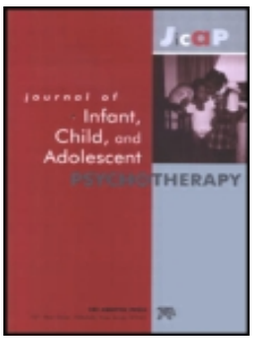

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A Mentalization-Based Treatment Approach to Caring for Youth in Foster Care

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Children and adolescents in foster care settings are at risk for development of emotional and behavioral problems due to a history of traumatic experiences combined with constant changes in their living environment with frequent shifts in caregivers, creating challenges in forming secure attachments. There has been a wealth of research evidence highlighting the importance of secure attachments in promoting the development of healthy mentalization abilities (Fonagy et al., 1991; Fonagy & Target, 2006), which facilitate the processing of traumatic experiences (Sharp, Fonagy, & Allen, 2013). Mentalization is the ability to think about and interpret self and others in terms of mental states (Luyten & Fonagy, 2009). Given the established link between traumatic experiences including child maltreatment with impaired mentalization abilities (Allen, 2013; Fonagy & Luyten, 2009; Ensink et al., 2014a; Ensink et al., 2014b), a mentalization-based approach to the treatment and care of youth is important to implement in foster care settings. This paper provides an outline and description of a mentalization-based treatment approach along with several clinical tools for caregivers and staff members to implement in the treatment and care of youth in foster care settings.

INTRODUCTION

Children and adolescents placed in foster care often have experienced some kind of abuse or neglect (Clausen et al., 1998). There is considerable empirical and theoretical evidence that early traumatic experiences, such as removal from primary attachment figures, and early maltreatment, including physical or sexual abuse and emotional neglect, place youth at a greater risk for the development of a range of psychopathology (Dubner & Motta, 1999; Ensink et al., 2014b; Pecora

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et al., 2009; Van der Kolk & Courtois, 2005; Van der Kolk et al., 2009). Specifically, child maltreatment and emotional neglect hinders the development of mentalization abilities, which is important in processing traumatic experiences (Allen, 2012; Allen, Fonagy, & Bateman, 2008; Allen, Lemma, & Fonagy, 2012; Ensink et al., 2014a; Fonagy & Luyten, 2009; Sharp, Fonagy, & Allen, 2013).

Mentalization is the ability to think about and imagine mental states, desires, beliefs, and intentions which drive behavior in self and others (Fonagy et al., 2002; Sharp & Fonagy, 2008a). Fonagy and colleagues (Fonagy, 2006; Fonagy & Luyten, 2009) have theorized that the capacity to mentalize develops during infancy and childhood from early attachment experiences with secure attachment experiences fostering the development of optimal mentalization capacities (Fonagy et al., 2002; Fonagy et al., 1991; Fonagy & Target, 1996; Midgley & Vrouva, 2012; Target & Fonagy, 1996). Youth in foster care settings face significant attachment traumas, including removal from primary attachment figures and being placed in the foster care environment, which is an institutional setting often dominated by multiple caregivers with constant change in caregivers. These attachment traumas, along with other traumatic experiences, create adverse effects on the child's developing mentalization capabilities because they lack a secure base in which to form and maintain healthy relationships.

Most importantly, much of the literature has emphasized the role of the parents' mentalization capabilities as a vital part of enhancing the quality of the parent-child relationship (Ensink et al., 2014a; Sharp & Fonagy, 2008b). A mentalization-based treatment approach provides a foundation and theory for the development of healthy caregiver-child relationships, which can help provide youth in foster care with skills that may promote healthy psychological outcomes. The overall aim of a mentalization-based treatment approach to foster care is to promote the child´s development by imitating the natural qualities of the parent-child relationship (Jacobsen & Guul, 2015). To achieve this, a treatment approach focusing on promoting the youth's mentalizing abilities is especially pertinent. Increasing mentalization capacities in children and adolescents will promote a positive sense of self, increase emotional regulation abilities, and ultimately positively influence the youth's abilities to form and maintain healthy relationships. The aim of this article is to describe and outline a mentalization-based approach to the treatment and care of youth in foster care settings, by providing clinicians and caregivers with specific tools and recommendations for promoting mentalizing abilities in foster care youth.

