Introduction to Mentalization-Based Approaches for Parents, Children, Youths, and Families

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Family members mentalize when they try to understand each other's behavior on the basis of intentional mental states. This article aims to introduce and briefly describe how the concept of mentalization can provide a useful framework for clinicians to understand psychopathology of children, youths, and families. The authors further outline how mentalization-based techniques and interventions can be applied to build epistemic trust and to reestablish mentalizing in families by presenting clinical vignettes of initial sessions from various clinical settings in the United Kingdom and Germany. The article concludes with a brief summary about the current evidence for mentalization-based interventions with children, adolescents, and families and provides an outlook for future clinical and research work.

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When parents mentalize about their children, they are engaging in a form of (primarily preconscious) imaginative mental activity (e.g., "What is making my child behave like this right now?"). In other words, they are trying to understand the intentional mental states underpinning their child's behavior—the feelings, thoughts, desires, attitudes, and goals that shape how the child behaves (1, 2). For example, a father is trying to mentalize his daughter's state of mind when he is wondering about her being quiet at dinner and considering that her behavior may be related to her not being allowed to see her friends or him not having time to watch a movie with her after dinner because of his work. Mentalizing is imaginative; the father is trying to imagine what is going on inside his daughter's mind, and he can never be a 100% sure whether he has it right (3). He may also become curious about why his daughter's silence is irritating him so much today, when other times he has not minded. In other words, he is trying to mentalize his own state of mind, as well as his daughter's.

Although mentalizing may seem like a simple activity, the way that this capacity develops is complex. Fonagy and colleagues (4) suggest that mentalizing develops when there is an intersubjective process of shared experience between the infant and the attachment figure (usually a parent), and the infant is treated as a psychological entity with a mind (5). These repeated interactions with the caregiver form the basis for the infant to be able to develop a coherent sense of self and a capacity to make sense of how self and others behave in terms of intentional states (6). Hence, the ability to mentalize can be understood as a transactional and intergenerational process between children and their caregivers (3). Furthermore, in the context of early attachment relationships, the child learns to assess whether the information transmitted by the caregiver is relevant, trustworthy, and generalizable. The concept of epistemic trust has been defined as the expectation that interpersonally communicated knowledge may be true and relevant (7). In those moments, parents are able to base their interactions on mentalized aspects of themselves, their child, and the representation of themselves in the child's mind, and they lay the foundation for their child to build epistemic trust in the information that is communicated to them. The basis for transmitting relevant and trustworthy information is formed by providing ostensive cues, such as eye contact or smiling, designed by the speaker to generate an

HIGHLIGHTS

- Mentalizing can be regarded a transactional, intergenerational process in families, and the concept provides a useful framework to understand psychopathology in parents, children, and youths and their families.
- Mentalization-based approaches represent a promising integrative and manualized treatment approach.
- Considerable evidence supports using mentalization-based treatment with adults, and the number of studies on mentalization-based interventions for children, youths, and families has increased in the recent years, with promising findings.

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interpretation of communicative intention in a recipient (8). Parents send ostensive verbal and nonverbal cues in their communication to prime their child that information is significant. Children are sensitive to these cues in the way that they recognize they are being addressed and can expect to learn referential information (8). Studies in developmental psychology show that this feeling of being recognized allows for the rapid transmission of knowledge—the ability to benefit positively from one's environment. The child can then experience that the parent has a (reasonably accurate) representation of him or her, and thus the child can experience him- or herself as a psychological entity and agent with a mind.

PREMENTALIZING MODES

When emotional arousal rises in families, individual family members' mentalizing capacities are at risk of becoming increasingly impaired or may get lost at a certain point. According to the cognitive-psychological switch point model, controlled and explicit processes in the prefrontal cortex shift to automatic and implicit processes in the posterior cortex and subcortical areas as the level of emotional arousal increases (9). At the switch point, explicit mentalizing is deactivated (10) and evolutionarily earlier protective functions, namely fight, flight, or freeze responses, are activated (11). Accordingly, adolescents experiencing high emotional shame arousal in front of their parents may find themselves automatically attacking (verbally), fleeing, or freezing, as they pass their switch point. Mental processes then take place in one or a combination of three prementalizing modes: teleological, psychic equivalence, or pretend. These modes are associated with ineffective mentalizing and naturally occur during the development of mentalizing capacities in growing children (Bateman, 2014, unpublished manuscript).

