# The role of mentalization in child psychotherapy, interpersonal trauma, and recovery: A scoping review

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# The role of mentalisation in child psychotherapy, interpersonal trauma and recovery:

# A scoping review

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**Abstract**

Children who are exposed to trauma often develop difficulties with reflective functioning, affect and emotion regulation. These problems are thought to arise from and are reflective of disruptions in the process of mentalisation, or the human capacity to interpret and reflect upon the thoughts, feelings, wishes and intentions of oneself and others. This scoping review sought to describe the empirical support for focusing on mentalisation processes in psychotherapy for children who have been exposed to trauma. Two independent researchers searched electronic databases, Psychology and Behavioural Sciences Collection, MEDLINE, PsycARTICLES, PsycINFO and Cochrane. Search terms child, trauma, mentalisation and mentalisation-based therapy were applied. A total of 425 studies were screened against the inclusion criteria to include 18 studies comprising quasi-experimental, cross-sectional, naturalistic, case-control and case studies. Three themes were identified across the papers (i) trauma and mentalisation, (ii) measurement of mentalisation, and (iii) charting recovery. The literature suggests the role of mentalisation treatment in the remission of symptoms for internalising and externalising disorders and shaping mentalisation deficits over time. Mentalisation focused treatments may also improve reflective functioning, emotional regulation capacity and the quality of attachment. The implementation of a child mentalisation-based model as a preventative intervention may contribute to increased positive outcomes for vulnerable children. This scoping review presents an overview of the evidence for program developers, mental health services, family support services and those in private practice that wish to adopt a mentalisation approach in child psychotherapy. Future systematic reviews are needed to support this evidence.

Keywords: children; mentalisation; interpersonal trauma; emotion regulation; reflective functioning

**The role of mentalisation in child psychotherapy, interpersonal trauma and recovery: A scoping review**

Children who experience interpersonal trauma often have difficulties with aspects of mentalisation, particularly reflective functioning, affect and emotion regulation (Berthelot et al., 2019; Halfon, 2017). Mentalisation is an umbrella term which has evolved out of the psychoanalytic and psychodynamic psychotherapy tradition and is broadly "defined as the ability to understand feelings, cognitions, intentions and meaning in oneself and others" (Robinson et al., 2019, p. 1). Mentalisation has subsequently been validated in studies of human development, neuroscience and psychology as a form of metacognition or "thinking about thinking" of oneself and others (Bateman & Fonagy, 2013; Malda-Castillo et al., 2019; Ridenour et al., 2019). The concept is now explicitly embedded in contemporary treatment models such as mentalisation-based therapy for children (Muller & Midgley, 2015).

Early in infancy humans begin to attribute intentionality to people, and in early childhood 'theory of mind' develops, whereby children begin to understand the beliefs and desires of themselves and others (Ensink & Mayes, 2010). The development of mentalisation has been found to mediate against the impact of childhood trauma positively and contribute to resilience in the face of childhood adversity (Ensink et al., 2017; Taubner & Curth, 2013). Trauma in formative periods of childhood development can disrupt the development of mentalisation capacities and predispose individuals to later problems with emotional regulation and distress tolerance manifested in conditions such as borderline personality disorder (Weinstein et al., 2016).

While the literature on interpersonal childhood trauma is quite broad, accounting for no single definition, children's exposure to interpersonal victimisation and violence may result in co-occurring symptoms such as separation anxiety, disruptive behaviour or mood disorder (D'Andrea et al., 2012). According to the National Centre of Excellence for Complex Trauma interpersonal trauma can be defined into three categories, (i) 'trauma from something done to a child' (Blue

Knot Foundation, 2020, p. 2), this could be either physical, sexual or emotional abuse internal or external to the place of residence, (ii) 'trauma from something that doesn't happen' (Blue Knot Foundation, 2020, p. 3) in the form of neglect of a child's basic physical and emotional needs, and (iii) 'trauma because a child's parent or caregiver is affected by their own trauma' (Blue Knot Foundation, 2020, p. 4), including post-separation conflict, parental mental illness, substance or alcohol misuse, or the effects of an imprisoned parent.

Strathearn (2011) has suggested that neglect lies at the core of all forms of child abuse (sexual, psychological, bodily harm) and that neglect may be the centre of attachment trauma in children burdened by psychological isolation and loss of psychological attunement. Bowlby (1988) suggests that when attachment trauma has taken place, and attachment is threatened, there are anxiety and anger in the child, where an attachment is broken, there is grief and depression. Interpersonal childhood trauma has been found to lead to post-traumatic stress disorder, as well as complex developmental impairment such as self-regulation capacity (Musicaro et al., 2020). When trauma is linked to mentalising failure, reflecting a secure attachment helps ameliorate and regulate a child's overwhelming emotions (Allen, 2012). Psychotherapy is, therefore, an attachment relationship in which to provide the child with a safe place to re-organise intrusive memories, make sense of attachment loss and re-develop a secure base (Allen, 2012).

Fonagy and Adshead (2012) suggest that most forms of psychotherapy, including cognitive therapy, mindfulness training, interpersonal therapy, patient-centred therapy and behavioural therapy work by enhancing mentalisation. However, only some schools of psychotherapy such as mentalisation-based therapy (Bateman et al., 2016) and some forms of psychodynamic therapy explicitly examine or measure the development of mentalisation capacities and correlate these with symptom improvement.

Psychotherapy with children is approached differently to adults with a long tradition of play therapy adapted to treat complex psychopathology (Blazek, 2013; Greenberg, 2018).

Winnicott (1974) suggested that through play, adults could engage with children in an authentic, less defended way (Sapir & Tal, 2017). The 'play space' is where children can freely express their thoughts, feelings and needs, including the development of reflective functioning, thus increasing the capacity to mentalise (Bat Or, 2010). Only recently have there been systematic attempts to measure improvements in mentalisation in children (Fonagy et al., 2016). The research appears to focus on specific diagnoses such as attention-deficit/hyperactivity disorder (Conway et al., 2019), autism spectrum disorder (Keenan et al., 2017) and eating disorders (Kelton-Locke, 2016).