This article builds on existing knowledge of the consequences of abuse and neglect, theory on mentalization, as well as the application of mentalization based treatment (MBT) to other populations (Bateman & Fonagy, 1999, 2008, 2012; Midgley & Vrouva, 2012). The theoretical and empirical background will not be further explored as the focus is on how mentalization can be used by foster care parents and staff in their everyday interactions with children and adolescents (from here on only the term "child" or "children" will be used).

A Mentalization-Based Treatment Approach in Foster Care

To facilitate the development of mentalization, understanding the child in terms of mental states is a crucial element. As mentioned earlier, research points to the parent's mentalization capabilities (reflective function) as an essential part of the quality of the parent-child interaction (Ensink et al.,

2014a; Fonagy et al., 1991; Sadler, Slade, & Mayes, 2006; Sadler et al., 2013). Reflective function (RF) refers to one class of mentalization capacity and specifically describes mentalization in the context of attachment relationships (Fonagy, Target, Steele, & Steele, 1998; Karterud & Bateman, 2010; Target, Oandasan, & Ensink, 2001). In the psychodynamic literature, mentalization and RF have been used interchangeably (Fonagy et al., 1998; Ha et al., 2013). Within a mentalization-based treatment approach to foster care settings, a key aim is to increase RF in foster parents, which in turn is expected to promote RF and mentalization capacity in children. Given the individual variation in foster parent/staff mentalization abilities, it is important to consider and assess baseline level of RF in foster parents/staff before the child is placed in care. Understanding specific foster parent/staff baseline mentalizing abilities is an important part of providing adequate education, training and ongoing supervision to ensure quality implementation of the MBT approach. Specific assessment tools are further elaborated upon in the mentalizing tools section. Creating a secure attachment relationship and adopting a mentalizing stance are essential aspects, which we shall now turn to before describing some of the mentalizing tools that can be used in foster care.

Attachment

Foster care (whether it includes foster parents or staff at a foster care institution) should offer the child a possibility to create one or more secure attachment relationships to an adult wherein he/she can learn about minds (his/her own as well as others') and develop abilities to regulate emotion (Allen, 2012; Bateman & Fonagy, 2012). One of the most important functions of the attachment relationship is to provide the child with a sense of safety, which fosters regulation of emotion (Fonagy et al., 1991, 2002; Fonagy & Target, 2006; Midgley & Vrouva, 2012).

While it can be challenging to form a secure attachment relationship with a child who has an insecure attachment style, it is not an impossible task (Allen et al., 2012; Sharp & Fonagy, 2008a). Most importantly, it requires patience along with several other skills. Further, an explicit and systematic focus on mentalization can help the adult maintain a mentalizing stance. What is the mentalizing stance? We turn to this now.

The Mentalizing Stance

The mentalizing stance is a core aspect of MBT and also plays an essential part of the quality of the parent-child interaction (Allen et al., 2008; Bateman & Fonagy, 2012; Karterud & Bateman, 2010; Sharp & Fonagy, 2008b). The parent's capacity to see the child as a psychological agent with his/her own mental states, that are separate yet intimately connected to the parents' mental states, is a basic aspect of the parent's RF (Sadler et al., 2006).

A mentalizing stance implies being curious and not-knowing of the child's mental states. Mental states are opaque and the adult refrains from attributing feelings, thoughts, and intentions to the child with pure certainty. The adult is empathic and interested in understanding the child's behavior in terms of mental states. Even when the behavior is deemed unacceptable, it is regarded as meaningful and understandable when examining the feeling, thought, intentions etc. *behind* the behavior. In practice, in order to foster attachment and mentalizing in a child, a parent has to communicate *contingent, marked*, and *ostensive* cues, which infants are hard-wired to preferentially attend to (Fonagy et al., 2002; Kim, in press). *marked* communication (Fonagy, Gergely, & Target,

2007) refers to communication where a parent understands the infant's internal state, while concurrently signaling that the parent's expression of emotion concerns the infant, not the parent him/herself. The expression of emotion is marked by modifying (e.g., exaggerating or slowing down) the display of the child's affect, such that the parent's emotional expression resembles but modulates the child's emotion simultaneously. *Ostensive* communicative cues (Csibra & Gergely, 2011) refer to the process of calling attention to what the parent is about to communicate. This is often done by making direct eye contact with the child while calling the child by name, tilting the head toward the child, and in the case of an infant, speaking with a "motherese" intonation. These ostensive cues signal to the child that the parent's emotion expression concerns the child and is of importance.