Families in which prementalizing modes prevail have a high risk for family members to feel misunderstood, overlooked, and/or scapegoated, and these feelings may lead to coercive and controlling behaviors in place of connection and repair after conflict. Additionally, epistemic trust among family members is reduced, and family members are unable to learn from each other in a positive way. These results in turn increase stress and negative emotions because the family is caught in a vicious cycle of nonmentalizing.

MENTALIZATION-BASED TREATMENT (MBT) FOR CHILDREN, YOUTHS, AND FAMILIES

MBT is a manualized treatment protocol first developed by Anthony Bateman and Peter Fonagy (12) to treat patients with borderline personality disorders. MBT has been further adapted for other mental disorders in which mentalizing deficits may be part of what underlies or maintains the difficulties (e.g., eating, anxiety, depressive, and psychotic disorders) and for various settings, ages, and target groups (13–15). During the past 20 years, MBT has also been adapted for parents, children, youths, and families (16). Below, we provide a brief overview of how MBT works, the therapist's basic "stance" toward the patient, and common interventions. We then describe specific mentalization-based program adaptations for parents, children and their families, and adolescents, including clinical case examples from initial sessions.

In MBT with children, young people, and families, the therapist works with the parent or parents, family, or youth to interrupt the vicious cycle of nonmentalizing and to regain or stabilize mentalizing in certain areas. This process can create a psychic buffer between affect and behavior to enhance affect regulation and subsequently promote functional family or other interpersonal interactions (17).

The therapist's basic mentalizing stance, which is also referred to as a "not-knowing stance," is characterized by showing interest, openness, and curiosity. Basic mentalizing interventions for high arousal include empathic validation techniques. As emotional arousal levels normalize, additional interventions are used, such as exploration, critical and challenging questioning, affect elaboration, affect focus on interpersonal problems, and relational mentalizing (18).

When both patient and therapist are able to mentalize, the therapist can use "contrary moves" to create more flexibility in balancing different poles of mentalizing. For example, if one family member is stuck in thinking about him- or herself, the therapist will try to shift that person's thinking toward others or will directly address the other members to obtain their perspectives (self-other pole). Or, if an adolescent is too certain or makes quick assumptions, the therapist will try to slow down and question the assumptions (implicit-explicit pole). By sharing or disclosing his or her interpersonal experience from the beginning and throughout the therapeutic process, the therapist can help parents and other patients or clients "find themselves" in the mind of the therapist and reflect on how the therapist represents them in his or her mind. In this way, the therapist models mentalizing and how the technique is linked to the family members' own representations of themselves (epistemic match).

The therapist's mentalizing stance and interventions aim to promote the patient's mentalizing ability and serve as ostensive cue stimuli. That way, epistemic trust can be established or enhanced, and family members can benefit from communicating with the therapist so that they can learn new skills and knowledge, which they can subsequently transfer to their lives and social environments outside the therapy room. According to Fonagy et al. (17), this step-by-

step process takes place in three communication systems: the therapist's explanatory model and the therapeutic techniques derived from it create the basis of a new understanding when they are transparently presented to the family (e.g., a therapist may offer an explanation for a family member's silence and withdrawal, which may have initially been perceived as hostile and dismissive by another family member, as perhaps the result of insecurity and shame of the withdrawing family member); systematic improvement of mentalization and the use of intensive ostensive means of communication (e.g., cues) contribute to better affect regulation, impulse control, and self-coherence among family members; and new social learning experiences, initially within the therapeutic relationship, reduce feelings of isolation and create more positive social interactions outside therapy, thus creating a positive reinforcing (virtuous) cycle.

