Title: Mentalization-based approaches for parents, children, youth and families: an introduction

Running head: Mentalizing in youth therapy

Abstract (109 words)

Families mentalize when they are trying to understand each other's behavior based on intentional mental states. This manuscript aims to provide an introduction and brief overview on how the concept of mentalization can provide a useful framework for clinicians to understand psychopathology in children, youth and their families. Furthermore, we outline how mentalization-based techniques and interventions can be applied to build epistemic trust and re-establish mentalizing in families using clinical vignettes of first sessions in different clinical settings. The manuscript concludes with a brief summary about the current evidence base for MBT interventions with children, young people and families and provides an outlook for future clinical and research work.

Plain language summary (130 words)

Families mentalize when they are trying to understand each other's behavior based on inner thoughts, feelings or wishes. Mentalizing is a helpful concept to understand the risk for developing mental health problems and stress and conflict in families. This manuscript aims to provide an introduction and brief overview on how the concept of mentalization can be useful for clinicians to understand mental health problems in children, youth and their families. We outline how mentalization-based treatment can be applied to help families understand each other better and resolve conflict. Clinical vignettes from three programs: the Lighthouse parenting program, MBT for school-aged children and MBT for young people with conduct problems are described. We conclude with a brief summary about the current research findings and future needs for clinical and research work.

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Introduction

Mentalizing in families

When parents mentalize their children, they are engaging in a form of (primarily preconscious) imaginative mental activity – 'what's making my child behave like this right now?'. In other words, they are trying to understand their child's behavior based on intentional mental states - on the feelings, thoughts, desires, attitudes, and goals which shape how they behave (1, cf. 2). For example, a father is trying to mentalize his daughter when he is wondering about her being quiet at dinner and considering that this may have something to do with her not being allowed to see her friends or him not having time to watch a movie with her after dinner due to his work. Mentalizing is imaginative as 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 got it right (3). He may also become curious about why his daughter's silence is irritating him so much today, when other times he hasn't minded. In other words, he is trying to mentalize himself, as well as his daughter.

Although mentalizing may seem the most obvious of activities, 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). Based on numerously repeated interactions with the caregiver, these experiences 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 (Fonagy, et al., 2016). In those moments, as a parent, when we are able to base our interactions on mentalized aspects of ourselves, our child and the representation of ourselves in the child's mind, we lay the foundation for our child to build epistemic trust in the information that we communicate 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 interpretation of communicative intention in a recipient (7). 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 being addressed and can expect to learn referential information (7). Studies in developmental psychology show that this feeling of being recognized opens the channel for the rapid transmission of knowledge - the ability to benefit positively from one's environment. The child can then experience that we have a (reasonably accurate) representation of them, and thus, can experience him- or herself as a psychological entity and agent with a mind.

Pre-mentalizing modes

When emotional arousal rises in families, their mentalizing capacities are at risk to become increasingly impaired or can 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 (8). At the switch point, explicit mentalizing is deactivated (9) and evolutionarily earlier protective functions, namely fight, flight or freeze responses, are activated (10). Accordingly, an adolescent experiencing high emotional shame arousal in front of their parents may find himself automatically to (verbally) attack, flee or freeze, as they pass their switch point. Mental processes then take place in one or combined forms of these three pre-mentalizing modes: (a) teleological, (b) psychic equivalence, or (c) pretend mode. These modes are associated with ineffective mentalizing, which naturally occur in the development of mentalizing capacities in the growing child (11).

In families in which pre-mentalizing modes prevail, there is high risk for family members to feel misunderstood, overlooked and/or scapegoated and this may lead to coercive and controlling behaviors in place of connection and repair following conflict. Alongside this, epistemic trust in family members is reduced and they are unable to learn from each other in a positive way. This in turn increases stress and negative emotions, as- the family is caught in a vicious cycle of non-mentalizing.

What is MBT and how does it work in families?

Mentalization-based Treatment (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 where mentalizing deficits may be a feature (e.g., eating disorders, anxiety, depressive and psychotic disorders) and for different settings, ages and target groups (for an overview see 13, 14, 15). Over the last twenty years, MBT has also been adapted for parents, children and youth and their families (16). In the following pages, we will provide a brief overview of how MBT works, the MBT stance and interventions before describing in more detail some specific mentalization-based program adaptations for parents, children and their families, and adolescents including illustrations with clinical case examples of first sessions.

