) Stop, rewind and explore c) Transference tracer comments, d) Interpretative mentalizing.

4.2.2. Data collection

Each therapist recorded all therapy sessions during the first year of psychotherapy. Afterwards, they selected four to five sessions from the beginning, middle and also the final period of the first year of therapy. This selection was non –randomized and was based on clinical, theoretical and empirical interest in the therapeutic interventions but adhered to three main criteria: 1) the therapist used different intervention strategies from a mentalization perspective during the session. 2) The session compared with the other sessions had more intervention strategies to observe. 3) Compared against other selected sessions the session demonstrated new interventions strategies.

At the end of the first year of therapy, twenty eight therapy sessions were selected (thirteen session with the 10 year old boy and fifteen with the 13 years old teenager). All therapy sessions were successfully recorded and transcribed. In total, all the sessions produced 521 pages of transcript.

4.2.3. Coding process

The codification process was based on the observation method used by the Verheugt-Pleiter and Zevalkink (2008) group, which proposes allocating observation units (codes) to all the interaction between the therapist and patient. This means that for example any short discussion between therapist and patient related to a particular subject will always be part of the same code.

4.3. Scientific Rigor Criteria

To ensure analytical rigor, three verification strategies were applied. Firstly, as suggested by Miles and Huberman (1994) different categories were defined in order to facilitate the interpretation of the therapy sessions transcripts. These descriptions contributed to the standardization of the codification process. New categories were the subject of discussion among researchers, with four meetings held to discuss the main emerging codes.

Secondly, the clarity of categories was verified. After completing the coding of transcripts from several therapy sessions, the researcher informed a second coder of the research objective, the categories developed and their respective descriptions. Utilizing this coding tree, the second coder assigned codes to three therapy sessions transcripts. Some variation was observed between the two coders. After clarifying some of the descriptions, a second sample of four therapy sessions was coded independently by the second coder. This step helped to stabilize the coding tree (Thomas, 2006).

Thirdly, a stakeholder or member check was completed with both therapists (Thomas, 2006). The researcher informed the two therapists of the research objective, the categories developed and the codification of one of their therapy session. Based on the coding tree and the two coded transcripts, the researcher and the two therapists discussed all passages coded. The agreement between the coder and the therapists was analyzed. In total, 99 excerpts were coded and the coder and therapists were in agreement for 90 passages. Moreover, this procedure provided contextually-sensitive and empirically-grounded data useful for the researcher and the coding tree.

4.4. Data Analysis

Data analysis was based primarily on the written transcripts of the twenty eight therapy sessions. Some additional sources, such as complementary literature reviews, discussions with disciplinary experts and the observations and suggestions of the therapists involved in the research project, was allowed to enrich the analysis and validate certain information.

The analysis process was based on a deductive/inductive approach, which allowed for distinguishing of significant themes in the raw data based on the pre-established categories. This codification process, which limits and condenses the information, is central to the grounded theory approach (Corbin & Strauss, 1990; Glaser & Strauss, 2009). The QDA Miner software version 4 was used to facilitate data analysis. Initially, four categories and three sub-categories were identified on the basis of the literature review made. These themes or categories were subsequently adapted to emerging ideas, with some of them grouped together, others expanded and one eliminated (pre-established category). The different passages of therapy sessions transcripts were subsequently associated with the different categories.

At the end of this inductive process, twenty four categories (13 main categories and 11 subcategories) were established and grouped under one general theme and 3 subthemes. Overall, 969 passages extracted from the therapy sessions were coded.

5. Analysis of results

Figure 5.1 illustrates the final conceptual framework with the 24 mentalization based techniques (categories) identified in the coding process. The figure indicates when the categories were pre-established (PEC), i.e. based on the review of the literature; when they were pre-establish but modified (PEC-M), i.e. category was modified based on emerging ideas; and when they were emerging (EC), i.e. a category that emerged out of the analysis of the tapes themselves.

The mentalizing stance principle was observed in all therapy sessions and was the main theme that gave coherence to the whole conceptual framework. Indeed, the twenty four categories were grouped under this general theme and 3 subthemes described below.

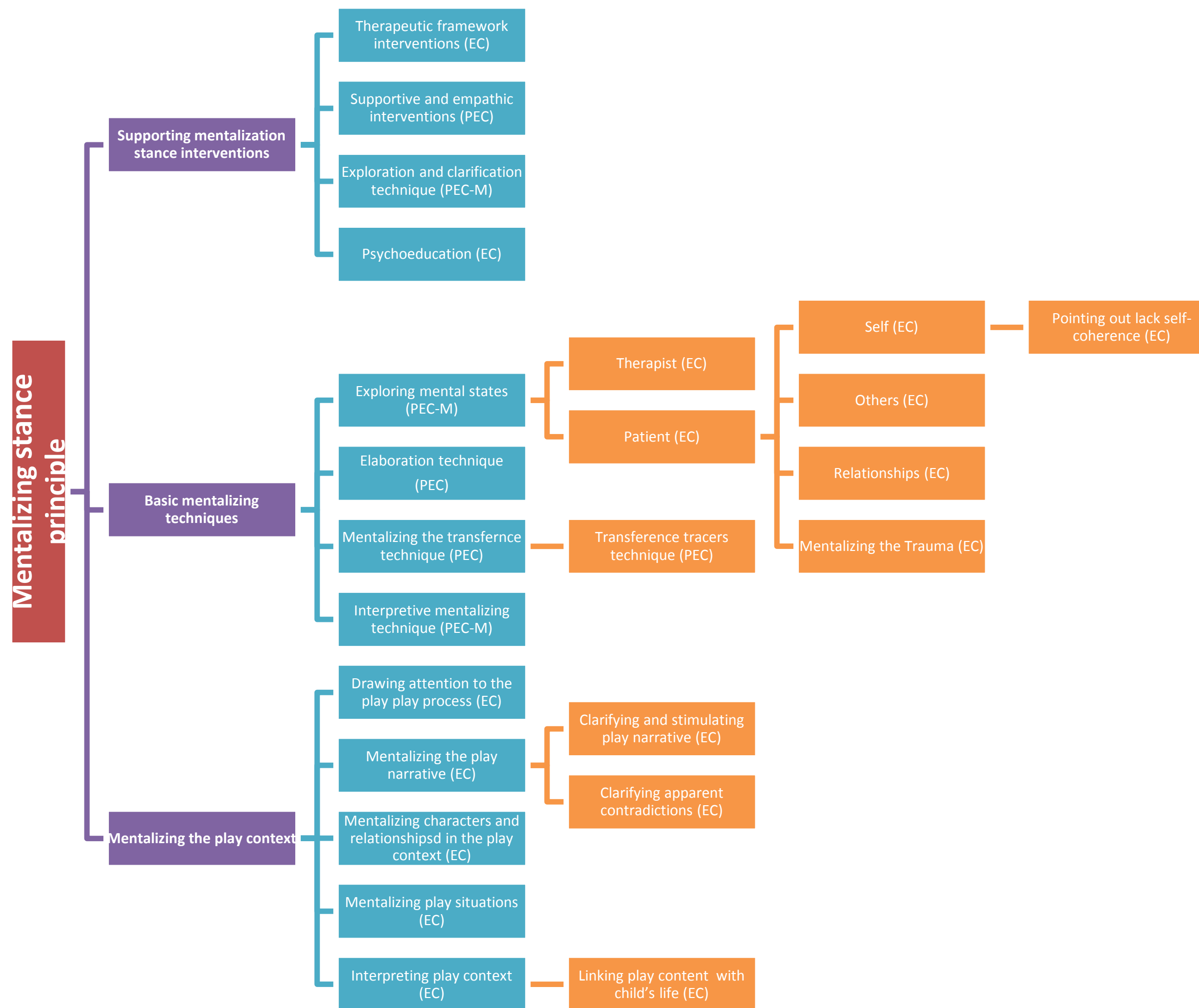

Figure 5.1 - Final conceptual framework with all mentalization based techniques

5.1. Mentalizing stance principle

In general terms the mentalizing stance principle is the therapist's capacity to maintain a persistent focus on their own and their patient's mental states, with this being used as a constant orientation through the therapy sessions. Allen et al., (2008) suggest that in order to restore and consolidate the patient's capacity to mentalize, the therapist has to adhere to the mentalizing stance principle during the duration of the treatment.

The therapist primary concern has to be the patient's state of mind during the therapeutic process. As a matter of fact, the therapist has to continually construct and reconstruct an image of the patients in his/her mind to help the patient understand what he/she feels and why. In this way the patients and therapist develop a mentalizing process together.

5.2. Supporting mentalization stance interventions

During the coding process we realized that some interventions used by both therapists were not directly mentalization based interventions, but were however extremely helpful for introducing mentalization based intervention and were of important for stimulating the mentalization stance in therapy. Indeed, without this kind of intervention mentalization would not have been possible in the therapy. Therefore, we decided to include them in the coding tree and categorize and organize them under the *supporting mentalization stance interventions* theme. At the final stage of the coding process four categories were grouped under this theme.

Figure 5.2 illustrates the conceptual framework with all mentalized based techniques (categories) that were organized under the supporting mentalizing stance intervention theme.

