

**The Use of Mentalization-Based Techniques in Online Psychodynamic Child  
Psychotherapy**

### Abstract

**Objective:** Psychodynamic child psychotherapy is an evidence-based approach for a range of child mental health difficulties and needs to constantly adapt to meet the needs of children. This study is the first to investigate whether the use of mentalization-based interventions (i.e., a focus on promoting attention control, emotion regulation, and explicit mentalization) predicted a good therapeutic outcome in online psychodynamic child therapy sessions conducted during the COVID-19 pandemic. **Methods:** The sample included 51 Turkish children ( $M_{\text{age}} = 7.43$ , 49% girls) with mixed emotional and behavioral problems. Independent raters coded 203 sessions from different phases in each child's treatment using the Mentalization-Based Treatment for Children Adherence Scale (MBT-CAS). **Results:** Multilevel modeling analyses showed children with higher emotional lability benefited more from attention control interventions compared to those with lower emotional lability. **Discussion:** Interventions that focus on developing the basic building blocks of mentalizing may be effective components of therapeutic action for online delivery of psychodynamic child psychotherapy, especially for children with greater emotional lability.

*Keywords:* psychodynamic child psychotherapy, mentalization-based techniques, emotional lability, attention control, COVID-19 pandemic

*Clinical or methodological significance of this article:* This paper is the first to investigate the effects of mentalization-based techniques in online psychodynamic child psychotherapy with children experiencing high arousal and distress, such as was common during the COVID-19 pandemic. For children who tend to get dysregulated easily under distress, utilizing techniques to create joint attention and attunement are especially beneficial to instigate the basic building blocks of mentalization and regulate arousal levels. Future research should investigate other treatment contexts to determine whether there is broader empirical support for the effectiveness of attention control interventions.

## **The Use of Mentalization-Based Techniques in Online Psychodynamic Child**

### **Psychotherapy:**

Psychodynamic child psychotherapy is an evidence-based approach to working with young people that draws on psychoanalytic principles, whilst also integrating ideas from other disciplines, including developmental psychology, attachment theory, and neuroscience (Kegerreis & Midgley, 2014; Midgley et al., 2021). One of the theoretical strands that has informed contemporary models of psychodynamic child psychotherapy is ‘mentalizing’ (Fonagy & Target, 1998). Mentalization refers to the ability to interpret one’s own and other people’s behaviors in terms of underlying mental states such as feelings, beliefs, and/or intentions (Fonagy et al., 1998). Mentalization-informed interventions aim to promote this capacity and are carefully matched to the mentalizing capacity of the patient, with the therapist drawing on a spectrum of interventions such as paying attention to physical and ostensive cues, scaffolding the patient’s regulation of affect and explicitly verbalizing mental states (Bateman & Fonagy, 2016). Enhancing mentalization is considered a potentially common process factor in all effective treatments, including psychodynamic child psychotherapy (Allen et al., 2008; Goodman et al., 2016).

A mentalizing framework is especially necessary in contexts where therapists are working with children with high levels of stress and/or emotion dysregulation (Fonagy et al., 1994). During the COVID-19 pandemic, children and parents presented with high levels of anxiety and emotional arousal due to health concerns, changes in daily routines, financial difficulties, social restrictions, isolation from social life, as well as uncertainty regarding the future (Bate et al., 2021; Fiorillo & Gorwood, 2020). Furthermore, psychotherapeutic treatments were rapidly transitioned to remote working and telehealth, placing further stress on clinicians who were experiencing the strain of the pandemic alongside their patients and exposed to vicarious trauma (Aafjes van Doorn et al., 2021). Several papers have suggested

that because mentalizing is a concept that is transtheoretical and potentially transdiagnostic, techniques drawing on a mentalization-based approach could be particularly effective in the context of the pandemic and the abrupt transition to telehealth (Bate & Malberg, 2020; Wurman et al., 2021). Therefore, this study aimed to examine the impact of using techniques drawing on a mentalization-based approach on outcome in online psychodynamic child therapy sessions conducted during the COVID-19 pandemic.

### ***Mentalization***

The extent to which an individual develops the capacity for mentalize is dependent on their early attachment relationships (Fonagy et al., 2002). In a secure attachment relationship, this process starts with the caregiver's contingent mirroring of the infant's pre-verbal experiences and responsivity to the moment-to-moment changes in their affective and sensory states. Ostensive cues like eye contact, marked mirroring, and affective attunement help the infant attend to relevant information and generalize this learning to other circumstances, enabling them to learn about the physical, psychological, and interpersonal world through social relationships (Csibra & Gergely, 2009). The caregiver's ability to attune to the infant's states and mirror them back also helps the infant to develop basic representations of their mental states and start to regulate them. Mentalizing is a resilience-promoting factor that plays a central protective role against psychopathology (Luyten et al., 2020) and traumatic experiences (Ensink et al., 2015; Huang et al., 2020). Impairments in mentalizing are associated with a wide range of psychopathology, including internalizing and externalizing problems in children (Bizzi et al., 2020, 2022).

