Mentalization in Systemic Therapy and its Empirical Evidence

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The emergence of mentalizing approaches

Mentalizing (Fonagy, Steele, Steele, Moran, & Higgitt, 1991) refers to the attitude and skills involved in understanding mental states, both one's own as well as those of others, and their connections with feelings and behaviour. The terms 'mentalization' and 'mentalizing' are often used interchangeably; the latter is derived from a verb and therefore perhaps more accurately captures that this is a continuous activity rather than a fixed state of mind or the specific characteristic of an individual. Mentalizing mostly occurs without effort or specific consciousness; it is a process of perceiving and interpreting human behaviour in terms of intentional mental states such as feelings, needs, reasons, or purposes. Mentalizing enables us to create a picture of the thoughts, feelings, and intentions of those around us and to help us make sense of their actions in the same terms that we organize our own subjective experiences. It is important for representing, communicating, and regulating feelings and belief states linked to one's wishes and desires.

Mentalizing is a fundamentally bidirectional or transactional social process which develops in the context of interactions with others, and in the first instance in the context of early attachment relationships. Its quality in relation to understanding others is influenced by how well those around us mentalize. The experience of how other people mentalize is internalized, enabling us to enhance our own capacity for empathizing and better engaging in interactive social processes (Fonagy, Gergely, Jurist, & Target, 2002). In situations of stress, difficulties in mentalizing almost inevitably arise. If mentalizing cannot be restored, a rapidly emerging vicious cycle can emerge, with intense emotions erupting, leading to a temporary loss of the capacity to think about the thoughts and feelings of others and the self in a balanced way (Bateman & Fonagy, 2016). For example, when stressed, a parent's mind might become temporarily closed to seeing his child from a perspective other than his own. So when she is calling out for her father to play with her, whilst he is working on his computer, he might see this as her just 'being difficult', and call out to her to *"be quiet and wait"* and to entertain herself. If the child feels that she is not being

appropriately responded to, she may escalate her demands and accompanying behaviours to 'get through' to the father in the hope that he will respond. However, the intensification of the child's behaviour is likely to further derail the father's capacity to mentalize (his child and, recursively so, himself), and the two are quite likely to end up in a vicious cycle of non-mentalizing. In other words, the child's emotional arousal compromises the parent's capacity to provide the psychological recognition that the child craves. This happens intermittently a lot in ordinary family life, but when this non-mentalizing cycle becomes chronic, it can lead to more serious difficulties.

A major objective of mentalization-informed family work is to enhance and maintain mentalizing during emotionally highly charged family discourses which so often trigger and sustain family conflicts, including intra-family violence. The focus of this type of work is on the contexts that generate the specific feelings, needs, desires, beliefs, and thoughts that may contribute to the collapse of mentalizing, with the aim of disrupting the feedback cycle of non-mentalizing that generates confusing and destructive interactions between family members. The ability to see oneself through the eyes of others and appreciate that others can see the world in ways different from us is at the heart of effective mentalizing. Perspective-taking is often impaired, and at times completely lacking, in families where acrimony, violence and mutual blame are common currency.

Over the past 10 – 20 years many systemic practitioners have attempted to 'remember' and integrate psychodynamic concepts. Bridges were re-built between the psychoanalytic and systemic worlds (Akister & Reibstein, 2004; Dallos, 2006; Diamond & Siqueland, 1998; Flaskas, 2002; Fraenkel & Pinsof, 2001) and the arrival of Mentalization-based therapy (MBT), developed initially for adults presenting with borderline personality disorder (Bateman & Fonagy, 2016), further inspired systemic practitioners. A family-focused form of MBT emerged, MBT-F, leading to various attempts to manualise this approach (Asen & Fonagy, 2012b; Fearon et al., 2006; Keaveny et al., 2012). However, questions were raised soon whether MBT-F could really be regarded as yet another new 'brand' of family therapy, or whether one was dealing merely with a new emphasis when working with families, with some innovative and plenty of rather familiar techniques. Our own view is that mentalizing is an important ingredient of *all* psychotherapies (Fonagy & Allison, 2014) and that it

can enrich systemic practice; it brings forth a set of strategies and techniques that can be grafted on to well-established systemic approaches.

