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## **Two Approaches to Treating Preadolescent Children With Severe Emotional and Behavioral Problems: Dialectical Behavior Therapy Adapted for Children and Mentalization-Based Child Therapy**

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# Two Approaches to Treating Preadolescent Children With Severe Emotional and Behavioral Problems: Dialectical Behavior Therapy Adapted for Children and Mentalization-Based Child Therapy

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In this paper, we discuss dialectical behavior therapy and mentalization-based therapy in the context of their application to preadolescent children. The paper presents brief overviews of the 2 approaches, with clinical vignettes exemplifying representative techniques, followed by the analysis of each vignette from the perspective of an alternative approach. The main goals of the paper were to describe the key strategies used in each therapy and to highlight the points of convergence and divergence between approaches.

*Keywords:* dialectical behavior therapy, mentalization-based therapy, child, emotional dysregulation, behavior problems

Similarities and differences are highlighted in this paper between two approaches to treating preadolescent children with severe emotional and behavioral difficulties: dialectical behavior therapy (DBT) and mentalization-based therapy (MBT). DBT is an empirically supported intervention for patients with borderline personality disorder, characterized by emotional and behavioral dysregulation, suicidality, nonsuicidal self-injury, and interpersonal difficulties (e.g., Linehan, 1993). The DBT model maintains that patients with BPD are biologically predisposed to problems with self-regulation and are usually raised in invalidating environments, i.e., their emotional development is jeopardized by erratic and extreme responses from caregivers. Thus, the children do not learn how to understand and manage their emotional experiences, and instead develop maladaptive coping strategies in their attempt to self-regulate. Indeed, research indicates that people with borderline pathology

have frequently been raised in families with psychopathology, physical and sexual abuse, and domestic violence (Links, 1990; Shachnow et al., 1997). DBT balances change strategies with acceptance. Patients with intense emotional pain often experience change intervention as invalidating their suffering, and may become noncompliant and prematurely drop out of therapy (Linehan, 1997). On the other hand, interventions that only provide acceptance would not help clients change dysfunctional behaviors. Thus, DBT provides a synthesis of three paradigms: *behaviorism* to foster change, *mindfulness* to foster awareness and acceptance, and *dialectics* to balance acceptance and change.

MBT is based on mentalization as a theory-of-mind construct introduced by French psychoanalysis in the 1960s (Fain & David, 1963; Fain & Marty, 1964) and relocated by Fonagy and his colleagues (e.g., Fonagy, Gergely, Jurist, & Target, 2002) in the context of attachment theory as a developmental process in which the primary caregiver simultaneously communicates an empathic understanding of the child's mental states and a separateness from them that enhance the symbolization of emotional phenomena as mental states to be observed as well as experienced. Bateman and Fonagy (2004a, 2004b) have organically embedded the concept of mentalization in an empirically supported treatment for BPD patients

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called mentalization-based treatment (MBT). “Retaining mental closeness” (Bateman & Fonagy, 2004a, p. 44) is the therapeutic principle used to accomplish the enhancement of mentalizing capacities. Specific therapeutic interventions include

Representing accurately the current or immediately past feeling state of the patient and its accompanying internal representations and by strictly and systematically avoiding the temptation to enter conversation about matters not directly linked to the patient’s beliefs, wishes, feelings, and so forth (Bateman & Fonagy, 2004a, p. 44).

Empathic attunement to changes in mental states, active differentiation of mental states, and discussion of the patient’s mental states in relation to the therapist’s and others’ perceived mental states in the here and now are other specific interventions that enhance mental closeness.

The remainder of the paper specifies the adaptations to children of DBT and MBT and presents clinical vignettes to exemplify approaches. Dr. Perepletchikova describes DBT for children (DBT-C) approach and comments on the MBT vignette, and Dr. Goodman elucidates MBT for children (MBT-C) approach and reflects on the DBT vignette.

### **Dialectical Behavior Therapy Adapted for Preadolescent Children**

The downward extension of DBT-C to preadolescent children (6–13 years of age) incorporates all four modes: individual therapy, skills training, coaching calls, and therapist-team consultation. DBT-C also adopts DBT principles, strategies, procedures, and its theoretical framework. At the same time, the developmental level of the target population necessitates substantial revisions to the content and framework, including simplification and reorganization of the skill-training material; introduction of a psychoeducational component to individual therapy; development of child-friendly activities and materials; and involvement of caregivers in treatment.

### **General Approach**

DBT is a multifaceted intervention that includes skills training, cognitive restructuring, exposure techniques, and contingency manage-

ment. DBT introduces patients to complex concepts, such as dialectical thinking, nonjudgmental stance, radical acceptance and validation. It cannot be realistically expected that a 7-year old be able to understand and appreciate a concept such as, for example, mindfulness. However, a child can readily grasp the idea via experiencing a technique. In one such exercise, a child balances a peacock feather on the finger. Usually a child is able to state right away that if he did not concentrate only on the feather it would fall. The child is able to understand the meaning of being in just this one moment, without thinking about the past or the future, and these are the main aspects of mindfulness. Learning through experiencing is the main teaching principle of DBT-C. There is less of an emphasis on discussing concepts and techniques, and heavier reliance on experiential learning through modeling, practice, role plays, games, and use of multimedia.