Emotional arousal plays a central role in mentalizing. When it is high, mentalizing may be disrupted and cause an individual to revert to pre-mentalistic modes of functioning (Debbane & Nolte, 2019; Fonagy & Luyten, 2009). These pre-mentalizing modes are ways of making sense of behavior in terms of underlying internal experiences typical of early

development. The onset of the COVID-19 pandemic was highly stressful for most people and traumatic for some (Bate et al., 2021). Children were one of the most psychologically vulnerable populations during the pandemic, suffering from a high prevalence of anxiety, depression, and post-traumatic symptoms (Bussi res et al., 2021; Marques de Miranda et al., 2020). The immense anxiety and burden likely made mentalizing more difficult for both children (Bate & Malberg, 2020; Bate & Schulder, 2022) and their parents (Yatziv et al., 2022). And yet, studies identified parental mentalization, where available, as serving a protective function against distress and children’s behavioral problems in the context of COVID-19 (Bianco et al., 2021).

***The use of mentalization-based principles and techniques in psychodynamic child therapy***

There are therapies that target mentalization under the umbrella of Mentalization-Based Treatments (MBTs), including Mentalization-Based Treatment for Children or MBT-C (Midgley et al., 2017). Additionally, various mentalizing techniques appear to be used by psychodynamic clinicians more generally when working with children (Mu oz Specht et al., 2016). In several single-case studies of psychodynamic child therapy, specific techniques used to promote mentalizing were shown to play an important role in therapeutic improvement (Carvalho et al., 2019; Halfon et al., 2017). Preliminary empirical evidence also shows that the use of principles and techniques drawn from a mentalization-based approach in child therapy is associated with improvements in affect regulation, reflective functioning, and the quality of attachment patterns (see Oehlman Forbes et al., 2021 for a review). Promoting mentalization predicts better affect regulation and symbolic play (Goodman et al., 2015; Halfon & Bulut, 2019) as well as improved functioning (Halfon et al., 2019) in psychodynamic child therapy.

When patients are in a state of heightened distress and arousal, as was the case during the COVID-19 pandemic, one of the clinical challenges in psychotherapy is supporting the

mentalizing capacity. An innovation in the application of a mentalization-based framework to child psychotherapy was the creation of a scaffolding approach that supports the building blocks of mentalizing, by integrating techniques targeting attention control and emotion regulation, as well as explicit mentalizing. The balance between these techniques may depend on the child's developmental level, both globally and at a moment-by-moment level (Bate & Malberg, 2020; Bate & Schulder, 2021).

Mentalization-based techniques fostering attention control include noticing and naming, focusing on what is happening in the here and now, creating opportunities for joint attention by actively introducing or co-constructing an activity, joining with the child, and matching their verbal and nonverbal rhythms (Midgley et al., 2017). Attention to physical signals such as ostensive cues (facial expressions, bodily mannerism, voice of tone, etc.) is especially needed when patients are in a state of epistemic vigilance; that is, when they are unsure of whom to trust for information that will be accurate and generalizable. This type of attunement and the intentional use of ostensive cues may need to be emphasized in remote therapies, where there is reduced access to the full array of nonverbal cues that usually provide means for emotional engagement and contact (Fisher et al., 2021). They also help to keep the child engaged in online sessions (Bate & Malberg, 2020). Emotion regulation interventions centre around playing with arousal and regulation, identifying emotions, making affective states real by showing curiosity and interest, monitoring moments of dysregulation and mentalization breakdowns, and offering support and empathy to help the child recover from these moments.

During times of traumatic stress, focusing on the building blocks of mentalization (i.e., establishing attention control and enhancing emotion regulation) rather than promoting explicit mentalizing might be essential, especially for children who get dysregulated easily (Bate & Malberg, 2020). These interventions are deemed safe because they have the potential

to decrease arousal allowing for the chance to reinstate mentalizing and reduce the risk of exposing the child to potentially overwhelming emotions that they cannot process quickly (Bateman & Fonagy, 2012). Explicit mentalizing interventions are only used with child patients if they are at an optimum arousal level where they can mentalize about mental states (Midgley et al., 2017). Explicit mentalizing interventions include linking mental states to behaviors, playing with different perspectives, and mentalizing the therapeutic relationship.

All of the interventions described above are practiced with a mentalizing stance that involves empathy, warmth, being non-judgemental and showing a genuine interest in the mind of the child. The therapists adopt a “not-knowing” position and instead of placing themselves in an expert position, genuinely try to invite curiosity and work to find out the child’s mental states (Allen et al., 2008; Midgley et al., 2017).