In all then, it is not essential that the adult is perfectly accurate every time that he/she guesses what might be going on in the mind of the child. The point is that the adult is genuinely interested in the child´s mind and the child senses this (Sadler et al., 2006).

Example

A 10-year-old girl who has recently been placed in foster care with her younger sister consistently arrives home late from school. The foster mother finds the girl's behavior provoking, as she seems to be deliberately and consistently late by 20 minutes. During one of these late arrivals, the foster mother was about to punish the girl for being late but stopped herself and reflected on what might be the reason behind the girl's late arrival home. This enabled the foster mother to put aside her own needs at that specific time (making the girl come home on time) and instead allowed her to speak in a gentle and curious manner to the girl, and inquire about why this might have occurred. The girl was reluctant initially, but after a few minutes, responded that she often stops and cries by a special tree on her way home. She reported that she feels different from the other kids at school.

After having talked to the girl, the foster mother now understands that the girl´s behavior is not about breaking the rules, but might be about something far more significant to the girl. The foster mother understands the behavior in terms of the girl's mental states and as a result is no longer as frustrated with her. She soothes the girl and talks to her about her emotions. When the foster mother does this, she mirrors the girl's emotions in a contingent and marked way and acknowledges that there are different ways of understanding and thinking about the world, oneself, others, and what goes on in relationships. This provides the girl with the opportunity to find herself in the foster mother's way of seeing her. This also allows the girl to begin to see things from the foster mother's perspective.

While a scenario such as the one above may not occur immediately between a caregiver and foster child, the caregiver's consistency and patience in taking a mentalizing stance will help to create a safe environment for the foster child to feel comfortable in expressing his/her mental states. To support a mentalizing stance, knowledge of mentalization, normal development, and the consequences of abuse/neglect/trauma on a child's development are helpful. Ensuring safety and mentalizing the child should be the first step in foster care as well as a principle guiding the interventions and interactions continually.

Mentalizing Tools

To implement a mentalization-based treatment approach to foster care settings, a short educational program and ongoing supervision are needed. The education program typically consists of three to five training days to provide an overview of mentalization, the importance of mentalization, the impact of child maltreatment on the child´s development, and a mentalization-based treatment approach to foster care. This training provides a common framework for foster parents/staff to understand mentalization constructs and terminology (Jacobsen & Engberg, 2014). At the start of the training, it is important to consider individual variation in foster parent/staff's baseline mentalization abilities, as different individuals will require different levels of education, training, and supervision. This is important to ensure quality implementation of MBT approaches. While there are several tools to assess RF abilities in adults such as coding RF from the PDI (Slade et al., 2003) or AAI (Main & Goldwyn, 1998), a self-report measure may be preferable in settings with limited time and financial resources, as it is easy to administer and score. A widely used self-report assessment of RF in adults is The Reflective Function Questionnaire (RFQ; Fonagy & Ghinai, unpublished manuscript). This instrument asks adults to rate RF statements on a six-point scale. Collection of baseline RF will aid in supervision and training for staff with different mentalization abilities, and therefore ensure quality implementation of mentalization approaches with youth in foster care. During the educational program, mentalizing tools described below are handed out to the staff for them to use in their daily practice (for a full description of the mentalizing tools contact the first author).

Through supervision from an off-site MBT-trained supervisor, the staff is mentalized and has the opportunity to reflect on difficulties, dilemmas, and experiences with using the mentalizing tools. The use of video in supervision of daily interactions provides the staff with a tangible sense of what having a mentalizing stance is and the significance it holds for the child. Due to limited resources, supervision typically occurs once a month for a three-hour session, or on a bimonthly basis (every other month). Depending on the availability of resources and infrastructure of a particular institution, other strategies for supervision should be considered, such as telephone supervision or supervision through video conferencing.

