The unbroken circle: From child analysis to Mentalization Based Treatment (MBT) and back again to MBT with children, adolescents and families

Abstract:

It is now more than thirty years since Peter Fonagy published his classic 1991 paper introducing the concept of 'mentalization' into the psychoanalytic literature, and in the period since then Mentalization Based Treatment (MBT) has emerged as an important therapeutic approach. In reviewing the history of this treatment, it is often assumed that MBT emerged at the interface between three domains: firstly, the developmental research on theory of mind; secondly, the clinical challenges of treating borderline personality disorder; and thirdly, the empirical research on inter-generational patterns of attachment. This paper suggests that there was one more domain, which was equally important to the development of MBT, and which is perhaps less widely recognised. This fourth domain was developments in child analysis, especially those taking place during the late 1980s and early 90s at the Anna Freud Centre in London. Although the origins of MBT theory and technique in child work is perhaps not widely acknowledged, recognising these roots helps us to better understand mentalizing therapy. It also enables us to see how the development of MBT for children, young people and families can be understood as a closing of the circle in the development of mentalization-based interventions.

The unbroken circle: From child analysis to Mentalization Based Treatment (MBT) and back again, to MBT with children, adolescents and families

It is now more than thirty years since Peter Fonagy published his classic paper on 'Thinking about thinking: some clinical considerations in the treatment of a borderline patient' (Fonagy, 1991). In that paper, which draws on the concept of 'theory of mind' to articulate a new way of understanding borderline states of mind, Fonagy refers to 'the achievement of a representation of mental events', which he notes has been referred to in the psychoanalytic literature as the 'capacity for symbolization'. This term, he suggests, had become 'over-burdened with meanings, particularly in psychoanalysis' (p.641). So he says, almost as an aside:

"For the sake of brevity I would like to label the capacity to conceive of conscious and unconscious mental states in oneself and others as the capacity to *mentalize*" (p.641, italics in original).

Although the term 'mentalize' was used by French analysts in the 1960s (Marty, 1969), and Fonagy himself had written about it in the *Bulletin of the Anna Freud Centre* two years earlier (Fonagy, 1989), the signal point for the use of the term and the catalyst of the mentalizing tide can be found in the seminal paper 1991 paper which ushered in a remarkable increase in the number of citations to papers on this topic over the last thirty years. Certainly Peter Fonagy and Anthony Bateman, in a review paper about MBT (Bateman & Fonagy, 2013), point to 1991 as a significant historical moment themselves, by using 1991 as the baseline date to chart the rise in popularity of the term. They note, with evident pride, that the use of the term 'mentalizing' in titles and abstracts of scientific papers on the Web of Science increased from 10 in 1991, to 2,750 in 2011, encompassing a wide range of authors now using the term: 'from psychoanalysts to neuroscientists, from child development researchers to geneticists, from existential philosophers to phenomenologists' (p.595). Since 2011, the popularity of the concept has only continued to rise.

The 1991 paper situates the development of the concept of mentalizing at the interface of a number of independent domains. First and foremost, there is the clinical sphere, and in particular the treatment of Mr S, a 'violently abused and abusive' 27 year old man with clear features of a borderline personality disorder, who was in intensive psychoanalytic treatment with Fonagy. Into his discussion of the considerable clinical challenges that he faced with this case, Fonagy brings into play the concept of 'theory of mind' (ToM), a perspective that Simon Baron-Cohen (1990) had recently proposed in relation to autism. In the 1991 paper, Fonagy quotes Premack and Woodruff's definition of theory of mind as 'the ability to take account of one's own and others' mental states in understanding and predicting behaviour' (Premack & Woodruff, 2010)p.640). After a lengthy digression into the literature on theory of mind, Fonagy anticipates that his reader may well be wondering about the relevance these ideas may have to a psychoanalytic case study. He answers this question by proposing that some of the key features of borderline personality disorder can be best understood when examined from the perspective of theory of mind.

Within a few years, Fonagy and Bateman were describing BPD as 'a disorder of mentalizing', in which the key features (impulsivity, rapidly changing emotional states, a fragile sense of self) were best understood in terms of a vulnerability in the capacity to mentalize in the context of interpersonal relationships. But they were also suggesting that a therapeutic focus on enhancing mentalizing might offer a better approach to treatment, and beginning to describe certain modifications to technique that would follow from this premise. It was not, however, until 2004 that the term 'Mentalization-Based Treatment' first saw print describing a distinct therapeutic approach (Bateman, 2004). Thousands of clinicians have been trained in MBT in the intervening years, and an evidence-base has gradually been established (Vogt & Norman, 2019). MBT is now recognised as a significant evidence-based treatment model, increasingly adapted to a range of clinical populations.

While there is no doubt that MBT can be understood as an approach that emerged around 1991 out of the convergence between a philosophical tradition (theory of mind, ToM) and a clinical problem

(the treatment of borderline personality disorder), in this paper I would argue that this view neglects the significant place of attachment-based developmental research and clinical work with children in the origin of the MBT approach. Providing two other equally significant legs supporting the MBT table. Both of these other legs - which are very much part of the field of child mental health - were also marked by the publication of key papers in 1991, the same year that the 'Thinking about thinking' paper was published.

The origins of MBT in attachment research

If theory of mind and the clinical challenges of BPD are configured as two of the fundamental 'legs' of the MBT table, then perhaps the third should be seen as developmental research, in particular attachment theory. Although the 1991 'Thinking about Thinking' paper makes no direct reference to Bowlby's work, Fonagy's collaborations with colleagues such as Miriam and Howard Steele, Mary Target, George Moran, Anna Higgett and later George Gergely, helped to link the emerging ideas of mentalization and BPD with the empirical study of intergeneration patterns of attachment.