### **Aims of the Current Study**

This study is the first to investigate whether the appropriate and skillful use of mentalization-based techniques in online psychodynamic child therapy sessions during the COVID-19 pandemic predicts a good therapeutic outcome in the form of a decrease in children’s problem behaviors. In this study, mentalization-based techniques (i.e., a focus on attention control, emotion regulation and explicit mentalization) were treated as separate variables in contrast to previous studies (i.e., Goodman & Halfon, 2021; Halfon et al., 2017) because we were interested in their differential effect on outcome. Moreover, given that the interplay between emotional arousal and mentalizing is a central tenet of the mentalizing framework, we predicted that patients’ baseline emotional lability would interact with different types of mentalizing intervention in predicting outcome.

It was hypothesized that (1) more skillful (in terms of appropriateness, extensiveness, and frequency) use of attention control, emotion regulation, and explicit mentalization interventions would predict fewer problem behaviors and (2) children with greater baseline

emotional lability would benefit more (in terms of reduced problem behaviors) from a focus on the building blocks of mentalizing, i.e. attention control and emotion regulation interventions, compared to children with lower emotional lability.

## **Methods**

### ***Study design***

The data were collected between Fall 2019 and September 2021 as part of a more extensive research program that aims to investigate baseline predictors and effective treatment factors of outcome in psychodynamic child therapy. The study was designed as naturalistic process-outcome research. The patients applied for psychotherapy services just before or during the COVID-19 pandemic. Cases were assigned to clinicians in an ecologically valid manner based on caseloads. The study was conducted at Istanbul Bilgi University Psychological Center (IBUPC) in Istanbul, Turkey. The research protocol was approved by the Ethics Committee of Istanbul Bilgi University.

### ***Study population***

IBUPC is a community-based mental health clinic that provides low-cost psychotherapy services. Referrals were made by the parents or by mental health professionals. After they were referred to the clinic, the parents and the children were screened by a clinical psychologist to see whether they met the study protocol inclusion criteria. Children were excluded and referred to appropriate services if they had psychotic symptoms, a significant risk of suicide attempts, serious risk of harm to others, severe developmental delays, severe learning difficulty or a diagnosis of eating disorders or substance abuse. The patients and their parents were informed about research procedures before commencing therapy. Parents provided written informed consent and children's oral assent was taken. This research was approved by Istanbul Ethics Committee Project No: 2020-40024-53.

### ***Study sample***

### *Children*

A group of 57 patients admitted consecutively from January 2019 to September 2021, and who were eligible to receive psychotherapy services at our clinic, consented to research and video recording of sessions. Six of these patients dropped out of therapy during the intake process. The final sample comprised of 51 patients between the ages of 4 to 10 years old ( $M = 7.43$ ,  $SD = 1.79$ ). 21 children started the assessment phase of therapy just before COVID-19 pandemic broke-out, they received the intervention phase of their treatment fully as online therapy under the pandemic conditions (41.2%). All other psychotherapies (assessment plus intervention phase) started during the pandemic and were delivered as online psychotherapy (58.8%). Children were from Istanbul (the largest metropolitan city in Turkey), from low (27.3%) to middle-income (72.7%) backgrounds, and mostly intact families (71.4%). The demographic characteristics of the patients are in Table 1. We used the Children's Revised Impact of Event Scale (CRIES; Perrin et al., 2005) to screen children's PTSD symptoms in response to the pandemic. The CRIES is a self-administered measure of post-traumatic stress symptomatology in the past seven days in response to a particular event. Based on previous research, a cut off score of 17 or above on the total of intrusion and avoidance subscales was used as an indication of a high probability of obtaining a diagnosis of PTSD (Perrin et al., 2005). Other studies conducted during the pandemic also used this scale to report elevated PTSD symptoms (e.g., Bhushan et al., 2021, Curatola et al., 2022). 27.5 % of the children showed elevated PTSD symptoms in response to the COVID-19 pandemic.

### *Therapists*

The therapists were 23 clinical psychologists in training to obtain a master's-degree; 86.9% were female, with ages ranging from 24 years to 37 years ( $M = 26.72$ ,  $SD = 2.77$ ). Each therapist was educated in the theoretical background of psychodynamic child therapy, including ways of using a mentalizing approach to support and promote attention control and

emotion regulation, over the course of two years during master's-degree classes, supervisions, and case seminars. Therapists' experience level was the uniform (1–2 years of supervised psychotherapy experience). On average, therapists treated 2 ( $SD = 1.21$ ) patients (range: 1–6). Each therapist had a minimum of 4 hours of supervision per week (i.e., 1 hour of individual and 3 hours of group) by licensed psychodynamic supervisors with at least 10 years of experience.

### ***Study interventions***

The standard treatment conducted at IBUPC is psychodynamic play therapy with a focus on mentalizing (i.e., Verheugt-Pleiter et al., 2008; Winnicott, 1971). The therapists are encouraged to utilize mentalizing techniques, including: adopt a mentalizing stance; show genuine curiosity and interest in the child's mind and not just behaviors; join the child's play activities in pretend mode; notice, mirror and contingently respond to non-verbal mannerisms; regulate the child's arousal levels through up-regulation or down-regulation interventions; explore and make comments on mental processes; and point out the connections between mental states and behaviors (Midgley et al., 2017). The treatment process includes parallel parental work that aims to increase parental mentalization (Slade, 2005), helping the parent to think about the child's mind, particularly the relations between behavior and mental states, and noting the links between the parent's and child's mental states.