A critical role of research is theory-testing which identifies and investigates some of the reasons how, why, and for whom specific interventions are effective (Kazdin, 1997). There is strong theoretical support for the development of mentalisation being disrupted by trauma and support for mentalisation enhancement in therapy. However, there is weaker empirical support for these propositions, which this review attempts to address. The nature of psychotherapy with children is that it is often lengthy, intensive and rarely allows the degree of control or scale associated with randomised controlled trials of brief interventions for circumscribed problems.

There are current gaps in the literature on the impact of childhood interpersonal trauma on mentalisation, such as conceptual implications for working with child psychopathology and their families. These gaps suggest that practitioners who work in the foster care and child protection systems may find mentalisation a developmentally oriented and sound clinical approach combining long-established and contemporary theory. This scoping review will seek to draw together and summarise the evidence, on psychotherapy process and outcomes relating to mentalisation in children. This scoping review summarises and presents themes across the studies and will describe how mentalisation is measured and accounted for in child psychotherapy.

## Method

A systematic scoping review was conducted using the Preferred Reporting Items for Systematic Review and Meta-analysis PRISMA statement (Moher et al., 2009) to document

search logic. Scoping reviews can help to identify research gaps, set research agendas, improve evidence-based practices and provide recommendations for policymakers and practitioners (Colquhoun et al., 2014). This scoping review was informed by steps outlined by Arksey and O'Malley (2005) and was considered the best approach to answer the research question: What is the role of mentalisation in child psychotherapy, interpersonal trauma and recovery in school-aged children?

## Search Strategy

The strategy was developed with the aid of a librarian and consisted of the following key search terms: mentalization, mentalisation, mentalisation-based therapy, child*. Adding the terms 'trauma' and 'recovery' to the literature search did not yield more results. Therefore, screening of titles and abstracts informed the authors if the study was related to mentalisation in child psychotherapy, interpersonal trauma, and outcome and recovery.

The search was limited to title, abstract and keywords, English language. Secondary and grey sources of literature were excluded. Five databases were searched, including the Psychology and Behavioural Sciences Collection, MEDLINE, PsycARTICLES, PsycINFO and Cochrane's Central Register of Controlled Trials electronic databases. These databases were chosen as they reflect a range of articles from the psychiatric, psychotherapy and psychology fields relevant to the intervention type. Searches for studies published between 2002 and 2019 ensured relevant studies were not missed given that adult and adolescent studies have taken precedence with a much slower uptake for child studies in the identified age range. It was noted that several empirical studies are currently in the protocol and pre-trial phase. The reference lists of chosen articles were also examined for missing articles.

## Study Selection

Papers were screened by title and abstract by two independent reviewers (DOF, ML). Results that met all the following inclusion criteria were included: (i) were primary research (ii) described intervention techniques from child psychoanalytic/psychodynamic and/or mentalisation-oriented assessment, (iii) clinically relevant to relational trauma, maltreatment or neglect, (iv) included children aged between six and twelve years, (v) scholarly peer-reviewed sources. The full text of papers that met the inclusion criteria were read and included in the scoping review.

The literature search method yielded 425 articles, including three studies through citation chaining. Once duplicates (n=47) were removed, the title and abstract of 381 articles were screened for inclusion in this review. A total of 353 articles were excluded for the following reasons: age of participants (either infants or older than inclusion criteria), the outcome not related to trauma or the intervention not specific to mentalisation. For example, while one randomised controlled trial (RCT) measured affect recognition, mentalising, and social skill in children with Autistic Spectrum Disorder, the intervention related to computer-assisted face processing instruction and was not specific to trauma (Rice et al., 2015). Other articles were excluded because they presented protocol and feasibility phases of an RCT currently being conducted in the UK foster care system, with the outcomes yet to be published (Midgley et al., 2017; Midgley et al., 2019). See Figure 1. PRISMA flow diagram of article screening and selection.

**Charting the data, analysis, and reporting the results**

Decision-making processes were made by consensus between all three authors. As recommended by (Levac et al., 2010), this procedure involved determining the study inclusion and exclusion criteria through negotiation at the beginning of the scoping review process. This was followed by discussions on clarifying the concepts and identifying and agreeing on three key themes (i) trauma and mentalisation, (ii) measurement of mentalisation, and (iii) charting recovery. The data from the selected articles were extracted and presented in table form for

comparison. All authors contributed to drafting theoretical content, data analysis/synthesis and used comparative analysis to compare different mentalisation interventions and their applicability.

## Results

Collectively the studies involved 719 child participants; 396 were female, 323 were male. Most of these studies included children with no significant developmental delays, psychotic symptoms, significant risk of suicide, or current abuse. The results are summarised under the following themes: (i) interpersonal trauma and mentalisation, (ii) measuring mentalisation, and (iii) charting recovery.

### Quality of Studies

A scoping review does not generally require a critical appraisal of the quality of every study acquired and there is presently a lack of consensus on how to undertake such an appraisal when the research may include different methodologies (Tricco et al., 2018). This review has taken a pragmatic approach to the appraisal of quality which is in accord with the recommendations of Pluye et al. (2009) to utilise professional judgement in appraising content validity and relevance. The authors have commented (in Table 2.) on issues such as sample size, rigour, and control and potential for bias as reported in the papers or inferred from reading them.

