MENTALIZING IN CHILD THERAPY

Guidelines for Clinical Practitioners

SECOND EDITION

ANNELIES VERHEUGT-PLEITER
AND JOLIEN ZEVALKINK

ROUTLEDGE

Mentalizing in Child Therapy

Mentalizing in Child Therapy focuses on open-ended psychotherapy for children with complex mental health issues and attachment problems. It offers examples of personalized and integrated treatment that is "firm in structure yet flexible in its focus" (Peter Fonagy, foreword to first edition).

The book is based on the systematic observation of the treatment of complex problems in children (4–12 years) using a mentalizing therapeutic stance and a range of techniques to enhance mentalizing abilities and trust in other people, incorporating aspects of the more relationship-oriented and competence-oriented treatments. In this updated edition, the authors have elaborated on the topic of attention regulation, having included Siegel's concept of the "window of tolerance". They've also written more on the mentalizing abilities of the therapist, the importance of providing structure at the beginning of the treatment and the value of communication for developing epistemic trust.

Featuring guidelines for clinical practitioners, this book is important for the clinical training of child psychotherapists, as well as for professional child psychiatrists, child psychologists and other therapists working with 4 to 12-year-old children experiencing significant developmental problems with mentalizing.

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Guidelines for Clinical Practitioners

Second edition

Annelies Verheugt-Pleiter and
Jolien Zevalkink

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Chapter 1

Introduction to the second edition

Annelies J.E. Verheugt-Pleiter and Jolien Zevalkink

As Fonagy stated in his foreword to the book edited by Midgley and colleagues (2017, p. x): "If learning in general is undermined by profound difficulties in mentalizing because the source of knowledge is not self-evidently trustworthy, then a mentalization-based approach may be the most helpful and important thing that we can provide." In this treatment we focus on children who experience difficulties sensing intuitively what they and others express with their actions: children who are inhibited or disrupted in the development of their mentalizing capacity and in trusting social information from relevant others. The caregivers did not succeed in making the behaviour of their children meaningful by interpreting it as a being motivated by thoughts, feelings and intentions. Normal development of mentalizing abilities becomes inhibited when children do not recognize themselves in the mind of their parents. Traumatic or atypical attachments undermine the social-cognitive development progress and make these children suspicious of social knowledge coming from others. Because their needs are not sensitively met, they don't develop a sense of self-worth and are not open to receiving new information. Sometimes they actively resist new information and might come across as rigid and stubborn, which can be described by therapists as 'hard to reach' (Bateman & Fonagy, 2019). For these children, short-term treatment will not be enough, because they have experienced very disturbed attachment relationships that have often made them too entangled in their own mind and distrusting of others, including an empathetic therapist. The development of a new and secure attachment relationship with the therapist takes a long time but is necessary for the child to become open to 'learn' from other human beings. We argue (Chapter 4) that flexibility in the frequency and duration of the treatment is important, due to the risk of overheating a disturbed attachment system. When the child feels that the therapist is genuinely interested and tries to understand their perspective – which can take a long time – they are able to develop epistemic trust (Fonagy & Allison, 2014). When the child is able to rely on the social information given by the therapist, their communication skills towards their parents and other relevant people in their life also improve. This development can only happen when the people around the child, especially the parents, develop their mentalizing potential too.

While working with children in mentalization-based therapy, we found parent guidance (now referred to as 'parent therapy') to be more intensive and different in nature to regular psychoanalytic child therapy. On the one hand, this has to do with the parents' problems. These parents are often people whose thinking is highly concrete and who spend little time reflecting on their children's intentions. If parents become better able to untangle complicated family interactions, with the help of the parents' therapist, this is of great therapeutic value. They will begin to feel more competent, and their ties with their children will improve. This in turn makes it of great value for the treatment of the child. If parents gain a better picture of their children's thoughts or intentions – not only those of the child who is in therapy, but of their other children or the child's friends as well – they will be able to deal with and coach their children better. If the situation at home becomes more reflective, there is a greater chance that the mentalizing ability of the child will improve and communication at home will be improved. In this kind of therapy, 'integration of therapists' is essential, by which we mean that the parent therapist, child psychotherapist and any other care workers that may be involved need to work together so they can all focus on mentalization. It is easy for schisms to occur between therapists, which is why they require mutual attunement. The better integrated the therapists, the safer the climate becomes for parents and children. There is a great deal to be said for the use of a family-focused form of mentalization-based treatment (Asen & Midgley, 2019), where parents and children work together to acquire a picture of each other's mental situation and gain some perspective on how much one can know about another person. Especially if treatment has yet to start, such a form is preferable, considering stepped-care. However, if different treatments have already been attempted and there is a lot of suffering in the family, it is preferable to work with children and parents separately, because this allows the therapists to focus on building up the sense of self in both parties. Often, these are children and parents with a negative self-image, who need an exclusive relationship with a therapist in order to experience truly feeling understood. Only then will it become safe to mentalize about the relationship between the self and the other.