All services at IBUPC were modified in response to COVID-19. In April 2020, the government ordered a legal lockdown in Turkey due to the pandemic. Accordingly, all services at IBUPC switched to remote psychotherapy and the sessions were conducted through the Zoom app. Before starting online therapy, the therapists initially assessed whether the child's needs could be addressed in an online format. Afterwards, therapists informed parents about the required equipment (i.e., smartphone, tablet or computer, microphone and speakers, internet access, and the Zoom app) as well as the need for a private room where the

sessions could take place. A safety protocol was established with the parents such that the therapists confirmed the telephone number and accessibility of the parents in the same house while their children were participating in an online therapy session, in case of an emergency. Moreover, therapists formulated a plan with the parents for technology failures and obtained permission to contact the parents if the connection was lost.

For all patients, a clinical interview was conducted with parents to learn about the history of the presenting problem, as well as the developmental history and family background of the child. This interview also comprised of a detailed assessment of how the pandemic and lockdown affected the family and the child, including recent losses, health problems, economic problems and other changes in the routines. If the initial sessions were conducted face-to-face after which a forced transition to online therapy took place, an additional meeting was conducted regarding the effects of the pandemic as well as their feelings regarding this forced transition. In the second session, the therapist met with the child. The therapists adapted the activities and materials to be delivered in an online remote format. As such, they asked the parents to have the child's preferred toys as well as art materials in their own room. They also used the different functions of the Zoom app such as chat, whiteboard and other online games that could be accessed. The therapists acknowledged the effects of the pandemic and lockdown as well as informed the child about the guidelines of online therapy sessions. After this session, the therapist presented a clinical formulation and treatment plan.

The standard treatment plan at the clinic involves a once-weekly therapy session of 50 minutes with the child, along with once-monthly parent sessions. The same frame was applied in online therapy sessions; however, for some children who had a harder time keeping their attention during online therapy, shorter sessions of 30 minutes were advised. Treatments were open-ended in duration and were determined based on progress toward goals, life changes,

and the decisions made by patients' families. The mean number of sessions for this sample ( $N=51$ ) was 44.5 ( $SD = 17.49$ ). All patients attended at least 20 sessions, 77.1 % of the sample attended at least 30 sessions and 53.5 % of the sample attended at least 40 or more sessions.

### ***Data collection procedures***

The Child Behavior Checklist (CBCL) was completed by parents during the intake and at the final session of the psychotherapy process. Parents also filled out the Emotion Regulation Checklist (ERC) and demographic information at intake. All children were assessed on problem levels at regular intervals, that is every tenth session in treatment with the Brief Problem Monitor (BPM) completed by the parent. All psychotherapy sessions were videotaped and transcribed. The session on which the BPM was completed was chosen for the assessment of in-session use of mentalization-based techniques, so that it was possible to examine associations between observational variables and problem behaviors. Videotapes and transcripts of these sessions were arranged in random order, and entire sessions were rated independently using the Mentalization-Based Treatment for Children Adherence Scale (MBT-CAS). A total of 203 sessions from every tenth session in each child's treatment was coded by independent raters who are not associated with the treating clinicians or the cases, and blind to the purposes of the study. The mean number of sessions coded for each child was 4 ( $SD=1.14$ ).

### ***Measures***

Demographic information (age, education, socioeconomic and marital status) was obtained using a standard intake form and from information obtained in the initial intake interview. The children also filled out Children's Revised Impact of Event Scale (CRIES, Perrin et al., 2005) in order to screen for post-traumatic stress symptoms associated with the pandemic.

The Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) is a 24-item questionnaire that assesses children's emotion regulation capacity through ratings on a five-point scale (1 = "never" to 5 = "always"). It involves two subscales; one of which is emotional lability and negativity, defined as high arousal, anger outbursts, dysregulation, and mood changes; and the second is emotion regulation, defined as socially appropriate emotional displays, empathic stance, and affective self-awareness. The Turkish version has been shown to have high internal consistency and discriminant validity (Batum & Yagmurlu, 2007). In the current study, the emotional lability scale had an adequate level of internal consistency ( $\alpha = 0.71$ ).