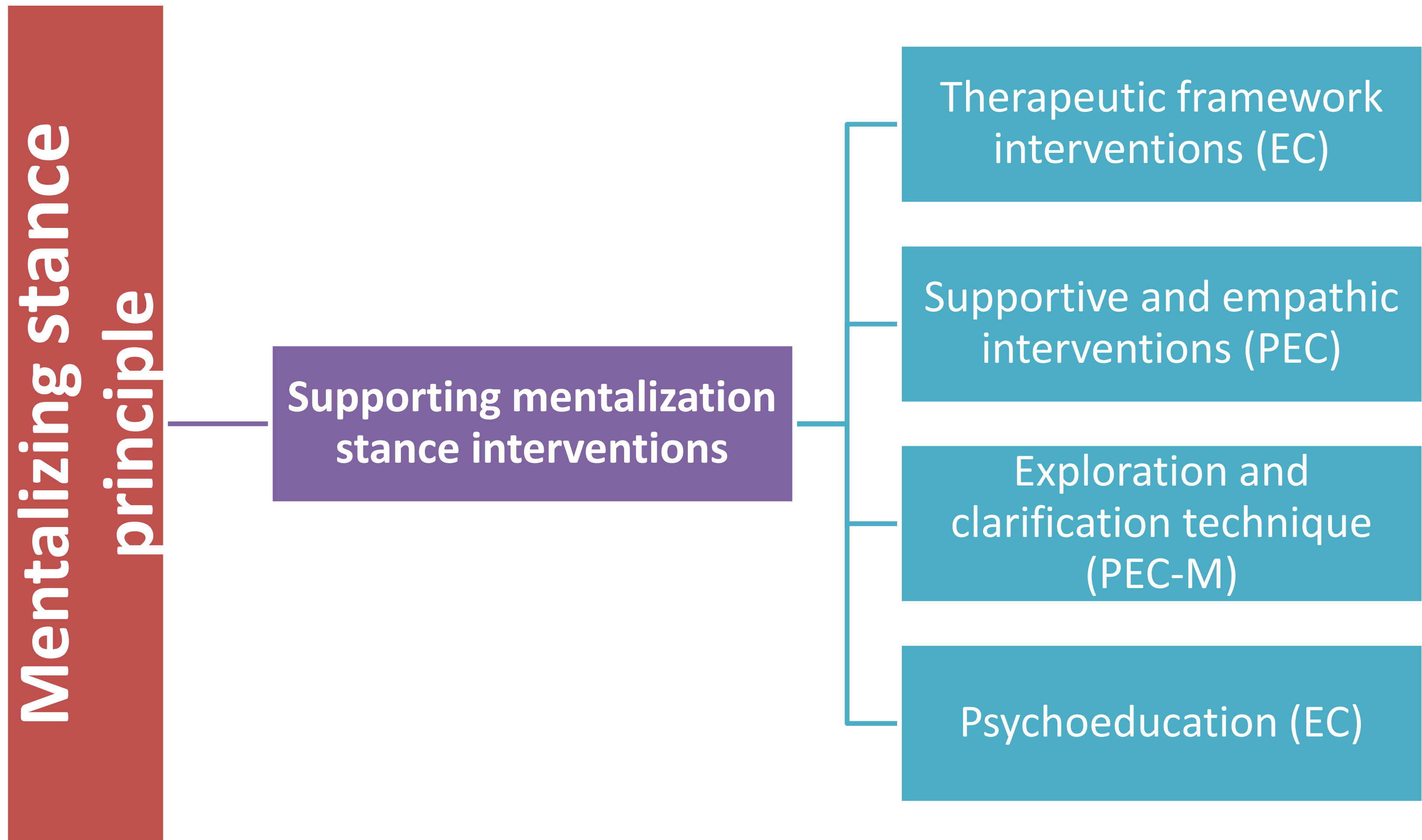

Figure 5.2 - Section one of the conceptual framework: Supporting mentalization stance intervention

5.2.1. Therapeutic framework interventions (Emergent category, EC)

Therapeutic framework interventions refer to all interventions where the therapist explains, discusses and explores the therapeutic frame with the patient. Issues like rules, the work plan, the limits and the engagements of the therapist and the child or the adolescent are addressed. Normandin et al., (2014) states that the therapeutic framework interventions serves two main purposes: first, to create the conditions for the therapist's to work with the child and adolescent in a way that the therapist can be mentally free from concerns about for example weighing the patient, keeping the patient from harming himself or the therapist, in order to be able to focus on the mental state of the patient, and second, to establish a treatment frame that protects the child and adolescent and the treatment from dangerous acting out, unconstructive parental involvement and considers the particular reality of the child and adolescent in terms of relations to home, school, and street.

The codification of therapy sessions confirms that both therapists used this type of intervention in almost all sessions (Adolescent therapist 9 of 15 and child therapist 13of 13). This intervention helped the therapist to set limits, clarify some therapeutic rules, address trust and confidentiality issues, but also to set the conditions to work with the patient and explore his mental state. This are one of the several passages were the adolescent therapist used this type of interventions:

> **Therapist**: … Never what will be discussed here will be discussed with your parents… when I'll be at the stage of explaining it will also be the time to explain it to your parents what I conclude from that, from our meetings because they have to know they are responsible for you, they have to know a bit what we will do together, what I will conclude (results). That, I'll tell you before, we will have time you and me to discuss about it and you won't and it won't be about things about which we had discussed together. What happens here will stays here… **A***:-Okay. (Adolescent transcribed session # 1).

5.2.2. Supportive and empathic interventions (Pre-establish category, PEC)

This intervention is used to establish emotional contact and therapeutic alliance. At any stage in the therapy when the child or the adolescent is in a state of emotional arousal and

mentalization failure, the therapist returns to this empathic stance to attempt to mentalize the heightened affective arousal with the young person (Fonagy et al., 2014). This intervention is an active process, making use of active questioning where necessary checking that the therapist has understood what the adolescent has said, validating the patients point of view and being in contact with his emotional state.

In the early stages of the therapy process this technique is use frequently to stablish an alliance with the child or the adolescent and only then other type of techniques can be useful to enhance mentalization (Fonagy et al., 2014). Indeed, this type of intervention was used by both therapist in almost all sessions (Adolescent therapist 11 of 15 and child therapist 9 of 13) and supports the idea that an empathic stance is an important stage in therapy that permits to establish contact or allows to repair or consolidate the therapeutic alliance. An example of the therapeutic use of this technique can be observe in the section below where the adolescent therapist highlights the courage of his patient to deal with a difficult situation in a common session with the patients parents:

> **Therapist**: I found you courageous for saying this. At this meeting. … I think I had said it to you in front of your parents…and I maintain that. That I found you courageous for…tolerating … this meeting, staying with us. You didn't… you didn't subside down in your chair, you didn't fall asleep. You didn't… you didn't provoke your parents too much. You, you were able to tell me enough about what happened… (Adolescent transcribed session # 9).

In this case the therapist is being empathic and supportive with his patient since he points out the patient's effort to stay calm and behave in a mature way.

5.2.3. Exploration and clarification technique (Pre-establish category was modified with emerging ideas PEC-M)

Is an active technique, in which the therapist asks many questions with the aim of reconstructing the events that led to a mentalization breakdown, so that they are more clearly understood. This technique is also the first step to make sense of the patient's behavior (Fonagy et al., 2014).

Moreover, it helps to explore events that the patient presents during the therapy sessions and facilitates an exchange of ideas and thoughts (mental states) about the experiences discussed. The therapist's listening response is a continuous inquiry regarding the material presented. This technique permits to have access to important psychological content that could be useful for the psychotherapy process. Therefore, the exploration and clarification technique it's a useful tool that will allow the therapist understand the patient's mental state and will help him to choose the right mental based intervention afterwards.

As a matter of fact, the exploration is the first step that further on will lead to the clarification. It is during the exploration stage were the therapist may realise there is an important issue to clarify with the patient. After identify the important or problematic issue, the clarification act as the mechanism to slow down and helps to identify the interpersonal context in the child's or adolescent's life in which the difficult situation was trigged (Fonagy et al., 2014).

This technique was used by both therapist in almost all sessions (Adolescent therapist 15 of 15 and child therapist 12 of 13) and seemed to have been very useful for both therapist, since it was frequently coded. Actually, for the adolescent therapist this technique was the interventions most used (28.9%) and it was the fourth intervention most used by the child therapist (10.7%). This is one of the several passages were the adolescent therapists explores and try's to clarify an interpersonal context presented in therapy. In this particular case the therapist explores the adolescent's family context and try's to clarify what has changed:

> **Therapist:** How is it going at home? … **A***: Fine… **Therapist**: Ah yeah? **A***: (Silence) **Therapist**: What is going fine? **A*:** Fine… at home? **Therapist:** Hmhm! What is going well? What do you find that goes well? **A***: Everything. Except my brother. **Therapist**: Sorry? **A***: Except my brother who annoys me. **Therapist**: Ah! Except your brother? **Therapist**: Which means that with mom, it's going well, with dad, it's going well. **A***: Hmhm... **Therapist**: … what has changed? **A***: Well, nothing has changed… (Adolescent transcribed session #5).

5.2.4. Psychoeducation (Emergent category, EC)

This technique is another important supporting tool to enhance mentalization during therapy. Trough psychoeducation the therapist is able to explain the child and adolescent the importance not only of mentalization, but also of other important developmental and practical issues, such as, the neurobiological and socio-emotional development of children and adolescents.

Moreover, with this technique the therapist can discuss various facets of mentalizing and the benefits of mentalizing skillfully for self-awareness and healthy relationships. The therapist can describe and explore with the patient the optimal conditions for the development and maintenance of mentalizing in terms of secure attachment and optimal arousal. With this technique the therapist employs explicit instructions to draw attention to process that also must be performed implicitly (Allen et al., 2008).

For example, in the section below the child therapist explains the importance and the benefits of expressing and mentalizing difficult emotions (sadness and stress) to others:

> **Therapist**: It is…Maybe what I am going to tell you might sound weird… **C***: Yes, Yes, its ok, it's ok… **Therapist**: It is true that when we talk about sad things it stress us, but, you know why, when we finish talking about it we feel less stressed… **C***: It's more when you talk about it… **Therapist**: Yes, when you begin to talk about it you are stressed but in the end it can make you feel better… (Child transcribed session #3).