A key paper highlighting this contribution was a 1991 paper in the *Journal of Infant Mental Health*, 'The Capacity for Understanding Mental States: The Reflective Self in Parent and Child and Its Significance for Security of Attachment' (Peter Fonagy, Steele, Steele, Moran, & Higgitt, 1991). This paper, one of the first reports of the Anna Freud Centre / University College London Parent-Child Project (LPCP), led by Miriam and Howard Steele, prospectively examined the influence of parental attachment representations, assessed before the birth of the first child, on the child's attachment pattern to that parent at 1 year and at 18 months. Using the Adult Attachment Interview with a predominantly middle-class group of 100 first-time mothers and 100 first-time fathers, the study examined what impact parental attachment would have on the child's attachment status, as rated using Ainsworth's Strange Situation Task.

Not surprisingly, the LPCP found a strong association between expectant mothers' attachment status prior to giving birth, and the subsequent attachment security of their child at 12 and 18 months. (A slightly weaker, but independent association was found between the father's attachment classification and the child's attachment to the father). In 75% of cases, it was possible to successfully predict whether an infant would be coded as either secure or avoidantly attached to the mother at 18 months, based on the coding of the AAI before the baby was born.

These findings were certainly noteworthy, although they largely replicated previous findings by other attachment researchers. But the LPCP went one step further, in a way that was to have a profound impact on the development of MBT. The team developed a new coding system, in order to examine the question of how attachment security (or insecurity) gets passed down through the generations? what is the mechanism by which these patterns are repeated - and perhaps more importantly, the mechanism by which they can be broken?

The new coding system, drawing partly on Mary Main's work on 'meta-cognition' (Main, 1991), was one of parental reflective-self functioning (later shortened to reflective functioning - RF). It was based on a psychoanalytic hypothesis about how a parent passes on their own patterns of attachment (secure or insecure) to their infant. In particular, they hypothesised that 'in any individual case a caregiver's capacity to *conceive of and think about relationships in terms of mental processes and functions* will determine the infant's security with that caregiver' (Peter Fonagy et al., 1991)p.208, my italics). Parents who were rated at the bottom end of this new scale were either unable or unwilling to reflect on their own intentional states or those of others, often using platitudes or generalizations to explain behaviour; while those with high scores showed a capacity to reflect on the motivations of their parents and themselves, and an awareness of the impact of those relationships. In other words, a capacity to *mentalize.*

When RF was added into the mix, something quite remarkable was found. Not only was it un-related to levels of verbal intelligence, social class or other key demographic variables, but high RF turned

out to be the most robust predictor of infant security, with infants of mothers with high RF showing less avoidant behaviour and more maintenance of contact. In a further analysis (Peter Fonagy, Steele, Steele, Higgitt, & Target, 1994), the LPCP research team was also able to demonstrate that mothers with a history of social deprivation were more likely to have low RF and have infants with insecure attachments (as we might expect). However, for this sub-group, the capacity to mentalize seemed to be of special significance. Those mothers whose infant *was* securely attached to them, despite the mother's own history of adversity, all had unusually high RF. It seemed that in such cases a high capacity for reflective functioning might help to understand why some families are able to overcome 'the ghosts in the nursery'.

Taken together, these empirical findings suggested that a key determinant of infant security is the caregiver's capacity for 'mind-mindedness' (Meins et al., 2002), i.e. to see their child as a person with a mind, and to show sensitivity to that mental world. Such a capacity to mentalize may well be a way of understanding 'resilience', the capacity to overcome difficulty. And conversely, when a parent's capacity to reflect on mental states is poor, the child is likely to inhibit their own capacity to reflect on mental states, which in turn may create what we see as insecure patterns of attachment. This perspective, Fonagy and his colleagues suggested, in their 1991 paper, 'may force us to reconsider the nature of security in the child's mind':

"In our view, a child may be said to be secure in relation to a caregiver to the extent that, on the basis of his or her experience, he or she can make an assumption that his or her mental state will be appropriately reflected on and responded to accurately [...] We believe that this sense of safety, which evolves as part of an initially shared mental process between infant and caregiver, stays with the child as a relatively stable aspect of mental functioning" (Peter Fonagy et al., 1991)p.215).

In subsequent years, this link between attachment, mentalizing and the development of the self was further elaborated - first in a series of important conceptual papers, written by Fonagy and Target, on theory of mind and the normal development of psychic reality (P Fonagy & Target, 1996)(Target

& Fonagy, 1996), and then in a set of studies carried out with the Hungarian child psychologist and developmental researcher, George Gergely. Gergely's work on the 'social biofeedback theory' (Gergely & Watson, 1996) which provided a more detailed and nuanced account of how the environment can shape the capacity to mentalize, in contrast to the theory of mind literature, which had suggested a more innate capacity that simply switched on when children reached a certain age. In particular, Gergely and colleagues demonstrated empirically the role of marked and contingent mirroring in the development of the mentalizing self, and subsequent research confirmed the hypothesis that, when this was absent, a child's capacity for mentalizing was impaired. In their magnum opus, *Affect Regulation, Mentalisation and the Development of the Self,* published in 2002, Fonagy, Gergely, Jurist and Target demonstrated how secure attachment laid the groundwork for mentalizing later in life, and set out the various processes by which this developmental capacity was achieved.

Two years after this, when MBT was set out as a method of treatment for adults with BPD, the links between this clinical field, the theory of mind research and attachment theory were very explicit. The capacity to mentalize, facilitated by secure attachment, forms the basis for self-organization and a sense of self as meaningful and coherent. Such a capacity depended, fundamentally, on the parent's capacity for mind-mindedness, as demonstrated through the process of contingent and marked mirroring. Such a process helped to establish second-order representations of affect states, which were crucial to the process of affect regulation. When the infant’s attachment relationships inadequately helped them develop a sense of themselves as an intentional being - often in relationships marked by neglect, maltreatment or trauma - then anxious, avoidant or disorganized patterns of attachment were likely to develop. When this happened, instead of a coherent sense of self, there may be a sense of a self as riddled with ‘alien’, un-represented aspects, that are prone to fragment under stress. These children grow up feeling trapped with un-represented experiences that leave them feeling alone, with an unbearable sense of badness that cannot be shared. In time, these hostile representations may need to be expelled onto other people, creating patterns of unstable

relationships, affect dysregulation and an unstable sense of self – in other words, a borderline personality disorder.