In this section, we will give a brief overview of some of the mentalizing tools. Some of these tools (e.g., The Mentalizing Detective) are introduced to the child by their foster parent or a staff member during biweekly meetings between child and caregiver. This provides a structured time for the child to communicate openly about their feelings with their caregiver and to facilitate mentalizing interactions. In particular, the aim is to ask the child how he/she feels, if he/she feels safe, if he/she feels the foster parents/staff understands and listens to him/her and so on, to empower the child and involve the child in decisions. By structuring it thus, the caregiver ensures that the process establishing the child's voice actually takes place.

"Mentalization staircase" (adapted from Bateman & Fonagy, 2006; Jacobsen & Guul, 2015).

"The mentalization staircase" guides the specific interventions, from moment to moment, in the interaction (See Figure 1).

What the foster parent/staff member does or says (or does not do or say) should be tailored to the child's current level of emotional intensity. When the child experiences high levels of emotional intensity, the ability to mentalize is compromised. The adult must be supportive and empathize with the child and try to create an emotional connection with the child. When the child is calmer, emotions can be elaborated on and explored. Basic mentalization entails challenging

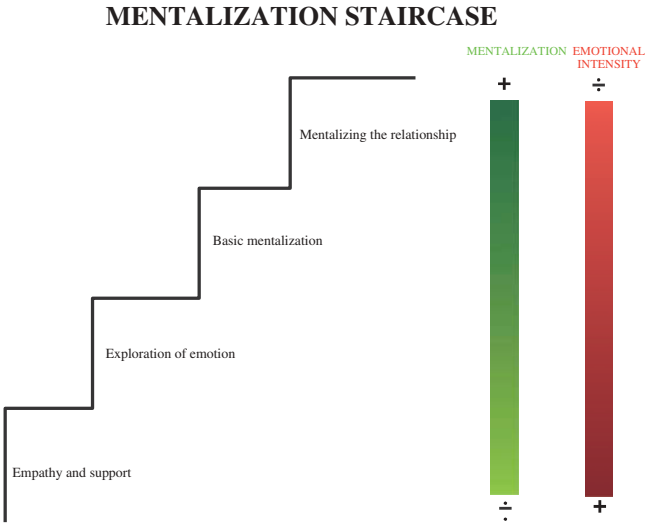

FIGURE 1 Mentalization staircase.

the child's view by exploring an alternative explanation, by asking the child about someone else's perspective, or by asking the child about her/his own perspective. The child is invited to reflect on the mind of self and others in an open and nonjudgmental manner. Once emotions have been reflected upon, the next step is to mentalize the relationship. This denotes verbalizing what happens between the child and adult, in terms of mental states. More specifically, and following MBT (Bateman & Fonagy, 2008; Fonagy, Luyten, & Bateman, in press), the aim of mentalizing the relationship is to increase the affective interpersonal experience with the child whilst maintaining mentalizing. In practice, this means that the mental states within the context of the relationship is discussed. If an attempt to mentalize the relationship triggers nonmentalizing, the process is abandoned and the foster parent/staff member returns to empathy, validation and supportive work before trying to move down the relational trajectory again.

The decision of what step to start with will be determined by the emotional state of the child at that time. As "the mentalization staircase" illustrates, the aim of the intervention is to restore the ability to mentalize by helping the child regulate his/her emotions.

"The mentalization staircase" helps the foster parent/staff member to interact with the child on the basis of the child´s current mental states. Consideration of the child's current emotional intensity is a prerequisite to interacting with the child in a sensible manner. One of the caveats is the adult assuming that the child is capable of reflection on his/her own behavior when this might not be possible, for instance when the child is upset and the adult says: "Why did you do that?" or "Stop crying, we have to go now." Also it is essential that the adult monitors his/her own emotional intensity at any given moment, and has strategies to regulate high emotional intensity. When using the rest of the tools described in this article, it is essential that the foster parent/staff member remains flexible from moment to moment and adjusts what he/she does or says to the emotional intensity of the child. A mentalization-based treatment approach for children in foster

care emphasizes process over content. The tools in themselves are not helpful, but the mentalizing approach in use of these tools is important.

"Mentalize your colleague" (adapted from Bevington & Fuggle, 2012).