The Child Behavior Checklist (CBCL; Achenbach, 1991) is a widely accepted method to assess behavioral problems in children, with two versions for ages 1.5–5 years and 6–18 years. The CBCL identifies how "true" a series of 112 items of problem behaviors is for the child on a three-point scale (0 = "not true", 1 = "somewhat or sometimes true", and 2 = "very true or often true"). Outcomes indicate significant problems for internalizing (e.g., depression, anxiety), externalizing (e.g., aggression, violence) or total problems. This scale has high levels of internal consistency (CBCL for 1.5–5 years and 6–18 years:  $\alpha = 0.97$ ) and 1-week test-retest reliability (CBCL for 1.5–5 years:  $r = 0.90$ ; CBCL for 6–18 years:  $r = 0.94$ ; Achenbach, 1991). The scale was adapted to Turkish with good internal consistency and test-retest reliability for internalizing ( $\alpha = 0.87$ ,  $r = 0.93$ ), externalizing ( $\alpha = 0.90$ ,  $r = 0.93$ ) and total problems ( $\alpha = 0.94$ ,  $r = 0.93$ ) scales (Erol & Şimşek, 2010). In the current study, all the total problems subscale showed excellent degrees of internal consistency (CBCL for 1.5–5 years:  $\alpha = 0.93$ ; CBCL for 6–18 years:  $\alpha = 0.92$ ).

The Brief Problem Monitor (BPM; Achenbach et al., 2011) is a 19-item subset developed from items included on the comprehensive CBCL (Achenbach, 1991) through item-response theory and factor analysis. It employs the same three-point scale and is

applicable to children within the same age range. Children's problematic behaviors are rated by mothers, specifically internalizing (e.g., "self-conscious or easily embarrassed", "feels too guilty"), externalizing (e.g., "argues a lot", "stubborn, sullen, or irritable"), and attention problems (e.g., "fails to finish tasks s/he starts", "impulsive or acts without thinking"). This scale demonstrated good internal consistency ( $\alpha = 0.74$ ), test-retest reliability over an 8–16-day period ( $r = 0.77$ ), and criterion-related validity (Achenbach et al., 2011). In the current study, the BPM total problems subscale showed good internal consistency ( $\alpha = 0.82$ ).

The Mentalization-Based Therapy for Children Adherence Scale (MBT-CAS; Bate & Midgley, 2020) is the first observer-rated measure developed to assess the use of mentalization principles in psychotherapy sessions with children. The therapist's mentalization stance is assessed through six items: "(1) adaptation to the child's developmental level; (2) non-judgmental stance; (3) not-knowing mentalizing stance; (4) playful stance; (5) making implicit explicit and (6) use of self." In addition to the therapist's stance, coders evaluate the therapist's interventions in each of the three building blocks; which are "(1) attention control (i.e., mirroring, joint attention, becoming aware of child's bodily signals); (2) emotion regulation (i.e., taking an active role in keeping the arousal level of the child at helpful level, identifying triggers); and (3) explicit mentalization (i.e., linking mental states to behavior)". All intervention items are initially rated as present or absent and, if the item is present, then it is assessed on a 5-point Likert scale for Skill Level (1 = "poor", 5 = "very good"). Skillfulness is characterized by expertise, appropriate timing and pace, and adaptation and responsiveness to the patient, and based on frequency, extensiveness, and appropriateness of the intervention (Bate & Midgley, 2020). According to the manual, "A highly skillful clinician makes interventions with the frequency and extensiveness that is appropriate to the given situation." Lastly, intervention ratings are assigned for each of the

three blocks (attention control, emotion regulation, explicit mentalization). In the present study, ratings of each of the three blocks were used as separate variables in the models.

The coding team consisted of six students obtaining their Master's degree in clinical psychology and six Master's level clinical psychologists who had prior training in mentalization-based theory and practice. Coders were trained over a 2-month period by Authors 1 & 2. Training consisted of studying the MBT-CAS coding manual, attending two 4-hour training meetings, coding specific session segments at these meetings, and practice coding sessions after each meeting (a total of 5 practice sessions). Coders received extensive feedback on the practice sessions. Following the training, they independently coded 20 pilot sessions. Coding commenced once coders met adequate pre-study reliability on the pilot sessions (intra-class correlation;  $ICC \geq .70$ ). During coding of the main data, regular reliability assessments were performed and the results were discussed in fortnightly meetings to help minimize coder drift. All the sessions in this data were double coded by independent pairs over a one-year period, with good to excellent level of ICCs ranging from 0.70 to 1.00 ( $M = 0.89$ ,  $SD = 0.08$ ). ICC estimates were calculated based on two-way random model. The mean scores of the coded sessions for each patient were used in the analyses.

### ***Data analyses***

All descriptive statistics were computed using SPSS version 25. In our data, sessions ( $N = 203$ ) were nested within children ( $N = 51$ ) who were nested within therapists ( $N = 23$ ). Therefore, we used a multilevel modeling (MLM) approach using MLwin v3 (Rasbash et al., 2019) to test our main hypotheses as well as psychotherapy outcome. The model testing procedure took place in three steps: In the first step, we ran an unconditional (null) model with no predictors to determine whether there was significant variation at the therapist and patient levels. The intraclass correlation (ICC), denoting the proportion of variability attributable to therapists and patients, was calculated. We used two-level (sessions nested

within patients) and three-level (sessions nested within patients nested within therapists) “empty” multilevel models, where BPM total problems was entered as the dependent variable with no predictor variables. The therapist-level intra-class correlation (ICC) was 0.00, which showed that therapists accounted for none of the variance. In contrast, the between-patient ICC was 0.23 ( $p < 0.01$ ), suggesting that a two-level model was appropriate because not all variance was attributable to session-level variables.

