**Lighthouse© MBT-Parenting Programme**

**A Mentalization Based Treatment with Psychoeducation for Parents**

**General Information**

**10 January 2017**

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## Introduction

### The Lighthouse MBT-P Programme

The Lighthouse MBT-Parenting programme was developed to promote mentalizing[[1]](#footnote-1) modes of thinking and parenting in this high-risk, exacting clinical population. It aims to enhance parents’ capacity to mentalize and in particular to mentalize their children, to enhance attunement in parent-child relationships, to promote secure attachment and reduce Disorganization and to reduce risk of harm and risk of trans-generational transmission of psychopathology including BPD traits.  In addition to using MBT treatment interventions (group, individual and adapted MBT-Parenting techniques), images and metaphors of the lighthouse, sea, sea journeys and the shore etc., help parents grasp hold of key mentalizing, attachment and psychoanalytic concepts.

## Rationale

### Core aim of Lighthouse MBT-P

* The core aim of the Lighthouse programme could be stated as enabling the parent to see her child more clearly; that is to equip the parent with the skills to seek to continuously restore mentalizing; to continuously approach the child with a curious, *wanting-to-know* mentalizing stance. We tell our parents that this programme will not equip them with strategies such as the number of minutes they should put their child in time-out when they misbehave. What it aims to do is to provide them with ways of approaching the child that will enable them to better understand the child’s points of view and in turn, this will enable them to make decisions on how to respond in any given situation.  As a child’s cry can mean many different things, it is important for the parent, in our view, to adjust their response according to the cry, its meaning, and its intensity.

### Adapting MBT for high risk families - rationale

A child’s experiences in the first years of life can have a substantial and long-lasting influence on their future well-being (Fraley et al., 2013), with insecure or disorganized attachments in the early years associated with poor emotional, social and educational functioning in the long-term (Dutra et al., 2008; Groh et al., 2012; Lyons-Ruth & Jacobvitz, 2008). The enormous cost to society and the individual negative outcomes associated with early experiences of neglect and maltreatment has been well documented, and there is a strong call for investment in preventative therapeutic interventions for high-risk families (Gilbert et al., 2009). A report for the Early Years Commission has called for policymakers to shift their focus to preventative strategies to support the relationships between parents and children in the early years (Centre for Social Justice, 2008). The successful promotion of secure attachments and positive experiences in the early years can have far reaching health and cost-benefits for children, their families, and society.

### Mentalizing framework for understanding borderline personality disorder

In addition, most of the parents of children who suffer neglect and other forms of maltreatment have themselves suffered abuse and neglect as children; many have mental health difficulties including personality disorders. Research shows that there is a high prevalence of severe, insecure attachments (disorganized, preoccupied and fearful attachment styles) in borderline personality disorder (BPD) psychopathology, supporting the central role of disturbed interpersonal relationships and low reflective functioning in clinical theories of BPD (Agrawal et al., 2004 and Levy, 2005, Fonagy et al., 1996). Fonagy and Bateman articulate a mentalization theory of BPD first suggesting that individuals are constitutionally vulnerable and/or exposed to psychological trauma; second, that both these factors can undermine the development of social/cognitive capacities necessary for mentalization via neglect in early relationships; third, that this results in a hypersensitive attachment system within interpersonal contexts; and fourth, that this leads to the development of an enfeebled ability to represent affect and effortfully control attentional capacity; rendering mentalizing capacity fragile (Bateman and Fonagy, 2010).

### Mentalizing framework for understanding child maltreatment

Mentalization is an integrative conceptual framework; its coherence with Social-Ecological, Neurodevelopmental, and particularly Attachment models means that it lends itself well to applications extending beyond adult borderline personality disorder and has particular relevance to treatments aiming to intervene early in an child’s life to prevent the development of later psychopathology including BPD. Secure attachment relationships provide the child with the safety to explore the mind of the attachment figure and finding himself accurately represented there as a thinking and feeling intentional being ensures that his own capacities for mentalizing develop well (Fonagy, Gergely, Jurist, & Target, 2002). Attachment relationships enable the development of epistemic trust, that is, trust in the authenticity and personal relevance of interpersonally transmitted knowledge (Fonagy, Luyten, Campbell, Allison, 2014) which allows the individual to benefit from their (social) environment.