Below, we provide clinical case examples of mentalization-based interventions for parents, children, young people, and families. These vignettes illustrate how the mentalizing approach can be used when first starting clinical work. We discuss these vignettes with a mentalizing approach and briefly describe new developments in this rapidly emerging field. Prior research (13, 16, 19, 20) is available for further reading on these topics.

MBT FOR PARENTS: THE LIGHTHOUSE PARENTING PROGRAM

Clinical Vignette: Building Trust With Parents at Risk

THERAPIST: Thank you for agreeing to meet with us today Ms. A, and before we start, can I just check, what do you need to know about me, us, or our service that might help you decide if we are the right people to work with you and your daughter?

[Ms. A hesitates and looks confused. Perhaps she was not expecting the interview to begin this way.]

Ms. A was referred to the Lighthouse Parenting Program (LPP), which uses an MBT approach, because she attacked her 9-year-old daughter, Katie, in a rage and bit her. The therapist is assessing Ms. A to see if they can work to reduce risk of recurrence of abuse and facilitate her daughter's return home. They meet via Zoom along with her social worker. Ms. A had multiple adverse childhood experiences and automatically assumed that all professionals are out to judge and blame her, an assumption strengthened by the removal of her daughter by the family court. LPP encourages parents to adopt the mentalizing, not-knowing stance, also called the "illuminating beam," which enables them to see their child more clearly (21). The therapist believed that Ms. A's daughter was not only not seen but was "mis-seen," caught in Ms. A's "projecting beam," and that Ms. A perhaps experienced her daughter as judging and blaming, thereby inciting the assault.

To effect change in Ms. A's parenting and reduce risk of recurrence of the abuse, Ms. A must see the therapists as a trusted source of information about her, her child, and their relationship; furthermore, she needs to trust that the therapist's intentions are benign. For the establishment of epistemic trust, Ms. A must feel that the therapist is trying to understand how the world and her situation look and feel from her perspective and that the therapist empathizes with her, even when they might hold a different perspective (13). Offering her a reasonably accurate picture of her in the therapist's mind and signaling a willingness to let her shape that picture is also crucial. This and other ostensive cues (e.g., using her name and occasional eye contact) are important, and for Ms. A, the stakes could not be higher.

MS. A [answering the therapist's question]: Just sort of, to know the kind of things that you do, if that's not too detailed, and how you might be able to help us, please.

The therapist suspected that Ms. A's stated willingness to engage belied a deep mistrust in the therapist and his ability to help, even though a family court mandated that she work with LPP. Turning up for sessions is not the same as meaningful engagement, and it was not Ms. A's fault if she felt deeply mistrustful. She believed that the therapist held a lot of power as the expert clinician, but therapists have true agency only if they can elicit epistemic trust.

THERAPIST: OK, so I may not be able to answer how we can help at this point, and look, it is fine to ask for any amount of detail you need. Feel free to stop and ask at any point. . . . So, I'm a child psychotherapist and—

The therapist broke eye contact, and over 7 or so minutes, described the program. The therapist occasionally made eye contact, allowing Ms. A time to study the therapist's expressions and hear his tone of voice, which conveyed, warmth, interest, and concern. These early moments in the first meeting with a hypervigilant, epistemically mistrusting parent are similar to the moment when a hostage negotiator approaches a kidnapper with his arms raised and spins around to show that he is unarmed and means no harm.

THERAPIST [concluding]: So, is there anything from that that you need me to expand on, or do you have any questions about any of that?

MS. A: It all sounds like it makes sense and would be useful.

The therapist believed Ms. A. did not yet trust him, so he modeled curiosity about her previous assessment with the expert psychiatrist and learned that Ms. A. did not feel listened to about her health condition, myalgic encephalomyelitis, and fibromyalgia. The therapist offered empathic validation.