### Interpersonal Trauma and Mentalisation

Interpersonal trauma described in the studies reviewed included childhood sexual abuse, neglect, maltreatment, and witnessing violence. Across the studies, children were diagnosed with a range of co-occurring conditions such as major depression with soiling, anxiety with eating disorders and emotional disorders. Children in the most severe range of psychopathology had a history of neglect, violence, deprivation, loss, and abandonment (Ramires et al., 2012a). In five studies childhood, sexual abuse was described as having a damaging effect on a child's capacity for growth in mentalisation, and development of psychopathology leading to increased

dissociation. Dissociation was found to be a critical mental process which mediated the impact of sexual abuse (Ensink et al., 2017; Ensink et al., 2020; Ensink et al., 2016b; Strehlow, 2009; Tessier et al., 2016). In one study where the index trauma was sexual abuse (Ensink et al., 2017) the capacity to mentalise was impaired, and this diminished capacity was conceptualised as a 'defensive shutdown' to deal with affect and distress. Maternal mentalisation and insecure attachment were associated with increased psychopathology in sexually abused children, such as lowered reflective functioning, depressive symptoms, child externalising difficulties, and sexualised behaviours (Ensink et al., 2016a). During the early stages of play-based psychotherapy, children with sexual abuse histories who experienced trauma symptoms were found to struggle to symbolise (i.e. through toys and art) and to create play narratives when engaged in pretend play (Tessier et al., 2016).

**Measurement of Mentalisation**

The capacity to mentalise was operationalised as affect and emotion regulation, reflective functioning, and attachment security. Across the studies, multiple measurement tools were used including evidence-based assessments and questionnaires such as the Emotion Regulation Checklist (Shields & Cicchetti, 1997), Children's Global Assessment Scale (Shaffer et al., 1983), Manchester Child Attachment Story Task (MCAST) (Goldwyn et al., 2000), and the Children's Play Therapy Instrument (Kernberg et al., 1998). Studies conducted in the foster care system used a combination of trauma, mentalisation scales and attachment-based interviews (Ingley-Cook & Dobel-Ober, 2013; Ostler et al., 2010). Five studies used the child reflective functioning scale (CRFS) to measure affect regulation, reflective functioning, attachment and implicit mentalisation (Ensink et al., 2017; Halfon & Bulut, 2017a; Stefini et al., 2013; Tessier et al., 2016) When using the MCAST, Ramires et al. (2012a, p. 4) assessed for significant improvement in mentalisation capacity for "self-representation, perception of own mental functioning, and perception of others' feelings and thoughts". Halfon and Bulut (2017a) used a wide range of measurement tools to

measure the complexity of play patterns, affect regulation, coping and defensive strategies, appraising the feelings and intentions of others, as well as psychosocial functioning including parent and teacher measures. Measuring utterances in mentalisation in a subsequent study on separation anxiety disorder by Halfon et al. (2017a), mental state talk in narratives were coded and combined with the Children's Play Therapy Instrument to determine a change in affect regulation.

### Charting Recovery

The final theme, charting recovery, included length of the therapeutic relationship, process and outcome. The research varied in how authors measured or accounted for recovery. Studies using quasi-experimental, case-control and cross-sectional design showed clinical significance in children treated by psychoanalytic/psychodynamic play therapy. These studies suggested that play was both a mediator and a predictor of change in the severe range of internalised and externalised disorders, along with gains in mentalisation processes (Ensink et al., 2020; Göttken et al., 2014; Halfon et al., 2019). When charting the recovery of children diagnosed with separation anxiety, reactive attachment disorder, attention-deficit and disruptive behaviour disorders, as well as general anxiety disorder, it was the naturalistic and longitudinal studies which reported significant symptom reduction, notwithstanding the short-term study by Göttken et al. (2014). Further to these reductions, there was an improvement in psychological and global functioning as well as repaired parent attachments, improved peer relating, frustration tolerance, mental state talk and higher self-mentalising, including a reduced risk of relapse and comorbid conditions (Halfon et al., 2018; Muratori et al., 2003; Odhammar et al., 2011).

## Discussion

According to Fonagy and Adshead (2012), mentalisation is an important process and a therapeutic factor in most forms of psychotherapy. This scoping review focused on mentalisation as an explicit process and focus of therapy in childhood trauma. It has drawn together

psychotherapy research which attempts to measure aspects of mentalisation and relate therapeutic change or resolution of psychopathology to changes in mentalisation capacity. The studies which reflected diverse research methodologies were mostly descriptive, and there was considerable variation in therapeutic approaches. The range of clinical problems were also heterogeneous despite the focus on exposure to interpersonal trauma. There were no randomised controlled trials or tightly controlled manualised treatment approaches as are often employed in brief psychotherapy research which is somewhat reflective of research into psychodynamic styles of therapy in general. Some authors recommend that naturalistic studies observing the phenomena over time without the constraints of randomised control are best for psychotherapy research (Gelo et al., 2015). However, this lack of control, standardisation and rigour makes it difficult to extrapolate findings and makes generalising about effectiveness difficult.

Mentalisation based treatment for personality disorder has the most robust evidence for it's effectiveness (J.Malda-Castillo, C. Browne, & G. Perez-Algorta, 2019). However, recent reviews can only conclude that results are promising and recommend the urgent need for methodologically sound and sufficiently powered studies to investigate both effectiveness and efficacy (Volkert, Hauschild, & Taubner, 2019). An even stronger caveat needs to be made in interpreting the body of work on mentalisation based treatment in children. All the studies reviewed supported the hypothesis that improvements in mentalisation were associated with various measures of symptom reduction and improved functioning. However, there may be publication bias in the current body of work, and bias inherent in the chosen methodologies in that these studies are primarily undertaken by highly skilled and trained clinicians who believe in the process of therapy and often invest long periods (sometimes years) in therapy with children and caregivers. It would be quite unlikely for champions of mentalisation to invest in sharing case studies which do not demonstrate evidence of improvement. This review echoes the authors of other reviews which call for the development of a more robust evidence base for mentalisation based treatment in children.