We suggest that many instances of severe child abuse and neglect occur in the midst of catastrophic, parental failures in mentalizing and/or in families in which non-mentalizing modes of thinking and behaving predominate. In short, mentalizing deficits in parents can result in pervasive emotional and physical neglect; mentalizing failures in parents can result in impulsive acts of psychological, emotional and physical abuse. It is important to note child sexual abuse (CSA) and child sexual exploitation (CSE) often utilize a misuse of mentalizing as commonly, the perpetrators use mentalizing skills to establish epistemic trust for the purposes of grooming the child. We do not admit perpetrators of CSA/CSE into the Lighthouse programme. Similarly, sadistic abuse (physical and/or emotional) may also be a contra-indication for admission to the programme.

### MBT for Borderline Personality Disorder

Fonagy and Bateman point to the BPD patient’s exquisite sensitivity to interpersonal interactions, his poor regulation of emotional arousal and unstable sense of self. Therefore, MBT treatment targets the patient’s mentalizing capacity, aiming to re-establish it within the context of a therapeutic relationship that takes into account the vulnerability to collapse in mentalizing that therapy can unintentionally evoke by targeting, in treatment, the identification and expression of affect and thus stabilize the patient’s emotional expression.

Fonagy and Bateman developed MBT specifically with Borderline Personality Disorder. It has proved effective at reducing depressive symptoms, decrease in self-harm and suicidal acts, reduced inpatient days and better social and interpersonal function. An eight year follow up found that only 14% of patients treated still met the diagnostic criteria for BPD (Bateman Fonagy, 2002).

In summary, MBT aims to:

* Identify and promote expression of affect (through empathy, support, clarification)
* Restore mentalizing of self and other
* Enhance mentalizing
* Provide a safe space, in the controlled conditions of individual and/or group therapy, to the patient to practice the skills of mentalizing under stress (including the therapist-patient relationship).

## Illuminating the child and the ‘child-in-mind’ - Lighthouse MBT-P

### Being seen is being believed

Mentalizing is sometimes defined as seeing ourselves from the outside and others from the inside. Mentalizing is not only about *seeing* self and other more clearly; it is about *striving* to see each more clearly. As Fonagy states, we do not expect to be perfectly understood by other people, but we feel valued when someone shows interest in acquiring more knowledge of us and when we see evidence of a revision of us based on that knowledge, even if it remains somewhat inaccurate.  One could say that to be seen accurately (or reasonably accurately) and to experience someone as trying to see us accurately results in feeling understood, in a feeling of being believed in: *to be seen is to be believed*.  When a child suffers neglect, what we commonly find is that the perpetrator has not set out to sadistically neglect the child, but has a deficit in his capacity to truly see the child and her needs. Selma Fraiberg, in *Ghosts in the Nursery,* famously cites the young mother who cannot hear her baby’s cries; Fraiberg concludes that the mother’s cries were not heard when she was a baby/child and so she cannot recognise her baby’s cries. In our work, over many years, with parents who have maltreated their children, we find parents are often not just deaf to a child’s cries, but fundamentally unable even recognise their child’s unique voice. Often they are blind to the child’s needs, and often, through the mechanism of projective identification, they mis-take their child for someone or something else. Such *mis-takes* are present in misattributions for instance, and often it is the mis-taken child that is the target for abuse, perceived inaccurately as a persecutor, for example (“*he started crying the moment I lit up a cigarette. He knew it would wind me up”*).  Wanting-to-know/-to-see clearly is more important than knowing/seeing clearly