"Mentalize your colleague" urges the foster parents/staff to spend 10 minutes daily (or weekly depending on staff constraints) in creating a special room to mentalize each other in addition to the staff meetings and supervision.

The aim is twofold. The first goal is to provide the means for reflection in everyday practice to support the staff´s mentalization capabilities. The foster parent/staff will from time to time experience mentalization failure in emotionally intense situations. For instance, situations may occur where the child denies going to bed, bangs his head against the wall or continually yells at the staff, creating challenges to maintaining a mentalizating stance as the adult's own emotional arousal increases. Therefore, it is important that the adult continually is attentive to his/her own mentalization ability and mental states and finds the time for reflection in daily practice. To better maintain one's own mentalization ability, continually being mentalized by someone else can be helpful.

The second aim is to exercise a mentalizing stance. The exercise stresses exploration of mental states. There are two important aspects to exploring mental states and they are both necessary to facilitate mentalizing in the other person. The first is *to understand*. When adopting a mentalizing stance toward a colleague, the staff member must really try to understand what it must be like for the colleague. This process corresponds to the two lower steps on the mentalization staircase (Figure 1). The second aspect is *challenging the colleague's mental states* and corresponds to the two upper steps on the staircase. Only after having achieved a feeling of understanding, can the colleague be challenged. This can be done by asking a different view on the subject or by asking how someone else might have felt in the same situation.

Take, for example, John, a male staff member who was threatened by a 15-year-old boy, Michael. Michael said that he would kill John. John´s colleague Laura mentalizes John that same evening, after having said good night to the adolescents at the institution. First, Laura asks John what he would like to talk about. John gives a brief description of the episode. Laura is aware to stop John if he continues to talk about what happened such as when the situation happened and who said what. Instead, Laura focuses on what mental states John has, both during the episode as well as in the present moment as they are talking. For Laura, the goal is to understand what it is like for John. Next, she challenges John by asking what might have been going on in Michaels mind. Some examples of what she may ask John would be: "I wonder how Michael might have felt in that situation?"; "Was he experiencing highly intense emotions?"; or "Did anything happen just before that might have triggered this state in Michael?" While it may be challenging to devote 10 minutes of time to consistently mentalize with colleagues, foster parents/ staff members are encouraged to support each other as frequently as possible, particularly when there are high conflict between situations.

"Creating a Mentalization-Based Crisis Plan"

A crisis plan can be made conjointly with the child when relevant (Bateman & Fonagy, 2006; Rossouw & Fonagy, 2012). Following the mentalization-based treatment for adolescence (MBT-A) sessions as described by Roussow and Fonagy's (2012) study, a crisis plan for foster care parents/ staff members is outlined below and should be implemented only when necessary,

particularly for youth engaging in significant risky behaviors. The crisis plan describes particular destructive or self-destructive behavior (e.g., self-harm, aggressive behavior, drug abuse); explores the feelings, thoughts, bodily sensations, and so on behind the behavior; and identifies alternative methods for managing these behaviors. The crisis plan consists of several questions that the child and foster parent/staff member seek to explore in a collaborative fashion. Creating a crisis plan is a way of engaging the child in a mentalizing process about his/her own behavior. To consider the child's motivation for engaging in the self-destructive behavior, the child rates on a scale from 0–10 how much the child *believes* he/she will be able to use the crisis plan and likewise on a scale from 0–10 how much the child *wants* to use the crisis plan. It is important that the foster parent/staff member does not expect the behavior to change as a direct result of having made a crisis plan. Making a crisis plan is an ongoing process and the plan is evaluated and modified continuously. The child can have a little card with him/her that summarizes the crisis plan. The process of working with a crisis plan entails both maintaining a mentalizing stance aimed at developing the child's affect regulation and mentalization capacities as well as treating the symptomatic behavioral expressions of the underlying capacities current level of functioning.