The basic clinical model

As in systemic therapy, the key proposition of the mentalizing approach is that emotional and behavioural problems are essentially relational in nature. However, MBT specifically holds that it is the breakdown in mentalizing which gives rise to relational problems that undermine family coping, creativity and resilience. Families and individuals vary in their capacity to mentalize for a multitude of reasons (e.g. genetics, early experience, trauma, current stressors). Chronic problems with mentalizing can contribute to distressing and stressful family interactions which further undermine mentalization. Given that the consideration, interpretation and appraisal of mental states (in self and others) are all essential for healthy relationships, the primary goal of therapy is to terminate non-mentalizing interactions and communications and to restore effective mentalizing. To that effect the primary therapeutic focus is on the mental states – the thoughts, feelings, wishes, needs, desires and beliefs - of each member of the family, and the relationships between them (Asen & Fonagy, 2012a).

To achieve this, the therapist shows a genuine interest in wanting to understand family members' different perspectives – even those of family members not present. He pays careful attention to levels of arousal and comments when family mentalizing appears to go 'off line'. He notices and names family patterns of interaction and works with them directly in the 'here and now'. He explores thoughts, needs and emotions in a relational context; and he remembers to mentalize himself – in other words, he pays attention to his own mental states and is prepared to explore openly the impact these may have on the family. The therapist acknowledges and positively connotes different perspectives put forward by family members, checking repeatedly and explicitly that he has properly understood what somebody has said or means *("let me just check that I've got this right").* The therapist also continuously demonstrates that he can simply not know what anyone feels, without asking questions to find out. He may assist family members to communicate and express what they feel by, for example, stopping the conversation to ask what it is that the person feels she cannot say or explain. When a family member engages in blaming

statements, such as *"he's always trying to wind me up*!" the therapist may inquire*: "and does this feel to you that he is being deliberately annoying? Or could there be other reasons?"* The therapist can follow this up with 'triadic mentalization-eliciting' questions, such as for one of the family members to comment on the relationship between two other people: *"what do you think it was like for your Mum that time that you had a tantrum in the car?" or "how do you think your parents felt towards each other when you were screaming so much*?" Invoking hypothetical scenarios and using 'what if' questions explicitly encourages people to temporarily slip into the shoes of another family member: *"what would you think she would have felt if he had just walked out of the room at that point? And do you think your father might have felt the same or something quite different? What if your mother had just left the room"* and to the mother: *"what did you think he would think and feel if you did stop?"*

These questions are reminiscent of the 'circular questions' put forward by the Milan team many decades ago (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). However, their aims were both similar and yet somewhat different from those in the use of questioning in MBT. The Milan team's questioning process aimed to create and highlight differences, to draw connections and distinctions between family members in order to provide information that framed problems in new ways and released new information about the problem into the system. This, they argued, would encourage new ways of viewing family interactions and communications. The Milan team invented specific questions to achieve this by, for example, investigating a dyadic relationship by asking a third person for their perceptions on that relationship. The focus was primarily on behavioural sequences and each person's interpretation of behaviour by, for example, asking family members to rank each other on specific behaviours so that discrepancies in the views of various family members became more noticeable as a way of establishing circularity and new meaning. One of the aims of these techniques was to *"fix the point in the history of the system when important coalitions underwent a shift and the subsequent adaptation of that shift became problematic for the family"* (Penn, 1982, p. 272) so that the differences in family relationships before and after the problem emerged became more evident.

Whilst mentalization-focused techniques also aim to encourage family members to adopt new and different perspectives, the main goal is to focus on the states of mind of each family member and, via a recursive process, on each individual's own state of mind in relation to everyone else. The aim is *not* to ask

circular questions in order to devise elaborate hypotheses on problem emergence and family dynamics, but to strengthen attachments and other aspects of family relationships by promoting effective mentalizing. Mentalization-focused interventions often move from initial orienting questions to creating an agreed language about affect. The interpersonal and emotional context of important events will always be explored by reference to accompanying mental states. This can be quite a taxing demand, as family members often want to restate the sequence of concrete events and what they see as 'facts'.