In MBT, the therapist works with the parent(s), family or youth to interrupt the vicious cycle of non-mentalizing and regain or stabilize mentalizing in certain focus areas in order to create a psychic buffer between affect and behavior to enhance affect regulation, and subsequently promote functional family or other interpersonal interactions (17).
The basic mentalizing or not-knowing stance is characterized as showing interest, openness, and curiosity. Basic mentalizing interventions for high arousal levels include empathic validation techniques. As emotional arousal levels normalize, further interventions such as exploration, critical, even challenging questioning, affect elaboration and affect focus on interpersonal problems, and relational mentalizing are used (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 the self, the therapist will try to shift towards thinking about others or directly address the other members to obtain their perspective (self-other pole). 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 the therapist’s interpersonal experience with parents or other clients or patients from the beginning and throughout the therapeutic process, they can experience “finding themselves in the mind of the therapist” and reflect on how the therapist represents them in his or her mind. This is how the therapist models mentalizing and how this is linked to the family’s 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 and subsequently transfer this to their lives, their social environment outside the therapy room. According to Fonagy et al. (17) this takes place stepwise in three communication systems:

1. 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. For example, a therapist may offer the explanation for a family member's silence and withdrawal that was initially perceived as hostile and rejecting by another family member, as perhaps the result of insecurity and shame of the withdrawing family member.
2. Systematic improvement of mentalization and the use of intensive ostensive means of communication ("cues") contribute to better affect regulation, impulse control and self-coherence in the family.
3. New social learning experiences initially within the therapeutic relationship reduce feelings of isolation and create more positive social interactions outside therapy. This creates a positively reinforcing/ virtuous cycle.

MBT work for different groups: parents, children, adolescents and families

In the following we will 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 from a mentalizing position and briefly describe new developments in this rapidly emerging field. The interested clinician is referred to the following online materials and references for further reading (13, 19, 16, 20).

MBT for parents: the Lighthouse parenting program

Clinical vignette: Building trust with parents at risk

'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, 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 MBT-Parenting Program (LPP) because she had attacked her 9-year-old daughter, Katie, in a rage and bitten her. I am assessing Ms. A to see if we can work with her to reduce risk of recurrence of abuse and facilitate her daughter's return home. We meet on Zoom, with her social worker. Ms. A has had multiple adverse childhood experiences (ACEs) and automatically assumes that all professionals are out to judge and blame her, an assumption strengthened by the removal of her daughter by the Family Court. In the Lighthouse program we encourage parents to adopt the mentalizing, not knowing stance, which we call the *illuminating beam*, enabling them to see a child more clearly (21). I imagine Ms. A's daughter was not only not seen but mis-seen, caught in what we call Ms. A's *projecting beam*, perhaps experienced as judging and blaming of her mother inciting Ms. A's assault of her.

If we are to effect any change in Ms. A's parenting, and reduce risk of recurrence of abuse, she will need to see us as a trusted source of information on her, her child and on their relationship and furthermore, trust that our intentions are benign. For the establishment of epistemic trust Ms. A will need to feel that I am both trying to understand how the world and her situation looks and feels from her perspective, and that I empathize with her, even when I might hold a different perspective (22). Offering her a reasonably accurate picture of her in my mind and signaling a willingness to let her shape that picture is crucial too. This and other ostensive cues (using her name, eye contact) are important and for Ms. A, the stakes could not be higher.

She answers, '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?' I suspect her stated willingness to engage belies a deep mistrust in me and in my ability to help as even if mandated to work with us, turning up to sessions is not the same as meaningful engagement, and it is not her fault if right now she is deeply mistrustful. I am felt by her to hold a lot of power as the expert clinician, but I only have true agency if I can elicit epistemic trust between us.

I say, '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, and feel free to stop and ask at any point… So, I'm a child psychotherapist and…' I now break eye contact with her and over 7 or so minutes I give a description of the program occasionally making eye contact, allowing her time to study my

expressions, and hear my tone of voice which conveys, warmth, interest and concern. I liken these early moments in the very first meeting with a hypervigilant, epistemically mistrusting parent to the moment when a hostage negotiator approaches a kidnapper with his arms raised and spins around to show he is unarmed and means no harm. I finish with; 'So, is there anything from that that you need me to expand on or any questions about any of that?' Ms. A replies; 'It all sounds like it makes sense and would be useful.'