Crisis Plan Example

When I feel the urge to run away because I feel restless and it feels as if my head will explode, then I can:

1. Talk to one of the adults (if it is to difficult for me to approach them in person, I can text them and they will come to my room)
2. Call a friend
3. Listen to my favorite tune

"The Mentalizing Detective" (Jacobsen, 2015)

"The mentalizing detective" is a means for exploring mental states. It is completed together with the child for any given situation focusing on the child´s feeling, thoughts, bodily sensations, behavior and triggers for engaging in behaviors (Figure 2). An example of when to complete a structured analysis of the behavior would be after the child hits another child or refused to take a shower. Retrospectively exploring mental states of any situation involving destructive or self-destructive behavior is a tool for managing the behavior (as opposed to punishing the child or telling the child how wrong his/her behavior is). The mentalizing detective provides a common item for the foster parent/staff member and the child to share their attention on. The child is invited to actively participate and write or draw on the picture. This can be less anxiety provoking for a traumatized child who might experience increased arousal when having eye contact.

Mentalizing strategies (adapted from Blaumstein & Kinniburgh, 2010).

The individual foster parent/staff member reflects continually on his/her strategies to maintain mentalization in emotionally intense situations and takes notes on this. An essential part of helping the child learn how to regulate emotion is the individual foster parent/staff member's ability to regulate his/her own emotions, when interacting with the child. Some of the questions used for this are:

MENTALIZING DETECTIVE

- To explore and investigate emotions, thoughts, bodily sensations and what else you may feel inside.

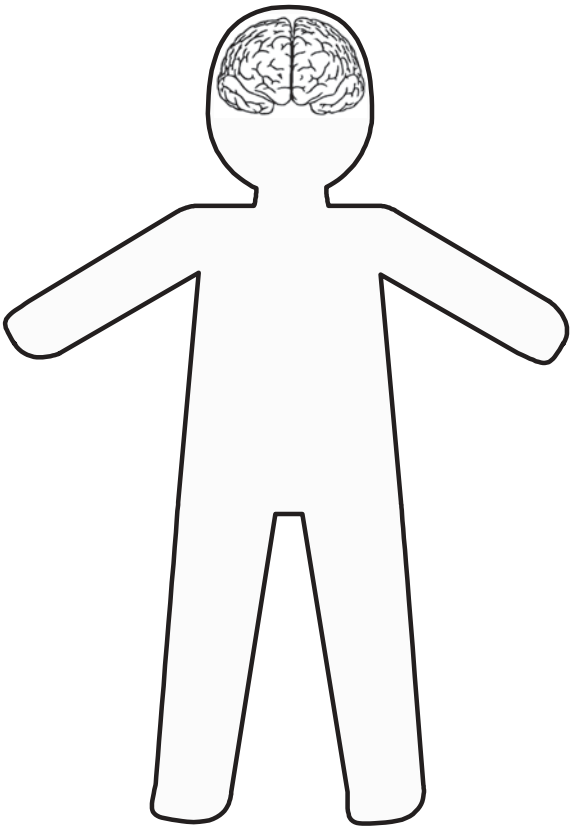

FIGURE 2 Mentalizing detective tool.

- What do you do to remain calm? Examples of strategies are counting to ten, deep breathing, thinking about something nice, reminding yourself they are just children, remembering the words "curiosity," "mentalize," and so on.

- Consider what generally makes you feel calm. This might be thoughts, images, seeking comfort from others, and so forth. Would you be able to use some of these elements in highly stressful situations?
- In what ways do you prepare yourself when entering a tense situation? For instance, before entering the child's room after you have just learned he has lied to you. Can you use some of these strategies when in the situation?

Implementation of a Mentalization-Based Treatment Approach to Foster Care in Denmark: Challenges, Limitations, and Future Directions

In this section, we provide an example of foster care settings in which this approach has been implemented in Denmark and discuss some of the challenges, limitations, and goals for our current work. In addition, we provide recommendations on how to address these challenges and limitations and provide a specific example of a newly developed program to implement MBT in a foster care setting in Denmark. Several of the mentalization tools and strategies that have been described in this article have been implemented in both foster care institutions and with foster care families. Foster care staff including case workers, staff working in agencies or group homes, clinicians (i.e., counselors or social workers) working directly with foster care youth may benefit from mentalization training in these settings. In one setting, a total of 11 foster care staff members received training in the mentalization-based treatment approach and have used this approach to their care with six full-time youth in foster care ages 9–17.