Therapists themselves may serve as appropriate role models for mentalizing when they ask for clarification and reflection, using the sequence of 'stop, replay, explore and reflect'. This is particularly useful when faced with crass examples of non-mentalizing. The re-viewing process by which mentalizing was impaired or lost is a key effective component of the approach. Unless the therapists determinedly "stop' or 'pause' non-mentalizing narratives, so that the feelings and thoughts at the moment before the loss of mentalization can be re-captured, they may inadvertently feed into the proliferation of a non-mentalizing stance. The 'pause and review' technique, part of the mentalizing loop (see figure 1), has the effect of slowing down interactions, thereby gradually permitting each family member to resume effective mentalizing, in which emotion is integrated with cognition, and the focus on self and others gets equal weight. The sequence of (1) action, (2) pause, and (3) reflection aims to restore balance to mentalizing. The rebalancing will be reflected in relevant commentary that implies (1) curiosity, (2) respect for the opacity of other minds, (3) awareness of the impact of affect on self and others, (4) perspective-taking, (5) narrative continuity, and (6) a sense of agency and trust.

The mentalizing loop

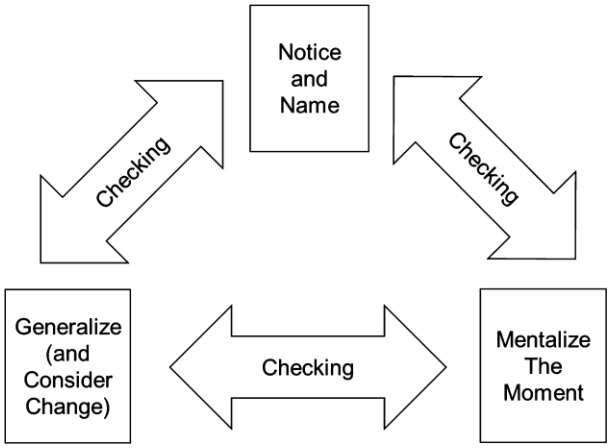

Figure 1: The Mentalizing Loop

In order to facilitate the emergence of productive mental states, the therapist constantly tracks the family members' ability to mentalize. When the capacity to mentalize is undermined the therapist helps the family member to recover from this disruption and to reinstate mentalizing processes. The mentalizing loop (Asen & Fonagy, 2012b) is a tool as well as a 'route map' which defines the therapist's stance, allowing him to support both his own and the family members' effective mentalizing. The mentalizing loop can describe and draw attention to specific interactions and communications between family members. Focusing explicitly on these states of mind – by *'noticing and naming'* them – has the effect of putting family interactions temporarily on hold. Here the therapist might notice a meaningful family interaction and decide to punctuate it: *"I noticed that when you father talked about the fight you had with your son James, you mother, looked away. Has anybody noticed this or is this my own imagination?"* The therapist's emphasis on a certain event is followed by an act of checking whether this observation has also any validity for the family members: *"has anybody else noticed this?"* The act of checking is of great importance and repeats itself throughout all phases of the loop because it models the mentalizing process. Furthermore, it creates a respectful and inquisitive setting and protects the therapist's own position from becoming a non-mentalizing one. After all, the therapist's mentalizing capacity - like anyone's - inevitably falters at times and the mentalizing approach encourages honesty about this. It may, for example, be sometimes appropriate for the therapist to talk about how mentalizing fluctuates and, if temporarily lost, how it come back 'online'.