Thus, as we can see, attachment theory and research provided a third 'leg' to the conceptual and clinical development of MBT. But a fourth leg can be recognized, alongside the developmental research on theory of mind; the clinical challenges of treating borderline personality disorder; and the attachment research on inter-generational patterns of attachment. This fourth leg, less well recognized, was particular developments in the field of child analysis, developments which were taking place during the late 1980s and early 90s at the Anna Freud Centre in London, and which were marked by an important - if lesser known - publication also printed in MBT's 'annus mirabilis', 1991.

The origins of MBT in child analysis

In the late 1980s , following the death of Anna Freud in 1982, was a period when the place of analytic work with children seemed uncertain (Midgley, 2012). The classical psychoanalytic model of the mind, as set out by Freud in his first and second models, was increasingly seen as out-of-date and inconsistent with contemporary developmental research, leading some to sound the alarm bell that heralded a crisis in child analysis (Gomez, 2005).

Anna Freud herself had recognised that the classical model of child analysis, in which a child's neurotic disturbance was addressed through interpretation of unconscious conflict, was only a meaningful fit for a relatively small number of children referred for therapy. In many ways, classical child analysis assumed quite healthy levels of psychic functioning - assuming a degree of motivation, a certain capacity to tolerate awareness of conflicts as they were brought into consciousness, without resorting to either disorganization or to even more maladaptive defences (E Bleiberg, Fonagy, & Target, 1997). Among the population of maltreated and neglected children who made up

the vast proportion of children referred to child guidance clinics, however, this approach to treatment was felt to be inappropriate, and probably ineffective. To use Anna Freud's own language, these children were presenting with fundamental deficits in their ego-development, which she believed needed an approach which focused more on building up ego-capacities, rather than one that focused on un-doing defenses.

Anna Freud stressed the importance of a full developmental assessment in order to identify the underlying nature of each child's disturbance, and as early as 1965 she recognised that using traditional child analytic techniques for treating children with 'developmental disturbances' was likely to be unsuccessful. And as she added, somewhat sardonically, when analysis ‘fails to bring about improvements, the blame is usually laid not on the psychopathology of the case as such, but on unfavourable external circumstances such as the therapist’s lack of experience or skill, the parents’ failure to cooperate, insufficient time being allowed for the analytic process, interruptions due to bodily illness, upsets in the home, change of therapist, etc.’ (1965, p.214).

Anna Freud gave her clinical staff at the Hampstead Child-Therapy Clinic (now the Anna Freud Centre) considerable freedom to experiment with different ways of working with these complex cases, resulting in the ground-breaking papers on technique with borderline children (e.g., Rosenfeld & Sprince, 1965). But Anna Freud herself could not help but see this type of work as somehow “inferior” to classical psychoanalysis. She contrasted the 'truly analytic measures' used to interpret defenses against unconscious impulses with the 'subsidiary therapeutic elements' that might be effective with these children with developmental disturbances. Among such elements, she mentioned suggestion, reassurance, new superego identifications, verbalization of affects, the clarification of internal and external reality (quoted by Hurry, 1998) and 'even corrective emotional experience' – a much maligned term introduced in the 1940s by Franz Alexander (1946). While recognising the value of these elements, Anna Freud could not help but see them as merely 'educational', 'not truly analytic'. However just a few years before her death, in a paper published in

1978, she recognised that 'to the extent to which developmental harm can be undone belatedly, child analysis may accept as its *next duty to devise methods for this task'* (1978, p.109, my italics).

It was only after Anna Freud's death, in 1982, that the staff at the Anna Freud Centre felt more emboldened to take on this challenge explicitly - by working out the consequences of these changes in the conceptualization of psychopathology for treatment technique. One forum for this was the 'Research Group on the Efficacy of Child Psychoanalysis', that ran at the AFC from the late 1980s to the early 1990s, and included within it experienced child analysts such as Hansi Kennedy and Rose Edgcumbe, as well as Peter Fonagy, Mary Target and George Moran, who took on a role as the Director of the Anna Freud Centre in 1986, working closely with Peter Fonagy and others until his premature death at the age of 40, in 1992.

George Moran's contributions to child analysis, and to the development of MBT, should not be under-estimated. In the last decade of his life, he was leading a clinical research project into the psychoanalytic treatment of children with diabetes - in particular, those children whose non-compliance with the diabetic treatment was leading to repeated admissions to hospital, often with life-threatening consequences. As Peter Fonagy has noted, he and George Moran would meet at the informal 'Saturday Club', where these challenging cases were discussed, and new ideas tried out. One product of this project - and these discussions - was the third of our significant publications from 1991, 'Understanding psychic change in child psychoanalysis' (Fonagy & Moran, 1991), published in the *International Journal of Psycho-Analysis*. This paper illustrates the way in which developments in child analysis played a crucial role in the emergence of MBT.

The Fonagy and Moran (1991) paper begins with a review of Anna Freud's distinction between pathology based on neurotic conflict, and one based on developmental disturbance. Drawing on the work of Joseph Sandler (Sandler & Rosenblatt, 1962), Fonagy and Moran reconceptualize this distinction as one between children with a *representational disorder* (where unwelcome representations of the self or the other are repudiated), and those who have a pervasive *inhibition*

of mental processes themselves, often as a result of early experiences of neglect or maltreatment. With the former, a repudiated self-representation (e.g. of the self as angry) may need to be re-integrated with a representation of the self as lovable; in the latter case, the child may have inhibited the very process of forming mental representations of his own mind or the mental states of others, because to do so was felt to be too dangerous. In other words, these children may have inhibited the capacity to mentalize.