Both for children and parents, their capacity to mentalize is mediated by their arousal level, meaning that the capacity is diminished when their level of arousal results in the activation of attachment behaviour. Attachment and mentalization can in fact function antagonistically (Fonagy & Target, 2008). Attachment trauma in particular hyperactivates the attachment system, because the person to whom the child looks for reassurance and protection is the one causing fear (Main & Hesse, 1990). Attachment trauma has been proven to lead to a quick breakdown of mentalizing abilities (Fonagy & Target, 2008, p. 39) and epistemic vigilance (Fonagy & Bateman, 2019, p. 17). In therapy, it is therefore important that, when an attachment relationship develops, the therapist is attentive to the attachment system's level of activation. When the level is too low, there is no movement or change; when the level is too high, the related stress inhibits the capacity to mentalize. In the latter case, reducing arousal is necessary to make

mentalizing possible again. It is unsurprising that enactments of past abusive relational patterns only gradually shift towards mentalizing interactions and feelings of self-agency (Knox, 2016).

We developed this manual for the treatment of children between 4 and 12 years of age and their parents. We focus primarily on this age group for two main reasons. First, it is a period in which intensive treatment might prevent the development of even more serious psychopathology in adolescence or life-course disorders (e.g. Costello & Maughan, 2015; Sharp & Tackett, 2014). Indeed, a retrospective study found long-term treatment to be particularly effective for seriously disturbed children under 12 years of age compared to older children (Fonagy & Target, 1996). Second, a big change in attachment relationships occurs between three and four years of age, in tandem with young children's psychological development. Around four-to-six years of age, unless development is disrupted by severe social adversity, children are likely to have developed a working capacity to read their own and other people's minds, i.e. to mentalize. "Thus, the *psychological connection* becomes paramount, and the connection depends on open lines of communication, which then remain critical to attachment security throughout life" (Allen, 2013, p. 26). Children are now, in principle, able to understand the goals and intentions of their parents, to communicate their own goals and intentions, and to recognize the differences between them. The success with which new social tasks are accomplished by the child during this period depends to some extent on the degree to which the child is supported to disengage from intimate concerns with their parents. This allows them to freely and creatively explore the social world that is beginning to open up to them, engaging playfully and diligently, learning new skills and amassing information. In a secure attachment relationship, the emergence of mentalizing happens smoothly. Yet for a child who is sexually overstimulated, or is under constant physical or emotional threat, this broadening may be fraught with intense anxieties that complicate the free development of mentalization. Such a child may use characteristically rigid patterns of defence to bring their anxieties under control, which may make them appear timid or obsessive (Waddell, 1998). In this way, the capacity for mentalization is inhibited. A child who understands more about what might motivate others and who can show some empathy for their motives will have greater flexibility in thinking and will be able to learn from incorrect assessments. This gives the child a fantastic resource that can be used in social life, in dealing with stress and in building up a sense of self that will give direction to their actions. This process can come to a standstill in certain areas when children do not feel seen, heard or understood in their primary attachment relationship. These children build up little in the way of an inner world or epistemic trust, or they have a chaotic inner world that has internalized, for example, an overpowering, aggressive person or a rejecting, depressive person. This can lead to rigid, controlling behaviour or to withdrawing, avoidant behaviour and huge problems in communicating with others. For children between ages 4 and 12 years

old and their parents, this is a crucial period in which important changes towards a more secure pathway are still relatively easy to make, avoiding the debilitating life-long psychopathology that is waiting for them if serious attachment and mentalizing problems remain untreated.