### **Adaptation of Strategies**

DBT-C retains all strategies of DBT for adults; however, some modifications have been made. For example, *commitment to treatment* is elicited, but is not required of children. Caregivers’ commitment to DBT, on the other hand, is mandatory. Some of the strategies are augmented with additional requirements. Specifically, therapists are required to elicit *self-validation* and *self-reinforcement* from children during each session. Further, given the developmental level of preadolescent children, it is imperative for therapists to ensure comprehension of the instructions and didactic information. Toward this end, therapists use *developmentally appropriate language and materials*.

Unlike in standard adult DBT, it is not expected that children will be calling their therapists for *coaching* between sessions in DBT-C. Instead, children are encouraged to ask their caregivers (e.g., parents, inpatient staff) for help with skills and problem-solving difficulties. Caregivers are invited to call therapists for coaching, resolving issues, and managing crises. Given that caregivers and not children are expected to call therapists, the *24-hr rule* (i.e., a contingency-management strategy of prohibiting clients from calling the therapist within 24 hr of deliberate self-harm) is not observed. DBT-C also does not use the *taping of individ-*

ual session strategy, in which a client is encouraged to listen to the tape between sessions. It is not expected that children will be listening to tapes, and the confidentiality of children's disclosures may be at risk, as caregivers would have access to the tapes.

Due to considerations regarding preadolescents' developmental level, in DBT-C children are not expected to fill out *diary cards* on their own. Caregivers are asked to help children with this task. DBT-C diary cards monitor suicidal ideations and behaviors, self-harm, aggressive acts, positive and negative emotions, effective and ineffective behaviors, and used skills. Definitions of targets are detailed on the diary cards to ensure consistency.

### Adaptation of Skills Training

DBT-C retains all of the four DBT skill-training modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. However, the content of the skills training has been simplified and condensed. For example, "Wise mind ACCEPTS" and "IMPROVE the moment" were combined into one "DISTRACT" skill (please see Perepletchikova et al., 2011, for a more detailed description).

DBT-C favors a play-like and fun atmosphere for skills training. Games and multimedia help engage children and motivate learning. For example, the "Skills Master" card game was created to assist with review of the learned skills at the end of each module. In this game, a child, a therapist, and a parent draw cards containing questions on skills. Multimedia presentations include video clips with cartoon characters performing the skills. Children indicate enhanced understanding of skills following video presentation and discussion, as well as better skills recollection.

### Adaptations of Individual Therapy

Similar to DBT for adults, during individual sessions therapists provide didactic information about development, maintenance, and change of behavior in general; address specific concerns; review diary cards of negative behaviors; and perform behavioral chain analyses, cognitive restructuring, problem solving and troubleshooting. During the first five individual sessions in DBT-C, children and their caregivers

receive didactic instructions on emotions that include discussion of the importance of emotions; the difference between emotions, thoughts and feelings; and myths about emotions (see Perepletchikova et al., 2011 for further information).

One of the most important and difficult DBT strategies is behavioral chain analysis. Chain analysis is used to evaluate problem behaviors, as well as their antecedents and consequences. Furthermore, the analysis can identify behavioral deficits, and help find effective alternative responses. Chain analysis conducted with children follows the adult DBT format in choosing a focus within the priority list, formulating problems in terms of behaviors, describing problems specifically, and validating distress. Chain analysis is simplified in DBT-C and follows a specific sequence of links: event, thought, feeling, action urge, action, and after effects. To assist in that task, the "Three-Headed Dragon of Chain and Solution Analysis" board game was developed. Children write their feelings, thoughts and behaviors on specifically designated cards that function as links in a chain, and place them on the Dragon. The middle neck of the Dragon is used to establish a chain leading from the event to the problematic response. The other two necks are used to develop chains with alternative responses. These responses are then role played.

### Addition of Caregiver Training

The central notion of DBT is that change can only occur in the context of acceptance. To facilitate children's adaptive responding, caregivers are taught how to create a validating home environment. In addition, to effectively prompt and reinforce children's use of coping skills, caregivers learn DBT skills. To these aims, caregivers are asked to participate in skills-training sessions with their children; learn didactics on emotions; and take part in experiential exercises, role plays, and practices. As well, caregivers are provided with separate individual sessions to discuss progress and troubleshoot difficulties. Caregivers also learn behavior modification and validation techniques, which were adapted from parent management training (Kazdin, 2005) and DBT for adolescents (Miller et al., 2007).

The way therapy is structured depends largely on organizational demands. For example, on the outpatient basis, individual sessions are provided in which children and parents are seen once weekly as a family unit (30 min for individual child therapy, 20 min for individual parent component, and 40 min for skills training with a child and a parent together). In residential care facilities, children and parents participate in separate skills trainings, conducted in group formats. DBT highlights function over form. DBT does not prescribe a specific form for implementing treatment components, but rather emphasizes adherence to DBT principles and procedures, thus, flexibility of implementation is enhanced.

### DBT-C Psychotherapy Vignette

David (a pseudonym) is a 7 year-old Caucasian boy referred to treatment for daily nonsuicidal self-injurious behaviors, including scratching himself with his nails and biting himself on his arms. He has also had frequent suicidal ideations. No prior suicide attempts have been reported; however, the child has been seen in the ER three times during the past year due to a stated intent to die with a specific plan. David has also had frequent aggressive outbursts toward his mother and peers at school and he has been diagnosed with mood disorder NOS, attention-deficit hyperactivity disorder, and oppositional defiant disorder. David has a history of maltreatment. At the age of 5, he was removed from his mother due to substantiated physical abuse by his step-father and lived in foster placement for 6 months. He is currently residing with his biological mother and two older sisters. The child has been in treatment for 8 weeks at the time of this session. His self-injurious behaviors have decreased in frequency to 1–2 occurrences per month. However, he continues to have suicidal ideations and aggressive outbursts multiple times per week at the time of the vignette.