Referencing the work of Baron-Cohen (1990) and others, Fonagy and Moran showed how the lack of a fully formed theory of mind can underlie the kind of developmental disturbances that are so common in referrals to child mental health. They give the example of a boy called David, aged 7, who was referred for treatment because of his violence to family members, to other children at school and to himself. Coming from a family background marked by a 'remarkable lack of empathy' from his parents, he entered treatment having learned early on that it was 'no longer safe for David to think about his parents' thoughts about him, as these thoughts all too clearly entailed their wish to harm him' (p.20).

How did this child's inadequate theory-of-mind manifest itself in the clinical setting? Not surprisingly, David soon began to attack and provoke his analyst, whom he perceived as frightening and potentially violent. (We might now say, to use the language of MBT, that David was operating in a 'psychic equivalence' mode). At times he would then withdraw into the corner of the room, muttering obscenities under his breath (Fonagy & Moran, 1991, p.19). The analyst's attempts to interpret David's projections of his aggressive wishes onto the analyst were met with limited success. Instead, the authors note, 'action-play' seemed to be more helpful. In particular, they describe one game that began during the second year of the analysis, and continued for several months - played especially when there was a heightened level of anxiety in the consulting room. In this game, David and his analyst would both make notes on 'what I think you think I am thinking about you today' (p.19). These notes described a range of feelings and wishes, which seemed to

contribute to David, over time, gradually becoming better able to differentiate his own complicated feelings, fears, and wishes as well as to distinguish which feelings belonged to him and which ones belonged to his analyst.

In this description of the analytic treatment of David, we see glimpses of a mentalization-based conceptualization of childhood psychopathology, and the outlines of a clinical approach to its treatment. David's fundamental difficulty in being able to represent his own mind and the mind of others went beyond the internalization of rejecting, unempathic parents. The authors suggests that there was a poorly established mental process, one which was only precariously available, and easily lost under stress. Fonagy and Moran compare this, rather strikingly, to a child who has only just achieved bladder control, but who under stress is almost certain to wet his bed once more.

For children such as David, they suggest, a 'technique which relies solely upon interpretation' (p.16) will be insufficient, as the problem is not integrating different representations of the self or other; instead, there is a need for an approach which helps to develop psychological processes related to the capacity for representing mental states. What might this look like? In so far as the treatment with David was effective, they note that this was probably due to:

a) A mitigation of shame due to the analyst's *clarification and acceptance* of negative affects;

b) An increased control over overwhelming affect as a result of the *labelling of emotional states*;

c) An improvement in the appraisal of internal and external reality aided by the analyst's careful *differentiation of external and internal reality*; and

d) An increase in the child's own mental capacities thanks to the *analyst making his own mental processes available for the child to explore* (p.20).

The features described here are all ones that were further elaborated during the 1990s by child analysts and researchers working at the Anna Freud Centre, under the umbrella term of

'psychodynamic developmental therapy' (Fonagy and Target, 1996). A further impetus for this came from work that Fonagy and Target undertook with Dr Efrain Bleiberg, from the Menninger Clinic, looking at the case notes of children who had been in treatment at the Hampstead Child Therapy Clinic between the 1950s and 80s. In her retrospective study of the outcome of child analysis (Fonagy & Target, 1994)Mary Target had discovered a group of children with complex, long-standing and severe problems, who generally benefitted little from classical child analytic treatment. However, a certain proportion of them had been helped, especially where they had been offered more intensive (3-5 weeks) treatment. Reviewing the case notes of these children with Dr Bleiberg, the question being asked was: 'What was going on in these cases which meant that they were able to benefit from treatment, when others had not?'.

The conclusions that the team reached were intriguing. Although all of the children in this group presented with severe disturbances of social and emotional development, they did not fit easily into DSM diagnostic categories. One group (which they designated as Cluster A) presented with fragile reality testing and quite severe thought disorganization, and their ability for empathy and normal social interaction was often limited; the other (Cluster B) came into therapy with 'intense, even dramatic, affect and hunger for social response' (1998, p.91), and a high level of affective lability. Once in adolescence, this Cluster B group were more likely to self-harm, or to use drugs, food or promiscuous sex 'to block feelings of being out of control, fragmented, and lonely' (p.92).

Despite the clinical heterogeneity, the study group concluded that 'these youngsters seem to share a characteristic that we think is crucial and that we focus on: Some pervasively (Cluster A) and others intermittently (Cluster B) seem to lack the capacity to make use of an awareness of their own and other people's thoughts and feelings' (Fonagy & Target, 1998) p.92). What is being described here, we could say, is a picture of *emerging* borderline personality disorder, where difficulties in mentalizing are placed at the heart of the assessment of pathology. Drawing on more recent conceptualizations, we might say that the cluster A children are the concrete mentalizers, often

operating in 'psychic equivalence' mode; while the cluster B children are more like the 'hyper-mentalizers' whom Carla Sharp and her colleagues have studied so carefully in their work on ‘borderline adolescents’ (Sharp & Vanwoerden, 2015).

But the team went further than identifying pathological types, noting that the case notes seemed to suggest that the kinds of *techniques* that the therapists were effectively using with these children were very different to the ones typical for the less complex cases. In particular, the interpretation of unconscious conflict, and an emphasis on developing insight, played a fairly small part in these treatments. In place of these, what kind of change processes were taking place? And what were the therapists doing that promoted such changes?

In their 1998 paper on the changing aims of child analysis, Fonagy and Target try to answer this question by focusing on three elements of therapeutic technique: increasing the capacity for playfulness, enhancing reflective functioning, and working in the transference.