Before we provide a quick overview of our project and the structure of the book, we would like to point out some changes that have been made in this new edition. With this edition we still aim to fill a need in mental health care for children and their caregivers: personalized and integrated treatment that is "firm in structure yet flexible in its focus" (Fonagy, 2008) in order to deal with complex problems tailored to the child and larger family involved. Treating complex problems in children using a range of techniques that enhance mentalizing abilities adds an extra dimension to clinical practice, one that can integrate the more relationship-oriented and competence-oriented treatments. Our book is in line with the recognition that transdiagnostic approaches are highly relevant when tackling childhood mental health problems (Chu et al., 2016; Fonagy et al., 2017a). In this updated edition, we include novel developments (since 2008) with regard to mentalization theory and treatment development, findings from developmental and neuroscientific research, and our own clinical experiences during treatment and while training therapists in the applied method.

What are the most important changes compared to the first edition? First of all, we elaborate on the topic of 'attention regulation' – described in Chapter 7 – which has become even more relevant for working with school-age children. Daniel Siegel's (2012) concept of the 'window of tolerance' has sharpened our clinical work with highly over- or under-aroused children with a low capacity to mentalize. Attention regulation requires the therapist to adopt special qualities of communication called 'ostensive cues', implying a method of capturing the child's attention for triadic communication (joint attention to a shared object). Nonverbal, bodily-based interactive behaviour is necessary when working with children whose mentalizing capacity is underdeveloped. Work on attention regulation involves many small steps, which we clarify by identifying several different techniques (see Chapter 7). Misunderstandings in subtle communications need to be addressed at this basic level to restore the child's trust before verbalizing affects or mentalizing about feelings, wishes and so forth. The therapist's not-knowing stance (see Chapter 4) is essential in this phase and is a central mechanism in the therapeutic process.

The second change you will find in this edition is that we pay more attention to the mentalizing abilities of the therapist. The mentalizing abilities of the therapist are crucial when working with children and their parents who have mentalizing problems, as stated repeatedly by Fonagy and colleagues (e.g. Allen et al., 2008, pp. 163–171; Bateman & Fonagy, 2016, p. 182). She (we use the feminine pronoun when referring to therapists throughout the book) needs to be transparent about what she experiences in her relationship with the child and/or parent. In this way she can model how mentalizing works. She takes responsibility for all the mismatches that occur in the interaction and she tries

to mentalize about what went wrong: "I do think that my reaction was a bit over the top. You know, I was in shock after what you told me." Because the therapist's mentalizing is key to the therapeutic process, we pay much more attention to the moments when the mentalization of the therapist breaks down (see Chapter 4).

Third, in this edition the relevance of imposing more structure at the beginning of the therapeutic process is highlighted more, and we have made more explicit how to handle this. We now encourage the use of a treatment plan, especially as it includes a discussion of the personalized goals of the treatment. Even though the formulation of the treatment plan can take several sessions, it is very much worthwhile, because it provides a unique opportunity to discuss the treatment model and the usefulness of mentalizing, as well as more opportunities for psychoeducation.

Fourth, over the years we have moved from an exclusive focus on mentalization to acknowledging the importance of communication. Publications by Fonagy and others (Fonagy & Allison, 2014; Fonagy et al., 2017a; Fonagy et al., 2017b) on epistemic trust have helped a lot to put the goals of treatment in a broader perspective. Ultimately, the most important outcome is for the child and parents to learn to communicate better, to become open to learn from one other and to support each other. Improving the capacity for mentalization is a very relevant therapeutic tool towards smoother communication.

The current book reports on a project in which the initial stages of six treatments were followed intensively, and the observing therapists wrote down interventions they had noted in each observed therapeutic session. The result is the unique dataset that has formed the basis for this manual. At the end of the project, we gathered observational material from 62 therapy sessions and abstracted descriptions of 186 interventions. We have given the six children, who will often be quoted in this book, the following names: 'Paul' (nine years old), 'Geert' (eight years old), 'Ivo' (eleven years old), 'Xander' (nine years old), 'Eduard' (ten years old) and, the only girl, 'Maartje' (seven years old). In this second edition, we comment on the clinical vignettes of these treatments with our current knowledge. This discussion will be particularly useful for novice therapists, who will want to learn this treatment strategy and know the different options a therapist can have in a practical situation. We thought it best not to change the vignettes themselves because they are natural therapy fragments. In writing about the first phase of the treatment, with feedback meetings and the treatment plan, we have now created some examples based on the raw material of the assessment and feedback phases from 2002. These 'constructed' examples can be found in Chapter 10. In writing this text, one of our additional objectives is to stimulate therapists to perform scientific research. The text describes techniques intended to promote specific aspects of a child's development. On another front, the guidelines provided here aim to fill practitioners' need to gain more insight into mentalization-based child and parent therapy. In this light, the book can also be used as a textbook for training courses and (peer-)supervision.