The following is a demonstration of a behavioral chain and solution analysis that was done after the review of a diary card and the setting of a session agenda. The therapist is using the “Three-Headed Dragon of Chain and Solution Analysis” game. Specific therapeutic strategies implemented by the therapists are highlighted in bold.

Therapist: So you said you had a rating of 8 on anger on Thursday, an urge of 6 to self-harm, and you checked one aggressive behavior that day. Is that all one event? (Child nods.) What happened?

Child: I punched my mom.

Therapist: So how did it start? (Eliciting specificity and establishing the “event” link of the chain.)

Child: (Child is holding the hood of his jacket on his head and looking down.) When I wanted to take a shower . . .

Therapist: You wanted to take a shower . . . Okay . . .

Child: In the morning there was no time ‘cause I didn’t want to get up. Yeah, it was already like 8:30 and she said that we are late.

Therapist: She told you that you couldn’t take a shower because there was no time (validation via accurate reflection).

Child: Let’s not do this. It’s gonna take long.

Therapist: “It’s gonna take long?” Okay, well we can take breaks if you get tired. Do you know why we are doing this? Do you remember your goals? (Clarification of goals.)

Child: I wanted to be the boss of me, be in control.

Therapist: Exactly! (Reinforcement.) And we are now figuring out what happened so we can help you think about more helpful ways in dealing with your anger, which is one of your goals. So you wanted to take a shower and mom said no. So then what did you think? (Establishing the “thought” link of the chain.)

Child: (Covers head with arms and slumps down in chair.)

Therapist: What were you thinking when she said that?

Child: It’s not fair.

- Therapist: Okay so you thought this isn't fair. Any other thoughts, or was that the main one?
- Child: That was the main one.
- Therapist: That was the main one. So then when you thought, "This isn't fair." How did you feel? (Establishing the "feeling" link of the chain.)
- Child: (Speaking very softly, and slumping down in chair again.) Angry.
- Therapist: Angry. Look, we already have three cards done! I am sure you can finish this chain (cheerleading). And so then what was that anger telling you to do? What was your emotion mind saying? (Establishing the "action urge" link of the chain.)
- Child: (Spinning in chair.) I wanted to scream, punch, and scratch myself.
- Therapist: Um, so you wanted to yell, punch, and scratch yourself. And what did you actually do? (Establishing the "action" link of the chain.)
- Child: (Still turning chair, looking down and not answering.)
- Therapist: Is it making you upset to talk about this?
- Child: (Nods.)
- Therapist: Okay so you're feeling upset when we talk about this. (Validation via accurate reflection.) What do you mean by feeling upset? (Eliciting specificity.)
- Child: (No response.)
- Therapist: Well, your head is down, you are not looking at me, and it seems like you may be feeling guilty for hitting your mom (Validation via mind reading unstated emotions.)
- Child: (Nods.)
- Therapist: I see. You know it makes a lot of sense that you do not want to talk about this because you are feeling guilty. (Validation of feelings in terms of current events.) Why don't you take a minute and say "It makes sense that it is difficult to talk about this, as I feel guilty right now." (Eliciting self-validation.)
- Child: It makes sense. I feel guilty.
- Therapist: It does. It makes absolute sense. Now, it is difficult to talk about this, and we need to get through this to figure out how to handle these kinds of situations without making them worse. (Modeling dialectical thinking.) Do you like feeling guilty? Do you like hitting your mom? Do you like getting in trouble? (Clarification of contingencies.)
- Child: (Shakes his head to every question.) No, I don't like that.
- Therapist: You know what, I don't like feeling guilty or getting into trouble either. (Self-disclosure.) So, are you ready to work on this?
- Child: Uh huh, yeah. (Nods.)
- Therapist: Okay! So what happened after you hit your mom? (Establishing "after effect" link of the chain.)
- Child: Mom took away my Xbox.
- Therapist: I see. So the "after effect" was you getting punished. You could not play Xbox. For how long?
- Child: The whole day.
- Therapist: The entire day. Did you like that? (Clarification of contingencies; child shakes his head.) Now before we talk about the plan of what to do instead, I want to hear what helped you not to scratch yourself. How did you cope with that urge?
- Child: I thought that it will just make it worse.
- Therapist: Oh, I see. You thought about the "cons" of scratching yourself, right?