Once the therapist has received acknowledgment and permission from the

family members to further explore the subject, the main part of the intervention can begin: *'mentalizing the moment'*. The therapist facilitates this by encouraging everyone to contemplate other family members' feelings and thoughts, for example by asking: *"what are your thoughts about what just happened? What do you imagine mother is feeling that makes her behave like this? And how does this affect others? What do you make of it, father? Can I ask you, Mary, what it feels like for you when this happens between your parents? And what do you think, mother, it feels like for Mary or your husband? If one could see thought bubbles coming out of your wife's head, what might be 'written' in them?"* In this way, the therapist animates family members to bring in their perspectives, to brainstorm about states of mind ('mindstorming'), and to always check with others whether they see matters similarly or differently. This process of continuous checking – which includes the therapist – creates a loop: what has been noticed is named and what has been named is questioned, and perceptions are checked all round. When family members are encouraged to rewind and review a specific sequence, a meta-perspective is generated, which can reignite an effective mentalizing stance. At some point, the therapist may ask a family member to connect the here and now mental states to other similar situations that may arise in the course of ordinary family life, in an attempt to link the specifics of the acute interactions to the general and habitual patterns unfolding at home. This can be facilitated by a simple open question: *"Have you noticed that things like this are also happening at home?"* This, in turn, puts family members into a position that allows them to contemplate how similar situations could be man-aged in less problematic ways in the future, perhaps in response to the therapist asking: *"and how might you manage this differently next time something like this happens?"* It is this move to *'generalizing and considering change'* which appeals to family members' creativity and self-help potential and, if it leads to suggestions by one family member, then this is *'noticed and named'* by the therapist: *"I can see that Dad thinks if this happens, Mum should take him calmly aside and not talk in front of the child—have I got that right?"* and the *'checking'* loop starts again.

Innovative techniques to stimulate mentalizing

Various playful techniques, described in more detail elsewhere (Asen & Fonagy, 2017), have been developed with the aim to stimulate mentalizing in a family context.

Winnicott (Winnicott, 1971) has written extensively about the therapeutic use of play and stated that playing happens in the interface between our inner world and external reality, in that space where our imagination is able to shape the external world without the experience of compliance or too much anxiety. This offers the experience of a 'non-purposive state' in which 'creative reaching-out' can take place (Winnicott, 1971); it opens up a space of trust and relaxation in which the need to make sense is – at least temporarily - absent. Playful games and exercises encourage implicit mentalizing and provide a balance to primarily language-oriented methods which generally tend to be based on question and answer formats. Play can also counterbalance the intellectualizing tendencies for hyper-reflectiveness of some adult family members. The invitation to 'play' creates a different therapeutic context, one which is seemingly less 'serious', overtly experimental, prompting creativity and surprise – and being fun! What playful exercises achieve is the simultaneous experience of intense emotion and the contextualizing and containing effect of thoughts, building the capacity to regulate affect during episodes of emotion escalation (Fishbane, 2007). Below we describe a few playful games and exercises that stimulate mentalizing.

In the exercise *'reading the mind behind the face'* all family members are asked to name any feelings they know, with the therapist writing each of these down on separate cards. Once 15 – 20 feelings have been chosen, each person draws a card and displays the feeling state without using words, with the other family members having to speculate what is being conveyed. Usually, there is much guessing and laughter, followed by discussions about how feelings can be correctly identified or how facial expressions can be misleading. If these expressions are captured photographically (via a camera, I-pad or mobile phone) there may be, after several rounds of this, a collection of 20 or more photographs, which can be printed and placed on the wall of the consulting room, like exhibits in an art gallery, and be viewed and discussed in turn by the family members. This may trigger memories, particularly if they are asked about times when they felt the way they are depicted in the photographs and whether anyone else in the family had spotted their 'state' -and if they had not, whether this would have been 'ok' or not. Some or all of the photos can be taken home and specific photos may be prominently displayed, serving as a reminder of how 'mental state snapshots' can lead to useful conversations and how they can continue to stimulate inter-session curiosity about mental states. Affect state

snapshots can thus enable cognition to bring about improvements in the regulation of affect within the family.

Another version of *'reading the mind behind the face'* involves the *'therapeutic use of selfies'*, with the aim to address the brittle nature of self-representations, particularly when working with teenagers and their families. Taking pictures of oneself in a range of different individual as well as social situations with a mobile phone is very much in fashion these days. The therapist can ask the young person to prepare 10 'selfies' for the subsequent session when they are jointly viewed with family members who are encouraged to speculate about the thoughts and feelings depicted in each photo and comment on them from their perspective. This can also be done when the parents bring 'selfies' and get their children to respond to questions such as *"what is Mum thinking and feeling", "what went on in his mind when he took this photo"* and *"what might your parents wish or fear when they see this photo?"* The work can be extended by getting each family member to bring three photos of themselves to the next session. In the session, they are asked to fill in 'mental state thought bubbles', first on their perception of the feelings and thoughts of the other, followed by the way they think the others might fill in the thought bubbles belonging to their own photos. At the core of taking and mentalizing 'selfies' is the encouragement of mental movement from 'within' to 'without'. The essence of effective mentalizing is recognizing the tension between accepting the opaqueness of minds and yet desiring transparency which the interpretation of actions in terms of mental states offers. This requires a continuous awareness of the limitations of one's capacity to 'know for sure' what others feel and think, as well as playful imagination in guessing what is motivating others around us.