This technique was principally used by the child therapist (Adolescent therapist 2 of 15 vs child therapist 5 of 13). Nevertheless, both therapists seem to use this intervention in very specific situations, since the coded frequency was low in all therapy sessions (Adolescent therapist 0.9% and child therapist 1.6%).

5.3. Basic mentalizing techniques

It is the second sub theme of the coding tree and under this theme all common mentalize based intervention used by the child therapist and the adolescent therapist were organized. All interventions described below have the aim of stimulating directly the mentalization

capacity of the child and adolescent during the therapy sessions. Four main categories and eight sub categories were grouped under this theme.

Figure 5.3 illustrates the conceptual framework with all mentalized based techniques (categories) that were organized under the basic mentalizing techniques theme.

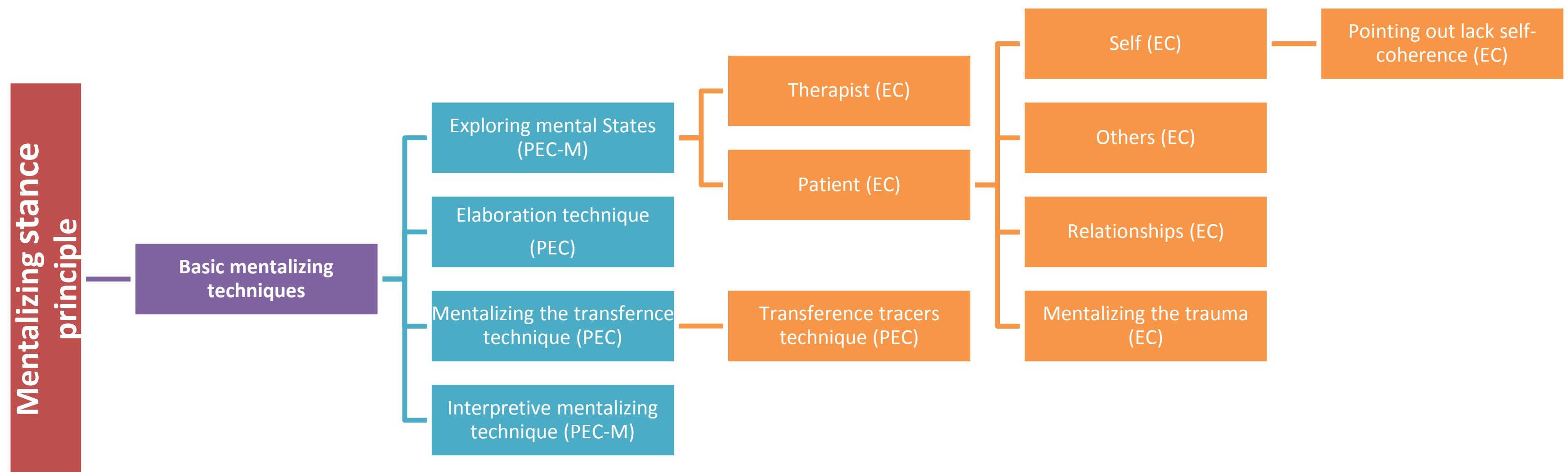

Figure 5.3 - Section two of the conceptual framework: Basic mentalizing techniques

5.3.1. Exploring mental states (Pre-establish category was modified with emerging ideas PEC-M)

This is one of the fundamental techniques that aims to enhance mentalization directly and is centred on the therapist's capacity to question continually what internal mental state both within his patients and within himself can explain what is happening now.

Fonagy emphasizes the importance of using curiosity and adopting a "not knowing attitude" towards the thoughts and emotions of the patient. As a matter of fact, wanting to explore the patient's mind requires both curiosity and the desire of having the patient's mind in the therapist's mind in order to understand what is going on. For example: Asking the patient how he lived it, how are this events important, or asking him definitions of seemingly obvious things, such as what does he mean by depression, what does it mean to be selfish, etc. (Allen et al., 2008).

5.3.1..1. Self, others and relationships (Emergent categories, EC)

During the coding process we realized that the mentalization discourse technique was used by both therapist in three different contexts: *self, others and relationships*. This three sub categories explore and enhance mentalization from different perspectives. The *self-category* refers to the patient's mental state and indicates that the therapist continuously inquires and enhances the mentalization of the child's or adolescent's own mind. The *others-category* refers to the mental state of the others and the aim of the therapist is to promote the capacity of the child and adolescent to understand others in term of mental states. Finally, the *relationship-category* makes reference to interventions where the therapist supports the patient to think about how people and their mental states have impacts on the other, how their different perspectives are affected by their interactions and by their thoughts about the other's mind, feelings, or thoughts.

Comparing the coding frequency of the three different types of mentalization discourse techniques, the self-category was the intervention most use by both therapists. Actually, this technique was used by both therapist in almost all sessions (Adolescent therapist 13 of 15 and child therapist 12 of 13) and was used frequently by both therapists. Indeed, for

both therapists this technique was the third most frequently used intervention (11.8% child therapist, 14.8% adolescent therapist).

This is one of the several passages were the adolescent therapists adopts a "not knowing attitude" towards the thoughts and emotions of the teenager, explores his mental state and stimulate the patients curiosity by linking his mental state (been disappointed) with his performance at school:

> **Therapist**: … This is surprising - you are not so proud of yourself when you have generally good notes? (Said with a quizzical and playful tone) And I am curious! How does that work? You were expecting more? …**A***: Sometimes yes…**Therapist**: Why? Because you worked harder? … **A***: Yeah … **Therapist**: Yes. Ok. So in that sense, you are disappointed? Despite the fact that you have generally good notes, you are disappointed? (Adolescent transcribed session #8).

5.3.1..2. Pointing out lack self-coherence (Emergent category, EC)

This technique is used when the therapist realises that there is an important lack of coherence in the mentalization process of the child or adolescent (incoherence explaining and describing his and others mental states). This lack of self-coherence can be observed when the patient changes his opinion completely toward a same event without any apparent reason, presents opposite points of views to explain the same mental state without realising the difference, etc. When this happens the therapist can point out this lack of self-coherence by highlighting the opposite points of view that the patient has exposed.

This technique helps to draw the patient's attention on the lack of self-coherence. Such comments can be employed judiciously to stimulate the self-coherence and increase his mentalization capacity. To illustrate this technique the section below shows how the child therapist raises awareness of a lack of self-coherence by highlighting how the child is reacting in opposite ways toward a similar situation (lending toys):

> **Therapist**: … I am surprised because sometimes you put a big sticker on your door, which says "if you touch, I am going to kill you" and other times, you are ready to share everything... **C***:-Well yes… **Therapist**: Sometimes, you protect a lot, a lot, a lot, and sometimes you don't protect at all and you are

> ready to share even your most precious things. That's why it took me by surprise a little bit… (Child transcribed session #5).

This type of intervention was an emergent subcategory and was only observed in the child therapy sessions (3 of 13). The child therapist seemed to use it in very specific situations, since the code frequency was very low in all therapy sessions (0.5%).

5.3.1..3. Therapist (Emergent category)

This refers to the ability of the therapist to use his own experiences as a model to help the child and adolescent to mentalize. At the simplest level, the therapist may express his emotional state to something to help the patient to recognize the feeling too. For example, in the section below the adolescent therapist, explains why she is being so patient (her mental state), in other words she links her mental state to a specific interpersonal context, stimulating the patient's curiosity and helping the patient to recognize this mental state too:

> **Therapist**: Do you know that I'm patient? ... **A***: MmMm (Nodding)... **Therapist**: Yes?...And do you know why am I patient?... **A***: (Saying no with his head)… **Therapist**: I'm patient because I'm curious to understand what is going wrong A*. How we can get out from this impasse? We are in a dead-end! (Adolescent transcribed session #7).

This type of intervention was principally used by the adolescent therapist (Adolescent therapist 3 of 15 vs child therapist 1 of 13). Although, the code frequency was very low in all therapy sessions (Adolescent therapist 0.9% and child therapist 0.2%).

5.3.1..1. Mentalizing the trauma (Emergent category)

This intervention has the aim of helping to child to put the traumatic experience into words or represent it in words rather than just in visual affective memory (Ensink & Normandin, 2011). As much elaboration as possible is encouraged as it is rare that children and even adults are able to mentalize trauma given how far outside normal experience it tends to be. Mentalizing the trauma technique is in general followed by, or use in conjunction with *mentalizing discourse-self* and *elaboration* to address and mentalize the child and adolescent traumatic experience. Is an active technique, in which the therapist asks several questions with the aim of helping the child and adolescent to develop a coherent narrative

of the traumatic experience and avoid potential confusions and attribution of responsibility to the self (Ensink & Normandin, 2011). In the section bellow the child therapist give us a good example of how she supports the child to mentalize the trauma by aiding him to put the traumatic experience into words and by helping him not to feel responsible of the traumatic experience (you were too young to call 911 for help):

> **Therapist**: That's normal… (they are taking about one character of the game)…. but some one that had an heart attack for example … **C*:** Yes it happened to my father, I don't quite know how it happened. **Therapist**: Oh yes? **C*:** Do you want me to show you? **Therapist**: Explain to me what happened. **C*:** Ok … I will show you and make the movement. It is like that and then you die […] Yes, right in front of me […] I said to the police « no it wasn't my fault, he fell like that himself » […] **Therapist:** I imagine you did not know what to do, That is normal. **C***:Yes, I did not even know the telephone number […] I dialed perhaps 639… Me, I wanted to dial 911, but I dialed 963. **Therapist**: It would seem like normal that at four years old you would not know how to phone, does it not? **C***: Yes of course (Child transcribed session #3).

This technique was observed in one of the child therapy sessions and the code frequency was of 0.5%.