- Child: Yeah and it wouldn't help. I remembered you told me, and I promised.
- Therapist: So, let me get this straight, you remembered your commitment not to hurt yourself and you stayed true to that commitment, right? (Reinforces progress.)
- Child: (Nods.)
- Therapist: Well, this is fantastic! I think you did a great job staying away from hurting yourself! What do you think? (Eliciting self-reinforcement.)
- Child: I did well.
- Therapist: Yes, you did! Are you proud of yourself?
- Child: (Nods and smiles.)
- Therapist: I am so proud of you. You did not scratch yourself like you promised! Now, let's come up with a plan of what to do instead of hitting your mom. What could you have done differently? Any skills you could have used? What helped you before? (Starts solution analysis.)
- Child: The STOP skill.
- Therapist: Perfect! So, how do you do your STOP skill? (Activation of behavior.)
- Child: (Stands, takes a step forward, and stops motionless.)
- Therapist: He's frozen! He's frozen! (Therapist is naming the steps of the STOP skill: S = stop, T = take a step back, O = observe what is going inside and outside of yourself, and P = proceed mindfully.)
- Child: (Taking deep breaths.)
- Therapist: Did you take a step back? I haven't seen that yet.
- Child: Oh! (Takes a step back.)
- Therapist: Observe. Tell me what you're feeling.
- Child: I feel mad.
- Therapist: You feel mad. And what's the "P" in stop? Do you remember? What could you do after that?
- Child: Proceed mindfully. (Starts to sit.)
- Therapist: Stand up! Stand up! We're not done yet. So how are you going to proceed mindfully? What does your wise mind say? (Generating solutions.)
- Child: Just stop. Just stop asking to take a shower.
- Therapist: And what would you do instead? (Eliciting specific "opposite action" behavior.)
- Child: Just breathe and go to school.
- Therapist: Breathe and go to school. Okay . . .
- Child: And then when I come back home from school I could take a shower.
- Therapist: Oh and you could take one later! (Validation via accurate reflecting.) And what would happen if you just go to school and take a shower later? (Establishing "after effect" of the effective behavior.)
- Child: I will not get punished.
- Therapist: And how will you feel about yourself?
- Child: Proud. Like I was in control.
- Therapist: So, it sounds like a very effective solution! Great job! (reinforcement). Okay, our first solution is to just follow mom's direction. Mom is saying get up, get dressed, and go to school. So that is what you are going to do?

The therapist continues with solution analysis, and generates the second solution to the problem. As the first solution is on the acceptance side (breathe, let go, follow directions), the therapist helps the child generate a second solution that will represent a change side (e.g., using opposite action skill, interpersonal effectiveness skill). After both solutions are generated, the therapist and child role play both solutions and select the one that the child thinks will work better. The second solution is kept as

a backup plan. The therapist then assigns the selected solution as homework, elicits commitment from the child to implement the skill in similar situations, and troubleshoots problems.

### Mentalization-Based Child Therapy

MBT for children has been discussed elsewhere (Fearon et al., 2006; Fonagy & Target, 2000; Midgley & Vrouva, 2012; Ramires, Schwan, & Midgley, 2012; Verheugt-Pleiter, Zevalkink, & Schmeets, 2008; Zevalkink, Verheugt-Pleiter, & Fonagy, 2012). Mindful of the family's role in cultivating mentalization, Fonagy and his colleagues (Keaveny et al., 2012; Asen & Fonagy, 2012) manualized MBT for families (MBT-F). The following discussion depicts an individual child-treatment setting in which MBT techniques in the context of a psychodynamic therapy are used. Treatment frequency and duration are determined by the pace of the child's mentalizing acquisition; however, Zevalkink et al. (2012) suggested twice weekly sessions for 18 months as optimal.

Fonagy and Target (2000) highlighted three aspects to enhancing mentalization in child therapy: (a) enhancing reflective processes, (b) providing opportunities for play, and (c) working in the transference (see also Bleiberg, Fonagy, & Target, 1997). First, enhancing reflective processes consists of the therapist helping the child to observe his or her own emotions (resembling one facet of mindfulness; Goodman, 2010). This process includes understanding and labeling the child's emotional states, including physiological and affective cues. Noticing how these mental states change over time in the here and now of therapy is crucial to enhancing mentalization in child therapy and helping the child to regulate his or her own emotional states.

Second, play within the therapeutic relationship provides the child with opportunities to symbolize his or her dysregulated emotional states, which enhances impulse control, delay of gratification, and affect tolerance, key outcomes for children who tend to externalize their affects in harming themselves or others. Play provides a potential space (Winnicott, 1968) or pathway to explore relationships one step removed from reality (Mayes & Cohen, 1993) by testing out new ways of relating to the therapist and regulating affect through the therapist and by form-

ing new expectations of affective responses from the therapist. The play process enables "feelings and thoughts, wishes, and beliefs [to] be experienced by the child as significant and respected on the one hand, but on the other as not being of the same order as physical reality" (Bateman & Fonagy, 2004b, p. 84). This process naturally enhances symbolic functioning, which enables words to encode unnamed affects and thus provide affective containment.

Third, working in the transference consists of allowing the child to explore within the therapist's mind. The work of therapy takes place through observations of the therapist-patient relationship, focusing on the mental states of therapist and patient. Keaveny and her colleagues (2012) suggested two techniques that enhance this mentalizing stance: "pause and review" and "Columbo-style curiosity," the latter coined by Fowler, Garety, and Kuipers, (1995). In pause and review, the therapist invites the child to stop the interaction and reflect on what has just transpired between them, emphasizing what the therapist might have been thinking or feeling. Columbo-style curiosity enhances the review process. The therapist investigates the interaction in a somewhat naïve way that acknowledges that the child might have perceived the interaction in a way unanticipated by the therapist. The therapist demonstrates an interest in and understanding of the child's perspective without reflecting back the affective tone of the original interaction. The therapist works in the here and now, placing emotions stimulated by the therapeutic relationship in a context of sequential mental experiences.