Work with masks is another playful activity as people tend to behave differently when wearing a mask; they are more willing to explore and expose parts of their private thoughts and feelings which they tend not to make public in their everyday life. The use of masks in therapy aims to create a playful frame to overcome barriers imposed by fears of social condemnation, ridicule, or blame and generate curiosity through revealing the mind, or more about the mind, behind the mask. The activity '*Masked Ball'* specifically utilizes one of the freedoms masks can afford to their wearers, namely to encourage story telling. If this is focused on oneself, or one's self, then 'prospective life stories' or 'prospective CVs' can be constructed, enabling each family member to examine their (imagined) life 'story' from a future

perspective. This allows otherwise unthinkable – or indeed non-mentalizable – possibilities to emerge. Each family member is asked to choose a theatrical mask, depicting a dramatic looking person. All put on the mask at the same time and look at each other, having formed a circle – with the therapist sitting outside the circle. He explains that the year is 2070, everyone is alive but that, for whatever reason, family members have lost touch with each other and that this is the first time they all are meeting in decades. Each family member is asked to role-play themselves as at the suggested age, meeting up in 2070 for a family dinner party and exchanging their life time experiences. The therapist starts by asking each family member as to where they are 'now' (the year 2070), what they do and how they got there. He slants the narratives by sharpening focus on mental states – probing their 2070 needs, disappointments, beliefs, hopes and fears. He gradually encourages mutual exploration and discussion, keeping up the playful and 'fantasy' character of the 'masked-ball'. Having created a distant future, the imaginary clock is gradually rewound by one or two decades each time, and the family members imagine themselves meeting up in ever more recent periods eventually finding themselves one year from now. Conversation at each of these times centre around: *"when you look back on your life, what were the turning points? What made a difference? What might other family members think and feel if that really came true?"* The focus can then be on the concrete steps family members can undertake to achieve particular 'scenarios'. In this way the family may be helped to create a mentalized continuity of its functioning and a potential change that can be achieved which is (a) rooted in current experience and (b) entails the changes in thoughts in relation to others, feelings about oneself and beliefs about each family members' contribution which may be necessary to get there. Quite a number of different applications of the therapeutic use of masks to stimulate mentalizing have been developed and these can be found elsewhere (see,Asen & Fonagy, 2017).

Playful exercises and activities involving the body can be employed to stimulate mentalizing, and non-mentalizing affective and somatic states can thus be made accessible to mentalization. Maps, or other types of visual representation, encourage a collaborative approach. A large piece of paper on a table with family members and therapist sitting around it allows participants to look at their representations from an external or meta-perspective. The cognitive perspective on bodily states if shared with family members allows a distancing from physical

experience and places the individual in the position of an onlooker permitting alternative perspectives. In the presence of other members of the family this becomes a collaborative venture and can give rise to and shape a new narrative. These exercises start from involving the body, literally placing the mind in the physical body and the brain, then moving to create physical representations of family fights via 'conflict maps' and ultimately translating relational constructs from physical into psychological language. For example, putting affective states on a body map, 'externalizing' these so to speak, permits family members to view and examine mental states. In the presence of other members of the family, this becomes a collaborative venture and can give rise to, and shape, a new shared narrative. In the exercise 'body-feeling scan', each family member is asked, in turn, to lie on a large piece of paper or paper roll. The outlines of each person are drawn with a pen, and each family member is then asked to draw or paint their feelings into their body shape, using different colors, shapes, and forms, and labeling these. In the 'mind–brain scan', each family member is provided with a paper diagram of a cross-section of the human brain, but adapted so that instead of the usual four ventricles, there are altogether 10 larger and smaller spaces depicted in the diagram. Everyone is asked to speculate about *"what goes on in the head"* of one other family member and then to fill in the spaces with the feelings, wishes, beliefs, or thoughts they imagine that person harbors.