5.3.1. Elaboration technique (Pre-establish category, PEC)

This intervention is in general used after the therapist has explored and clarified the child and adolescent difficulties. Here, the therapist may often help the child or the adolescent by reflecting on how it must feel to be in that situation, but without telling him what he is feeling. Careful elaboration permit to uncover deeper feelings that be not apparent, for example, the adolescent or child may appear angry, but underlying this, there may be a sense of guilt, humiliation, or failure (Fonagy et al., 2014).

Elaboration is the way the therapist helps the patient to mentalize what he may be feeling and what may be happening during the interpersonal context in which the feelings were trigged (Fonagy et al., 2014). In conclusion, this techniques allows the therapist to summarize all the information received, integrating the affects and giving sense to the child or adolescent experience. To illustrate this technique the section below shows how

the child therapist recapitulate a problematic experience (a fight) and try's to focus on the child affects:

> **Therapist**: And he laughed at you… **C***: And he was with his little gang. I wasn't even scared of his little gang… **Therapist**: You mean that when there are people that make comments that bother you, it makes you want to punch them and sometimes you do it... **C***:Yeah... There's nothing that can stop me from doing it (Child transcribed session #10).

This type of intervention was used in almost all child therapy sessions (10 of 13), but was considerably less used by the adolescents therapist (4 of 15). Nevertheless, both therapists seem to use this intervention in very specific situations, since the coded frequency was relatively low in all therapy sessions (Adolescent therapist 3.8% and child therapist 4.6%).

5.3.2. Mentalizing the transference technique (Pre-establish category PEC)

This techniques aims to gradually mentalize the therapeutic relationship between patient and therapist, by reflecting with the patient on the here-and-now interaction between them (Fonagy et al., 2014). The therapist supports the patients to think about how each impacts on the other, how their different perspectives are affected by their interactions and by their thoughts about the others mind, feelings, or thoughts. As a matter of fact, Fonagy et al., (2014) emphasizes that working with the transference provides an ideal opportunity to address how the child and adolescent mind is working with the therapist during the therapy session.

Fundamentally, the therapist wants to evoke the patient's curiosity in considering relationship patterns as just one of many other puzzling situations that require thought and contemplation as part of the not-knowing stance (Fonagy et al., 2014). Indeed, thinking about the relationships the child and adolescent has with his therapist at the current moment, helps them to focus on another mind, the mind of the therapist, and to assist them in the task of contrasting their own perception of themselves with how they are perceived by others (Allen et al., 2008). To illustrate this technique the section below is one of the several passages were the adolescent therapists with a "not knowing attitude" explores

how the teenager perceives her as therapist and what kind of relationship he think they may have:

> **A***: Personally, I don't think that you are here to scold me… **Therapist**: Oh well. It has changed a bit since last week…? (Therapist says this using a tone to indicate that she is inviting a more playful reflection) **A***: Last week, it's not really that I thought that you were going to scold me… it's like… **Therapist**: That I was like a school teacher, a school mistress…? **A***: Oh yes, a school principal. Now, I would see you as a principal. **Therapist**: Now… today, I am a school principal? (Adolescent transcribed session #1).

This technique was used by both therapists in almost all sessions (Adolescent therapist 15 of 15 and child therapist 11 of 13) and seemed to have been very useful for the adolescent therapist, since it was frequently coded in her sessions. Indeed, for her this technique was the second interventions most used (18.2%) and it was the ninth intervention most used by the child therapist (4.1%).

5.3.2..1. Transference tracer comments (Pre-establish category PEC)

Transference tracer comments are in general followed by, or use in conjunction with mentalizing the transference interventions to address the patient relationship issues. Interestingly, this technique is generally used early in the therapeutic process to highlight potential interpersonal difficulties that the child or adolescent may present. Especially related to the therapeutic relationship, but without overheating it.

Allen et al. (2008) suggest that when for example a patient declares that his relationships never last longer than a few months, the therapist could use a *transference tracer comment* to highlight a potential interpersonal problem, by answering the patient "they better watch out for their relationship in a few months…". Such *transference tracer comments* can be employed judiciously to nudge the patient gently in the direction of work in the transference later on (Allen et al., 2008). Indeed, this technique is use to draw the patient's attention to a characteristic non-mentalizing distortion that seemed to occur in several interactions.

Transference tracer comments refers to all relationships in the patient's life. Not just the therapeutic relationship, but it is restricted to the here and now; the emphasis is on understanding the current interpersonal interactions and the feeling states that results from this interactions in therapy (Fonagy et al., 2014). For example, the adolescent therapist in the section below, highlights an avoiding strategy used by the teenager, by drawing very gently the adolescent's attention on the way he deals with social interactions when he don't want to be disturbed:

> **A***: Do you have Skype? (Pointing to the therapist laptop that she uses to record the sessions)… **Therapist**: If it starts again, we will put ourselves offline (talking about computer program "Skype" that seems to be on) […] **A***:- When I type, I try to make the Skype thing go up…. It's gonna explode… **Therapist**: It's still interesting to see how…you have many strategies to avoid being disturbed... **A***: No, it's not a strategy… **Therapist**: Many strategies… Sometimes it's the balls, other times, it's playing… **A***: Other times it's Skype... **Therapist**: Other times it's Skype… **A***:-Other times it's sleeping **Therapist**: Have you…you notice that. **A***: Well…yeah (Adolescent transcribed session #4).

This type of intervention was principally used by the adolescent therapist (Adolescent therapist 7 of 15 vs child therapist 1 of 13) and seemed to have been useful for her in specific situations, since it was coded in her therapy sessions in some occasions (3.8%). Whereas the child therapist had rarely used (0.2%).

5.3.3. Interpretative mentalizing technique: Self, other and relationships (Pre-establish category was modified with emerging ideas)

This technique has the aim of increasing the mentalization capacity of the child and adolescent by stimulating them to explore alternative perspectives to understand their reality (self, other and relationships). After exploring and clarifying the patient's point of view, the therapist may proceed to use this technique by proposing an alternative perspective to consider (Fonagy et al., 2014).

This technique is based on the therapist's combined assessment of the child and adolescent's verbal communication and nonverbal communication using an open-ended style of communication were the therapist shares his alternative point of view as

something to be examined in the same way as the patient perspective (Normandin et al., 2014).

However, this intervention has to be used with precaution, adopting a "wondering" approach so that the patient does not feel dismissed. For example, by using phrases like: "Have you consider the possibility that…" or "I'm wondering also if…" or "If we see it from another perspective..." (Fonagy et al., 2014).

To illustrate this technique the section below is one of the several passages were the adolescent therapist challenges the patient's point of view (about the fight) by proposing an alternative one (you hit him to protect you):

> **Therapist**: And do you want to know? Afterwards, I think…I had understood that the famous incident where you hit someone… the serious… big case... I asked myself the question, if there was a link between the two…you know between the fact that this person had probably provoked you by humiliating you and the only way you found at that moment, to stop the torture, was hitting him… (Adolescent transcribed session #9).

This technique was used by both therapists in almost all sessions (Adolescent therapist 10 of 15 and child therapist 10 of 13) and seemed to have been very useful for the adolescent therapist, since it was frequently coded in her sessions. Indeed, for the adolescent therapist this technique was the fourth intervention most used (12.3%) and it was the seventh intervention most used by the child therapist (4.7%).

5.4. Mentalizing the play context

This is the third sub theme of the coding tree and all mentalization based interventions used in the play context by the child therapist were organized under this theme. All intervention described below have the aim of enhancing the child's awareness of mental states in themselves and in others, using play therapy techniques. Indeed, they were exclusively used by the child therapist, since the play itself was used from different perspectives (using different techniques) to enhance the child's mentalization capacity. Five main categories and three sub categories emerged from this coding process.

Figure 5.4 illustrates the conceptual framework with all mentalization based techniques (categories) that were organized under the mentalizing the play context theme.