In another setting, consultants of foster care parents receive ongoing training and supervision in the mentalization-based treatment approach to foster care. The consultants' primary tasks include supervision of foster care parents, matching of specific children and families and in some cases approval of foster care families. As part of the MBT approach the consultant's primary task is to support and provide mentalization-based supervision to foster care parents with children aged 0–18. Before the child is placed in care with a foster parent, baseline RF level of the foster parent is in some cases assessed using the Reflective Functioning Scale (Fonagy et al., 1998). RF is coded from transcriptions of the Adult Attachment Interview (Main & Goldwyn, 1998) or the Parental Development Interview (Slade et al., 2003). The PDI is sometimes used in foster families where the child has already been placed in care. On the basis of the assessment, the final decision of approval and match between child and foster care parent is made. Also a support/supervision-plan is made in collaboration with the foster care parents that draws upon relevant aspects from the assessment. Due to structural obstacles (i.e. naturalistic setting, lack of organizational infrastructure, time commitment, training in coding and scoring, cost) RF is only assessed in some families. While no preliminary data are available in this setting, five foster parents have received an RF assessment using either the AAI or PDI. Each consultant typically supervises 20–25 foster care families and on the current team, there are four consultants being supervised by a MBT-trained clinical psychologist (first author).

Our initial experiences with implementing the MBT approach in several foster care settings have been associated with several challenges in terms of consultant and staff motivation for various reasons. Some factors we have observed to affect staff motivation and interest in learning MBT education and training include: 1) the constant shift in procedures in this type of setting leading to decreased motivation to learn about a new approach, 2) staff may be overwhelmed with a heavy caseload and the increasing demands of learning a new approach, 3) the lack of an

infrastructure for organizations to implement an MBT approach including constant staff turnover or inconsistent delivery of MBT training (i.e. "What difference can this approach make if we mentalize, but other team members do not?"), and 4) different perspectives on what works best for children in foster care. It is important to assess these factors and address them during education, training, and supervision of staff. One possible solution to these potential limitations in gaining staff motivation would be to give staff a chance to voice their concerns and resistance to this new approach. This may help them to feel heard and they may be more likely to be receptive to a new approach in their setting.

While several of the mentalization tools and strategies that have been described in this article have been successfully implemented in both foster care institutions and with foster care families, there are additional points to consider. The approach has been used with children of all age groups at various developmental levels and with different mental disorders. As usual, when working with youth, appropriate developmental considerations must be considered including the youth's age, cognitive and physical ability, and emotional states. The mentalization-based treatment approach supports the child's development and reinforces that the foster parent/staff member meets the individual child as a psychological agent in the moment as well as from his/her specific developmental level. Further, children in foster care present with various individual factors (difficulties as well as strengths), that influence the individual child's ability to mentalize. Among these are attention regulation capabilities, attachment style, affect regulation ability and cognitive abilities, which should be considered in relation to every child. Also cultural influences such as ethnicity and socioeconomic status may be of relevance. In terms of youth from minority ethnic groups, it is especially important to mentalize the child´s behavior and avoid the so common misunderstandings when different cultures interact.

As mentioned earlier in this article, foster parents and staff members vary in mentalization abilities and some have reported difficulty in achieving a balance with mentalizing the child and setting appropriate boundaries (Jacobsen & Engberg, 2014). For some foster care parents/staff members, it can be challenging to be genuinely curious about what mental states may explain the child's behavior and they may end up getting into power struggles with the child and quickly react by punishing the child's behaviors. Other foster parent/staff members may lean too far the other direction and interpret mentalization to mean acceptance all of the child's behaviors without setting limits or reflecting on the child's mental states which influenced the behavior. Furthermore, it is an ongoing challenge for the individual foster care parent/staff member to remain calm, not take the child´s behavior personally, and to maintain a mentalizing stance. These challenges point to the importance of ongoing mentalization-based supervision.