In the second step, in order to assess psychotherapy outcome, we tested a mixed-effects multilevel model with maximum likelihood (ML) estimation to analyze the change in BPM Total Problem scores. To capture change over time, a time variant session variable was created to model the linear change of BPM Total Problems over the course of treatment. Time was centered at the first session in order to measure change from baseline to termination. In order to control for the effects of children’s age, gender and baseline problem levels, these were included at Level 2 as time invariant predictors.

Thus, the multilevel modeling (MLM) equation predicting the change in BPM Total Problem was as follows:

$$\text{BPM Total Problems}_{ij} \sim N(XB, \Omega)$$

$$\text{BPM Total Problems}_{ij} = \beta_{0ij} + \beta_1 (\text{Sex})_j + \beta_2 (\text{Age})_j + \beta_3 (\text{Baseline Problem Level})_j + \beta_4 (\text{Session})_{ij}$$

$$\beta_{0ij} = \beta_0 + u_{0j} + e_{0ij}$$

$$[u_{0j}] \sim N(XB, \Omega_u) : \Omega_u = [r^2_{u0}]$$

$$[e_{0ij}] \sim N(XB, \Omega_e) : \Omega_e = [r^2_{e0}]$$

where N indicates the normal distribution for the fixed part ( $XB$ ) and random part ( $\Omega$ ) of the model.  $\beta_{0ij}$  is the intercept,  $u_{0j}$  represents the between patient variance and  $e_{0ij}$  is the Level 1 residual.

Subsequent model testing pertained to our main hypotheses. In order to test our initial hypothesis, we added the time-variant mentalization technique variables (attention control, emotion regulation and explicit mentalization) at Level 1. All intervention variables were included separately in the models. In order to control for patient characteristics, time invariant predictors were added at Level 2, namely children's age, sex, baseline problem levels and emotional lability. Moreover, since some children had face-to-face assessment sessions and then transitioned to online sessions, whereas others solely received online sessions, we created a dummy variable called treatment modality (1= face-to-face assessment & online intervention phase; 2 = fully online therapy) to control for this effect. Finally, to investigate our second hypothesis to assess whether children's baseline emotional lability moderated treatment response, we included cross-level two-way interactions between mentalization interventions and emotional lability. Thus, the equation tested was:

$$\text{BPM Total Problems}_{ij} \sim N(XB, \Omega)$$

$$\begin{aligned} \text{BPM Total Problems}_{ij} = & \beta_{0ij} + \beta_1 (\text{Age})_j + \beta_2 (\text{Sex})_j + \beta_3 (\text{Treatment Modality})_j + \beta_4 \\ & (\text{Baseline Problem Level})_j + \beta_5 (\text{Baseline Emotional Lability})_j + \beta_6 (\text{Attention Control} \\ & \text{Interventions})_{ij} + \beta_7 (\text{Emotion Regulation Interventions})_{ij} + \beta_8 (\text{Explicit Mentalization} \\ & \text{Interventions})_{ij} + \beta_9 (\text{Baseline Emotional lability} * \text{Attention Control Interventions})_{ij} + \beta_{10} \\ & (\text{Baseline Emotional Lability} * \text{Emotion Regulation Interventions})_{ij} + \beta_{11} (\text{Baseline Emotional} \\ & \text{Lability} * \text{Explicit Mentalization Interventions})_{ij} \end{aligned}$$

$$\beta_{0ij} = \beta_0 + u_{0j} + e_{0ij}$$

$$[u_{0j}] \sim N(XB, \Omega_u) : \Omega_u = [r^2_{u0}]$$

$$[e_{0ij}] \sim N(XB, \Omega_e) : \Omega_e = [r^2_{e0}]$$

All variables were grand-mean centered (except the time variable) as this is advised when including interaction terms (Singer & Willett, 2003). Independent variables and interaction terms were added stepwise to the null model (i.e., the unconditional model) and

compared against each other using -2loglikelihood as indicator of goodness of fit (Singer & Willet, 2003). Lower values on this index indicates better model fit to the data. To assess effect size, we calculated pseudo- $R^2$  as the proportion of total within-person variance from a completely unconditional or base model that is accounted for when main variables are added to the model (Snijders & Bosker, 1999). The traditional  $R^2$  is not directly applicable to multilevel models because there is variance across multiple levels of the nested data. However, pseudo- $R^2$  computations are used.