THERAPIST: So, if you are going to feel understood by us, you will need for us to grasp just how—and these could be the wrong words, tell me if I'm wrong—just how stressful being in constant pain and having movement difficulty will enormously add to the parenting stress. You need to feel we understand that, that we get that.

MS. A: Yes, it is so unfair what has been said about me.

Later, when Ms. A said, "You're the psychologist, you might explain to me the link with childhood," the therapist answered, "If there are answers, we will only get there with your help, as you are the expert on your experience, not us."

This concept is not only crucial to building epistemic trust but also true, because the only meaningful links that might effect change in Ms. A's parenting are those that she makes or, at the very least, coproduces. At the end of the first session, Ms. A trusted the therapist enough to bring her daughter to the next appointment. However, the therapist believed he needed to win and rewin Ms. A's trust, session by session, for quite some time, before epistemic trust was truly established.

Settings and Adaptations for the MBT LPP

The LPP was developed for parents at risk of mistreating their children. In addition to using MBT interventions (group, individual, and MBT-adapted parenting techniques), images and metaphors of the lighthouse, sea, sea journeys, and the shore are used to help parents grasp key mentalizing, attachment, and psychoanalytic concepts (e.g., projection). In the LPP, the parent is seen as a lighthouse, providing a gentle attentive light for their child's journey and guiding the child back to shore for support, help, or comfort when needed. The aims of the LPP are to help parents better understand and respond to the needs of their child or children, to facilitate the growth of epistemic trust in the parent-child relationship, and, ultimately, to reduce the risk of harm. The program's strength is in engaging parents who are hard to reach and who typically do not benefit from parenting programs. The program (22) has now been adapted for use with different populations (e.g., parents receiving inpatient psychiatric treatment) and is being evaluated with regard to its effectiveness as part of randomized controlled trials (RCTs) in the United Kingdom and Germany.

MBT FOR CHILDREN AND THEIR FAMILIES

Clinical Vignette: Mentalizing Work With School-Age Children

About 20 minutes into the therapist's first meeting with Mrs. B and her two children, Zac (age 8) and Amanda (age 10), and the consultation was not going well. The therapist had begun the meeting by trying to understand what had brought them to seek help. Within moments, Mrs. B mentioned how awful Zac's behavior had been that weekend, and Zac shouted back at her, accusing her of not caring. Mrs. B looked at the therapist with desperation in her eyes. "You see what I have to put up with? What should I do?" As Mrs. B asked this question, the therapist noticed her own anxiety rising and felt under pressure to find a solution to this tense situation. She was the professional after all; shouldn't she have answers, or at least a good suggestion for how to make things better?

In mentalizing terms, the rising affect in the room, created as Mrs. B began to talk about the family's difficult weekend, had triggered a breakdown in mentalizing—both in the family and in the therapist. In describing what had happened during the weekend, Mrs. B spoke about her son in purely behavioral terms (his bad behavior), which in turn triggered Zac's anger ("You don't care about me!"). The emotional temperature in the room escalated rapidly, creating a breakdown of mentalizing, which led to Mrs. B's own wish for a "teleological" solution—the plea to the therapist to just do something. But breakdowns in mentalizing do not only happen within families; they also happen within the network around the family, including teachers and social workers or therapists Thus, under pressure, the therapist was also losing her capacity to stay thoughtful and curious and felt the need to come up with a solution to the problem.

In MBT with families, the therapist uses an approach called the "mentalizing loop" to address these breakdowns in mentalizing (23, 24). The first step is to simply notice and name what is going on. The process of noticing and naming in itself creates space to become curious about what is happening. That space can allow the opportunity for the second step, "mentalizing the moment," where some "mentalizing oxygen" can be pumped back into the family, like a deep-sea diver being offered oxygen to help him or her manage in the depths. Once a family has begun to recover the capacity to mentalize under pressure, the therapist can move to the third step of the mentalizing loop, "generalizing and considering change."