Using humor in the therapeutic relationship to show understanding without retaliating or withdrawing from the child also clears a space for patients to own and disown threatening mental states while testing the therapist's attunement to the most vulnerable aspects of the child's self (Bleiberg, 2000). Working in the transference requires the therapist to "do something fresh and creative . . . which has as one component the real impact of the real patient on the [therapist], yet through its novelty reassures the patient that his [or her] attempt at control and tyranny has not completely succeeded. . . . Without such creative spark the [therapy] is doomed to become an impasse, a rigid stereotypical repetition of pathological exchanges" (Fonagy & Target, 2000, p. 78).



Fonagy and his colleagues (Zevalkink et al., 2012) later expanded on these three aspects to enhancing mentalization in child therapy. First, the therapist can comment on the mental content of the play characters, the mental content that the therapist infers from the child's behavior or play, or an alternative mental content not already available to the child. Second, the therapist can identify mental states as motivators of the child's behavior or play, verbalize the wishes or intentions of the play characters or significant others in the child's life such as parents, or reflect on the uniqueness of the child's mental world.

Like DBT-C, a mentalization-based approach to child therapy also involves parent collateral sessions to explain the treatment approach and to gather information from the parents about how the treatment is working in the child's real-world settings: school, social events and play dates, and home. As mentioned previously, MBT-F focuses on the family first, whereas the treatment approach described here focuses on the child first and parents second. Often, parents want to see results but lack the time, motivation, or self-awareness to attend weekly therapy sessions; thus, a child-focused therapy becomes necessary. Also, like DBT-C, a mentalization-based approach emphasizes principles over specific treatment components and is flexibly implemented. In the following session, I hope to demonstrate the effect of a creative spark on the therapeutic process—retaining mental closeness to the child patient.

### MBT Psychotherapy Vignettes

Dennis Duress (a pseudonym), a 10-year-old only child of Italian and Irish descent from a working-class background, was referred to me for intensive treatment by his parents because he was defecating in his pants at home and sometimes at school. Dennis had been in full-time, center-based daycare since he was 2 years old because Dennis's parents both worked full-time to make ends meet. At the time of these sessions (reported below), I was treating Dennis in outpatient therapy multiple times per week. At the outset of treatment, Dennis denied having feelings about anything. He seemed to put his unpleasant feelings into a compartment and leave them there for long periods of time, which gave him an illusory feeling of control—

manifested by his ordering me around during sessions. He often behaved as though he were more powerful than I. Dennis had no friends at school and had alienated potential friends in his neighborhood. He seemed to be using encopresis as a highly effective mode of distancing himself from others and forcing others to distance themselves from him when he or they were getting too emotionally close and therefore making him feel too emotionally vulnerable. During the first half of the first year of treatment, Dennis erected roadblocks to the path of my discovery of his personhood: he incessantly played competitive board and card games in which he compulsively cheated to guarantee a favorable outcome. Dennis often spent entire sessions talking about monster trucks—their designs, the drivers, the tricks they perform, the winners in various categories of monster truck contests, and their sponsors. He also demonstrated an encyclopedic knowledge of monster truck trivia. He was delighted and content to maintain a monotonous pattern of sharing facts about monster trucks. I felt marginalized in our relationship, unable to reach him.

Toward this end, I sought to break up this in-session monotony. Dennis was making a Lego house for a monster truck driver to live in. I started building a Lego monster truck.

Dennis: Don't do that; it won't fit into the garage.

Me: I'm going to build a monster truck called The Duress Express. I'm going to make it out of aluminum because it's an ultralight metal. It's going to be super light, and I'm going to catch some really sick air (a colloquial expression I learned from Dennis that indicates that during a jump, the truck stays in the air a long time).

Dennis: You can't do that. Aluminum monster trucks were outlawed in 2000, and besides, monster trucks have to be a certain weight. You'll get disqualified.

Me: Well, I'm going to hide cinder blocks in my truck's secret compartment that the inspectors will never find, and then I'll just pop them out after the precontest weigh-in. And then I'll catch such

sick air, the broadcasters will call it “diseased air,” and if you breathe it, you will die—that’s how sick the sick air will be that I’m going to catch.

Dennis: There can’t be any secret compartments. You’ll get disqualified because your monster truck won’t be regulation.

Me: Well, I’m also going to attach wings to my monster truck—The Duress Express—and it’ll be able to fly.

Dennis: There’s a monster truck sponsored by the Air Force that already has wings. And I’ll sue you for using my last name. If you’re so smart, how are you going to finance your monster truck?

Me: I have the American Psychological Association lined up as a sponsor.

Dennis: It’s never going to happen.

In spite of its mildly antagonistic nature, we were engaged in a relationship. I was making emotional contact with him by using my own imagination and getting him to engage with my mind. In such cases in which the child has experienced abuse or neglect and thus phobically avoids contact with an adult’s mental world because of what he or she might find there, the therapeutic intent is “to facilitate the establishment of a beachhead, an area of self–other relatedness” (Fonagy & Target, 2000, p. 86). I was engaging Dennis any way I knew how so that he could risk peering into my mind and see that, not only was it harmless, but it was also favorably predisposed to his private interests. Every child in play therapy should be able to peer inside the therapist’s mind and find a reasonable facsimile of his or her own authentic self—both good and bad parts. The child observes that if the therapist can tolerate and survive the presence of the bad parts (the so-called “alien self”), perhaps the child can, too. As illustrated below, Dennis responded to this provocative interaction by showing me more of his internal world and permitting himself to enjoy our developing relationship.