The structure of the book is as follows. Chapter 2 describes the theories on which mentalization-based child therapy is based. The concepts involved and the theoretical framework are discussed at length. At the back of the book there is a Glossary for easy reference, giving the meanings of the constructs described. In Chapter 3 we discuss our target population, which comprises children who function inadequately in important developmental areas, such as attachment, stress regulation and/or self-organization, and related assessment instruments. Chapter 4 covers treatment strategy and guidelines in carrying out mentalization-based child therapy. It sketches the therapeutic frameworks of the treatment and concludes by formulating basic principles and the therapeutic stance underlying this form of treatment. Chapter 5 describes the specific characteristics of treatment for parents with children in mentalization-based child therapy. Chapter 6 focuses on observation methods as a tool for ameliorating psychotherapeutic skills. Also described are the procedures that were followed and the methods used to obtain the data that form the basis for this text. Chapters 7, 8, and 9 contain the empirically observed and identified mentalization-based child therapy techniques, classified into three groups: attention regulation, affect regulation and mentalization. In this second edition we also comment on these techniques with our current, further developed knowledge. These observation categories are useful when discussing the therapy during peer review meetings, for training purposes and as a process measure in the effect study. They offer a perspective on the practice of mentalization-based child therapy. For ease of identification, the categories have been summarized and tabulated in Appendix B, and each has been provided with a short label. Appendix A contains examples of prementalistic modes in play. Chapter 10 summarizes issues that may come up in carrying out the treatment, covering matters such as becoming acquainted, the therapeutic setting and the various stages of a treatment. Finally, in Chapter 11, research topics are discussed that point the way for future research and show what aspects should be included when setting up further research on the effectiveness of mentalization-based child therapy.

Chapter 2

Theoretical concepts

Jolien Zevalkink

The development of mentalizing in children

Social interactions are driven by the need to belong, and thwarted by social exclusion and rejection (Baumeister et al., 2007). In this chapter, several developmental milestones in social interactions are identified before a child forms mental models of self-other relationships. A powerful motivational basis for interpersonal behaviour beginning in early life is the need to belong and its counterpart, rejection sensitivity. Being socially excluded, neglected or rejected by a parent may not only lead to emotional distress; research has also shown that it leads to a reduced sensitivity to pain and an emotional insensitivity that hampers empathy, interpersonal behaviours, self-organization and intelligent thought (Baumeister et al., 2007). The past decade has witnessed more and more theoretical and empirical research on these first developmental milestones in relation to self and others. We know more about the development of this capacity for mentalizing, which may progress smoothly or become inhibited or derailed at a certain point (Fonagy, 2017, p. viii). This chapter provides a theoretical and empirical framework for the developmental process itself, as well as conditions that inhibit this process and need to be addressed in treatment to improve the mentalizing capacity of the child and their parents.

Developmental milestones in self-other relationships

It is compelling to see that, just minutes after birth, infants learn to imitate facial expressions if given the chance (Beebe et al., 1997; Meltzoff & Moore, 1977; Oostenbroek et al., 2016). We are born with the rudimentary gift to read the minds of other humans by paying attention to their facial expressions as well as their behavioural activities. Interpreting the intentions of others is a strong accelerator for the organization and shaping of the neurological system (Siegel, 2012, p. 15; Tronick, 2007). Infant research has shown that in the first months of life a baby already actively seeks interaction with its caregiver (Beebe & Lachmann, 1988). From birth onwards, "experience-expectant and experience-dependent maturation are a part of even the basic sensory systems

of our brain" (Siegel, 2012, p. 26). An infant responds to the facial expression of their caregiver on the basis of stored information and already expects something of the other person (Nagy, 2008; Tronick & Beeghly, 2011). If their caregiver provides them with a 'still-face' at about three months of age, they respond with anxiety and agitation, because this is painfully unexpected. A relatively short exposure to an emotionless, blank face from their caregiver makes infants anxious and afraid of losing emotional connectivity with their caregiver. Repeated exposure to the still-face procedure shows that these infants have not forgotten this previous negative experience, as evidenced by their heightened stress response of expecting a negative emotional experience (Nagy et al., 2017). Starting at one month of age, infants seem to adapt rapidly to the level of responsivity of their caregivers, as shown by repeated measurements over a period of three months. Infants with high-responsive mothers were more attentive and affectively engaged during the still-face task after three measurements compared with infants with low-responsive mothers (Bigelow & Power, 2014; Haley & Stansbury, 2003). Infant whose mothers were clinically depressed were more likely to deal with the still face by still looking at her, even though it was upsetting, and more often used self-soothing behaviours compared to infants of nondepressed mothers (Manian & Bornstein, 2009).