## Results

### *Descriptive analyses*

Our sessions showed good to adequate therapist adherence to a mentalization-based model of therapy in terms of using techniques with a focus on attention control ( $M = 4.33$ ,  $SD = 0.40$ ,  $\min = 3.00$ ,  $\max = 5.00$ ), emotion regulation ( $M = 3.83$ ,  $SD = 0.38$ ,  $\min = 2.63$ ,  $\max = 4.75$ ) and explicit mentalization ( $M = 3.61$ ,  $SD = 0.38$ ,  $\min = 2.00$ ,  $\max = 4.30$ ). All these interventions were practiced with a strong mentalizing stance ( $M = 4.15$ ,  $SD = 0.30$ ,  $\min = 3.06$ ,  $\max = 4.67$ ). The results of the inter-correlations between mentalization interventions and baseline characteristics (age, gender, problem levels) indicated that as child age increased, the appropriate and skillful use of attention control interventions decreased ( $r = -0.46$ ,  $p < 0.001$ ). None of the other associations with demographic variables were significant.

### *Psychotherapy outcome analyses*

The main effect of time (i.e., session) on BPM Total Problems indicated significant linear decrease (please see Table 2). 3% of within patient variance in BPM Total problems was explained by time indicating a small effect.

### *Mentalization interventions and psychotherapy outcome analyses*

For our first hypothesis, we expected that more appropriate and skillful use of interventions focused on attention control, emotion regulation and explicit mentalization

would predict fewer problem behaviors. For our second hypothesis, we predicted that children's baseline emotional lability would be a substantial moderator such that children with greater lability at baseline would benefit more from therapies where there was a greater use of attention control and emotion regulation interventions. The variables were added to the model in a stepwise manner. The difference test of the deviance statistics between the base model and the conditional model with the intervention variables was significant [ $\chi^2(3) = 14.94, p < 0.05$ ], indicating that the conditional model with the intervention variables was a better fit, and therefore it was retained. Afterwards, the interaction terms between emotional lability and intervention variables were added. The difference test of the deviance statistics between the conditional model including only intervention variables and the conditional model with the intervention variables plus interaction terms was significant [ $\chi^2(3) = 8.25, p < 0.05$ ]. Therefore, the interactions were also retained.

Our findings (see Table 3) indicated that the main effect of a greater use of attention control interventions on outcome was significant ( $\beta = -3.02, SE = 1.45, p = 0.037$ ); however, this effect was moderated by the child's baseline emotional lability. The two-way interaction between baseline emotional lability and the use of attention control interventions was significant ( $\beta = -0.51, SE = 0.23, p = 0.029$ ). Hence, if baseline emotional lability was high (1 *SD* above the mean), the greater use of attention control interventions was associated with a steeper decrease in problem behaviors than when it was low (1 *SD* below the mean; see Fig. 1). None of the other interactions were significant. 7 % of the variance in BPM Total problems was explained by the interaction between attention control and baseline emotional lability indicating a small effect.

## Discussion

The aim of this study was to investigate whether therapists' greater use of mentalization-based interventions (including those focusing on promoting attention control,

emotion regulation and explicit mentalization) in online psychodynamic child therapy sessions during the COVID-19 pandemic predicted fewer problem behaviours. The effect of attention control interventions was moderated by children's baseline emotional lability such that attention control interventions were associated with greater change in problem behaviours for children with higher emotional lability at the start of treatment, compared to those with lower emotional lability. None of the other interventions or interactions were significant in the models.

Previous studies in psychodynamic child psychotherapy research showed that the use of a mentalization-based approach predicts better affect regulation (Halfon & Bulut, 2019) and outcome (Halfon et al., 2017). However, these studies measured "mentalization-based approach" as a global construct. This study was the first to examine the role of specific mentalization-based interventions in psychodynamic child psychotherapy, including those that are aimed at promoting the building blocks of a mentalizing capacity. Our findings provide preliminary answers about what works for whom in the context of psychodynamic treatment delivered online. Luyten and Fonagy (2015) described a spectrum of interventions to be employed depending on the mentalization profile of adult patients, and Verheugt-Pleiter et al. (2008) and Midgley et al. (2017) have shown how this approach can be adapted to work with school-age children. They emphasized that therapists need to adapt their technique to the 'level' at which the child is operating (Midgley et al., 2017; Verheugt-Pleiter et al., 2008). Our findings support their emphasis, suggesting that when children are easily dysregulated, focusing on the building blocks of mentalization, namely those that aim to promote attention control, can be especially useful. Therapeutic interventions that use ostensive cues, that work on joint attention to create rhythm and structure and that tune into the child's bodily signals can help build emotion regulation. Such interventions serve as a starting point on which more complex emotion regulation and higher order mentalizing can take place. These findings also

further support the notion that explicit mentalizing interventions may not always be optimal in psychotherapy. For example, Halfon et al. (2017) found that for children who have significant mentalization deficits, explicit use of mental state words in therapy may be overwhelming since they have not yet developed the symbolic capacities to elaborate on their internal world. These children may respond better to therapeutic interventions aimed at supporting the building blocks of mentalizing, such as marked mirroring, contingent coordination and techniques aimed at building joint attention. Such interventions pave the way for more complex affect regulation and mentalized affectivity.