In the following session, Dennis brought in his toy monster trucks in a customized suitcase, laid them out on the floor, set up ramps and

obstacles, and directed each truck through the obstacle course with no variation—each truck performing identically to the previous one. I took a truck and began doing unconventional tricks with it—counteracting his ritualistic “play.”

Dennis: That’s impossible.

Me: You know that The Duress Express has already performed these very same tricks at Monster Jam.

Dennis: There is no Duress Express.

As I watched him run each truck through his obstacle course in monotonous succession, something novel happened—he began performing more unconventional tricks with his own monster trucks. I settled into the role of an arena announcer:

Me: Did you see that? That back flip was unbelievable! And then the slap wheelie followed by—I don’t know what you would call that, but it was incredible! What was that? A *double* back flip? Ladies and gentlemen, what you are witnessing here today is unprecedented in the history of Monster Jam!

Dennis allowed himself to smile when I pretended to be an arena announcer. He even joined me occasionally in the announcing duties:

Dennis: Here’s Tom Meents attempting a *second* double back flip of the day. Can he save it? Oh, he saved it! He just completed the *second* double back flip of the day!

Me: Did you see him save it? Unbelievable!

We were collaborating for perhaps the first time in treatment. He was surreptitiously getting a taste of a relationship without having to defend against it. My efforts at engaging him—getting him to experience mental closeness to me—went unnoticed by him.

By making up tall stories, I was introducing myself as a person with my own intentions and feelings. Essentially, I was introducing Dennis to a separate person eager to engage with him on a series of adventures in fantasy, which he ultimately preferred to the monotony of his own

ritualized “play” that characteristically shut me out. I chose story lines that mirrored his own stories, yet illustrated to him that I had a different understanding of them. For example, in my story, I too had a monster truck that competed with the others, yet my monster truck was built differently and performed unconventional tricks. According to Fonagy and Target (2000), “The capacity to take a playful stance may be a critical step in the development of mentalization, as it requires holding simultaneously in mind two realities: the pretend and the actual. . . . The [therapist] has to teach the child about minds, principally by opening his mind to the patient’s explorations of the [therapist’s] internal world” (pp. 86–87).

Just as a mentalizing caregiver communicates his or her understanding of the infant’s mental states through the process of marking—using exaggerated facial and vocal expressions to indicate that the caregiver is aware of the infant’s mental state but is not experiencing what the infant is experiencing (Fonagy et al., 2002), so too did I use exaggerated storytelling to indicate to Dennis that I was aware of his mental state but was not experiencing what he was consciously experiencing. Thus, I was both attached to him as a secure base and separate from him. This stance simultaneously confirmed the existence of our relationship and challenged his need to dominate and control me, which deprived me of my subjectivity and thrust him back into his isolated, lonely position. Dennis’s parents reported that as the encopresis subsided, Dennis began making friends and became more helpful around the house. Dennis’s increased capacity to mentalize enabled this outcome.

### Commentaries on the Vignettes

#### Commentary on the DBT-C Vignette From the MBT Perspective by Dr. Goodman

This 7-year-old boy came for DBT because he was injuring himself on a daily basis and manifesting aggressive outbursts toward his mother and school peers. Although self-injurious behaviors decreased, aggressive outbursts remained at pretreatment levels after eight weekly sessions of 26-week DBT. At the beginning of the ninth session, the therapist asked the patient about a specific aggressive outburst that had occurred with his mother. The

therapist led the patient through a game called the “Three-Headed Dragon of Chain and Solution Analysis.” By the end of the session, the child told the therapist that in the future, he would not blow up at his mother but instead would stay in control of his emotions, which would prevent him from getting punished. What did this patient learn? I comment now on the points of convergence and divergence between mindfulness and mentalization as they pertain to this treatment.

#### Points of Convergence

Elsewhere (Goodman, 2010), I argued that both mindfulness and mentalization conceptually overlap on two features: (a) observing mental phenomena and (b) describing/labeling mental phenomena. Helping the child to observe his or her own feelings, thoughts, and intentions would fall under the purview of both DBT and MBT therapeutic strategies. In the DBT illustration, the therapist asked the child, “What did you think?” In so doing, the therapist was inviting the child to observe his mental state, which increases mindfulness but also increases the child’s mentalizing capacity. The therapist was inviting the child to treat his mental states as symbols that can be contained. The child responded that he was thinking that his mother’s behavior (refusing him a shower) was unfair. Then the therapist asked the child how he felt. Again, the therapist was inviting the child to observe his mental states. This process differentiates the child’s mental states from the actual circumstances of conflict with his mother and gives the child permission to examine these mental states as symbols in his mind. Unbounded affects have the capacity to overwhelm thinking, but symbolized affects have the capacity to be contained, therefore controlled, and thus restore thinking capacity.

The child responded that he was feeling angry. The therapist not only helped this child to observe his mental state but also prompted him to describe and label this mental state. This insight then allowed the child to describe his intention: He wanted to scream, punch, and scratch himself. Later, the therapist elicited from the child that he felt he did well because he had not hurt himself during this conflict. The child observed his behavior—keeping himself safe—and derived a feeling of self-satisfaction from that. The therapist facilitated these insights

because she asked the child what he was thinking and feeling and got him to observe these mental states and describe and label them. The therapist took this intervention a step further by getting the child to describe his intention, which followed his thoughts and feelings.