With Mrs. B and her children, the therapist used the mentalizing loop to avoid immediately suggesting solutions, which probably would not have been useful to Mrs. B in her high arousal, nonmentalizing state. Instead, the therapist tried to notice and name what had just happened between her and Mrs. B—the way that the therapist's question about the previous weekend had quickly exploded into this angry exchange. The therapist also noticed that Amanda had sat quietly as Zac and his mother got into a conflict, something that Mrs. B added, "happened all the time." Noticing and naming what had just happened created a change in mood in the room, and it felt as if some space was open for curiosity. To "mentalize the moment," the therapist turned to Amanda and asked what it was like for her sitting in the middle of these arguments between Zac and their mother. Amanda replied thoughtfully that it made her feel sad, but also angry. The therapist remarked on Amanda having more than one feeling at the same time and asked Zac if he knew that his sister felt both sad and angry when he argued with their mother. Yes, he did. How did he know?

> Zac: When she goes quiet, I know that she's angry.
>
> Therapist: And sad?
>
> Zac: Yes.

With their dad not at home anymore, he knew his sister was sad too.

> Mrs. B [surprised]: You're not sad, are you? Isn't it better now that we're not fighting all the time?"

The therapist asked if Mrs. B thought that there could be different feelings going on at the same time. For the first time she looked thoughtful, even a bit tearful, and said, "Yes, maybe there are."

This interaction was not a magical solution to the problems that had brought this family to therapy, and soon Mrs. B and Zac were fighting again. However, by using elements of the mentalizing loop (the participants did not reach the third step during this session), the family experienced that difficult interactions could be thought about and seen from different perspectives and had become curious about what was going on for the others in the room. Over time, such experiences help family members build a sense of epistemic trust, a feeling that the consulting room can be a safe place to go that offers more than teaching how to manage "bad" behavior; it can be a place where family members feel known and, consequently, become more open to each other's minds and trust in what they can learn from others. After a few family sessions, Mrs. B decided that Zac needed a space away from her where he could explore some of his feelings about his parents' separation, and he entered individual, time-limited MBT (25). The therapist continued to work with Mrs. B in parallel parent work and made sure that Amanda, and eventually the children's father, were also involved in the effort to help the family develop its own ability to keep the "mentalizing oxygen" pumping when faced by stress, hurt, and anger.

Settings and Adaptations for MBT With Children

As the above section makes clear, mentalizing is a concept that has relevance in many contexts within and beyond the therapy setting, including schools, residential care homes, and hospitals. Indeed, the interpreter who was translating for trainers teaching these concepts to a group of professionals in Italy last year approached the trainers at the end of the 3-day workshop and explained that she had taken home some of the ideas described and had been able to help resolve a long-standing family problem.

In a narrative review of MBT interventions for school-age children, Midgley et al. (26) identified 29 unique mentalization-informed interventions. These interventions (some of which were universal interventions and some more targeted) were developed for middle childhood, some for use in school settings and others for specific clinical groups, such as children who had attention-deficit hyperactivity disorder or autistic spectrum disorder or had experienced maltreatment or abuse. Although some of these mentalization-based interventions took the form of individual therapy, others were developed for families, care givers, or whole systems, aiming to promote mentalizing capacity across the entire network of professionals involved in the lives of children in need of help. Given the way that mentalizing can help individuals understand the impact of maltreatment and trauma, it is perhaps not surprising that a number of these interventions—such as Hagelquist's (27) STORM (security, trauma focus, obtaining skills, resource focus, and mentalization) model or the Reflective Fostering Program (28, 29)—have focused on the field of fostering and adoption. Although the evidence base for these approaches remains in the early stages, MBT trainings are popular, and practitioners are often enthusiastic about these approaches because they are practical, digestible, and often translate easily into practitioners' work across a range of settings.