Finally, from an organizational standpoint, a major limitation has been the difficulty in gathering empirical data on the results of this implementation in the different settings. This is primarily due to economic factors as well as obstacles in RF measurement for a group of foster care parents and staff members. To meet these challenges, the first author of this article has collaborated with psychologist Jens Hardy Sørensen to initiate revision of an existing mentalization-based treatment program that has already been evaluated empirically in Denmark (Afdeling for Traume- og Torturoverlevere, Psykiatrien i Region Syddanmark & Varde Kommune, 2014; Jespersen & Helstrup, 2014; Madsen, Helstrup, Jespersen, & Hart, 2014). The program is called NUSA, which in Danish denotes "Neuroaffektiv Udviklingspsykologisk Struktureret Aktivitet" (Neuroaffective Developmentally Structured Activity) and was originally developed to prevent secondary traumatization in children ages 6–12 in families with parents at risk of being traumatized themselves

(refugees and veterans). The revised version of NUSA, based on the original manual (Sørensen, 2012), is directly tailored to adolescents ages 12–18 in foster care. In this program, foster care staff/consultants/parents receive three days of training to become NUSA-therapists. Afterwards, two NUSA trained therapists run a NUSA-course with a NUSA-team of adolescents. This group preferably consists of 6–10 adolescents and is held twice a week for 60–90 minutes, for a total of 20 sessions. During the course, the NUSA-therapists receive supervision by MBT trained supervisors on a biweekly basis. The sessions have a definite structure to promote safety and predictability. Each session consists of different activities that build upon each other. The sessions are designed to develop the ability to regulate affect, implicit mentalization and finally explicit mentalization.

Currently, funds to support preliminary empirical validation is being sought, with the aim of evaluating outcomes and effectiveness of the implementation of MBT to this foster care setting. Measures of emotional development and mentalization capabilities of the youth will be used to assess improvements in mentalization following the NUSA-course. To assess adolescent RF, a self-report measure for RF in youth was recently translated for use with Danish youth called the Reflective Function Questionnaire for Youth (RFQY)—Danish translation (Jacobsen et al., submitted). Future plans are in progress for further validation of this measure. To assess emotional development and other aspects of mentalization, the following measures will be employed: The Level of Emotional Awareness Scale (LEAS) (Lane, Quinlan, Schwartz, Walker, & Zeitlin, 1990) and the Reading The Mind in the Eyes Child Version (RMET-C) (Baron-Cohen et al., 2001).

While the successful implementation of a MBT treatment approach to foster care settings can be challenging due to various demands for resources, it is beneficial to find cost-effective ways to implement a much needed program like this in foster care settings with youth. A current goal for researchers and clinicians in Denmark is to gather data to evaluate the effectiveness of this program implementation, as well as to assess outcomes in youth in the program.

CONCLUSIONS

The goal of this article was to introduce and describe a mentalization-based approach to treatment of youth in foster care settings. Given the significant attachment traumas and adversity that youth in foster care often experience, a mentalization-based treatment approach in foster care settings used by clinicians, foster care staff, and foster families would help to promote healthy caregiver-child relationships, which may ultimately aid in changing a youth's developmental trajectory by promoting better psychological outcomes and fostering resilience. Furthermore, an explicit and systematic focus on mentalization in foster care provides the individual child with the necessary conditions to develop, thrive and learn. Through fostering and promoting the child's mentalization capacities, this provides the child an opportunity to develop a healthy sense of self, abilities to regulate emotion, and ultimately the skills to form and maintain healthy relationships in diverse contexts.

There remains a lack of research examining effective and empirically supported interventions for children in foster care settings. Due to the early traumatic experiences and continued transitions in attachment figures that children and adolescents in foster care settings face, taking a mentalization-based treatment approach to their care will be beneficial in facilitating healthy social and emotional development. Further, the integration of empirical research into clinical

care is an important aspect of providing children and adolescents with the best and well-informed care. Importantly, the implementation of a mentalization-based treatment approach to youth in foster care settings will provide foster children with an opportunity to form better attachments and promote mentalization abilities. As evidenced by research, development of mentalization skills are necessary to help children overcome their early traumatic experiences (Ensink et al., 2014b; Sharp et al., 2013), and teach them how to successfully navigate and maintain healthy relationships in various contexts throughout their lifetime.Use of the mentalization-based treatment approach as a common language, the mentalization tools alongside ongoing supervision, affords clinicians, foster care staff members, and foster care families with the skills necessary to promote mentalization capacities in foster care youth.

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