The element of increasing the capacity for playfulness builds on the work of Winnicott and others. Fonagy and Target recognize that play is not only a means of communicating unconscious material (children's equivalent to free association, returning to Klein's idea), but also as an agent of change in it's own right – achieved by focusing not so much on the content but rather on the process of the play. Play, A transitional area between fantasy and reality, jointly created by patient and therapist, allows children to 'both own and disown their rejected feelings and experiences and test out the therapist's attunement, respect, and responsiveness to the vulnerable aspects of the self' (Fonagy, Target and Bleiberg, 1997, p.24). However, Fonagy and Target also recognize that for borderline children, play in itself can be experienced as both threatening and in some circumstances as 'too real'; so the capacity to take a more playful stance may become one of the therapeutic aims of the work in itself. In these cases, the therapist's role is to help children learn to play, first with objects, then with another person, and ultimately with ideas and different perspectives.

In the element of *enhancing reflective functioning*, child therapists first help children observe their own emotional states and develop a language to label their feelings, connecting them to what Gergely has called 'the primary constitutional self'. Therapists can do this 'by encouraging children's observation and labelling of somatic and psychological experiences, focusing their attention on states felt in the immediate situation, and encouraging verbalization of immediate feelings' (Fonagy, Target and Bleiberg, 1997, p.22). As the authors point out, this in some ways is the opposite of a more classical child analytic approach, in which the aim may be to open the pathways towards the experience of 'repudiated affect'. For these children, however, it is a question of developing their reflective capacity to *modulate* emotional experiences.

Finally, the element of *working in the transference,* while always considered a key to psychoanalytic therapy, shifts when the focus is on increasing mentalizing. As Fonagy and Target (1998) suggest, while the child-therapist relationship is still of central concern, it is approached differently than with children who are capable of a more robust reflective capacity. Rather than seeking to identify the repetition of unconscious patterns, it focuses instead on clarifying the children's emotional states on a moment-to-moment basis in the ‘here-and-now’ of the lived experience of the therapeutic relationship. The aim is not to think about the past, but to be able to think and feel in the present moment. This is especially true when behaviour in the interaction triggers powerful feelings in the child. Working in the transference in such cases involves 'attempts at placing affect into a causal chain of concurrent mental experiences' (p.109) - 'when I said that, your body seemed to tighten up and I think you were very frightened - and then you jumped up and hit the table'. When this kind of sequencing can be done in a slow and sensitive way, Fonagy and Target suggest that real therapeutic change is possible. Over time, children are able to find themselves in the mind of the analyst as thinking and feeling beings, achieving the capacity to represent that never fully developed in early childhood and was probably further undermined by subsequent painful interpersonal experiences. In this way, each child’s ‘core self-structure is strengthened, and sufficient control is acquired over mental representations of internal states that psychotherapeutic work proper can begin' (p.108).

All three of these elements - the importance of play, the focus on enhancing reflective functioning, and the importance of work in the transference - are elaborated in a book edited by Anne Hurry in 1998, *Psychoanalysis and Developmental Therapy*. This book is the most complete articulation of what a mentalization-based, developmental child therapy looks like. It begins with an introduction by Fonagy and Target, in which an interpersonal model of early development is laid out, with a focus on attachment, transgenerational transmission, and the role of reflective functioning in the development of the 'mentalizing self'. They then re-iterate the aim of child therapy, in cases of early developmental failure, as focusing on 'enhancing certain psychic processes' - in particular, 'the opportunity for the patient to find himself as a thinking and feeling person within the analyst's mind', in order to enhance the development of the 'reflective self-function' (p.29/30). In her own introductory chapter, Anne Hurry describes how this 'developmental therapy' aims to help children to develop a capacity to play, to name feelings, to control wishes and impulses (p.37), and in so doing draws much more overtly than classical analytic therapy on the individual personality of the therapist, and in their interactions with children which are marked by playfulness, spontaneity and an avoidance of the 'expert' position from which the analyst makes interpretations about the 'real' meaning of children's behaviour.

Acknowledging the important contributions of Winnicott and others, Hurry (1998) describes how play such as peek-a-boo and hide-and-seek may offer similar elements to the early mother-baby dance, in which contingent, marked mirroring of children's affects and mental states takes place. At these times, therapists become not only transference objects, but also 'developmental objects', based on an empathic recognition of children's arrested developmental needs. In this work, interpretation is seen not as the unearthing of 'hidden' parts of the mind from an expert position, but rather as one person offering a perspective on the mind of another, from an inquisitive, curious position. Likewise, transference is not simply viewed as the repetition of past relationships (fantasy or otherwise), but the opportunity to 'understand misunderstanding', in the context of a here-and-now relationship where two people are trying (and all-too-often fail) to make sense of the other's

intentional states of mind. Remembering Anna Freud's own ambivalence about these so-called 'subsidiary therapeutic elements', Hurry boldly suggests that rather than looking down on these approaches as 'not proper analysis', we should recognize their importance more fully: "Developmental work has moved to the forefront of psychoanalytic thinking; it is valued in its own right, it has been made 'respectable'" (p.38). At a public event some years later, Anne Hurry went one step further, saying that she wished she had been braver when publishing her book, and entitled it not 'Psychoanalysis *and* Developmental Therapy', but rather 'Psychoanalysis *as* Developmental Therapy'

Re-discovering the links between MBT and therapy with school-age children

Anne Hurry's (1998) book could have become a foundation for a new model of developmental therapy - Mentalization-Based Treatment with Children - several years before Fonagy and Bateman published their landmark paper on MBT as a treatment for borderline personality. To some degree this is what happened only some years later. In their introduction to their book on *Mentalizing in Child Therapy*, published in 2008 by Vergeught-Pleiter et al., the authors describe their model of 'mentalization-based child therapy' as being 'previously known as developmental therapy' (p.1). Fonagy himself, in his introduction to that work, identifies the familiar core principles: 'a concern with the here and now, contact with the current mental state of the patient, ensuring the re-presentation of internal experience, a certain playfulness, and the engagement with process over content' (p.xxiii).