### Silhouette to 3D and 4D view of the child

A key characteristic of mentalizing is that minds are opaque; we cannot know what is going on in another’s mind, we can guess and we can infer, but ultimately we cannot *know.* For some parents who have suffered neglect and abuse/trauma in their lives, often the representation of their child in their mind is impoverished (measured formally in the parent development interview (PDI); as a shorthand and to illustrate what we mean, we use the simile of a *silhouette.* Seeing someone in silhouette make it difficult to identify him or her as an individual, often leading to being seen as a stereotype, and/or can commonly result in mistaken identity. We suggest that when children suffer neglect or abuse they perhaps exist more as silhouettes than fully rounded, full-colour, three- dimensional, representational figures in the parents’ minds.

Parents can struggle to make temporal links in trying to understand how a child’s behaviour might link to past experiences, or to understand the behaviour in terms of a child’s wishes for the future. In this way, we suggest that they may struggle to see their child in the fourth dimension; that is, holding the child’s past and future in mind.

### Bringing children and parents to life in our minds

We are encouraging parents to approach their child with a mentalizing stance, wanting to see the child more clearly, adopting, as it wear, clearer lens through which to view the child. We believe we do this through three key components of the programme:

1. Mentalizing skills practice in group and individual treatment (most important component of any MBT programme)
2. Creating a safe space (secure base) in which mentalizing can be evoked, provoked, challenged and explored
3. Psychoeducation (including insights from neuroscience and child development research and key concepts from attachment and psychoanalytic theories

Each week we hear back from them in each group of what they have noticed or learnt that’s new about their child. If all goes well then as each week passes, each parent is developing clearer sight of his/her child, and indirectly, we *see* the child more accurately too; a richer representation of the child is built up in our minds and indeed, a richer representation of the parents too. The relative liveliness of the parent and/or child in mind is one way in which we can measure and reflect back on the therapy. We use images and metaphors of the lighthouse, sea, sea journeys and the shore to help parents grasp hold of key mentalizing, attachment and psychoanalytic concepts.

## FASS and ReConnect Lighthouse MBT-P Programmes

The Lighthouse© MBT-Parenting Programme has been developed in collaboration with the Anna Freud Centre and is delivered to parents in both the Family Assessment and Safeguarding Service (Oxfordshire, Wiltshire & BaNES) and the ReConnect Service (Buckinghamshire). An independent evaluation of the programme as it is run in the ReConnect Service was conducted by researchers from UCL and The Anna Freud Centre led by Professor Pasco Fearon and Dr Michelle Sleed (see *Independent Evaluation* and *Key Findings* sections).

The programme has been written to the strict guidelines provided within the Quality Manual for MBT to ensure treatment integrity (i.e.: treatment adherence, therapist competence and treatment differentiation) (Perepletchikova & Kazdin, 2005) and has been approved by Professors Anthony Bateman and Peter Fonagy founders of the MBT approach to working with BPD.

### Components of the Programme

As with all MBT programmes, there are two core components to the group work with parents: an MBT-Introduction precursory course (15 sessions), referred to as the Lighthouse© MBT-P-I and a treatment group, referred to as the Lighthouse© MBT-P Treatment Group. In the ReConnect and FASS services, we additionally provide one-to-one direct MBT treatment to all parents on the programme, plus a copy of *The Lighthouse© MBT-P Journal.* Additional treatments complementary to MBT work with parents can be added, for instance, in ReConnect and FASS we offer Video Interaction Guidance (VIG), as needed, to many of our parents.

The combined programme, which runs for 20 sessions. Parents are given a copy of the illustrated *Lighthouse Journal* at the beginning of the programme. The *Journal* summarizes the content of the programme and can be used throughout the programme to record personal reflections and for homework etc. Four sample pages from the *Journal* are provided at the end of this document.

The model is underpinned by research in the fields of attachment, child development and neuroscience, by core psychoanalytic concepts offering insight into how minds and relationships work & advances in Mentalization Based Treatment for BPD (see Table 2).