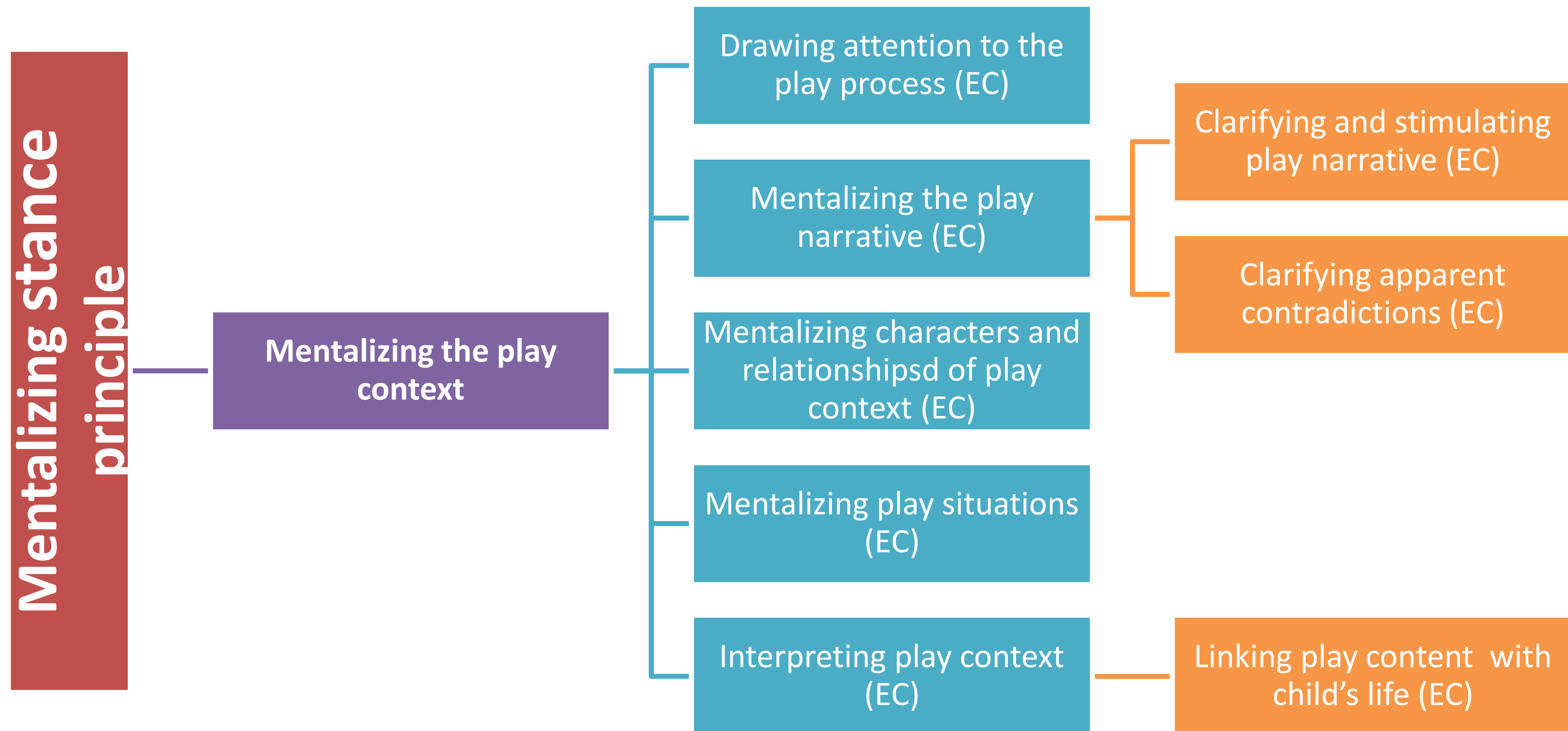

Figure 5.4 - Section three of the conceptual framework: Mentalizing the play context

5.4.1. Drawing attention to the play process (Emergent categories, EC)

The objective of this technique is to draw the child's attention on the way he plays during the therapy sessions. This technique is used when it becomes clear for the therapist that the child has a precise way of playing that is particularly relevant from a clinical point of view. This technique is an active process were the therapist continually summarizes and integrates all the information presented by child during the play session/s (frequency, intensity, organization, preparation, behaviors, affects, etc.) and labels and describes them (as a whole) in terms of mental states. This technique is used to highlight potentially problematic areas and/or helps to mentalize about the child's type of play, without overheating the emotional relationship by forcing the child to talk about painful or stressful situations that he is not ready to talk about. For example, in the section below the child therapist highlights the child's need of being meticulous by describing his way of preparing the play scenario:

> **Therapist**: When you prepare the room […] I noticed that you were very focused, right? … You were very careful, you made sure that things were done properly and you, you corrected small details to make sure that the road was very beautiful, that all else would be beautiful as well. And today it seems that you do that a bit too... Is it only here that you spend a lot of time concentrating on very, very small details to make sure that everything is nice? … **C***: Kind of… **Therapist**: Is it only when you come here that you do that? … **C***: Almost…. (Child transcribed session #10).

This technique was used by the child therapist in a few sessions (3 of 13) but seemed to have been useful to her only in specific situations, since the code frequency was relatively low (1.3%).

5.4.2. Mentalizing the narrative in the play context (Emergent category EC)

The basis of this technique is to explore the stories children present in play therapy and facilitates an exchange of ideas and thoughts about their stories. This means that the relationship between child and therapist is one of co-construction, sharing ideas and listening to each other to explore and understand the story that best supports the child in

what he or she wants to say. This concept is also used in narrative play therapy were they explains this process as a hermeneutic stance since the therapist listening response is a continuous inquiry toward the material presented in play session. This developing narrative (stories in play context) always presents the therapist with the next question (Schaefer & Kaduson, 2007).

Throughout the play sessions, the therapist has to maintain their mentalization stance, adopting inquisitiveness, curiosity, open-mindedness and a not-knowing position towards the stories the child is creating. By using this technique therapist is stimulating the emergence of the child's sense of internal coherence and self-organization (coherent autobiographical stories) that is a main objective of MBT for children (Verheugt-Pleiter & Zevalkink, 2008). The interventions related to *mentalizing the narrative in play context* were organize in two different subcategories, since they explore and enhance the narrative in play context from different perspectives.

5.4.2..1. Clarifying and stimulating play narrative: (Emergent categories, EC)

This is an active technique, in which the therapist ask many questions with the aim of understanding the story the child is narrating during the play. This technique is the first step to understand the play context that the child is presenting during the session and helps the therapist to make sense of what is going on. Additionally, this technique helps and encourage the child to elaborate the stories that he/she is presenting during the play, by continuous inquiring about the material presented and by demanding more details and descriptions. To illustrate this technique the section below is one of the several passages were the child therapist explores and stimulates the child's story by a constant inquiry about one play character and by demanding explanation about his current situation (being in prison):

> **Therapist**: Oh! You say that you've known him as a criminal for a long time? It's not the first time you arrest him?... **C***: No… not the first time, but now it's, it's, it's going to be the last, last time… **Therapist**: Oh really, what makes you say that… **C***: it's as if it was the first and the last time that he stays in prison. Until his death… **Therapist**: Until his death?... **C***: Unless he makes

> big progress, but it would surprise me. To date, none of them have been out of jail… **Therapist**: Oh yes? You don't have a lot of hope that someone who was once a thief stops stealing one day?... **C***: Well, he can't… can't really steal anymore because he… except during the night. (Child transcribed session #9).

This technique was used by the child therapist in almost all sessions (12 of 13) and was the intervention most used by her. The code frequency was of 22.7%.

5.4.2..2. Clarifying apparent contradictions (Emergent categories, EC)

This technique is used when the therapist realise that there is an important lack of coherence in the story narrated by the child. For example, completely changing the story context without a reason, not finishing the story and starting another one etc. In this situations the therapist can comment his difficulty to understand and follow the story by highlighting the contradictions or incongruences. This technique helps the therapist to draw the child's attention on the lack of coherence in his story by pointing out that he/she is lost or that he/she doesn't understand what is going on during the play. Such comments can be employed judiciously to nudge the patient gently in the direction of stimulating and giving coherence to the child's narrative in play context and enhance the emergence of the child's sense of internal coherence and self-organization (coherent autobiographical stories). For example, in the section below the child therapist point out the lack of narrative by expressing her difficult to follow the child play when he decided to changes the paly scenario without any reason:

> **C***: It's over… **Therapist**: Ah the race took place? ... **C***: It is over… **Therapist**: The race is finished? ... **C***: Yeah… **Therapist**: Ah yes? Okay. What happened during the race? That was quick huh? I didn't have the time to see, I think. I didn't understand that it was the race. What happened? **C***:-Now it's over… **Therapist**: Yeah… What happened before it ended? … **C***:But they had to go because it was the highway there. It's the highway… **Therapist**: Now, ah okay now it represents the highway… (Child transcribed session #1).

This technique was used by the child therapist in a few sessions (3 of 13) and seemed to have been useful for her in very specific situations, since the code frequency was low (0.5%).

5.4.3. Mentalizing characters and relationships in the play context (Emergent category EC)

The aim of this technique is to stimulate the mentalization capacity of the child by helping him to think in terms of mental states about the play characters and their relationships during the play therapy session. Indeed, the therapist has to maintain a mentalizing stance, in which the primary concern is the mental content that he infers from the character of the child's play. In this way the child and therapist develops a mentalizing process together during the play sessions. The therapist continually constructs and reconstructs an image of the characters of the child play in his mind to help the child to think in mental states, by asking what and why they feel, think or behave in a particular way during the play. Moreover, the therapist supports the child to think about the relationships between characters by asking how each character impacts on the other, how their different perspectives are affected by their interactions and by their thoughts about the others mind, feelings, or thoughts. As a matter of fact, this technique requires an active and curious stance, in which the therapist ask many questions with the aim of understanding the minds and relationships of the child's play characters. In the section bellow the child therapist give us a good example of how she explores the character's mental states and his relationships, by questioning the reasons the monster is angry and by trying to understand the reason he behaves with other in this way (aggressively):

> **C***: Now, because of him, it's a bit mad (Makes the dinosaurs fight)… **Therapist**: Ah, it did not calm down, but you know, he did not do anything in the end... **C***: I know… **Therapist**: People called him a monster, but in fact he didn't do anything wrong… **C***: No… he never stops making pwif pwif pwif (He makes gestures and noises to imitate it) Yoye... **Therapist**: What would he do? … **C***: Pwif, pwif pwif, he jumps on it… **Therapist**: Ah. Why did he do that? ... **C***: I don't know. It's a monster. You are dead. (Referring to the dinosaur)… **Therapist**: Yeah, yeah...maybe even monsters have good reasons to do things, but he (dinosaur)… We don't even ask him why? … and we crushed him without even trying to understand. We crush him and we get rid of him… (Child transcribed session #6).

This technique was used by the child therapist in almost all sessions (12 of 13) and was the second intervention most used by her. The code frequency was of 12.7%.

5.4.4. Mentalizing play situations (Emergent category EC)

The objective of this technique is to draw the child's attention on the themes he choose during the play sessions. This technique is used when the therapist realized that the child play themes are particularly relevant from a clinical point of view. The therapist helps the child to think in terms of mental states about particular situations or themes that came out during the play. For example, the therapist may describe how the whole game seems to be sad and scaring without pointing out a specific character. This technique in an active process were the therapist continually summarize and integrate all the information presented by child during the play session/s (stories, play characters, conflicts, emotions, etc.) and labels and describes them (as a whole) in terms of mental states. This technique is used to highlight clinical relevant subjects (depression, traumatic experiences, violence, anger, etc.) and helps the child to mentalize about his play themes, without overheating the emotional relationship by forcing the child to talk about painful or stressful issues that he is not yet ready to talk about. For example, in the section below the therapist highlights the child play scene (the jail) as dangerous and frightening:

> **Therapist**: I also learned that we are better not to end up in jail because it's dangerous. So then it's a bit frightening this idea of doing something wrong. We will make sure not to do something wrong because… if we do we end up in jail… **C***: Well in fact, for this one that I arrested, I think he will get along well with the others, because he is a tough guy too… (Child transcribed session #12).