I believe she does not yet trust me, so I model curiosity about her previous assessment with the expert psychiatrist and hear from her that she did not feel listened to about her health condition, ME and fibromyalgia. I empathically validate by saying; '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 movement difficulty – will enormously add to the parenting stress – you need to feel we understand that, that we get that?' She answers, 'yes, it is so unfair what has been said about me…' Later, when she says 'You're the psychologist, you might explain to me the link with childhood…' I answer, 'If there are answers we will only get there with your help as you are the expert on your experience, not us…'

This is both crucial to building epistemic trust but also true as the only meaningful links that might effect change in her parenting are those that she makes or, at very least, co-produces. By the time we finish she trusts me enough to meet her with her daughter at the next appointment, however, I believe, I will need to win and re-win her trust, session by session for quite some time before epistemic trust is truly established.

Settings and adaptions of the MBT-Lighthouse parenting program

The Lighthouse parenting program (LPP) was developed for parents at risk of maltreatment of their children. 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 (e.g., projection). In LPP the parent is seen as a lighthouse, providing a gentle attentive light for their child's journey and guiding them back to shore for support, help or comfort when needed. The aims of the LPP are to help parents to better understand and respond to the needs of their child/ren, to facilitate the growth of epistemic trust in the parent-child relationship, and ultimately to reduce the

risk of harm. Its strength is in engaging hard to reach parents, who typically do not benefit from parenting programs. The program has now been adapted for different populations, for example for parents in inpatient psychiatric treatment (23) and is currently being evaluated with regard to its effectiveness as part of a number of RCTs in the UK and Germany.

MBT for children and their families

Clinical vignette: Mentalizing work with school-age children

It was about 20 minutes in to my first meeting with Mrs. B and her two children, Zac (8) and Amanda (10), and so far, this first consultation was not going very well. I had begun the meeting by trying to get an understanding of what had brought them to seek help, and within moments Mrs. B was telling me how awful Zac's behavior had been that weekend, and Zac was shouting back at her, accusing her of not caring. Mrs. B looked at me with desperation in her eyes – 'You see what I have to put up with? What should I do?'. As Mrs. B asked me this question, I noticed my own anxiety rising. I felt under pressure to 'do' something – to come up with a solution to this tense situation. I am the professional after all – shouldn't I have some answers – or at least a good suggestion of how to make things better?

In mentalizing terms, you could say that the rising affect in the room, created as Mrs. B began to tell me about their difficult weekend, had triggered a breakdown in mentalizing – both in the family, and in myself as their therapist. In describing what had happened at the weekend, Mrs. B was speaking 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 went up rapidly, creating a breakdown of mentalizing which led to Mrs. B's own wish for what we might call a 'teleological' solution – in other words, the plea to me to just do something. But breakdowns in mentalizing don't just happen within families, they also happen within the system – so under pressure, I was also losing my capacity to stay thoughtful and curious, and felt the need to come up with something that would just 'fix' the problem.

In MBT with families, we make use of an approach called the 'mentalizing loop' to address these breakdowns in mentalizing (24, 25). The first step is to simply notice and name what is going on. The process of noticing and naming in itself creates some space to become curious about what is happening. That 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 them manage in the depths. Once a family has begun to recover their capacity to

mentalize under pressure, the therapist can move to the third step of the mentalizing loop, 'generalizing and considering change'.

So, with Mrs. B and her children, I used the loop to help me avoid jumping straight into suggesting solutions (which Mrs. B probably wouldn't have been able to make use of anyway, in her high-arousal, non-mentalizing state). Instead I tried to notice and name what had just happened between us – the way that my question about the previous weekend had quickly exploded into this angry exchange. I also noticed that Amanda had sat quietly as Zac and his mother got into conflict – something which Mrs. B added 'happened all the time'. By noticing and naming what had just happened, there was a change in mood in the room, and it felt as if some space was open now for curiosity. So, in order to 'mentalize the moment', I turned to Amanda and asked what it was like for her sitting in the middle of these arguments between Zac and their mum? Amanda replied thoughtfully that it made her feel sad – but also angry. I verbally marked the way in which Amanda had these two different feelings going on at the same time, and asked Zac if he knew that his sister felt both sad and angry when he argued with their mum? Yes, he did. How did he know? 'When she goes quiet, I know that she's angry'. And sad? Yes, with dad not at home anymore, he knew his sister was sad too. 'You're not sad, are you?' said Mrs. B, surprised – 'isn't it better now that we're not fighting all the time?'. I wondered 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 wasn't a magical solution to the problems that had brought this family to therapy, and soon Mrs. B and Zac were at each other's throats again. But through using elements of the mentalizing loop (we didn't get to the third step this time), the family had an experience that difficult interactions could be thought about and seen from different perspectives; of becoming curious about what was going on for the others in the room. Over time, such experiences build up a sense of epistemic trust, a feeling that the consulting room could be a safe place to go beyond being taught how to manage 'bad' behavior, to a place where family members can feel known, and consequently become more open to each other's minds and trusting 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 into an individual, time limited MBT therapy (26). I continued to work with Mrs. B in parallel parent work, and we made sure that Amanda – and eventually the children's father – were also involved in the

work we were doing, to try and help the family develop their own ability to keep the 'mentalizing oxygen' pumping when faced by stress, hurt and anger.