Infants are furthermore born with the capacity to experience primary emotional sensations that tell the infant to pay attention and appraise the situation as good, bad or neutral (Siegel, 2012, pp. 151–152). After the first primary appraisal process, more easily recognisable, basic emotions develop, such as fear, anger, surprise, sadness and joy (Ekman, 2009). The development of these basic emotions in a secure attachment relationship was nicely illustrated in the movie 'Inside Out'. However, the first phase of primary emotional states is relevant in itself. These states are also called the 'vitality affects', as they show how we feel at a basic level. Sharing these primary emotional states – for instance during affective attunement in a parent-child relationship or in a healthy relationship between intimate partners – allows the experience of 'feeling felt' and understood' to blossom (Schore, 2001). "Contingent communication in which the internal state of the child is perceived, made sense of and responded to by the caregiver is of vital importance to the development of the brain" (Siegel, 2012, p. 155). Being able to pay attention to these primary emotional states in another person is the starting point for the development of attention regulation capacities. It is easy to 'see' that this process of acknowledging primary emotional states in another person or oneself might not always go smoothly, because our attention easily gets distracted by all kinds of learned or experienced distractions. For instance, if a person has learned to dismiss the unpleasant feeling of not having been held, they cannot attend to or recognize this need in someone else.

Related to memory growth, a next developmental milestone unfolds while infants interact with their environment. Based on these interactions, infants store implicit memories of their behavioural, perceptual, somatosensory and

emotional experiences, and form 'mental models' or 'schemata' of what to expect (Bowlby, 1988; Gergely & Watson, 1996, p. 1189). Implicit memories do not require conscious processes of encoding and recalling, in contrast to explicit memories. Mental models that are based on implicit memories are harder to reach and reflect upon. These implicit mental models or internal working models are experienced as defining who we are and as the 'logical' way of how the interpersonal world works (Bowlby, 1988; Siegel, 2012, p. 132). From birth onwards, experiences of being seen, being held and being understood by someone else immediately start to be stored into implicit memories. This is also called the experience of 'intersubjectivity' or of 'holding mind in mind' (Allen & Fonagy, 2006, p. xix; Fonagy, 2006, p. 77). During this period, infants learn to actively pay attention to their caregivers' signals, also called 'social referencing' – as aptly demonstrated in the 'visual cliff' experiment (Campos & Stenberg, 1981) – to obtain patterned information about how their social and objective world works. At five months of age, infants can already actively show their preference for prosocial activities ('helpers') in contrast to activities related to negative intentions ('hinderers'). They quickly understand positive or negative intentions, even if these are square or round objects interacting (Hamlin et al., 2007; Hamlin, 2015). This highlights that infants already estimate how social (or non-social) the 'virtual other' is before forming specific patterns of relating, such as attachment patterns (Chae & Song, 2018; Fawcett & Liszkowski, 2012; see also Salvadori et al., 2015).

Not only do infants estimate what to expect from others, they already develop a sense of how they themselves are perceived by others. Via social referencing, they register expressions of positive affect directed towards themselves, but also quickly learn to register negative emotions, such as rejection or displeasure, directed to them personally (Aktar & Bögels, 2017; Campos & Stenberg, 1981; Walden & Ogan, 1988). A negativity bias – responding more strongly to negative than positive emotions – is already present in infants (Chae & Song, 2018; Vaish et al., 2008). Infants already hide their positive emotions in order to avoid negativity or rejection by another person who behaves disapprovingly about a certain play object and is unknown to them before the experiment (Repacholi & Meltzoff, 2007). Before the negative reaction by the stranger to the toy, infants reach out for the interesting toy. After the disapproval by the stranger, they will not touch it anymore, while looking towards the stranger with a blank expression (Vaish & Woodward, 2010). After being exposed to negative parental emotions early in life, infants appear to pay less attention to their caregivers' facial expressions, which is a developmental pathway to intergenerational transmission of depression and anxiety in families (Aktar & Bögels, 2017). When facial expressions of others are in line with the infants' own primary appraisals and social engagement, infants can freely use social referencing in the first year of life. For these infants, it is positively rewarding to watch and learn from others. This congruent and coherent communication between infant and caregiver is also called 'marked mirroring' (Bateman & Fonagy, 2006, p. 15; see also section on Mentalizing