Near the end of the session, the therapist reviewed these interventions with the child. Two of the STOP skills teach the child to “T—take a step back” and “O—observe what is going on inside and outside of yourself.” These interventions are completely compatible with mentalizing work. The method of delivery, however, diverges from MBT-C.

### Points of Divergence

Although two features of mindfulness and mentalization—observing mental phenomena and describing/labeling mental phenomena—conceptually overlap, the method of delivery of these two ingredients of therapeutic change dramatically differs in DBT and MBT. In DBT, the therapist was teaching the child how to observe, describe, and label mental states as if the child were taking a class. In the STOP skill, the therapist was coaching the child through each of the four tasks of STOP, which the child dutifully followed. By the end of the session, the child was repeating verbatim what the therapist had been rehearsing with him all along—stop asking to take a shower, go to school instead, take a shower later, avoid getting punished, and feel proud about himself for staying in control. Although an observer might say that the child “learned” what to do in the future, it is an empirical question whether these rehearsed procedures would come into the child’s mind in real-world situations where he is affectively aroused and whether in these situations he would then choose to enact these procedures.

In contrast, MBT eschews the rehearsal of procedures because this process is stored in declarative memory—a left-hemisphere activity (Schore, 2011). In MBT, therapeutic change occurs when both the left and right hemispheres of the brain are simultaneously engaged. Thus, the MBT therapist waits for *in vivo* experiences within the session that simulate real-world affect-activating situations and then enhances mentalizing in those situations. Play is a critical vehicle of such “learning” in MBT because all the action is happening in the here and now, as

with Dennis, not in the there and then, such as talking about an incident that had taken place with David and his mother. Play often simulates these same conflicts, providing visual demonstration to the child how the characters’ thoughts, feelings, and wishes impact others’ states of mind.

The MBT therapist also uses himself or herself as a vehicle for “learning” about mentalizing. In the DBT illustration, a conflict emerged between the therapist and the child because the child was feeling forced to respond and did not want to continue. The MBT therapist might have used that *in vivo* outburst as a “learning” opportunity, helping the child to articulate what he might be feeling toward the therapist *in that moment* and then eliciting the child’s intention toward the therapist. In addition, the therapist would invite the child to guess what the therapist might be thinking about him and how the therapist might behave toward him, given the child’s own mental state. In MBT, this *in vivo* “learning” is much more valuable than the rehearsal of procedures because it engages with both the left and right hemispheres of the brain and therefore gets stored in both declarative and procedural memory. The MBT therapist also addresses the child’s mental-state representations of the contents of the therapist’s own mind, which is the other half of the interpersonal equation not addressed in DBT.

### Commentary on the MBT Vignette From the DBT-C Perspective by Dr. Perepletchikova

Dennis was referred to treatment for encopresis and was seen in MBT multiple times per week for several years. Inappropriate voiding was conceptualized as the child’s attempt to distance himself from others, and prevent emotional closeness. The presented vignettes highlighted therapeutic targets during the first half of the first year of treatment. During sessions, the child engaged in incessant play with monster trucks, and monotonously shared his knowledge of monster truck trivia with the therapist. This was seen as a way to block the therapist from reaching the child and discovering his personhood. The therapist’s objectives were to break the child’s monotonous pattern, and enhance his contact with the adult mental world. By making the child peer through the therapist’s mind, the

child was expected to find a reflection of his own good and bad authentic self. Similarly, through the therapist's ability to survive the presence of bad parts of his mind, it was anticipated that the child would learn to tolerate the presence of his own "alien self."

### Points of Convergence

The techniques used in the two short vignettes of child-therapist interactions within the MBT approach were primarily consistent with DBT stylistic strategies (reciprocal and irreverent communications) and validation techniques. Within the reciprocal communications, the MBT therapist demonstrated that he could be influenced by the child's agenda, and that he took this agenda seriously. The therapist was easily moved by the client, as he readily jumped into the play dictated by the child. Such responsiveness is indicative of the therapist's openness to the client's influence and perspective, which is integral for establishing a collaborative and egalitarian therapeutic relationship. This relationship was further supported by the therapist's nonjudgmental position, being awake to the client's in-session behaviors, and warm engagement with the child. The MBT therapist clearly adopted a nonjudgmental stance during the interactions. Despite the child's opposition, the therapist maintained an accepting and accommodating attitude and allowed for divergent positions to coexist without using depreciatory feedback. At the same time, the therapist was awake to the child's in-session behaviors by noticing small shifts in his affect, statements and actions, and adjusting his own behavior accordingly.

Reciprocal communication strategies promote acceptance in preparation for change. Similarly, validation techniques help a client accept the self, the situation, and the other. These strategies communicate understanding of a client's position, articulate the validity of what the client is feeling, thinking, and doing, and, as in MBT, promote mental closeness. Validation strategies include paraphrasing, mindreading, finding the kernel of truth in the client's position, and cheerleading. The MBT therapist provided validation by expressing interest in the game the child was playing and in the child's responses, and by appearing radically genuine,

authentic, and spontaneous in his interactions with the child.