Family conflicts can also be made 'visible' via sculptures, made out of clay or similar materials. This can either be a joint exercise, with all family members working together on a family sculpture, or alternatively, each family member can be given the materials to do their very own sculpture of how they see their family at this moment. Once the sculptures are completed, each family member is asked to speculate about the mental states of the various sculpted figures, an exercise in both mentalizing self and others. The 'sculptor' then explains what had been on his mind. At some stage, family members can be asked how the sculpture would be different if it had been made before a major event in the family (illness, death, social welfare intervention) and some re- sculpting or re-positioning of figures can take place. Similarly, future scenarios can be explored by asking how family members might want the family to look like in months or years – and how this might affect each person's state of mind.

Building epistemic trust

The formation of a good therapeutic alliance counts as one of the main factors for positive outcomes in any form of psychotherapy (Falkenstrom, Granstrom, & Holmqvist, 2013; Tasca & Lampard, 2012). Above all it is essential to establish a relationship where the client(s) can trust the therapist and the therapeutic process; this will hugely assist them to take onboard new ideas and perspectives. Mentalization-focused practitioners have introduced the notion of *epistemic trust* in order to conceptualize the process of how the 'learning' of effective mentalizing takes place; it refers to a person's trust in the authenticity and personal relevance of interpersonally transmitted information (Fonagy, Luyten, & Allison, 2015). We acquire this early in our lives: securely attached children treat their parents as an authentic source for processing important new information. Feeling recognized in terms of their needs and thoughts makes children trust that source as they believe that their subjectivity is important to the parent. What the trusted person tells us, we can accept as part of our culture. In a therapeutic context, being recognized and validated as a person in one's own right and having agency, is a precondition for the opening up of epistemic trust.

The qualities required for a person to earn epistemic trust are, above all, benevolence and reliability. They trigger epistemic trust and open up channels that allow us to receive knowledge about a personally relevant social world— knowledge that transcends specific experiences and becomes relevant in, and generalizable to, many different settings (Fonagy et al., 2015). However, we also need to learn to discern not just who is to be trusted and who is benevolent and reliable as a source of information, but also who is uninformed, unreliable, or downright bad-intentioned. Being excessively and uncritically open to receiving any new information is as maladaptive as is being excessively closed to the possibility of receiving new information (Sperber et al., 2010; Wilson & Sperber, 2012). If an attachment figure is a source of both fear and trust, the child – and later on the adult - will seek assurance from elsewhere but feel doubtful at the same time. This position of 'epistemic mistrust' is often associated with 'epistemic hyper-vigilance': a seemingly restless, if not obsessive, preoccupation with reading contextual cues (Fonagy & Allison, 2014; Fonagy et al., 2015). Children, for example, who continuously watch their parents' facial expressions, anxiously anticipating any possible sudden 'changes of mind' in their parents, often have considerable difficulties tuning into their own states of mind.

Being mentalized in the context of attachment relationships in the family generates epistemic trust within that family unit. Mentalization-focused work aims to enhance effective mentalizing and build attachments all round and thereby build epistemic trust so that even if a parent is, for example, temporarily not able to stop their own work and immediately attend to their child, that very parent nevertheless recognizes that the child's wish to have the parent nearby may come from anxiety, or excitement, or a worry that the parent has 'forgotten' them.

The evidence base of mentalizing work with families

Mentalization-based therapy (MBT) for adults presenting with borderline personality disorder has a strong evidence base, as indicated in recent reviews of psychological interventions for BPD (e.g. Budge et al., 2013; Nelson et al., 2014; Stoffers et al., 2012). An early RCT of MBT in a partial hospital setting found that an 18-month programme resulted in lasting and significant changes in mood states and interpersonal functioning (Bateman & Fonagy, 1999, 2001). In comparison to treatment as usual (TAU), benefits were large, with a number needed to treat of two, and they continued to grow during the 18-month follow-up. A follow-up, 8 years on from initial entry into treatment found that the MBT group continued to do better than TAU, with better outcomes in levels of suicidality (23% in the MBT group vs. 74% in TAU group), diagnostic status (13% vs. 87%), service use (2 years vs. 3.5 years), and other measurements such as use of medication, global functioning and vocational status (Bateman & Fonagy, 2008).