Nor are Vergeught-Pleiter et al. the only ones who have continued to make these links. Bleiberg and others (Bleiberg, 2013) continued to use the concepts of reflective functioning and mentalizing in their work on therapy with adolescents, and a number of authors in the first book-length collection of papers on mentalization-based interventions with children, young people and families (Midgley

and Vrouva, 2012) linked mentalizing therapies to the psychoanalytic tradition. Perhaps surprisingly, given where the work began, very little of this work has focused on the treatment of school-age children (Midgley et al., 2021). Instead the majority of the early work on applying mentalizing to the treatment of young people focused on adolescents (e.g. Sharp et al., 2009)(Rossouw & Fonagy, 2012)(Fuggle et al., 2015)(Malberg and Fonagy, 2012; Bleiberg, 2013) or on work with parents and babies (e.g. Etezady and Davis, 2012; Slade et al., 2005; Ordway et al., 2014). Building on the work of Verheught-Pleiter et al. (2008), the first book-length guide to a mentalization-based treatment of school-age children was published in 2017 (Midgley et al., 2017). That book sets out a time-limited model which is currently being evaluated in a number of pre-post evaluations and randomized clinical trials (e.g. Halfon et al., 2022; Midgley et al., 2023).

This more recent model of MBT with school-age children shares with Fonagy and Target's 'psychodynamic developmental therapy' a focus on therapeutic qualities such as a capacity for playfulness, a focus on enhancing reflective functioning, and a focus on working in the here-and-now of the child-therapist relationship. But whereas the earlier work tended to assume that all mentalizing difficulties could be thought of as defensive inhibitions of the child's capacity to mentalize (breakdowns in mentalizing), the more recent work takes a developmental perspective, and recognizes that a crucial aspect of the therapeutic work is the focus on 'under-developed mentalizing' (Midgley et al., 2017, p.46). This is evident in children who do not know or fail to identify what they are feeling, including their reactions to hurt, sadness, fear and anger, and cannot use knowledge of affects to achieve self-regulation. MBT therapists, when working with such children, focus on supporting the 'building blocks' of mentalizing – in particular, attention control and affect regulation; this work may not only involve explicit, verbalized mentalization, but also non-verbal, bodily elements.

Circling back to Moran's (1991) case of David, the seven-year-old boy referred for treatment because of his violence to family members, peers at school and himself, gives us an opportunity to track the

evolution of MBT with children (MBT-C). Moran's assessment of the parents' 'remarkable lack of empathy' to their son led him to wonder whether, from early in life, the impact of lacking the feeling of physical and emotional holding created a feeling in David of not being comfortable in his own skin. Without the necessary support to learn how to put feelings into words, David may have only felt able to express feelings physically and act them out through his body.

Moran then described how he tried to work with David by helping him 'differentiate internal and external reality'. Nowadays we might go further and speak about the importance of working on the 'building blocks' of mentalizing, including working at a bodily level, supporting the development of attention control and affect regulation (Midgley et al., 2017). Although David's presenting issue is physical violence, little attention is paid in Moran's clinical work to his bodily states. We know that the earliest sense of self crystallizes around experiences of touching and being touched, hearing, seeing, smelling and tasting (Stern, 1985), helping to create a core sense of the embodied self (Ensink et al., 2016). Moran is playful in his interaction with David, but the game they play together is a purely verbal one, in which they take turns making notes on 'what I think you think I am thinking about you today' (p.19). Nowadays we might focus on contingent co-ordination, including the use of physical play, which is aimed at 'creating patterns of being together rather than only what is actually said' (Verheught-Pleiter et al., 2008, p.113). For example, by introducing a material such as clay, David could be allowed to play with his aggression, making noise (and even mess), alongside a therapist who can help him to accept that these feelings are normal and can be tolerated – even validated. At the same time, the MBT therapist can name what is happening ('You gave that a big whack!') and link it with effects in the world ('and what a big noise it makes!') and play with limits. In this way, is the therapist is promoting the beginnings of an implicit concept of intentional behaviour and an experience of some level of affect modulation (Midgley et al., 2017, p.145-148). Such clinical work may well precede any direct interventions inviting explicit mentalizing (e.g. asking David what *he thinks* his therapist is thinking), which we might now consider as assuming a more established capacity in David to mentalize. Instead, an MBT-C therapist working with David might try to offer an

experience of joint attention and attunement, creating rhythm and patterns in interaction, as well as clarifying and naming feelings and linking behaviour to its effects in the external world.

For example, in our book on time-limited MBT with children, we describe the work with 'Anne', a six-year old girl referred to therapy because of temper tantrums, oppositional behaviour and separation anxiety (2017, p.145-147). In sessions, Anne would often play quite wild, physical games, which left her therapist sometimes feeling as if she were at risk of turning into a 'police officer'. In one session, Anne found a toy syringe in the doctor's bag, and started filling it with water and spraying it around the room. Rather than trying to stop her (as often happened at home or at school, when Anne's play quickly got out of control), the therapist joined the play, inviting Anne to spray the water into a tray of sand in one corner of the room. The therapist tried to join in with Anne's play, making sound effects when the syringe was pulled apart ('Glug, glug, glug…. POP!'). This became a game between them, where Anne and her therapist both laughed as the popping moment came close. In her excitement, Anne sometimes sprayed the water beyond the sand tray, onto the toys on the shelf behind it, and (as Anne quickly glanced at her face to check the reaction) her therapist smiled and noted how far Anne had made the water go to reach the top shelf.