This technique was used by the child therapist in a few sessions (3 of 13) and seemed to have been useful for her in specific situations, since the code frequency was relatively low (1.1%).

5.4.5. Interpreting play context (Emergent category EC)

This technique is used when the therapist has reasonable clarity about the play context and feels comfortable to infer what the child might have in mind during the play, based on the child's behavior, emotional state, play content (e.g. characters, play scenarios, conflicts between characters, etc.) and therapist clinical knowledge.

Verheugt-Pleiter and Zevalkink (2008) describes this technique as a dynamic process were the therapist comments what he thinks the child might be fantasizing, thinking or wishing to express with the play. In other words, the therapist presents alternative perspectives to understand the child's play and helps the child to have in mind other ways of interpreting / seeing his play. Moreover, this process helps to uncover deeper feelings and thoughts that are not apparent for the child (e.g. shame, guilt, hate, doubts etc.) but present during the play session.

This technique has to be used with precaution, adopting a "wondering" approach so that the child does not feel dismissed or forced to accept the therapist point of view. For instance, in the section below the child therapist in a very gentle and cautious way suggest an alternative point of view to understand the play character motivation to be so generous (seeking love):

> **Therapist**: Okay. …you know earlier I was saying that the city's millionaire is a guy who seems to love being lowed a lot, who makes a lot of effort so that people love him. Eee, I don't know how you see it C*, but… […] In general, everybody wants people to love them eh? … **C***: Bzzzzzt. Bvuuut (car noise)…Yeah… **Therapist**: Yeah. Except that, there are people who are sure that others love them and there are people who are really afraid that others don't love them. […] The city's millionaire, I was wondering if we could say that he… he's someone who really wants people to admire him and to love him, that he's very generous to be sure sure sure that people love him. Because sometimes, maybe he has doubts… **C***: Hmhm… **Therapist**: How do you see it? … **C***: Yeah. … **Therapist**: It seems that he has doubts, so then I am wondering how come does he doubt that people love him? (Child transcribed session #8).

This technique was used by the child therapist in several sessions (9 of 13) but seemed to have been used in specific situations, since the code frequency was relatively low (2.8%).

5.4.5..1. Linking play content with child's life (Emergent category EC)

This technique could be understood as a second layer of interpretations, generally used when the therapist has a strong therapeutic alliance and a deep understanding of the child difficulties. In general, this intervention is used after *interpreting play context* and when

the therapist has reasonable clarity to infer links between the child play content and his real life. Liking play content with personal experiences is a complex and sensible process were the therapist decodes specific play contents and suggests possible links with what the child could be feeling, thinking or experiencing, in his real life.

This intervention is used as a way of helping the child express and explore in terms of mental states difficult life experiences using the play as starting point. Indeed, every story the child plays during therapy contributes to a self –portrait; this portrait can be used by the therapist to develop an understanding of the child. However, since the therapist could be addressing sensible issues, this technique has to be use with caution, adopting the inquisitive, "wondering" approach so that the child does not feel judged or overwhelmed by the therapist intervention.

In the section below the child therapist gives us a good example of how she links a specific play situation (discussing about the reactions of one important play character: "the city millionaire") with the way the child reacts in life (gives a self-portrait):

> **C***: Eee, he's a man. He's not a child… (They are talking about "the city millionaire") **Therapist:** Oh!... but it seems like he doesn't feel angry. Because when, when people hurt other people, when they run away…generally, not all the time, it's because they are angry […] If I understand well, the game that you play, is it a bit similar to what you do too? … **C***: A bit… **Therapist:** That sometimes you are a boy that wants to hit, sometimes you're a boy who's angry, you're a boy who's mad, who wants to hurt, but at other moments, you're also a boy who wants to do great things, who can be generous and who can also be calm. Could we say that it's what it means? … **C***: We can say that… (Child transcribed session #11).

This technique was used by the child therapist in some sessions (4 of 13) but seemed to have been used only in specific situations, since the code frequency was low (1%).

6. Discussion

This pilot study aimed to identify, categorize and conceptualize the mentalization-based interventions used by two therapists from our treatment unit for children and adolescents at the *Psychology Consultation Service Center - Laval University*, using a psychotherapeutic approach based on an integration of contemporary psychoanalytic object relations theory (Kernberg, 1993; Normandin et al., 2014) and a mentalization approach (Ensink & Normandin, 2011).

One child and one adolescent were followed up during the first year of psychotherapy at our clinic to obtain explicit information about how our most experienced psychotherapists integrate mentalization based interventions in their clinical practice.

After completing a literature review, we realized that very little has been written about mentalization based interventions in adolescents and children in clinical settings, including only a limited number of books and articles. From these, two main documents were selected to guide our process of identifying and categorizing mentalization based interventions: The MBT manual for adults developed by Bateman and Fonagy (Allen et al., 2008) and a recently released book chapter that describes the adaptation of MBT for adolescents developed by Fonagy and Rossouw (Fonagy et al., 2014).

Twenty four techniques (categories and subcategories) were identified in the coding process, of these seven techniques were pre-established categories, and seventeen emerged from the coding process. The twenty four categories were grouped under the mentalization stance principle (general theme) and divided in three different groups (subthemes) sorted by type of intervention.

The first group of techniques were organized under the *supporting mentalization stance interventions* theme, since they were not directly mentalization based interventions, but were however extremely helpful for introducing mentalization based intervention. Two of the four categories were new categories, which emerged from this coding process.

The second group of interventions were the *basic mentalizing techniques,* previously described by Fonagy and Rossouw in their recent book chapter about MBT adaptation for adolescents (Fonagy et al., 2014). All interventions organized under this theme had the aim of directly stimulating the mentalization capacity of the child and adolescent during the therapy sessions. Four main categories and eight sub categories were part of this group of interventions. Seven of the eight sub-categories were new categories.

The third group of techniques were the interventions observed in the play context and were organized under the *mentalizing the play context* theme. All these interventions described how play itself was used in different forms to enhance the child's mentalization capacity. All five main categories and three sub categories emerged from this coding process.

In addition, a conceptual framework was developed based on the coding process with the aim to organize in a coherent way all mentalization based interventions observed. Moreover, this conceptual framework allowed for the integration of both types of therapy, the "talk" therapy and the play therapy. This was particularly important, to enable clearer understanding of all intervention types and the two different levels of interventions that the therapist can use, especially with children: Play level and dialectical level.

Our findings demonstrate that both therapists used a range of mentalization based interventions in all their therapy sessions. Actually, this range was so extensive that seventeen of the twenty four techniques identified from the coding process were new.

Moreover, after analyzing the code frequency of the different mentalization based interventions used by both therapists, two of the four most frequently observed interventions were fundamental mentalization techniques that aimed to enhance mentalization directly (*Mentalizing discourse - Self* and *mentalizing characters and relationships in the play context*).

This finding suggests that both therapists adhered to the mentalizing stance principle and had a persistent focus on their patient's mental states throughout their therapy sessions. Indeed, this specific focus is vital from a clinical perspective, since as Bateman and

Fonagy (2012) indicates, that in order to restore and consolidate the patient's capacity to mentalize, the therapist has to adhere to the mentalizing stance principle during the duration of the treatment.

Additionally, these findings are consistent with Bateman and Fonagy (2004) proposition affirming that: "enhancing mentalization is considered by expert clinicians from different child treatment models as "central to therapy… [and] may unify numerous effective approaches" (p. 49). Furthermore, this is particularly present when the training of the therapists is psychodynamic and is highly influenced by the mentalization approach, as it was the case for this pilot study.

This findings are also consistent with preliminary evidence suggesting that promoting mentalizing may be a common feature in different adult treatments (Goodman, 2013), but also in psychodynamic and cognitive behavioral child therapy (Goodman et al., 2015). Both studies demonstrated that promoting mentalization (operationalized as reflective functioning) is a shared component of the way expert clinicians conceptualize these therapeutic approaches. However, further empirical investigation is needed, to conclude that stimulating mentalization is central to therapy and may unify effective approaches.

Another important finding of this study was that both therapists invested a significant amount of time and effort trying to explore and clarify current events in the lives and minds of the child and adolescent. To clarify further, for the adolescent therapist almost one third of the coded interventions were exploration and clarification interventions.

While the child therapist also used this technique to investigate the child's life experiences, there was also extensive evidence of exploration through the play context. Almost a quarter of all her interventions were centered on exploring and clarifying the child's play (*Clarifying and stimulating play narrative*).

These findings are reassuring, since in general therapists tend to assume that interventions must be elaborate in order to be effective. In this study both of these experienced therapists

invested significant time simply trying to explore and understand the child's and adolescent's mind and life.

However, while the clarification and exploration technique may superficially appear to be a simple exploration of the child and adolescents life experience, it is responsible for stimulating another important process. It helps the therapist and patient to focus on the patient's mental states. Indeed, this technique enables the therapist to construct and reconstruct an image of the patient in his/her mind, thus helping the patient to understand what he/she thinks or feels and why. Subsequently, as Fonagy et al., (2014) has expressed, the patient and therapist can develop a mentalizing process together.

Another valuable clinical finding was *the mentalizing the trauma* category that emerged from our coding process. This technique was used in specific occasions by the child therapist to address the traumatic experience of the child. Based on this interventions, we were able to define and describe a specific category related to how to mentalize trauma. This emerged category was a valuable contribution to a better understanding of how therapist could help the child and adolescent to mentalize their traumatic experiences.