Acknowledging the demands placed on the researcher to produce robust evidence, this review considers the implications for the child psychotherapist. It is important to recognise the pragmatic aims and challenges of the therapist in a complex interchange between delivering psychotherapy intervention and research-related factors that may impede expected treatment outcomes. By highlighting diverse research designs across a variety of ecological settings, these factors come to light. One factor for the child practitioner is that children coming out of abuse and neglect contexts require a degree of "readiness" when entering psychotherapeutic intervention (Howarth et al., 2019). This human capacity for readiness includes the protective parent or carer experiencing their readiness simultaneously to support the child. Along with the severity of symptoms and children with mixed diagnoses requiring longer treatments than initially forecast, these additional factors can significantly alter therapist and researcher objectives in terms of drop-out rates, balancing intervention and control groups, through to obtaining follow up treatment and testing.

Most studies were naturalistic and observed real-world therapy with real-world children and families in real psychotherapy services. The state of knowledge that this review highlight is that mentalisation based treatments appear to work in naturalistic settings and enhances mentalisation capacity in children improves functioning and reduces symptoms. How mentalisation should be measured in clinical practice remains a somewhat contested question (Shaw, Lo, Lanceley, Hales, & Rodin, 2019).

Capturing implicit mentalisation during interpersonal encounters is very likely to remain challenging due to natural and instinctual turn-taking in conversation (Davidsen & Fosgerau, 2015). Psychotherapy within a mentalisation therapeutic frame has the hallmarks of attending to ruptures in secure attachment, providing "a safe haven and a secure base" (Allen, 2012). According to (Munoz Specht et al., 2016), the mentalisation therapeutic frame encompasses the *empathic stance* and *exploration of the child's mental states*. The following example demonstrates

attentiveness in play therapy from the therapists' mentalising stance, illustrating responses to a child aged nine experiencing emotional dysregulation.

*Therapist: I felt you did so well when we worked together to build your dream home, I could see you thought carefully about how many rooms you'd like, and at the moment your new house has you feeling like you want to smash it to pieces…*

Exploring mental states is a technique used when a lack of coherence in the mentalisation process is noticed, namely when a child is functioning in opposing ways. The therapist adopts a "not knowing" stance, displaying explicit perception and using curiosity.

*Therapist: Although you said you really enjoyed building your new house, I am really curious to learn what you were seeing when you clenched your fists ready to smash your house down…*

By adopting the mentalising stance and for the child to achieve self-understanding, the therapist tentatively becomes present in the mind of the child by sharing the child's subjective experience, as well as naming verbal and non-verbal affect states such as thoughts, feelings, wishes and beliefs. The therapist makes exploratory links between behaviours and emotions and collaboratively works with the child to organise their mental states.

*Therapist: You said you didn't want to be angry today, this is a safe place for you to feel or think anything you wish. So if you could choose any figure (symbol) from the shelf and sit with me, to talk about how the figure is you today, I will carefully listen to your story…*

As with many psychotherapies, the therapist's manner of relating (to the child), their use of empathic understanding and exploration of the child's sense of self also rest within the most extensively studied, therapeutic alliance (Allen, 2012).

There is an evidence-base for mentalisation-focused treatment in symptom remission for both internalising and externalising disorders, and for shaping mentalisation deficits over time.

With the continuance of primary research and systematic reviewing of new studies as they become available, the work involved in building an evidence-base is about establishing better precedents in treating complex childhood mental health difficulties. Therefore, having conducted a robust literature search and an assessment of the findings, the implementation of a child mentalisation-based model as a preventative intervention may contribute to increased positive outcomes for vulnerable children.

## Limitations

Developing this review presented challenges regarding study design choice, as there is limited research on this topic in vulnerable school-aged children. As discussed by Munn et al. (2018), the difficulty of reviewing different study designs, ambiguous terminologies, and diverse research methodology may present some confusion when providing a source of evidence. On the other hand, the choice to conduct a pluralistic review appeals to the strengths of both quantitative and qualitative methodology (Munn et al., 2018) and attends to the idea of a comprehensive overview. Another challenge was appraising two research dimensions - process and outcome - as both are essential aspects of psychotherapy research (Gelo et al., 2015).

## Conclusion

The term "mentalisation" is used as an umbrella term for developmental processes sustaining mental, emotional, social and cognitive capacities, and the included studies describe how disrupted mentalisation capacities could be a consequence of child psychopathology. Reviews of child psychotherapy, interpersonal trauma and recovery outcomes using scoping review methodology have not been published to the authors' knowledge. Therefore, an extensive systematic review would be warranted and positioned to complement this review as future studies become available. The clinical implications for program leaders and practitioners who work in child protection, foster care, family support services and in private practice who have sought preferencing for more cognitive-behavioural based interventions, may find that a mentalisation

approach could improve the quality of attachments, developmental functioning, and advance their mentalising self in relation to their clients.

**Contributors:** DO-F provided a complete first draft along with the conception of idea, analysis and interpretation, developed inclusion/exclusion criteria, screened all articles, conducted the appraisals and drafted themes. ML proofed the initial draft, liaised with university librarians in construction of literature search, conducted the second literature search and data extraction, formatted tables and figures, drafted content throughout manuscript, formatted referencing, and proofed entire final draft. RL analysed content, drafted content across the manuscript, including the abstract and discussion, proofed and provided edits on the paper.