Although the foundation for change was being carefully constructed, the child seemed stuck in his inflexible and invariant play. To move the client, the MBT therapist used humorous and confrontational responses that were consistent with DBT's irreverent strategies. In DBT, irreverence is strategically and carefully used to push a client off balance, so rebalancing can occur. It usually entails unexpected, dramatic, provocative, and humorous responses that, in the context of the more common reciprocal and validating therapeutic stance, can catch the client off-guard and push the client out of the impasse. The MBT therapist's confrontational responses appeared to have a similar objective—to promote change when the client was stuck.

### Points of Divergence

Both approaches use play and games within the therapeutic process. However, whereas in DBT-C these techniques are supportive and are used mainly to encourage engagement and sustain attention, in MBT play is the main vehicle of the therapeutic process. Specifically, in DBT-C, games, role plays and multimedia are used to understand concepts and practice the taught skills. The content of the game is determined by the session agenda. In MBT, the content of the play is dictated by the child. The child's play is seen as a symbolic representation of child's dysregulated affective state, and is used to explore mental states and promote differentiation and self-regulation.

The approaches also diverge in how treatment objectives are targeted. DBT-C targets problems directly by discussing symptoms, engaging patients in problem solving, providing interpretations and cognitive restructuring, eliciting insight, utilizing exposures, practicing coping skills, and facilitating motivation and willingness to use the learned techniques. DBT-C promotes understanding and use of skills through guided exercises and role plays. Indeed, within the DBT-C approach, active "learning by doing" is emphasized above "talk therapy." Techniques and skills are deliberately overpracticed and overlearned with children to increase the probability that maladaptive auto-

matic responses will be replaced with adaptive coping. Given the developmental level of pre-adolescent children and severe psychopathology that is targeted by DBT-C (e.g., suicidality, self-harm, and severe mood dysregulation), a therapist cannot just assume that a patient has processed information efficiently and is now able to respond adaptively. A DBT-C therapist has to ensure that by the end of a session, a patient is equipped with the needed skills and knowledge, and is able and willing to use them. Evaluation of the homework assignments and discussions of how the child has been able to apply the learned techniques provide the therapist with an ongoing assessment of the child's level of functioning, effectiveness of the provided interventions relevant to the targets, as well as allow for corrective feedback and adjustment of treatment delivery to better address the child's needs.

MBT, on the other hand, targets problems indirectly by helping children mentalize, which is expected to give them the ability to attain higher levels of functioning on their own, including emotion regulation and adaptive coping. The main focus of therapy is obtaining an accurate depiction of the child's current emotions and associated internal representations while conversations on matters not directly linked to the patient's immediate feelings and beliefs are purposefully and systematically excluded from the therapeutic process. Similarly, direct discussion of progress is avoided. The relationship between therapeutic procedures and changes in the levels of functioning is not evaluated with the child on an ongoing basis. Progress relevant to the presented problems, regardless of the psychiatric condition, is judged by the quality of the therapist-child relationship.

## Summary

The vignettes indicated that, in the context of their application to preadolescent children, both DBT and MBT emphasize the present moment, current experiencing, and promote mental closeness as well as differentiation of mental states. Yet, considerable differences in the therapeutic process and treatment targets exist. DBT presumes that ineffective behaviors stem from skills deficit, emotion inhibition, faulty environmental contingencies, and

problematic beliefs and expectations. These factors are targeted via skill trainings, exposures, contingency management, cognitive restructuring, and promotion of insight. Further, DBT evaluates effectiveness of the therapeutic strategies on the ongoing basis by checking on the application of the learned techniques and their functional utility relevant to the presented problems.

MBT assumes that problems stem from an insufficient ability to mentalize. Achievement of mental closeness and differentiation are seen as the primary goals of therapy and are presumed to give a child an ability to resolve problems on his or her own. Thus, MBT does not necessarily include direct discussion of symptoms and instead relies on providing a safe environment for the exploration of the mind and reflective processing of the self/other mental states. Evaluation of the treatment gains relevant to the presented problem is examined by observing the development of the therapist-child relationship and maintaining ongoing contact with the parents.

The main objective of both approaches is to help children gain self-regulatory capacity and improve functioning. Yet, MBT and DBT diverge on how this outcome is achieved. MBT-C holds that enhancing a child's ability to mentalize during affect-arousing situations in session will produce emotion-regulating capacities outside the therapy office. DBT-C, on the other hand, relies on direct learning of skills as a function of instruction, practice, and motivation. As the child learns to modulate behavioral responses upon contextual demands, his or her ability to interpret the actions of the self and others as meaningful on the basis that intentional mental states may indeed be enhanced. The question of whether such insight precedes, follows, or occurs simultaneously with the change in behavior is primary for MBT and secondary for DBT. As DBT views behavioral dyscontrol as multidetermined, this approach relies on multiple venues to achieve change, including cognitive restructuring, facilitation of insight, exposure, skills training, contingency modification, and psychoeducation. MBT, on the other hand, focuses primarily on the role of mentalizing the states of self and others under conditions of affective arousal for improving self-regulation. Which approach can better address the needs of children with severe emo-

tional and behavior difficulties is an empirical question. Research is needed to establish feasibility and efficacy of both approaches for pre-adolescent children, as well as to elucidate the mechanisms of change. If DBT and MBT adaptations are shown to be equally effective in targeting affective difficulties in children, further research may evaluate client treatment matching.

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