problems in parents). Infants who experience caregivers with incongruent, negative, distorted or disapproving facial expressions, which are not related to what is actually going on, may head down a developmental pathway where their social referencing is characterized by withdrawing tendencies and chronically blocking affective expressions towards others (Siegel, 2012, p. 299). Alternatively, they may keep looking at their mothers, while trying to comfort themselves in other ways, as found to be the case for infants of clinically depressed mothers (Manian & Bornstein, 2009).

After about six months, a subsequent relevant process is the development of curiosity towards how others react to the physical world (Fonagy et al., 2007). Research shows that infants more actively pay attention to objects held by themselves or others and start to develop a rudimentary form of sharing objects or activities (Demetre & Vietze, 1998). For instance, they like to repeatedly hand an object to someone, or enjoy dropping it to the ground and laugh if it is handed back to them. Their first rudimentary sense of agency is developing, which is the subjective experience of being in control of one's actions. This provides them with mastery experiences of their surrounding world, and sharing this interest and excitement with others motivates them to explore further (Siegel, 2012, p. 40). At about nine months, Tomasello and Carpenter (2007) have shown that there is a revolutionary moment in which babies start to consciously realize that other people are intentional actors. Their emerging sense of agency of the physical world, such as by dropping stuff, can also transfer to the social world. After this realization, they can more actively ask for food or protection and can differentiate between caregivers, such as a grandmother who likes to hand out sweets versus a parent who does not. This "shared intentionality" (Tomasello & Carpenter, 2007) provides a basis for the development of social-cognitive skills. Around their first birthday, children begin to collaborate and communicate with others at a new level, because they now understand joint intentions and joint attention of their social and non-social surroundings (Tomasello, 2007; 2020). This is the start of developing more specialized social-cognitive skills all through adolescence, such as face-processing, mentalizing, perspective-taking and social-decision making (Kilford et al., 2016).

A next relevant developmental milestone for infants occurs in their second year, when they start to be able to talk about and remember daily events and experiences in the recent past, such as a trip to the zoo (Bauer et al., 2010). This maturation of the brain allows children to have 'explicit' memory, being able to include time and sequencing of experiences and to create a sense of the self (Siegel, 2012, p. 56). Studies show that 18-month-old children have a mental image of themselves (i.e. self-recognition) in mind when they look at themselves in the mirror with a mark on their face (Filippetti & Tsakiris, 2018; Keromnes et al., 2019). Although this explicit self-recognition is generally present at around 18 months, much younger infants already distinguish between their own image in the mirror and those of others (Rochat & Striano,

2002). Including time and explicit mental images of themselves into their experiences, such as a zoo trip, lays the foundation for autobiographic memories. This is also called the ability for 'mental time travel' (Corballis, 2019; Tulving, 1985). The richness of self-knowledge and autobiographical narratives is mediated by the way "caregivers co-construct narratives about external events and the internal, subjective experiences of the characters" (Siegel, 2012, p. 58; Nelson & Fivush, 2004). Research by Reese and Newcombe (2007) shows that when parents are trained to engage in elaborate reminiscing about events (like a visit to grandparents) with their 19-month olds, the children will have more detailed autobiographical memories a year or more later. A literature review shows that the development of autobiographical or long-lasting episodic memories not only improves the development of narrative skills, but also social sharing skills and the development of a more coherent sense of self across the lifespan (Dykas & Cassidy, 2011; Haggerty et al., 2010). Detailed and coherent narratives of the self are relevant for healthy identity development. Research on family narratives shows that "adolescents who tell intergenerational narratives that are rich in intergenerational connections and perspective-taking show higher levels of well-being" (Fivush et al., 2011, p. 45). Healthy development also means that neural integration has proceeded smoothly, with a child being able to feel attuned to their own internal processes and to other persons (Siegel, 2012, p. 349). Flexible self-regulation, smooth emotion regulation in relation to others, and coherent 'mental time travel' narratives for a typically developing child requires a caregiving context that is at least 'good-enough' (Winnicott, 1964). Before turning to the role of the caregiver, it should be noted that the above-mentioned developmental milestones lead to mental models of the social and emotional environment. These mental models form representations about self and other, and are relevant for understanding the construct of mentalizing and its potential developmental problems. Several mental models of self-other relationships have been identified. We focus on attachment patterns, emotion regulation patterns in relation to self-regulation, and the organization of the self via identity processes and descriptions of self over time.