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**Figure 1**

*PRISMA Flow Diagram of Article Screening and Selection*

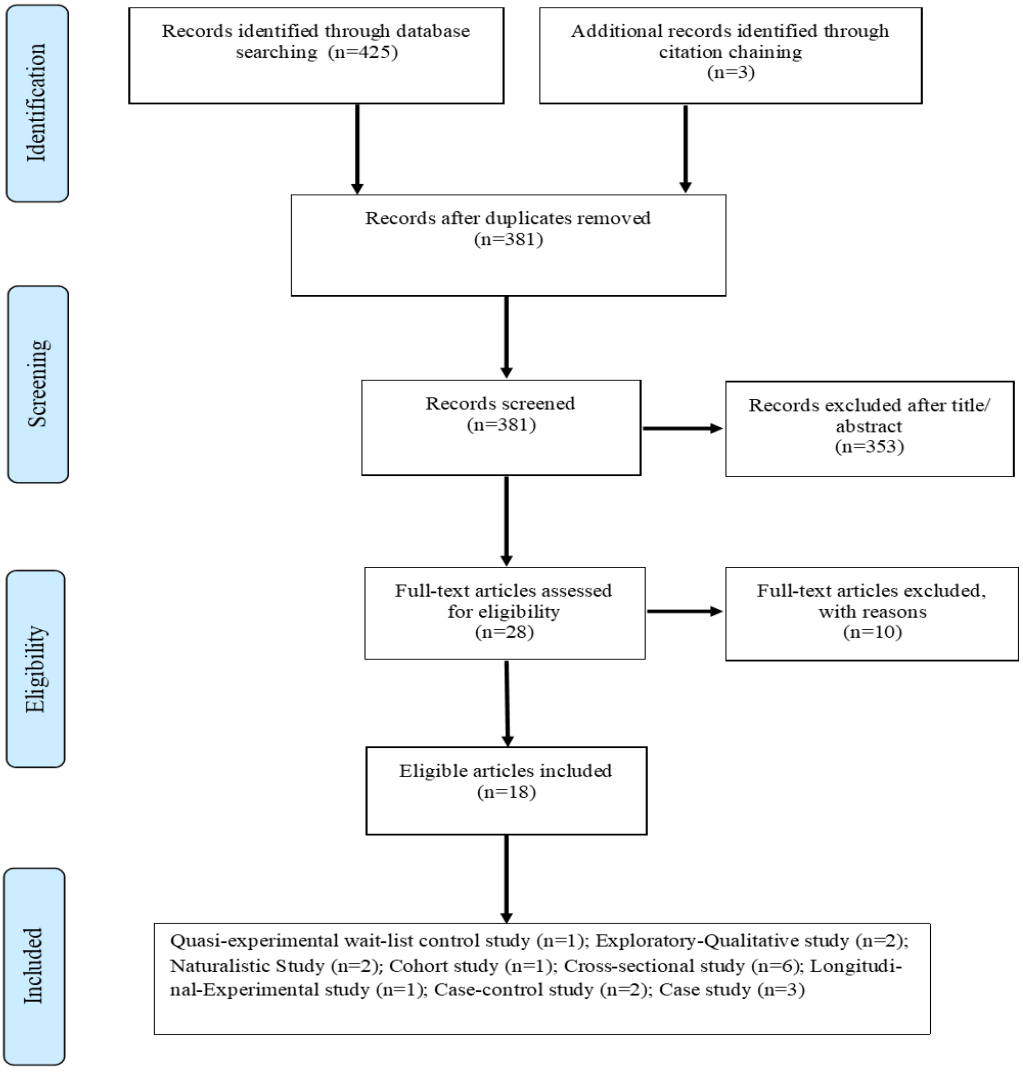

**Table 1**

*Key Methodological Features and Findings from All Studies*

| Author (year) country | Study design/ setting | Child sample/age | Diagnostic characteristics | Intervention | Outcomes | Limitations |
|---|---|---|---|---|---|---|
| Muratori et al. (2003) Italy | Experimental longitudinal study. Clinical, naturalistic setting. | (n = 58) outpatient 6-10 years. | Internalising disorders: generalised anxiety, social anxiety, dysthymia, separation anxiety, obsessive-compulsive disorders. | Time-limited Psychodynamic Psychotherapy: observations of play sessions. | Child Behavior Checklist CBCL; Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS); Children's Global Assessment Scale (C-GAS). | Lack of random assignment of subjects; possible introduction of bias and categorical diagnoses required further study by separating sub-clinical categories. |
| Strehlow (2009) Germany | Qualitative case study. Public organisation. | (n =1) 8 years. | CSA Intra-familial. | Dynamic analytical music therapy – long term. Mentalisation, RF and ER. | Assessments: musical, anatomical puppetry, art material. Interaction structures, therapeutic alliance. Mentalisation enhanced by musical play and RF. Strengths improved in dyadic thought and communication from 150 sessions across three years. | No limitations reported. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Ostler et al.<br>(2010)<br>USA | Cross-sectional<br>Study took place in foster carer homes. | Children in foster care family (n =26)<br>5–14 years | Maltreated/abused children not in the care of parents, formally charged with abuse. 65% of parents in jail for illegal substance abuse. | Home visiting model mentalisation-focused intervention. | Measured mentalisation capabilities. Children's Mentalisation Scale & Peabody Picture Vocabulary Test-III. Trauma Symptom Checklist for Children; and (CBCL). Higher mentalisation linked to fewer externalising and internalising problems. High mentalisation linked to fewer withdrawn/depressed behaviours, less attention problems, less dissociative/post-traumatic symptoms. | Cross-sectional nature of study precluded conclusions on the causal relationship between the variables. |
| Odhammer et al.<br>(2011)<br>Sweden | Naturalistic, multi-centre pre-post study. | (n = 33)<br>5-10 years. | Attention-deficit and disruptive behaviour disorders, separation anxiety or reactive attachment disorder, and anxiety disorder. | | Evaluated changes statistically and qualitatively in children's global functioning post psychodynamic psychotherapy, with parallel parent-work. | Addressed complex connection between process and outcome, however lack of comparison group and reliance on therapist's sessional observations only. |
| Ramires et al.<br>(2012)<br>Brazil | Mixed method case study<br>Setting: non-government organisation. | One male child<br>7 years. | Depressive symptoms: Maltreated, early abuse and neglect – living in a shelter more than two years. Chronic mourning; severe | Mentalisation-based child therapy (MBCT): part of broader Brazil study of (14) child cases. | Pre-treatment interviews; Children's Depression Inventory; Manchester Child Attachment Story Task (MCAST); Art-based interventions, formal analysis data collected at 6mth. Decrease in depressive symptoms were found at 6mth. Significant change in capacity for explicit mentalisation | Lack of available measurement tools and inadequate psychotherapeutic context. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | sense of helplessness. | | showed cohesive/integrated sense of self at 6mth. | |
| Stefini et al.<br>(2013)<br>Germany | Analytical cross-sectional design. Clinical setting. Process research. | (n = 71) Children under 13years, (n=48).<br>Mean age =11 years. | Anxiety, depression, conduct disorders, eating disorders. | Psychodynamic psychotherapy – secure and insecure attachment processes. | Pre-post comparison – ANOVA. Securely attached children (87.5%) achieved therapy with good outcome. As well (70.9%) of the insecurely attached patient. Clinically significant decrease of total impairment symptoms across (4) attachment styles. | Different instruments needed to reproduce results. |