Settings and adaptions of MBT with children

As the above section makes clear, mentalizing is a concept that has relevance in all kinds of contexts, within and beyond the therapy setting, including schools, residential care homes and hospitals. Indeed, when teaching a group of professionals in Italy last year, the interpreter came up to the trainers at the end of three-day workshop and explained that she'd taken home some of the ideas that we'd been describing, and they had helped resolve a long-standing family problem!

In a narrative review of MBT interventions with school-age children, Midgley et al. (27) identified 29 unique mentalization-informed interventions developed for those in middle childhood, some of which were universal interventions, especially in school settings, and others which were targeted at specific clinical groups, such as children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Autistic Spectrum Disorder (ASD), or children who had experienced maltreatment or abuse. Whilst some of these mentalization-based interventions took the form of individual therapy, others were developed for families, or carers, or indeed whole systems, aiming to promote mentalizing capacity across the whole network of professionals involved in the lives of troubled children. Given the way in which mentalizing can help to understand the impact of maltreatment and trauma, it is perhaps not surprising that a number of these interventions focused on the field of fostering and adoption, such as Hagelquist's (28) Security, Trauma-focus, Obtaining-Skills, Resource-focus and Mentalization (STORM) model, or the Reflective Fostering Program (29, 30). Whilst the evidence-base for these approaches is still in the early stage of development, MBT trainings are popular, and practitioners are often enthusiastic about these approaches because they are practical, digestible and often translate easily into their work across a range of settings.

MBT for young people/adolescents and their families

Clinical vignette: Engaging young people with delinquency

A 17-year old boy from a refugee migrant family was brought to our outpatient service as the school demanded him going into treatment. At our first meeting, when he entered the therapy room together with his father, he immediately busted 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!". As a

therapist my heart was beating anxiously when I came into the room, but I tried to stay calm, friendly and curious about his mental states behind his anger. What followed is often typical for first session episodes. The boy started to withdraw completely, making no eye contact, his arms folded while his father started explaining and also humiliating his son in front of me. In these contexts, to avoid further humiliation and to establish a robust therapeutic alliance, it may be necessary to interrupt these interactions quickly and talk to the adolescent alone, which I did. When we were alone, he repeated that he did not belong here, indicating that he was normal and not crazy. I chose here first to use psycho-educative interventions that establish full transparency about the purpose and methods and explained that the program was dedicated to adolescents with externalizing behavior problems (not craziness) and aimed to enhance understanding and lowering conflict between the young person and others including the family. He immediately tested me by stating: “I am losing at lot of money here” indicating that he was involved in drug dealing. I asked him: “How much do you earn per hour?” And when he answered that it was about 150€, I spontaneously said: ”Maybe we should swap jobs!?” He then smiled at me for the first time and shook his head and answered humorously: “I could not do all this talking.” By staying focused on his perspective, being appreciative and jointly attending the consequences of treatment for him, he was able to talk about his fears of turning crazy in therapy, being brainwashed and not feeling accepted. As a therapist, I continued in this session with validating these fears, assured full confidentiality, explored further motives and used a stance of “rolling with the resistance” meaning to support him in his conflicts and give him autonomy or agency: “When I summarize what you said, I can really understand why you do not want to start therapy.” At the same time, I offered him a rewarding relationship that allowed us to have an open conversation about his drug dealing involvement and 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 for the adolescent to decide for himself. I also used humor and showed acceptance to explore delinquent behavior without being patronizing, which helped to establish contact with the boy. In order engage and motivate him for treatment, I used the MBT stance and techniques, which in this case specifically addressed common problems of externalizing teens, namely low insight, externalized psychological strain, defiance, avoidant attachment, fear of peer exclusion and low help seeking behavior. After this first session, he decided to engage into treatment, and we started treatment to work on connecting his mental states with is actions. The more this was possible the less he engaged in violent and criminal behavior. After he had previously been thrown out of four schools because of his dysregulated

behavior, he was able to use his skills and abilities to complete a high school degree. Later on, he even recommended other young people to seek help at our outpatient department.