MBT FOR YOUTHS AND ADOLESCENTS AND THEIR FAMILIES

Clinical Vignette: Engaging Youths With Delinquency

A 17-year-old boy from a migrant refugee family was brought to our psychotherapeutic outpatient service at the university hospital in Heidelberg, Germany, because his school had demanded that he enter treatment. At our first meeting, when he entered the therapy room with his father, he immediately burst into a temper tantrum, yelling at his father with grand gestures: "What's all this? Why are you forcing me here? I don't belong here!" Entering the room, the therapist's heart beat with anxiety, but she tried to stay calm, friendly, and curious about the mental states behind his anger. The session proceeded with a pattern typical for first sessions. The boy started to withdraw completely, making no eye contact, his arms folded, while his father explained the situation, humiliating his son in front of the therapist. In such contexts, to avoid further humiliation and to establish therapeutic alliance, it can be necessary to interrupt these interactions quickly and talk to the adolescent alone, which the therapist did. One-on-one with the therapist, he repeated that he did not belong in the therapy room, indicating that he was normal and not crazy. In this instance, the therapist chose to first use psychoeducational interventions that establish full transparency about the purpose and methods. She explained that the program was dedicated to adolescents with externalizing behavior problems (not craziness) and aimed to enhance understanding and lower conflict between the youth and others, including the family. He immediately tested the therapist: "I am losing at lot of money here," he said, indicating that he was involved in drug dealing.

> THERAPIST: How much do you earn per hour?
>
> BOY: About 150 euros.
>
> THERAPIST: Maybe we should swap jobs!
>
> BOY [smiling for the first time, shakes head]: I could not do all this talking.

Because the therapist focused on his perspective, was appreciative, and jointly attended to the consequences of treatment, the boy became able to talk about his fears of turning crazy in therapy, being brainwashed, and not feeling accepted. The therapist continued the session by validating these fears, assuring full confidentiality, exploring further motives, and using a stance of "rolling with the resistance"—supporting him in his conflicts and giving him

autonomy or agency (e.g., "When I summarize what you said, I can really understand why you do not want to start therapy"). At the same time, the therapist offered him a rewarding relationship that allowed them to have an open conversation about the violent conflicts with his parents, which he felt horrible about. The session ended with a summary of the pros and cons of starting therapy and the task of deciding for himself whether or not to engage in therapy. The therapist also used humor and showed acceptance to explore delinquent behavior without being patronizing, which helped to establish contact with him. To engage and motivate him for treatment, the therapist used the MBT stance and techniques, which in this case specifically addressed problems common to teens with externalizing behavior, namely low insight, externalized psychological strain, defiance, avoidant attachment, fear of peer exclusion, and low help-seeking behavior.

After the first session, he decided to engage in treatment, and we started to work on connecting his mental states with his actions. The more this connection was possible, the less he engaged in violent and criminal behavior. After being thrown out of four schools because of his dysregulated behavior, he became able to use his skills and abilities to complete a high school degree. Later, he even recommended that other young people seek help at the outpatient department at the university hospital.

Settings and Adaptations for MBT With Youths and Adolescents

Young people are faced with the developmental tasks of establishing autonomy and self-directed identity. They often find themselves overwhelmed when dealing with relationships (20). Additionally, they are more vulnerable to mentalization failure because of structural and hormonal brain changes during this phase of development. These changes make young people sensitive to their own emotions and to the emotions of those around them. Young people generally live with their families, and the home can become a battlefield where mentalization failure in one family member triggers loss of mentalization in all other members.