Aims of The Lighthouse© MBT-Parenting

The MBT for Parents Lighthouse programme has been developed within FASS to adapt the psychoeducation component of MBTi to work with parents. The programme explicitly trains parents to mentalize their children and relationships with their children (understand their children’s stage of development, view of the world, and feelings, wishes and desires, emotional needs etc.).

The Lighthouse© MBT-P programme is designed to achieve the following 5 aims stated below (Table 1).

**Brief statement of aims of Lighthouse© MBT-P Programme**

1. To enhance parents’ self-mentalizing skills
2. To enhance parents’ mentalizing of their children
3. To enhance attunement in parent-child relationship
4. To promote secure attachment and reduce *Disorganization*
5. To reduce risk of harm and of trans-generational transmission of psychopathology including BPD traits

*Table 1*

### Underpinnings of The Lighthouse© MBT-P Programme

The model is underpinned by research in the fields of attachment, child development and neuroscience and by core psychoanalytic concepts that offer insight into how our minds and relationships work. It draws on advances in Mentalization based Treatment for adults with Borderline Personality Disorder (BPD). See Table 2 for summary.

### Components of the model

**The model is underpinned by the following**

* Research in the fields of attachment, child development and neuroscience
* Core psychoanalytic concepts that offer insight into how our minds and relationships work
* Advances in Mentalization Based Treatment (MBT) for BPD

*Table 2*

The model has psycho-educational and skills training components that are delivered to the parents in a group which are summarized in Table 3:

The psycho-education and treatment group is 20 sessions.

**Components of the model**

1. A psychoeducational course (MBT-P-I); couched in daily language and using readily understood images and metaphors to explain, illuminate and illustrate key concepts offering parents (first 12 weeks of combined group programme)
   1. a model of the mind
   2. a model of child development and
   3. a model for understanding relationships with children
   4. a model to enable parents to distinguish accurate perception from misperception, attunement from mis-attunement
   5. some skills based training in mentalizing
2. A Mentalization Based Group Treatment (remaining 8-10 weeks of combined group programme) that offers skills based training in:
   1. observation and attunement
   2. mentalizing
      1. of the self as individual and parent
      2. of the child (and child-in-mind)
      3. and of the child-parent and parent-child relationship

*Table 3*

## Independent Evaluation

Evaluation of the programme as run in ReConnect was carried out by by Professor Pasco Fearon (UCL, Anna Freud Centre), and Dr Michelle Sleed from The Anna Freud Centre.

The following paragraphs describing the service and the outcomes of the Evaluation are taken directly from the Report published in November 2015. Further detailed information can be requested from Gerry Byrne (Oxford Health) or from Dr Pasco Fearon (UCL) or Dr Michelle Sleed (AFC).

### Remit of this report

This report is based on the evaluation of the ReConnect service for the first two cohorts of families who participated in the individual *and* group therapy and who agreed to participate in the evaluation (n=16).

### Outcome measures used

1. **Patient Health Questionnaire- 9 (PHQ-9; Kroenke, Spitzer and Williams, 2001)**

The PHQ-9 is a brief and widely used measure of depression.

1. **GAD-7 (Spitzer, Kroenke,Williams & Löwe, 2006)**

A brief measure for assessing generalized anxiety disorder.

1. **Parenting Stress Inventory- Short Form (PSI:SF**; **Abidin, 1995)**

A 36-item questionnaire that measures stress level experienced within the parenting role.

1. **Clinical Outcomes in Routine Evaluation Scale (CORE; Evans, Meller−Clark, Margison, Barkham, Audin, Connell, and McGrath, 2000)**

A generic self-report measure of global distress which includes measures of subjective wellbeing, commonly experienced problems or symptoms, social/life functioning (including general functioning, functioning in close relationships and functioning in social relationships), and risk to self and others.