| Cook & Dobel-Ober<br>(2013)<br>United Kingdom | Qualitative interviews/focus group. | (n = 11)<br>In foster care and adopted.<br>9-16 years. | Affect regulation. | Group work: mentalisation-based. | Evaluation of clinical intervention; child interviews; qualitative data analysis of thematic content. Study found mentalization-focused group work supporting foster care/adopted children required appropriate boundary setting and age-related activity. | Success of group intervention reliant on children/young people's practical needs and separation of age ranges. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Göttken et al. (2014) Germany | Quasi-experimental wait-list control (University of Leipzig Medical Faculty). Pre-test/post-test with 6 mth follow up to each group. | (n =30) treatment group; (n =18), control group (n =12) intent to treat at 6 months. Gender balance. 4-10 years | Population were in the severe range of child psychopathology. Internalising disorders (anxiety, social phobia, depression, dysphoric mood, panic attacks, agoraphobia). | Psychoanalytic Child Therapy: emotion-oriented play focused. Mentalisation principles in parallel parent work. Short term treatment of 20-25 weeks. | The Berkley Child Puppet interview pre-post-follow up analyses. SDQ; CPQ at follow up. CBCL. Statistical test -ANOVA. (27) 66.67% (*n*=18) no longer met criteria for any anxiety disorder, (59.88% in intent-to-treat analysis). No child remitted across 6-mth waitlist interval, diagnostic and symptom remission rates maintained at 6-month follow-up. | Interviewers were not blind; child reports (puppet interviews) showed no change on repeat measures. |
| Ensink et al. (2015a) Canada | Case-control study Clinical setting | Clinical group (n =46), control group (n =48). 93% - French Canadian Mixed-gender Mean age 7 years | Child sexual abuse group compared to non-CSA control. Intrafamilial abuse and extra-familial abuse. | Psychodynamic therapy: evaluating measurement scale for use in measuring reflective functioning in CSA. | Validity of Child Reflective Functioning Scale confirmed. Analysis of variables of changes in reflective functioning Findings confirms CSA associated with mentalisation difficulties in both child reflective functioning for (self) and child reflective functioning for (other). Child reflective functioning was found to be mediated by maternal reflective functioning. | Recommended further research to explain the relationship between child RF and related mental state constructs, i.e. emotional understanding. |

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|---|---|---|---|---|---|---|
| Ensink et al.<br>(2015b)<br>Canada | Longitudinal quantitative study. Community/ clinical settings. | (n = 168) Child sexual abuse (CSA). 7-12 years. | Depressive symptoms and externalising difficulties. | Measuring reflective functioning; child and maternal mentalisation. | Measures: CAI, CDI, CRFS, assessed children's mentalisation. Findings indicated that by ages, 7-12 child mentalisation partially mediated relationships between CSA and depressive symptoms. And the relationship between CSA and externalising difficulties and maternal attachment. | Findings indicated need for replication with larger sample. |
| Munoz Specht et al.<br>(2016)<br>Canada | Exploratory pilot study. Systematic qualitative, induct/deduct approach. | Two male children<br>10 and 13 years. | Child (1): comorbid encopresis (soiling) and ADHD. Child (2): aggressive behaviour, oppositional type, potential personality disorder. | Two child psychotherapists - 14 mentalisation-based sessions across 12 months course of treatment. | Coded interaction with child to recognise the range of mentalisation techniques used by the clinicians. (25) mentalisation-based techniques were found, additional to (17) techniques Study to benefit other studies. Further studies using diverse therapists recommended. | Both child therapists hailed only from psychodynamic backgrounds. |
| Tessier et al.<br>(2016)<br>Canada | Cohort control<br>University psychology clinic. | Intervention group (n =39) comparison non-abused group (n =21).<br>Matched age/gender.<br>3-8 years | Child sexual abuse clinical group anxiety disorders. Mothers as secondary included in tests: reflective functioning scale. | Measure over time (3 years) children's reflective functioning and mentalisation growth. Play as facilitator of mentalisation capacity. | Children's Play Therapy instrument; Child Attachment Interview (follow-up at 3years). Child and Adolescent RFS. Self-other scales administered separately. Statistical test: ANCOVA. Hypothesis successful, consistent with previous studies (Fonagy,1996; Target 2000). | Small sample, unequal group matches, further studies on mentalisation variant recommended. |