The combination of individual and family therapy with the MBT approach has been shown to be more effective than treatment as usual in reducing depressive symptoms and self-harm for adolescents with these behaviors by enhancing mentalizing and reducing attachment avoidance (30). Although the Rossouw and Fonagy study (30) used deliberate self-harm as inclusion criteria, over 70% of the sample had borderline personality disorder. Efforts have also been made to work with adolescents in group therapy instead of in individual or family therapy, but a recent RCT (31) did not demonstrate efficacy of weekly MBT-group therapy over supportive therapy every two weeks. Low retention rates in that trial (31) were associated with low mentalizing, meaning that group therapy did not appear to be the setting of choice for adolescents with low reflective abilities (32). This association has been acknowledged in the development of a new MBT protocol for adolescents with conduct disorder (33, 34). This treatment protocol consists of a short psychoeducation followed by a combination of individual and family therapy that uses the core MBT model. The protocol focuses on engaging the young person by using motivational interviewing and a rewarding therapeutic relationship. From a mentalizing perspective, aggressive or delinquent behavior is understood as a teleological way of coping with unbearable affective states. As is characteristic of MBT applications for adolescents, creative ways of facilitating mentalizing are used, for example, talking, playing, drawing, and jointly attending to meaningful material from the young person's point of view, including cultural products (e.g., rap music) or current political issues (e.g., discussion of conspiracy theories). The therapist aims to restore epistemic trust by allowing the young person to experience a helpful other's mind. This goal is particularly challenging for the therapist in the face of antisocial behavior and requires constant inner work to create distance from patronizing, hostile, and punishing reactions to externalizing symptoms (33).

In summary, MBT for youths emphasizes the importance of combining individual and family work, considering the youth's developmental trajectory, providing scaffolding to help enable young people to achieve a sense of autonomy, identity, mastery, and accomplishment.

EMPIRICAL EVIDENCE FOR MENTALIZATION-BASED INTERVENTIONS WITH CHILDREN, YOUTHS, AND PARENTS

There is a considerable evidence base for using MBT when working with adults (35). In the past 15 years, research evaluating mentalization-based interventions with children, young people, and families has also increased. A systematic review (13) identified 34 studies, 14 of which focused on evaluating dyadic (parent-child) models of MBT for parents of babies and toddlers. For example, several RCTs have demonstrated the effectiveness of Minding the Baby and mother and toddler programs for different populations, including first-time mothers and their babies or mothers of toddlers in residential substance misuse programs. A number of well-designed studies have also evaluated adaptations of MBT for work with adolescents, including one RCT (30) that demonstrated the superiority of MBT compared with treatment as usual for adolescents who self-harm. Fewer studies have focused on MBT for preadolescent children, although Midgley et al. (36) have demonstrated the feasibility of such a clinical trial for preadolescent children in foster care.

Luyten et al. (35) have highlighted that adaptations of MBT for children and families often go beyond individual or dyadic therapies to target the broader social context by means of system-level interventions. Two systems in

particular where aspects of MBT have been adapted to provide a broader intervention include schools and children's social services. A systematic review (26) identified evaluations of schoolwide mentalization interventions, including one cluster RCT (37) examining the impact of a mentalization-based program to reduce school violence. A number of studies have also examined the impact of interventions on foster care providers, social workers, and the networks around children in foster care, with promising results. For example, Family Minds (38) and the Reflective Fostering Program (29) have both shown promising outcomes in early evaluations, with full-scale RCTs now underway.

SUMMARY, IMPLICATIONS, AND OUTLOOK

In this article, we aimed to provide an introduction on how clinicians can use the mentalizing framework in therapy for children, youths, and families. MBT can build epistemic trust, reestablish mentalizing in families, and subsequently enable or enhance clients' abilities to engage in meaningful, trustworthy communication that fosters social learning and generally healthy development of family members. In this way, MBT for parents, children, youths, and families represents a promising integrative, manualized treatment approach. Its therapeutic principles can generally also be integrated into other therapeutic procedures and other psychosocial work settings with families. Information about training opportunities in MBT and MBT for parents, children, youths, and families can be obtained from the Anna Freud Centre (https://www.annafreud.org/training).

Transdiagnostic development of MBT is ongoing, and studies to test its efficacy with individual target groups are forthcoming. Further differentiation of the approach will be important for specific groups and settings. From a research perspective, investigation of mentalizing as a mechanism of change in treatment, and as a way to enhance understanding of the transgenerational development of psychopathology and mentalizing deficits among families, will be important priorities for future work and will help to further improve clinical interventions.

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