1. **Maternal Self Efficacy Questionnaire (MEQ; Teti & Gelfand, 1991)**

10 item scale assessing maternal self-efficacy in relation to 9 specific mothering activities and 1 global item.

1. **Parent Development Interview- Revised (PDI-R; Slade, Aber, Bresgi, Berger & Kaplan, 2004)**

A semi-structured clinical interview intended to examine parents’ representations of their child, themselves as a parent, and their relationship with their child. The PDI is intended to assess internal working models of relationships.

1. **CGAS Children’s Global Assessment Scale**

The **Children's Global Assessment Scale** (**CGAS**) is a numeric scale (1 through 100) used by mental health clinicians to rate the general functioning of children under the age of 18.

1. **Maternal Sensitivity**

Maternal sensitivity is assessed via structured video-recordings of the parent interacting with their child (NICHD sensitivity measure).

1. **Parental RFQ (not used in first 2 cohorts ReConnect 2015)**

The Parental Reflective Functioning Questionnaire (PRFQ.

### Key Findings and Summary published November 2015

|  |
| --- |
| Key Findings There were significant improvements over the course of the programme in relation to:   * Parents’ self-efficacy in caring for their babies * Parents’ levels of stress in their parenting role * Parents’ sensitivity in responding to their babies’ needs and communications when playing with them   Although there were improvements on almost all measures, these changes were not statistically significant in relation to:   * Parental depression and anxiety * Parental reflective functioning (mentalizing capacity) * Parental sensitivity on structured tasks (such as reading a book, or changing the babies’ clothes)   There were several themes that emerged from the interviews with the mothers.   * The programme was seen by most as “a life changing experience” as it helped them to improve their confidence, sensitivity, attachment relationship and capacity to trust. * The combination of individual and group therapy was seen as highly valuable * The imagery (such as the lighthouse) used in the programme had a powerful impact on the parents * Most parents did not want the programme to end * Most parents felt this was something that should be widely offered to all parents |

### Summary

There were three domains in which there were noticeable and significant improvements for the ReConnect parents over time: self-efficacy, parenting stress and parental sensitivity during playful interactions.

It is interesting to note that the measures tapping more general emotional wellbeing in the parents (depression, anxiety, general distress) did not change significantly over time, but the two measures relating to the parental role did (maternal self-efficacy and parenting stress). Thus, the parents were clearly feeling more confident and relaxed in their ability to care for their baby, even if they may have continued to have emotional difficulties themselves. The improved capacity to cope with the demands of parenting a young baby may be an important protective factor for the children of these parents, many of whom have experienced a great deal of trauma in their past and for whom emotional difficulties are persistent. In the absence of a control group, it is not possible to attribute with certainty any findings to the fact that these families took part in the ReConnect programme. However, in the qualitative interviews, the parents themselves spoke of their improved confidence in themselves as parents and they clearly attributed these changes to the intervention. Furthermore, the improvements that were found are certainly aligned with the aims of the programme which are focused around improving the parent-child relationship.

A potentially very important finding is the improvement seen in maternal sensitivity during free-play interactions. Sensitivity, the capacity to recognise and respond appropriately to the infant’s communications, has been repeatedly shown in large studies to be a key predictor of secure attachment relationships. In turn, early attachment security is widely acknowledged as an important predictor of a host of psychological, educational and social outcomes later on in life. Thus, improvements on this measure may shift these young babies onto a much more positive developmental trajectory. This outcome is particularly notable because it was statistically significant even with a very small group – which in turn implies that the changes on that outcome were large.

The qualitative interviews provided a great deal of evidence for the value that parents felt the programme provided. For most parents the intervention was literally life-changing. The improvements they noticed following the intervention were all in important areas that contribute to secure attachment and positive parent-child relationships (parental confidence, trust, sensitivity, improved attachment).

### Conclusion

In conclusion, the results of this evaluation suggest that there were several clear improvements in the lives of the parents and children who participated in the ReConnect programme and these are likely to foster more secure and protective parent-child relationships in the long-run.