In fact, mentalization regarding trauma appears to be particularly important for the adaptive functioning for individuals who have experienced childhood abuse and neglect (Berthelot et al., 2015; Ensink et al., 2015). Indeed, failures in mentalizing the trauma appear to increase vulnerability to developing depressive symptoms and externalizing behavior difficulties (Ensink, et al., 2016). Alternatively, children who have faced traumatic experiences, likely require additional help to develop a capacity to mentalize that could enable them to integrate these difficult experiences (Allen, 2012; Fonagy et al., 2002; Shipman & Zeman, 2001). In sum, the importance of our findings are consistent with emerging evidence and clinical observations that suggests that children and adolescents who suffered traumatic experiences need help from therapists to develop mentalization capacities to deal properly with this difficult and intense experience.

Subsequently, one of the major finding of this pilot study were the emergent categories that describe the mentalization based interventions used in play therapy. Our findings have

shown that in play therapy our therapist utilized an extensive range of mentalization based interventions. Indeed, the child therapist used eight different techniques were the play itself served to enhance the child's mentalization capacity. Two of these interventions (*Mentalizing characters and relationships of play context and Clarifying and stimulating play narrative*) were the interventions most observed in the child therapy sessions, indicating the importance of these strategies for the psychotherapy process.

As mentioned previously, little has been written about mentalization for adolescents, and even less for children in clinical settings. Given that play is a precursor of mentalization (Target & Fonagy, 1996), play therapy may be particularly important for facilitating mentalizing and shows the importance of this findings. In fact, as we could observe in this study and was already described by several authors (Bleiberg, Fonagy, & Target, 1997; Fonagy, 2000; Goodman, et al., 2015; Zevalkink et al., 2012), through play therapy the therapist can comment on the mental content that the therapist infers from the child's behavior or play. Moreover, the therapist can identify mental states as motivators of the child's behavior or play. The therapist can also verbalize the wishes or intentions of the play characters, or reflect on the uniqueness of the child's mental world (Goodman et al., 2015).

Finally, it is important to highlight two important issues related to the codification process of this study. Firstly, in our literature review only one manual was identified as providing sufficient guidance for child mentalization based interventions in clinical settings (Verheugt-Pleiter & Zevalkink, 2008). However, even though the manual was used in some cases as a reference to define and develop some of the play therapy interventions emerged from our coding process. It was not use to guide the codification, since it was difficult to distinguish the psychoanalytical techniques from the mentalization-based interventions described in their handbook.

Secondly, the *stop, rewind and explore* pre-established category was at the end of the coding process discarded, since it was not observed in any of the coded therapy sessions. Fonagy et al. (2014) describes this technique as a strategy that the therapist uses when it appears that non-mentalization interactions are taking place in therapy and the adolescent

is losing control. At that point the therapist encourage the patient to rewind to the point where mentalization was lost and then explores with him what happened.

Although, this category was discarded, we think that this intervention could be very useful in other clinical settings. Is important to highlight that the psychopathology of the patients of our study may influenced the type of interventions used in therapy. Therefore, we think that this specific technique is more likely to be observed in therapy sessions with adolescents with borderline personality traits, presenting symptoms of low affect regulation and subjective dyscontrol.

7. Conclusions

Through this pilot study, we were able to use the empirical evidence to describe twenty-four mentalization-based techniques and link each intervention with the existing MBT framework. From our perspective this is an important step, since it contributes to enriching the practical process of mentalization in therapy and guides therapists in their psychotherapy.

Furthermore, as Midgley (2006) and Goodman (2013) have suggested, single-case naturalistic research holds tremendous promise. In this study we were able to demonstrate that experienced therapists are able to apply, adapt and develop new mentalization-based techniques, which could be useful to other therapists in similar settings. This, infers the vital need for further identification and description of mentalization based techniques, using the research design recommended by the present study.

Furthermore, these findings are important since, as Verheugt-Pleiter and Zevalkink (2008) and Bateman and Fonagy (2012) have suggested, a significant proportion of the severest child and adolescent pathologies are related to an inadequate capacity to mentalize. However as indicated by Kazdin (2002), these techniques have to be clearly conceptualized and defined in order to be able to examine their contribution to the effectiveness of psychotherapies.

Likewise, we hope that this study will promote greater interest in single-case naturalistic research since as Goodman et al. (2015) has already stated: “Working together, we could usher in a new era of best practice based on naturalistic single-case research rather than on the outdated medical randomized controlled trial model” (p.26). We are also agree with Blatt and Felsen (1993) statement that recognizes that the therapists need to work together to study “what works for whom” in their own practice settings, using naturalistic single-case research designs.

Moreover, we hope that this study will promote greater interest in process research and in the importance of linking process to outcome to identify the effective ingredients of

treatment (Goodman al., 2015). Perhaps this study will further interest in the development of evidence-based process research that will lead to further identification and description of mentalization based techniques used in with children diagnosed with other psychiatric disorders and with different treatment models.

Finally, due to several methodological limitations, these results should be interpreted with caution. Some of the constraints that preclude generalization of the data include; our small patient sample, which was chosen based on availability at the time of the study; and the psychopathologies, gender and age of these patients which could have therefore influenced the type of interventions used. The techniques described may not be representation of all possible mentalization based techniques. Moreover, since the pilot study was designed to identify only mentalization based interventions, it was not possible to recognize other (non mentalization based) techniques that would allow us to compare this technique with other important types of interventions used in therapy with children and adolescents.

A second empirical study which uses the same conceptual framework, but with a larger group of patients and therapists, and is organized by specific psychopathologies would be helpful to consolidate these findings and enrich the categories developed during this first stage of research.

Bibliography

Allen, J. G. (2012). *Mentalizing in the Development and Treatment of Attachment Trauma*. London, UK: Karnac Books.

Allen, J. G., Fonagy, P. & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Bartsch, K. & Wellman, H. M. (1995). *Children talk about the mind*. New York, USA: Oxford university press.

Bateman, A. W. & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, *18*, 36–51. doi: 10.1521/pedi.18.1.36.32772

Bateman, A. W., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Arlington, USA: American Psychiatric Publishing, Inc.

Beeghly, M. & Cicchetti, D. (1994). Child maltreatment, attachment, and the self system: Emergence of an internal state lexicon in toddlers at high social risk. *Development and Psychopathology*, *6*, 5–5. doi:10.1017/S095457940000585X

Berthelot, N., Ensink, K., Bernazzani, O., Normandin, L., Luyten, P. & Fonagy, P. (2015). Intergenerational transmission of attachment in abused and neglected mothers: the role of trauma-specific reflective functioning. *Infant Mental Health Journal*, *36*, 200–12. doi:10.1002/imhj.21499

Blatt, S. & Felsen, I. (1993). Different kinds of folks may need different kinds of strokes: The effect of patients' characteristics on therapeutic process and outcome. *Psychotherapy Research*, *3*, 245–259. doi: 10.1080/10503309312331333829

Bleiberg, E. (2001). *Treating personality disorders in children and adolescents: A relational approach*. New York, USA: Guilford Press.

Bleiberg, E., Fonagy, P. & Target, M. (1997). Child psychoanalysis: Critical overview and a proposed reconsideration. *Child and Adolescent Psychiatric Clinics of North America*.

Blos, P. (1970). *Young Adolescent*. New York, USA: Simon and Schuster.

Bowlby, J. (1982). Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, *52*, 664–678. doi: 10.1111/j.1939-0025.1982.tb01456.x

Bratton, S. C., Ray, D., Rhine, T. & Jones, L. (2005). The Efficacy of Play Therapy With Children: A Meta-Analytic Review of Treatment Outcomes. *Professional Psychology: Research and Practice*, *36*, 376. doi:10.1037/0735-7028.36.4.376

Butterworth, G., Lewis, C. & Mitchell, P. (1994). Theory of mind and the facts of embodiment. *Children's Early Understanding of Mind. Origins and Development*, 115–132.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F. & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *The American Journal of Psychiatry*, *164*, 922–8. doi: 10.1176/ajp.2007.164.6.922

Corbin, J. M. & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*, 3–21. doi: 10.1007/BF00988593

Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2016). Maternal and child reflective functioning in the context of child sexual abuse: pathways to depression and externalising difficulties. European Journal Of Psychotraumatology, 7. doi: 10.3402/ejpt.v7.30611

Ensink, K. & Mayes, L. C. (2010). The Development of Mentalisation in Children From a Theory of Mind Perspective. *Psychoanalytic Inquiry*, *30*, 301–337. doi: 10.1080/07351690903206504

Ensink, K., Normandin, L., Target, M., Fonagy, P., Sabourin, S. & Berthelot, N. (2015). Mentalization in children and mothers in the context of trauma: an initial study of the validity of the Child Reflective Functioning Scale. *British Journal of Developmental Psychology*, *33*, 203–217. doi: 10.1111/bjdp.12074

Ensink, K., & Normandin, L. (2011). Le traitement basé sur la mentalisation chez les enfants agressés sexuellement et leurs parents [Mentalization-based therapy for sexually abused children and their parents]. In: M. Hébert, M. Cyr, & M. Tourigny (Éds.), *L'agression sexuelle envers les enfants, Tome I* (pp. 399-440).

Fonagy, P., Gergely, G., Jurist E. L., & Target, M. (2002). Affect regulation, mentalization, and the development of the self. New York, NY: Other Press.

Fonagy, P., Rossouw, T., Sharp, C., Bateman, A., Allison, L. & Farrar, C. (2014). Mentalization-based treatment for adolescents with borderline traits. In *Handbook of borderline personality disorder in children and adolescents* (pp. 313–332). Springer. doi: 10.1007/978-1-4939-0591-1_21

Fonagy, P., Steele, M., Steele, H., Moran, G. S. & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 201–218. doi: 10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 77, 217- 233.