In her interactions with Anne, this therapist may not appear to be making any explicit 'mentalizing' interventions - and is certainly not asking the child what she thinks may be going on in the mind of her therapist, as Moran did with David. But by her contingent co-ordination with Anne, using a playful tone of voice and facial expressions which reflect the pleasure that Anne is experiencing (while also managing her own arousal levels) the therapist is creating patterns of 'being together' that create a sense of rhythm, predictability, joint attention, and togetherness. Naming Anne's actions and what follows (as with the spray that lands on the toy shelf) helps develop a simple awareness of cause and effect – the idea of intentional behaviour linking the child's actions with effects in the external world. All of this can help Anne to process information and modulate her emotions, learning to play with limits, as part of the building blocks of the capacity to mentalize.

In this way, the contemporary MBT therapist with children recognises that not all disturbance should be thought of as a *breakdown* of mentalizing; but, in some cases, it may be caused by an *under-developed* capacity to mentalize. In addition, rather than seeing the development of a capacity to mentalize as an end in itself, we might now say that this is what David would need to in order to make it possible for him to learn how to trust epistemically as the prerequisite to acquire the capacity to learn socially. Understanding that the key mechanism for therapeutic change is opening up social learning, contemporary MBT-C sees working with children's social networks, including parents and schools, as the key to create a social environment which can respond to children in a contingent and supportive way (Malberg, 2023).

Conclusion – the lost link between MBT and child analysis?

In their 1998 paper on the changing aims of child analysis, Fonagy and Target had written that developments in child therapy could be '*extrapolated* to the treatment of adults with BPD' (p.87, my emphasis), thus implying that the core model *developed in work with children* had the potential to be adapted for the treatment of adults. Yet when the term 'Mentalization Based Treatment' was first used in 2004, its roots in child analytic work were no longer apparent, and MBT was described as a treatment that was developed primarily to address the therapeutic challenges of working with adults with BPD. In the subsequent development of the field, the dynamic link of MBT with child analytic work increasingly seemed to have gotten lost. Meanwhile, the key innovations in mentalizing treatment were taking place in work with adults, thanks largely to the creative energy of Peter Fonagy and Anthony Bateman and their collaborators. The influence of the work with BPD adults is such that MBT is often now thought of as having its origins in this field, with relatively little link to child therapy. The fourth leg of the table, we might say, has been forgotten; but without this leg, the foundations of MBT lack a certain stability.

As I hope this paper has demonstrated, therapeutic work with children has in fact played an important role in the development of the concept of mentalizing, as well as some of the techniques that came to be known as Mentalization Based Treatment. Understanding this history provides us with a context to understand the more recent work in adapting MBT for use with children, young people and their families (see Midgley & Vrouva, 2012).

In the more than thirty years since 1991, when so many of the ground-breaking ideas about MBT were introduced, there has been an increasing awareness of the global crisis in child mental health and the importance of early intervention (Benton et al., 2021). As a number of review papers have indicated, and as reflected in the contributions to this volume, mentalization-based interventions are now well-placed to make a contribution to this field (Byrne, Murphy and Connon, 2020; Midgley et al., 2021). Coming full circle, the implications of mentalizing for work with children and young people are once again poised to be at the forefront of new developments, particularly in prevention and early intervention.

References

Alexander, F., French, T. (1946). *Psychoanalytic Therapy: Principles and Applications*. New York: Ronald Press.

Baron-Cohen, S. (1990). Precursors to a theory of mind: understanding attention in others. In Whiten, A. (ed.), *The emergence of mindreading: the evolution, development and simulation of second-order mental representations.* Oxford: Basil Blackwell.

Bateman, A. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, *18*(1), 36. doi:10.1300/J200v06n01

Bateman, A., & Fonagy, P. (2013). Mentalization-Based Treatment. *Psychoanalytic Inquiry*, *33*(6), 595–613. doi:10.1080/07351690.2013.835170

Benton, T., Boyd, R., Njoroge, W.. (2021). Addressing the Global Crisis of Child and Adolescent Mental Health. *JAMA Pediatr.* 2021;175(11):1108–1110. doi:10.1001/jamapediatrics.2021.2479

Bleiberg, E. (2013). Mentalizing-Based Treatment with Adolescents and Families. *Child and Adolescent Psychiatric Clinics of North America*, *22*(2), 295–330. doi:10.1016/j.chc.2013.01.001

Bleiberg, E., Fonagy, P., & Target, M. (1997, January 1). Child psychoanalysis - Critical overview and a proposed reconsideration. *CHILD ADOL PSYCH CL*. W B SAUNDERS CO. Retrieved from http://discovery.ucl.ac.uk/134183/

Byrne, G., Murphy, S., & Connon, G. (2020). Mentalization-based treatments with children and families: A systematic review of the literature. Clinical child psychology and psychiatry, 25(4), 1022–1048. https://doi.org/10.1177/1359104520920689

Cooper, S. H. (2007). Alexander's Corrective Emotional Experience: an objectivist turn in psychoanalytic authority and technique. *The Psychoanalytic Quarterly*, *LXXVI*(4), 1085–1102. doi:10.1002/j.2167-4086.2007.tb00294.x

Ensink, K., Berthelot, N., Biberdzic, M., & Normandin, L. (2016). The mirror paradigm: Assessing the embodied self in the context of abuse. *Psychoanalytic Psychology*, 33(3), 389–405. https://doi.org/10.1037/pap0000018

Fonagy, P. (1989). On tolerating mental states: Theory of mind in borderline patients. *Bulletin of the Anna Freud Centre*. Retrieved from http://discovery.ucl.ac.uk/133944/

Fonagy, P. (1991). Thinking about thinking: some clinical and theoretical considerations in the treatment of a borderline patient. *The International Journal of Psycho-Analysis*, *72 (Pt 4)*, 639–56. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1797718

Fonagy, P., & Moran, G. S. (1991). Understanding psychic change in child psychoanalysis. *The International Journal of Psycho-Analysis*, *72 (Pt 1)*, 15–22. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2050481

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, 51(3), 372–380. https://doi.org/10.1037/a0036505