Developing identifiable, patterned mental models of self-other relationships

Attachment patterns are mental models concerning the quality of self-other relationships based on implicit memories gathered during the first year of life (Ainsworth et al., 1978; Bowlby, 1969). Early attachment models are often carried forward in peer experiences and intimate adult relationships, but later experiences can also alter these early attachment models (Grossmann et al., 2005; Sroufe, 2005; Sroufe et al., 2005), such as being placed with adoptive families (Raby & Dozier, 2019). Starting with patterns identifiable in the behaviour of the child, a move to the level of mental representation soon follows (Bretherton & Munholland, 1999). The classification of attachment

representations can be divided into two main groups: secure and insecure (Ainsworth et al., 1978). In the main group with insecure attachment, three classifications are distinguished: two organized, non-pathological attachment patterns—avoidant and ambivalent—and one disorganized attachment classification (Hesse & Main, 2000; Main, 2000). A secure attachment pattern provides a mental model of 'feeling felt' and 'understood' by a parent (Kerns et al., 1996; Sroufe & Waters, 1977). A secure child has learned to tolerate high-intensity emotional states of connection-disconnection-repair while interacting with a caregiver and has developed flexibility in stressful situations, knowing that it can explore the world freely, while being monitored and sensitively responded to when needed (e.g. Roque et al., 2012).

An avoidant/dismissing attachment pattern minimizes attention to attachment needs and is related to a mental model of disconnection to the social and emotional world (Main, 1995; Siegel, 2012, pp. 126–137). Difficulties with reflecting in this model relate to a lack of recall for events that may have triggered a need for intimacy in relationships (Main, 2000). In this model, it is easier to form idealizing mental models and script-like impressions of early childhood as perhaps being tough, but nevertheless being able to deal with the world because these harsh childhood circumstances have made the person 'come out stronger'. The devaluing of emotional states with regard to attachment is a deactivating strategy (Dozier & Kobak, 1992). The relevance of feelings of closeness, belonging and intimacy are minimized. In fact, if the underlying need for these feelings is high and the arousal levels are outside this person's 'window of tolerance', an autonomic reaction of 'shutting down' or sense of 'numbness' might follow, also called 'hypo-arousal' or 'deactivation' (Ogden & Minton, 2000; Perry et al., 1995; Siegel, 2012, p. 283).

An ambivalent or resistant attachment pattern maximizes attention to attachment signals in relation to a mental model of confusion and having been 'unseen' or 'intruded upon' by a caregiver who is preoccupied with past experiences that intrude into present perceptions of their child's needs. These hyperarousal states produce high anticipatory anxiety and fear of separation (Perry et al., 1995; Schore, 2002). In fact, attachment needs are maximized, resulting in paying too much attention to signs of disinterest, rejection or abandonment (e.g., Fraley et al., 2006).

A third insecure attachment pattern was first described by Main and Solomon (1990): disorganized attachment. Disorganized or disoriented attachment is the temporary collapse – or absence – of strategies in relation to attention and behaviour in dealing with attachment-related stress (Hesse & Main, 2000). Alongside great uncertainty about the emotional availability of others, the child finds it difficult to develop trust in their own capacity to observe behaviour and mental states in others. Disorganized attachment is found more often in children who have experienced neglect or abuse and in children of parents with mental problems than in children with other forms of insecure attachment (Cummings et al., 2000; Lyons-Ruth et al., 2004). For disorganized attachment to develop,

children will have experienced a caregiver who is a source of fear and confusion to whom they could not turn to in times of uncertainty (Main, 2000). The child does not know what to do and stays confused, dissociated and utterly helpless, in other words disorganized or disoriented in times of attachment stress (Lyons-Ruth et al., 2004; Main, 2000). Mentalization-based child therapy targets this group in particular, alongside children with serious deactivating or hyperactivating attachment strategies (see Chapter 3).