Fonagy, P; (2000) Mentalization and Personality Disorder in Children: A Current Perspective from the Anna Freud Centre. In: Lubbe, T, (ed.) *The Borderline Psychotic Child*. (pp. 69-89). Routledge: London.

Fonagy, P., & Target, M. (2000). Playing with reality: III. The persistence of dual psychic reality in borderline patients. *The International Journal of Psychoanalysis*, 81, 853-873.

Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research*. New Jersey, NJ, USA: Transaction Publishers.

Goodman, G. (2013). Is mentalization a common process factor in transference-focused psychotherapy and dialectical behavior therapy sessions? *Journal of Psychotherapy Integration*, *23*, 179. doi: 10.1037/a0032354

Goodman, G., Midgley, N. & Schneider, C. (2015). Expert clinicians' prototypes of an ideal child treatment in psychodynamic and cognitive-behavioral therapy: Is mentalization seen as a common process factor? *Psychotherapy Research*, 1–12. doi: 10.1080/10503307.2015.1049672

Goodman, G., Reed, P. & Athey-Lloyd, L. (2015). Mentalization and play therapy processes between two therapists and a child with Asperger's disorder. *International Journal of Play Therapy*, *24*, 13. doi: 10.1037/a0038660

Hankin, B. L., Wetter, E., Cheely, C. & Oppenheimer, C. W. (2008). Beck's cognitive theory of depression in adolescence: Specific prediction of depressive symptoms and reciprocal influences in a multi-wave prospective study. *International Journal of Cognitive Therapy*, *1*, 313–332. doi: 10.1521/ijct.2008.1.4.313

Hoagwood, K. & Olin, S. S. (2002). The NIMH blueprint for change report: Research priorities in child and adolescent mental health. *Journal of the American Academy of Child \& Adolescent Psychiatry*, *41*, 760–767. doi: 10.1097/00004583-200207000-00006

Ingley-Cook, G. & Dobel-Ober, D. (2013). Innovations in Practice: group work with children who are in care or who are adopted: lessons learnt. *Child and Adolescent Mental Health*, *18*, 251–254. doi: 10.1111/j.1475-3588.2012.00683.x

Kazdin, A. E. (2002). The state of child and adolescent psychotherapy research. *Child and Adolescent Mental Health*, *7*, 53–59. doi: 10.1111/1475-3588.00011

Kernberg, O. F. (1993). *Severe personality disorders: Psychotherapeutic strategies*. London, England: Yale University Press.

Kernberg, O. F. (2006). Identity: Recent findings and clinical implications. *The Psychoanalytic Quarterly*, *75*, 969–1004. doi: 10.1002/j.2167-4086.2006.tb00065.x

Kernberg, P. F., Weiner, A. S. & Bardenstein, K. (2000). *Personality disorders in children and adolescents*. New York, USA: Basic Books.

Kroger, J. (2006). *Identity development: Adolescence through adulthood*. Thousand Oaks, CA, USA: Sage publications.

Landreth, G. L. (2012). *Play therapy: The art of the relationship*. New York, USA: Routledge.

Laurenssen, E. M., Hutsebaut, J., Feenstra, D. J., Bales, D. L., Noom, M. J., Busschbach, J. J., … Luyten, P. (2014). Feasibility of mentalization-based treatment for adolescents with borderline symptoms: A pilot study. *Psychotherapy*, *51*, 159. doi: 10.1037/a0033513

Lindqvist, K. (2013, April). *Mentalization based time-limited psychotherapy with children and parents*. Workshop at the Erica Foundation, Stockholm. Workshop document retrieved from http://www.ericastiftelsen.se/for/publ/Workshop_Erica_Foundation_April_2013.pdf

Midgley, N. (2006). The “inseparable bond between cure and research”: Clinical case study as a method of psychoanalytic inquiry. *Journal of Child Psychotherapy*, *32*, 122–147. doi: 10.1080/00754170600780273

Midgley, N. (2012). Reading Anna Freud. New York, USA: Routledge.

Midgley, N., & Vrouva, I. (Eds.). (2013). *Minding the Child: Mentalization-based interventions with children, young people and their families*. New York, USA: Routledge.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA,USA: Sage.

Normandin, L., Ensink, K., Yeomans, F. E. & Kernberg, O. F. (2014). Transference-Focused Psychotherapy for Personality Disorders in Adolescence. In *Handbook of Borderline Personality Disorder in Children and Adolescents* (pp. 333–359). Springer. doi: 10.1007/978-1-4939-0591-1_22

O’Connor, K. J. & Braverman, L. D. (2009). *Play therapy theory and practice: Comparing theories and techniques*. New Jersey, USA: John Wiley & Sons.

US Department of Health and Human Services; US Department of Education; US Department of Justice (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; 2000. Retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK44233/

Pope, C., Ziebland, S. & Mays, N. (2000). Analysing qualitative data. *Bmj*, *320*, 114–116. doi: 10.1136/bmj.320.7227.114

Ramires, V. R. R., Schwan, S. & Midgley, N. (2012). Mentalization-based therapy with maltreated children living in shelters in southern Brazil: A single case study. *Psychoanalytic Psychotherapy*, *26*, 308–326. doi: 10.1080/02668734.2012.730546

Reyna, V. F., Chapman, S. B., Dougherty, M. R. & Confrey, J. E. (2012). *The adolescent brain: Learning, reasoning, and decision making.* American Psychological Association. doi: 10.1037/13493-000

Ritchie, J. & Spencer, L. (2002). Qualitative data analysis for applied policy research. In *The qualitative researcher's companion* (pp. 305–329). Thousand Oaks, CA, USA: Sage.

Rossouw, T. I. & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlledtrial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*, 1304–1313. doi: 10.1016/j.jaac.2012.09.018

Schaefer, C. E. & Kaduson, H. G. (2007). *Contemporary play therapy: Theory, research, and practice*. New York, USA: Guilford Press.

Schneider-Rosen, K. & Cicchetti, D. (1991). Early self-knowledge and emotional development: Visual self-recognition and affective reactions to mirror self-images in maltreated and non-maltreated toddlers. *Developmental Psychology*, *27*, 471. doi: 10.1037/0012-1649.27.3.471

Scott, S., Knapp, M., Henderson, J. & Maughan, B. (2001). Financial cost of social exclusion: follow up study of antisocial children into adulthood. *BMJ*, *323*, 191. doi: 10.1136/bmj.323.7306.191

Sharp, C., Croudace, T. J. & Goodyer, I. M. (2007). Biased mentalizing in children aged seven to 11: latent class confirmation of response styles to social scenarios and associations with psychopathology. *Social Development*, *16*, 181–202. doi: 10.1111/j.1467-9507.2007.00378.x

Shipman, K. L. & Zeman, J. (2001). Socialization of children's emotion regulation in mother-child dyads: a developmental psychopathology perspective. *Development and Psychopathology*, *13*, 317–36. doi: 10.1017/S0954579401002073

Southam-Gerow, M. A. & Kendall, P. C. (2000). A preliminary study of the emotion understanding of youths referred for treatment of anxiety disorders. *Journal of Clinical Child Psychology*, *29*, 319–327. doi: 10.1080/14616734.2010.501988

Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review*, *28*, 78–106. doi: 10.1016/j.dr.2007.08.002

Suchman, N. E., DeCoste, C., Leigh, D. & Borelli, J. (2010). Reflective functioning in mothers with drug use disorders: implications for dyadic interactions with infants and toddlers. *Attachment & Human Development*, *12*, 567–85. doi: 10.1080/14616734.2010.501988

Target, M. & Fonagy, P. (1996). Playing with reality: II. The development of psychic reality from a theoretical perspective. *International Journal of Psycho-Analysis*, *77*, 459–479.

Taubner, S. & Curth, C. (2013). Mentalization mediates the relation between early traumatic experiences and aggressive behavior in adolescence. *Psihologija*, *46*. doi: 10.2298/PSI1302177T

Terradas, M. M. & Achim, J. (2013). Arrête de faire semblant, on joue pour vrai! Intégration de techniques d'intervention basées sur la mentalisation à la psychothérapie d'enfants d'orientation psychanalytique ["Stop Pretending, We Are Playing for Real!" Integration of Mentalization-Based Techniques in Psychoanalytically Oriented Child Psychotherapy]. *La Psychiatrie de L'enfant*, *56*, 439–465. doi: 10.3917/psye.562.0439

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*, 237–246. doi: 10.1177/1098214005283748

Verheugt-Pleiter, J. & Zevalkink, J. (2008). *Mentalizing in child therapy: guidelines for clinical practitioners*. London, England: Karnac Books.

Wellman, H. M. & Bartsch, K. (1988). Young children's reasoning about beliefs. *Cognition*, *30*, 239–277. doi: 10.1016/0010-0277(88)90021-2

Wellman, H. M., Cross, D. & Watson, J. (2001). Meta-analysis of theory-of-mind development: The truth about false belief. *Child Development*, 655–684. doi: 10.1111/1467-8624.00304

Wellman, H.M., & Lagattuta, K. H. (2000). Developing understandings of mind. In S. Baron-Cohen, H. Tager-Flusberg, & D. Cohen (Eds.), *Understanding other minds: Perspectives from developmental cognitive neuroscience*, second edition. Oxford, UK: Oxford University Press.

World Health Organization (2002). *Mental health: a call for action by world health ministers*. Geneva: World Health Organization. Retrieved from: http://www.who.int/mental_health/media/en/249.pdf

Zevalkink, K; Verheugt-Pleiter, A; Fonagy, P; (2012) Mentalization-informed child psychoanalytic psychotherapy. In: Bateman, A and Fonagy, P, (eds.) *Handbook of Mentalizing in Mental Health Practice*. (129 - 158). Washington, DC: American Psychiatric Publishing.