Fonagy, P., Steele, M., Steele, H., Higgitt, A., & Target, M. (1994). The Emanuel Miller Memorial Lecture 1992 The Theory and Practice of Resilience. *Journal of Child Psychology and Psychiatry*, *35*(2), 231–257. doi:10.1111/j.1469-7610.1994.tb01160.x

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*, *12*(3), 201–218. doi:http://dx.doi.org/10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

Fonagy, P., & Target, M. (1994). The efficacy of psychoanalysis for children with disruptive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*(1), 45–55. doi:10.1097/00004583-199401000-00007

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *The International Journal of Psycho-Analysis*, *77 (Pt 2)*, 217–33. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8771375

Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues*, *8*(August 2015), 87–114. doi:10.1080/10481889809539235

Fuggle, P., Bevington, D., Cracknell, L., Hanley, J., Hare, S., Lincoln, J., … Zlotowitz, S. (2015). The Adolescent Mentalization-based Integrative Treatment (AMBIT) approach to outcome evaluation and manualization: adopting a learning organization approach. *Clinical Child Psychology and Psychiatry*, *20*, 419–435. doi:10.1177/1359104514521640

Gergely, G., & Watson, J. S. (1996). The social biofeedback theory of parental affect-mirroring: the development of emotional self-awareness and self-control in infancy. *The International Journal of Psycho-Analysis*, *77 (Pt 6)*, 1181–212. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9119582

Gomez, L. (2005). *The Freud Wars: An Introduction to the Philosophy of Psychoanalysis* (1st ed.). Routledge. https://doi.org/10.4324/9780203698624

Halfon, S., et al. (2022). The Effectiveness and Change Mechanisms of Mentalization Based Therapy for Children (MBT-C): Trial Protocol. Downloaded from: https://clinicaltrials.gov/study/NCT05290714?cond=Internalizing%20Problems&intr=mentalization&rank=1

Malberg, N., Jurist, E., Bate, J. & Dangerfield, M. (2023). *Working With Parents in Therapy: A Mentalization-Based Approach.* New York: American Psychological Association

Meins, E., Fernyhough, C., Wainwright, R., Das Gupta, M., Fradley, E., & Tuckey, M. (2002). Maternal Mind-Mindedness and Attachment Security as Predictors of Theory of Mind Understanding. *Child Development*, *73*(6), 1715–1726. doi:10.1111/1467-8624.00501

Midgley, N. and Vrouva, I. (eds.), (2012) *Minding the Child: Mentalization-based interventions with children, young people and their families*, London: Roultedge.

Midgley, N., Ensink, K., Lindqvist, K., Malberg, N. and Muller, N. (2017). *Mentalization-Based Treatment for Children: A Time-Limited Approach*. American Psychological Association.

Midgley, N., Sprecher, E. & Sleed, M. (2021). Mentalization-Based Interventions for Children aged 6-12 and their Carers: A Narrative Systematic Review. Journal of Infant, Child and Adolescent Psychotherapy. https://doi.org/10.1080/15289168.2021.1915654

Midgley, N., Mortimer, R., Carter, C., Casey, P., Coffman, L., Edbrooke-Childs, J., Edridge, C., Fonagy, P., Gomes, M., Kapoor, A., Marks, S., Martin, P., Moltrecht, B. Morris, E., Pokorna, N., McFarquar, T. (2023). Emotion regulation in children (ERiC): A protocol for a randomised clinical trial to evaluate the clinical and cost effectiveness of Mentalization Based Treatment (MBT) for school-age children with mixed emotional and behavioural difficulties. *PLOS ONE*. https://doi.org/10.1371/journal.pone.0289503

Ordway, M. R., Sadler, L. S., Dixon, J., Close, N., Mayes, L., & Slade, A. (2014). Lasting Effects of an Interdisciplinary Home Visiting Program on Child Behavior: Preliminary Follow-Up Results of a Randomized Trial. *Journal of Pediatric Nursing*, *29*(August), 3–13. doi:10.1016/j.pedn.2013.04.006

Premack, D., & Woodruff, G. (2010). Does the chimpanzee have a theory of mind? *Behavioral and Brain Sciences*, *1*(04), 515. doi:10.1017/S0140525X00076512

Rosenfeld, S. K., & Sprince, M. P. (1965). Some thoughts on the technical handling of borderline children. *The Psychoanalytic Study of the Child*, *20*, 495–517. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/5835555

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(12), 1304–1313.e3. doi:10.1016/j.jaac.2012.09.018

Sandler, J., & Rosenblatt, B. (1962). The concept of the representational world.

Sharp, C., & Vanwoerden, S. (2015). Hypermentalizing in Borderline Personality Disorder: A Model and Data. *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(April), 33–45. doi:10.1080/15289168.2015.1004890

Sharp, C., Williams, L. L., Ha, C., Baumgardner, J., Michonski, J., Seals, R., … Fonagy, P. (2009). The development of a mentalization-based outcomes and research protocol for an adolescent inpatient unit. *Bulletin of the Menninger Clinic*, *73*(4), 311–38. doi:10.1521/bumc.2009.73.4.311

Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005). Minding the baby a reflective parenting program. *The Psychoanalytic Study of the Child*, *60*(August), 74–100. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16649676

Stern, D. (1995) *The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy.* Karnac Books, London.

Target, M., & Fonagy, P. (1994) Efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*(3), 361–71. doi:10.1097/00004583-199403000-00010

Target, M., & Fonagy, P. (1996). Playing with reality: II. The development of psychic reality from a theoretical perspective. *The International Journal of Psycho-Analysis*, *77 (Pt 3)*, 459–79. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8818764

Vogt, K., Norman, P. Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychol Psychother*. 2019 Dec;92(4):441-464. doi: 10.1111/papt.12194. Epub 2018 Aug 11. PMID: 30099834; PMCID: PMC6900007.