Further research with a larger sample size and control group is needed to verify these promising initial findings and to determine the effectiveness of the ReConnect programme.

## Where the Lighthouse© MBT Programme is delivered

Below is a table of where the programme (or components of the programme as specified) is being delivered as of Spring 2016.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Lighthouse© MBT-P Programme** | | | | **Population:** |
|  | **MBT-P-I** | **MBT-I+Tx** | **Ind MBT** | **VIG** |  |
| **Component:** | Lighthouse© MBT-P-I(Information)  (Psychoeducation 15 sessions) with Journal | Lighthouse© MBT-P-I+T (Psychoeducation combined with Treatment Group (20 sessions) with Journal | Individual MBT  Treatment | Video  Interactive  Guidance | **Population:** |
| **FASS** Oxford Health NHS Foundation Trust: Oxford | Yes  2 groups p.a.  Gerry Byrne  Gabrielle Lees  Clare Mein  Anna Motz  Jasmin Enayati | Yes | Yes | Yes | Parents of children (any age) on CP Plan or Pre/Post-Proceedings |
| **ReConnect**  Buckinghamshire  Oxford Health NHS Foundation Trust:  Buckinghamshire | Yes  2 groups p.a.  Gerry Byrne  Nicola Connolly  Alice Brady  Anne Wynne-Jones | Yes | Yes | Yes | Parents of children on CP Plan or Pre/Post-Proceedings + children under 2 |
| **Footprints**  Bath and North East Somerset County Council:  Bath | To commence 2017  Martin Elliott  Clare Still | Yes | Yes | ? | Parents who have lost previous children to care (may or may not be pregnant) |
| **Parental Pathways**  Dublin | Yes  Sept- Dec 2015  Feb-Aug 2016  Oct 2016 -Jan 2017  Maria McGrane  Linda O’Hanlon | N/A | N/A | N/A | Parents of children in treatment (Private therapy) |
| **Dublin Polish Group** | Karolina Kurszewska-Szemis and  Agnieszka Krzyzanowska | Yes |  |  |  |
| **Attachment and Mentalization Service**  *CrossCare Diocesan Charity Dublin* | Yes  Sept – Dec 2015  Feb-Aug 2016  Tom Casey | N/A | N/A | N/A | Foster carers and Adoptive Parents |
| **Adelaide Australia** | Teams trained; 2017 Groups to run February 2017  Dominic Kleinig |  |  |  |  |
| **Heidelberg, Germany** | Team trained; 2017 plans to run groups in development |  |  |  |  |

## Requests for training or permission to use Lighthouse materials

If you are want further information, or wish to discuss training in the Lighthouse© MBT-P programme please liaise with the programme lead, Gerry Byrne ([gerry.byrne@oxfordhealth.nhs.uk](mailto:gerry.byrne@oxfordhealth.nhs.uk)). Questions to consider:

* What current professional qualifications and level of MBT Skills (Basic Training/Practitioner) will the proposed facilitators possess?
* What population are you planning on offering the programme to?
* What components of the programme are you wishing to deliver: The 15 or 20 session MBT-P group programme alone, or group programme with additional individual MBT and/or parent-infant/child or family work?
* Can you comply with an agreed data set of measures before and after to evaluate the efficacy of the intervention and add the Anna Freud Centre’s growing database of evaluations of the programme’s efficacy in different settings?

## References

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## Excerpts from Lighthouse Journal





1. ### Mentalizing

   Mentalizing refers to our ability to attend to mental states in ourselves and in others as we attempt to understand our own actions and those of others on the basis of intentional mental states.  A focus on this very human activity as a therapeutic intervention forms the core of mentalization based treatment (MBT). MBT was initially developed for the treatment of borderline personality disorder (BPD) although it is now being used on a wide range of disorders and treatment groups including parents, children, adolescents and families. [↑](#footnote-ref-1)