Settings and adaptions of MBT with young people/ 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 due to structural and hormonal brain changes during this phase of development. These changes make young people very sensitive to their own emotions and the emotions of those around them. Young people are generally still living with their families and this can become a battlefield where mentalization failure in one family member triggers a spiral of loss of mentalization in all other members.

The combination of individual and family therapy using the MBT approach has been shown to be more effective than treatment as usual (TAU) for adolescents with self-harm in reducing depressive symptoms as well as self-harm by enhancing mentalizing and reducing attachment avoidance (31). Although this study used DSH as inclusion criteria, over 70% of the sample had BPD (31). Although efforts have also been made to work with adolescents using group therapy instead of individual or family therapy, a recent RCT could not demonstrate efficacy of weekly MBT-group therapy over a bi-weekly supportive therapy (32). Low retention rates were predicted by low mentalizing, meaning that especially for adolescents with very low reflective abilities, group therapy does not appear to be the setting of choice (33). This has now been acknowledged in the development of a new MBT treatment protocol for adolescents with conduct disorder (34, 35). This treatment protocol comprises a very short psychoeducation followed by a combination of individual and family therapy using the core MBT model. It particularly focusses on engaging the young person using motivational interviewing and a very rewarding therapeutic relationship. From a mentalizing perspective, aggressive or delinquent behavior is understood as a teleological way of coping with unbearable affective states of mind. As is characteristic for all MBT-A applications creative ways of facilitating mentalizing are employed using talking, playing, drawing and jointly attending to meaningful material from the young person's point of view including cultural products (for example rap music) or current political issues (e.g., discussion of conspiracy ideas). The therapist aims to restore epistemic trust by allowing the young person to experience a helpful other mind. This is particularly challenging for the therapist in the face of antisocial behavior and needs

constant inner work to distance from patronizing, hostile and punishing reactions to externalizing symptoms (34).

In summary, MBT for young people emphasizes the importance of combining individual and family work on the one hand as well as bearing in mind the developmental trajectory and provide scaffolding to help enable young people to achieve a sense of autonomy, identity, mastery and accomplishment.

Empirical evidence-base for mentalization-based interventions with CYP

There is now a considerable evidence-base for MBT when working with adults (for a review, see 36). In the last 15 years there has also been a significant increase in research evaluating mentalization-based interventions with children, young people and families. A systematic review (22) identified 34 studies, fourteen of which focused on evaluating dyadic (parent-child) models of MBT for those working in early years. For example, several RCTs have demonstrated the effectiveness of Minding the Baby (MTB) and Mother and Toddler Program (MTP) 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 demonstrating the superiority of MBT-A compared to treatment as usual for self-harming adolescents (31). Fewer studies have focused on MBT as a treatment for pre-adolescent children, although Midgley et al. (37) have demonstrated the feasibility of such a clinical trial for pre-adolescent children in foster care.

Luyten et al. (36) highlight the fact 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 care. A systematic review (27) identified a number of evaluations of school-wide mentalization interventions, including one cluster RCT examining the impact of a mentalization-based program to reduce school violence (38). A number of studies have also examined the impact of interventions on foster carers, social workers and the networks around children in care, with promising results. For example, Family Minds and the Reflective Fostering Program have both shown promising outcomes in early-stage evaluation studies (39), with full-scale RCTs now underway.

Summary, implications and future outlook

This manuscript aimed to provide an introduction on how clinicians can work with children, youth and their families using the mentalizing framework in order to build epistemic trust and re-establish mentalizing in families, and subsequently to enable or enhance their ability to engage in meaningful, trustworthy communication that fosters social learning and generally a healthy development of the family members. That way, MBT for parents, children, youth and families represents a promising integrative manualized treatment approach. The therapeutic principles can generally also be integrated into any other therapeutic procedure as well as into other psychosocial work settings with families. Information about training opportunities in MBT and MBT for parents, children, youth and families can be obtained from the Anna Freud Centre (https://www.annafreud.org/training/).

The transdiagnostic development of the concept is still ongoing and further studies on testing its specific efficacy with individual target groups are on the way. While, the further differentiation of the approach for specific groups and settings are necessary and important, from a research perspective, the investigation of mentalizing as a mechanism of change in treatment and enhancing our understanding of the transgenerational development of psychopathology and mentalizing deficits in families will be one important priority for our future work and help us further to improve our clinical interventions.

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