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| Ensink et al.<br><br>(2017)<br><br>Canada | Case-control (dyad structure)<br><br>Clinical setting. | (n =74)<br><br>Histories of sexual abuse. Control group non-CSA.<br><br>7-12 years | Dissociation in CSA and mentalisation context. Trauma, depressive symptoms, sexualised behaviour, externalised disorder. | Psychodynamic – mentalisation-based. | Examination of pathways from CSA to psychopathology – dissociation linked specifically to low mentalisation. Test: multivariate analysis of variance. RF significantly lower in CSA children, and for mothers compared to non-CSA group. Outcomes showed that sexual abuse and lower child RF led to higher levels of dissociation. Both groups had lower RF levels post Child Reflective Functioning Scale. | Parent report measures – potential for inflated reports on attachment relationships. |
| Halfon and Bulut<br><br>(2017)<br><br>Turkey | Analytical cross-sectional design. (overtime).<br><br>Outpatient. | (n =48)<br><br>4-10 years. | Internalising disorders/externalising disorders (anxiety, depression, conduct, aggression). | Mentalisation – psychodynamic psychotherapy. 40 sessions over 10 months. | Therapist, child, parent, teacher measures on affect regulation – CGAS, CBCL, HoNOSCA (total problems). Evidence of symptom remission, association between symbolic play and growth in affect regulation = symbolic play effective. | Improvement in methodology, recommended larger sample and add control group. Limited internal validity (but reflects clinical practice). |

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| Halfon et al.<br>(2017)<br>Turkey | Case study<br>Outpatient psychodynamic psychotherapy services. | Two female children<br>6 years. | Diagnosed with separation anxiety disorder. | Psychodynamic play-based child psychotherapy: to assess explicit mentalisation. | Quantitative coding structure for Mental State Talk (verbal descriptors) pre and post-tests. Process measures: (1) coded therapist use of mentalisation, (2) CPTI. Outcome: Time series analysis. Time-series Granger Causality tests showed symptom improvement in both children - association between mental state talk and affect regulation was only clinically significant in one child regarding symptom reduction. Therapists' use of 'mental state talk' as a facilitative process found for emotion regulation in psychodynamic play therapy. | One child required extended treatment for emotion dysregulation. While other tolerated emotions well post-treatment. |
| Halfon et al.<br>(2018)<br>Turkey | Naturalistic study – process/outcome design with multiple research questions. | (n =52),<br>Equal ratio of genders.<br>4-10 years | Internalising (anxiety, depression) and externalising (aggression, oppositional) disorders. | Psychodynamic child psychotherapy using mentalisation principles – long term. | Measuring therapeutic processes of interaction structures – therapeutic alliance. Comparators of pre-treatment/post-treatment outcome scales. Identified a range of change processes able to be reproduced in other studies. | Small sample size, no control group, interaction structures culturally influenced (cultural priorities). |

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| Ensink et al.<br>(2019)<br>Canada | Cross-sectional.<br>Outpatient setting | (n =111) 98% caucasion. Treatment group (n =43); comparison group (n =68).<br>7-13 years | Child sexual abuse (CSA). Externalising & internalising symptoms.<br>Comparison group were non-CSA from community. | Within a broader psychodynamic trauma-focused model. | Coders observed narratives, and video recorded. Tests used: (CAI nine-point scale, CDI & CBCL) Clinical group more likely than control group to be classified as having insecure/disorganised attachment. Strengths in control for child stress exposure during interviewing. | Lacked power to detect differences between different types of insecure attachment. |
| Halfon et al.<br>(2019)<br>Turkey | Analytical cross-sectional design. (over-time)<br>Outpatient setting. | Children<br>(n =40)<br>4-10 years. | Internalising and externalising disorders. | Open ended psychodynamic symbolic play therapy. Object-relations framework - 975 sessions coded. | (CBCL, ERC & CPQ) Children's Global Assessment Scale; Process measures - Children's Play Therapy Instrument. Dysphoric affect expression within the context of high mentalisation adherence predicted increase in affect regulation. Time Series Panel Analyses (TSPA) showed mentalisation practices improved AR. | Sample small, naturalistic without control group. therapeutic interaction structures not coded. |

Notes: CSA=child sexual abuse; RF=reflective functioning; ER=effect regulation; CBCL=child behavior checklist; CRFS=child reflective functioning scale; CAI=child attachment interview; ERC=emotion regulation checklist; CDI=child depression inventory; CGAS=children's global assessment scale; HoNOSCA=Health of the Nation Outcome Scales for Children and Adolescents; CPQ=Psychotherapy Q-Set technique; SDQ= Strengths and Difficulties Questionnaire; ANOVCA=Analyses of covariance; ADHD=attention-deficit hyperactivity disorder; CPTI=children's play therapy instrument

**Table 2**

*Quality Appraisal Table using CASP Checklists*[a]

| Author (year) country | Study design | Quality appraisal |
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| Muratori et al. (2003) Italy | Longitudinal | As the oldest study in this review, this longitudinal – cross-sectional design recruited a small sample, with minimal drop-out. The authors appear to have relied on some speculation as to results. However, valid sources were used to identify the "sleeper effect" in the experimental group. Unfortunately drawing conclusions on this study was difficult as the control group was suspected receiving active treatment aside to participation in the study. |
| (Strehlow, 2009) Germany | Qualitative case study | This single child case study kept goals of treatment for the child in mind. Mentalisation concepts were well described. Ethical considerations presented quality in terms of ethical practice. The seriousness of the child's experiences of abuse in the context of parental caregiving and assessment of child safety provided an accurate view of on-going safety concerns. |
| Ostler et al. (2010) USA | Cross-sectional | This study was conducted in a foster care environment with a small sample. Recruitment conducted appropriate selections and screening such as age range, separation from a non-protective parent, and drug addiction of parent(s). The study followed an ethical course, notably, overseen by child protection authority approval. |
| Odhammar et al. (2011) Sweden | Naturalistic, multi-centre pre-post study | As part of a much larger study, this study recognised the complex interplay between process and outcome. The sample was small but relied on individual case studies to better assess therapeutic processes. Potential for bias notable, as psychotherapists held varying psychotherapy experience. Clinically important variables proved problematic to quantify. However, one consistent variable was that all therapists were psycho-dynamically oriented. Obtaining reliability across the samples (qualitatively analysed) was guided by research approaches in psychology[b] in the attempt to lower the risk of bias by triangulating themes. |