A trial of MBT in an adult outpatient setting has also found better results to TAU (Bateman & Fonagy, 2009), particularly in the long term (Bateman & Fonagy, 2013). Significantly in this trial, control treatment was a manualized, highly efficacious treatment, structured clinical management (Bateman & Fonagy, 2009). A study of the treatment of adolescents who self-harm with outpatient MBT found that the MBT group showed a recovery rate of 44%, compared to 17% of those who received TAU (Rossouw & Fonagy, 2012). A study in Denmark investigated the efficacy of MBT versus a less intensive, manualized supportive group therapy in patients diagnosed with BPD (Jørgensen et al., 2013). The combined MBT was superior to the less intensive supportive group therapy on clinician-rated Global

Assessment of Functioning. An 18-month naturalistic follow-up found that treatment effects at termination were sustained at 18 months (Jørgensen et al., 2014). Half of the patients in the MBT group met criteria for functional remission at follow-up, compared with less than one-fifth in the supportive therapy group, but three-quarters of both groups achieved diagnostic remission, and almost half of the patients had attained symptomatic remission. In a second study from Denmark (Petersen et al., 2010), a cohort of patients treated with partial hospitalization followed by group MBT showed significant improvements after treatment (average length 2 years) on a range of measures including Global Assessment of Functioning, hospitalizations and vocational status, with further improvement at 2-year follow-up.

A naturalistic study by Bales et al. (2012) in the Netherlands investigated the effectiveness of an 18-month manualized program of MBT in 45 patients diagnosed with severe BPD. There was a high prevalence of comorbidity of DSM-IV Axis I and Axis II disorders. Results showed significant positive change in symptom distress, social and interpersonal functioning, and personality pathology and functioning; effect sizes were moderate to large (d = 0.7–1.7). This study however is limited by the absence of a control group. Another study (Bales et al., 2015) applied propensity score matching to determine the best matches for 29 MBT patients from within a larger (n = 175) group who received other specialized psychotherapeutic treatments. These other specialized treatments yielded improvement across domains, which was generally only moderate; in contrast, pre–post effect sizes were consistently large for MBT, with Cohen's *d* for reduction in psychiatric symptoms of −1.06 and −1.42 at 18 and 36 months, respectively, and *d*s ranging from 0.81 to 2.08 for improvement in domains of personality functioning. Given the non-randomized study design and the variation in treatment dose received by participants, the between-condition difference in effects should be interpreted cautiously. A multi-site randomized trial by the same group comparing intensive outpatient and partial hospitalization-based MBT for patients with BPD is currently underway (Laurenssen et al., 2014).

Mentalization-based work with families has not yet been reliably evaluated. At least one clinical trial is currently underway (Midgley et al., 2017), but there are no data available at this stage. Some small-scale evaluation studies have been carried out, mostly in the UK. For example, in a naturalistic evaluation of the effectiveness of short-term MBT work with families (up to 10 sessions), findings from the parent-report Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) showed a

statistically significant reduction in behavioural and emotional difficulties in children and young people. Over the course of therapy, parents reported an overall reduction in the impact that their child's difficulties were having on both individual and family functioning (Keaveny et al., 2012). In a small-scale qualitative study (Etelaapa, 2011), most parents spoke about their sense of 'stuckness' prior to starting therapy, and went on to describe the ways they felt the therapy had helped them. When asked to reflect on the impact of the therapy, most of the young people (aged 8 to 15) commented on the importance of feeling listened to and understood, and some described the way in which the sessions had positively affected the relationships within their family. Although small-scale, the evaluation studies described above provide some initial indication that families can be helped by a mentalization-informed family approach, and that this way of work is acceptable to families themselves. Further research is urgently needed, however, to explore whether a mentalization-informed family approach is effective, either as a 'stand-alone' model of therapy, or as a supplement to existing systemic approaches to working with families.

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