The importance of the relationships with those who care for the child continues to stay important after infancy. The specific attachment behaviours may change over time, as Bowlby (1988) already observed a normative decline in the frequency and intensity of specific attachment behaviours directed to the attachment figures (e.g. from crying to calling to a phone call). Also, Sroufe and colleagues (2005) observed that there may be a change in the set goal of the attachment system, with mental representational availability (a mental sense or image of a responsive parent) rather than physical proximity of the attachment figure becoming the set goal with increasing age. As stated earlier, open communication, parent responsiveness to the child's needs and the potential rather than the reality of the parent's physical accessibility to the child are becoming more important than literal proximity (Zevalkink et al., 2012, p. 132). A move from behaviour towards expectations, implicit working models and beliefs of children regarding their attachment figures signifies the development of mentalizing about themselves and others.

The quality of the attachment pattern is related to the process of self-organization, which is defined as "an innate property that creates a sense of order, cohesion, and stability over time" (Siegel, 2012, p. 195). Self-organization is an ongoing process and it is always moving us towards increasing levels of complexity. A child will develop certain, sometimes conflicting, self-states (e.g. friendly, curious, scared) based on experiences with others. This multifaceted self-concept continually fluctuates and stays open for change. The process of self-organization in which the mind integrates a sense of coherence across self-states over time is assumed to relate to well-being and resilience (Siegel, 2012, p. 211). This process may become inhibited when rigid or chaotic self-states are dominant, such as in insecure attachment (Siegel, 2012, p. 216). One of the main advantages of a secure attachment pattern is that it provides a fertile ground for integrating different self-states by providing a sense of coherence (Main, 2000; Siegel, 2012; Waters & Fivush, 2015). During childhood and adolescence, different capacities are practiced; some will feel more in line with someone's self-states than others. In this regard, healthy self-organization makes it easier to reflect or communicate with others and co-construct narratives that form new, coherent autobiographical memories across the lifespan (Waters & Fivush, 2015; Williams et al., 2007). For instance, if an individual sees itself as 'sensitive' and misses important social clues in a conversation, causing negative reactions in others, this individual may react by adjusting their self-state as 'sensitive but not flawless' and pay better attention next time if this is a desired self-state.

Self-organization and coherence

Insecure attachment patterns may result in different and often less flexible self-states, leading to less optimal self-organization. Self-organization in people with an avoidant attachment history may be characterized by attentional inflexibility, idealization and/or disconnection to others (Main et al., 2008; Siegel, 2012). The view of self is often limited to non-emotional domains, such as 'good baseball player' or 'very independent', and autobiographical memories often lack details and vitality, as if experienced from a distance. For ambivalently attached people, self-states may be fragile and easily disrupted. Uncertainty about reactions by others due to their sudden, insensitive, often disruptive and non-contingent communication has left implicit messages about self-states such as 'not always worthy of attention' or 'unable to self-soothe'. Models of self are intertwined with others, due to angry preoccupation with previous interpersonal experiences, and also "full of leaky boundaries between past and present" (Siegel, 2012, p. 131). In the case of disorganized attachment, mental models of self or self-states include frightened, frightening or disorienting images often leading to a state of dissociation, disconnections of attunement, and other communication problems. For instance, the self may be considered 'useless' or 'crazy'. Their self-organization is at best incoherent and their external presentation of their self-states to others can be as chaotic, rigid and unstable as their internal state of mind towards themselves. Incongruent, incoherent or fragmented mirroring by caregivers has forced the child to internalize the mental states of the caregiver as part of their self-identity, even though these are not contingent with their own self-state (Bateman & Fonagy, 2006, p. 15; Fonagy et al., 2007; Main et al., 2008). This subjective experience from the caregiver is nonetheless integrated into the self; this discontinuity within the self is called the "alien self" (Bateman & Fonagy, 2016, p. 20; Fonagy, 2006, p. 81). When the pressure is too high, children need to get rid of these alien parts in the self by projecting these experiences onto others. Some children with a disorganized attachment behave excessively controlling during middle childhood to project their own chronic feelings of insecurity and uncertainty on their caregiver, and this spirals both into a circle of nonmentalizing (see Chapter 4).

These mental models of self-other relationships need to be triggered before they become active. A child may be playing with her toys quietly until a situation may give rise to feelings of insecurity or unsafety, while her father is sitting nearby reading a book. When suddenly, her mother enters the room in an angry mood and starts to criticize the child and father out of the blue, the quality of the attachment patterns of each of the individuals will determine their reaction. In situations of elevated stress, implicit memories of primary emotional states with specific appraisals of what is good, bad or neutral are activated. These primary emotional states determine the boundaries of our 'windows of tolerance' in which we have learned to process various intensities