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| (Ramires et al., 2012b) Brazil | Mixed method case study | Single case studies are an appropriate approach for bringing to light, subjective experiences of a research participant. This study conducted in an out-of-home care setting with design, therapeutic methodology and practice framework (MBT-C) being well discussed. Risk of bias was lowered by using clinically reliable methods for qualitative analysis and clearly indicated. Importantly, treatment results included a case example. |
| (Stefini et al., 2012) Germany | Cross-sectional | A moderately sized sample was screened and selected appropriately (outpatient setting). The sample was heterogeneous, with more female subjects than male. Distribution of clinical diagnoses in the sample may have made it challenging to determine alterations and change in attachment style. However, given the near prognostic nature and study length, the results were found to be clinically significant across the final two test intervals. |
| Ingley-Cook & Dobel-Ober (2013) United Kingdom | Qualitative interviews/focus group | A small sample of out-of-home care and adopted participants recruited a wider age range. This short-term intervention focused on the stated goals of the participants in the group, in keeping with self-determination. The research approach was elucidated. In terms of a mentalisation therapeutic frame, the researchers could have elaborated more on justifications for mentalisation-based therapy for the children of the two age ranges in the setting. The focus group provided a forum for dynamic peer support, attachment analyses and relationship-oriented psychoeducation, which was a primary aim of the study. |
| (Göttken et al., 2014) Germany | Quasi-experimental wait-list control | This study came close to RCT design, but the sample was considerably small with minimal drop-out. This study did involve secondary participants (parents, teachers, interviewers) increasing qualitative reliability by measuring the treatment effect over time. In this appraisal, risk of bias is agreed to have been low, however randomised protocols of a standard RCT could be improved and replicated using the same model. |
| (Ensink et al., 2016b) Canada | Case-control study | This appraisal turns to process measures of social cognition related to mentalisation along with reflective functioning of a moderate size dyad sample. Recruitment procedures outlined conditions for developmental and trauma histories clearly separating experimental from control. Heterogeneity in terms of the range of experiences of abuse and maltreatment would have been difficult to accurately measure effect given the small size of the experimental group. Justification for matching the groups was explained. Quantitative and qualitative approaches were well described |

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| | | using examples. However, it is agreed by this review, process measures of mentalisation variables require a much higher quality design for prognosis. |
| (Ensink et al., 2016b) Canada | Cross-sectional | A large sample in comparison to many of the studies reviewed. Localised recruitment with matching of both groups, made intentional for the purpose of similar age of all children. One of the strengths noted in this study was the use of blind coding, which may have added to a decrease in bias during parent interviews. Adherence to the mentalisation stance was notable with examples provided, and findings from this study may be replicated. |
| (Munoz Specht et al., 2016) Canada | Exploratory pilot | Coding mentalisation techniques in this small sample would be of interest to the child psychotherapist. This breakdown of mentalisation techniques adds significantly to practice-based literature. The research provides a solid conceptual framework for both the practitioner and practice supervisor invested in mentalisation-based treatment operating in front-line services. |
| (Tessier et al., 2016) Canada | Cohort control | The experimental group, the majority being female, was almost twice the size of the control group. This study forecasted disrupted mentalisation by examining child play, post sexual abuse. Free play is considerably controlled and restricted, rather than collaborative in nature and is directed by the child. Coding of free play is then considered appropriate in the prognosis of post sexual abuse child reflective functioning. |
| (Ensink et al., 2017) Canada | Case-control | With a larger sample (mother-child dyad), this study sought to examine links between mentalisation and dissociation. The study with a sub-group design provided similar demographic cases in addressing a focused issue, although significant differences presented in the mother's circumstances from the control group. The control group was sufficiently selected. The experimental group consisted of confirmed or suspected cases of sexual abuse which again, is heterogeneous in nature. Minimizing bias involved reliable and appropriate tests. |
| (Halfon & Bulut, 2017b) | Cross-sectional | By investigating two functions of mentalisation, this study was reduced to a small local cohort post recruitment. The sample was homogenous and demographically sound. Secondary participants engaged, helping to report for external |

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| Turkey | | validity. However, it was noted there were only two time-points, pre and post. The treatment (psychodynamic play) was not manualised, leading this review to consider if each therapist adhered consistently to the core qualities of the mentalisation stance and therapeutic frame. To counter a possible lapse in adherence at the practice level, therapists received substantial weekly individual and group supervision. |
| (Halfon et al., 2017b) Turkey | Case study | Another study suitable for child psychotherapists in understanding explicit mentalisation with verbalised case examples. Both therapist and child received assessments of mental state talk. The two participants were matched well, which included teacher observations. The researchers thought carefully about scientific rigour and risk of bias, introducing strategies and adherence guidelines by operationalising mentalisation functions. |
| (Halfon et al., 2018) Turkey | Naturalistic | Identifying core treatment processes in naturalistic studies examines what facilitates change when change occurs and for whom change becomes amenable and linked to specific processes. The study design was intricate enough to provide for accurate external validity in a clinical setting. Though with a small cohort, and novice therapists' multiple variables may have been omitted from treatment processes. Nevertheless, the reviewers have considered the preliminary nature or start-point for further research. |
| (Ensink et al., 2020) Canada | Cross-sectional | A moderate sample and snapshot of a larger cohort, the two groups were matched considerably well, comparison group somewhat larger. With the aim of observing types of insecure attachment, this study used sound quantitative approaches. While open to bias, the study still sits within a larger study to inform and improve the likelihood of scientific rigour. |
| (Halfon et al., 2019) Turkey | Naturalistic Cross-sectional | A small sample with both treatment adherence scoring, process variables and regular therapist clinical supervision within the mentalisation frame. To lower bias, the study entailed valid and reliable measures and could be replicated within a much larger sample. |

Note: [a] CASP checklists (Critical Appraisal Skills Programme, 2018), [b] (Braun & Clarke, 2006)

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