While this study has relevance to the delivery of online therapy with children more broadly, its findings should also be discussed in the context of the COVID-19 pandemic. The stressful period of the pandemic may have intensified epistemic vigilance and emotionality; in those conditions, “arousal-adjusted interventions” can promote safety and regulation (Wurman et al., 2021). Attention control interventions bring a sense of predictability, structure and scaffolding at times of uncertainty. Trauma-focused therapeutic work with children also places importance on becoming attuned with the child affectively and maintaining joint attention in here-and-now (Becker-Weidman & Hughes, 2008; Vliegen et al., 2023). Matching the child’s emotional expression with relevant facial expressions, body gestures and vocal intonation – even when delivered via online therapy - could all be effective strategies to create “patterns of being together” and keep the child engaged despite the restrictions of the screen (Fisher et al., 2021).

It is also important to note that the use of attention control interventions, in the context of an *overall ‘good enough’ use of mentalization-based principles* and techniques, is associated with better outcomes. It is crucial that research determine both what is necessary and sufficient in psychotherapy process. It is possible that what is needed is good-enough adherence to all components of the model for therapeutic effectiveness. A similar relation was

found in psychodynamic adult therapy, such that moderate levels of dynamic interventions were associated with improvement (McCarthy et al., 2016). However, future research would need to empirically assess this hypothesis in child psychotherapy.

### ***Clinical implications***

Qualitative explorations of child and adolescent therapists' experiences have shown that the forced transition to delivering psychotherapy treatments remotely (i.e. online therapy) during the COVID-19 pandemic raised a number of challenges. Erlandsson et al. (2022) found that a "restricted therapeutic repertoire" regarding non-verbal communication emerged as the second most common theme in the child and adolescent therapists' experiences of online therapy psychotherapy. Therapists expressed frustration and feelings of incompetency regarding conveying nonverbal messages, increased difficulty understanding the children's affect and mirroring their feelings. Moreover, having to focus more on verbal communication instigated fatigue and stress. Trub (2021) found that therapists in fact felt forced to rely more on the verbal medium, paying less attention to, or becoming unaware of, embodied and implicit communication channels. Bomba et al. (2021) found that therapists felt the holding function of the physical therapeutic frame was absent and were under greater demands to find other ways to contain the patient. Moreover, the online format may pose particular challenges for certain patients who often present with severe emotion regulation difficulties or experience challenges sustaining attention (Comer & Myers, 2016). Specifically, therapists may struggle to engage such children.

Considering these findings, the mentalizing framework used in this study can provide psychodynamic clinicians working with children with tools that can help compensate for the limitations of embodied communication. A further study would be to see if attention control interventions could be integrated into other psychotherapies such as cognitive-behavioral therapy sessions. Attention control interventions can help therapists become aware of bodily

signals such as mutual gaze and other non-verbal cues essential to the healing nature of psychotherapy, as well as to help provide structure and holding during the sessions.

***Study limitations and directions for future research***

This was the first study to investigate whether the use of mentalization-based interventions predicted good therapeutic outcome in psychodynamic child therapy during the COVID-19 pandemic. The study also had some limitations. First, there was no control group, and the treatment was not randomized. Therefore, causal inferences cannot be made. Second, the sample size was relatively small which limits the generalizability of the results. Third, other potential moderating (e.g., children's baseline mentalization capacity) and mediating variables (e.g., children's emotion regulation capacity) were not investigated within the scope of this study. Future research should consider not only the moderator role, but also the mediating role of children's emotion regulation on the relationship between mentalization interventions and therapeutic outcome. Moreover, some therapies in our sample started just before the pandemic and transitioned to online therapy whereas others were delivered fully online. There may have been differences in the experiences of these patients and therapists. Even though we statistically controlled for this in our models, this may also limit the consistency of our results. Fourth, the therapists in this study were master's-level graduate students with a limited degree of training. Studies have shown that even though there was no difference between the effectiveness of remote and face-to-face therapies, novice therapists with limited experience struggled most with this transition (Lin et al., 2022). Future research should include a sample of more experienced clinicians. Fifth, our outcome measures were only based on parent's report of child symptomatology, therefore assessments based on child, therapist or teacher's perspective should be included in future research.

While this study was conducted during the pandemic and provides empirical support for the claim that the use of attention control interventions may be even more relevant at this

time, it is not known whether these findings would be true for in-person treatment and/or for online therapy delivered beyond the context of the pandemic. Future research should examine these specific mentalizing interventions in other treatment contexts, to determine whether there is broader empirical support to the utility of attention control interventions, which tend to focus on nonverbal behavior and utilizing nonverbal and para-verbal techniques to create joint attention and reciprocal interpersonal rhythms, and enhance epistemic trust, particularly for children presenting with emotional lability.

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