Edited by Trudie Rossouw,
Maria Wiwe, and Ioanna Vrouva

ROUTLEDGE

Mentalization-Based Treatment for Adolescents

A Practical Treatment Guide

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Mentalization-Based Treatment for Adolescents (MBT-A) is a practical guide for child and adolescent mental health professionals to help enhance their knowledge, skills and practice.

The book focuses on describing MBT work with adolescents in a practical way that reflects everyday clinical practice. With chapters authored by international experts, it elucidates how to work within a mentalization-based framework with adolescents in individual, family and group settings. Following an initial theoretical orientation embedded in adolescent development, the second part of the book illuminates the MBT stance and technique when working with young people, as well as the supervisory structures employed to sustain the MBT-A therapist. The third part describes applications of MBT-A therapies to support adolescents with a range of presentations.

This book will appeal to therapists working with adolescents who wish to develop their expertise in MBT as well as other child and adolescent mental health professionals.

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Foreword

Peter Fonagy

Something dramatic, unacceptable and hard to understand is happening. The scale and burden of the mental health problems experienced by our young people represent a public health crisis. In the UK, we now have relatively comprehensive and reliable information about the breadth and depth of mental health difficulties experienced by children and young people (Sadler et al., 2018). Overall, the prevalence of childhood mental disorder might have increased from one in ten to one in eight over fifteen years. When segregated by age, we find that in young women aged 17 to 19, this rate has increased to 24%. The adult morbidity survey (McManus, Bebbington, Jenkins, & Brugha, 2016), now six years old, similarly shows a substantial increase in the prevalence of anxiety and depression in particular amongst the 18 to 25-year-old cohort. Although less systematic, but impressive in terms of panel size, the UCL Covid-19 community survey has revealed an even more disturbing picture (Fancourt, Bu, Mak, & Steptoe, 2020). Week after week, tens of thousands of UK residents were surveyed in relation to their experiences during the national lockdown. The survey included two widely used and highly reliable measures of depression (PHQ-9) and anxiety (GAD-7). The overall level of mental health problems revealed a relatively reassuring picture. However, focusing on the 18-29-year-old sample, the many thousands of young people completing the survey showed mean levels of 10 and 8 on the PHQ-9 and the GAD-7 respectively. The mean clinical cut-off for these instruments are 10 and 8, respectively. Even adjusting for the abnormality of the distribution of underlying scores in both these instruments, the prevalence of anxiety and depression in this large panel survey would appear to be above 40%.

I do not believe that anyone fully understands the reason why mental health problems are so clearly focused in a young age group. There are many explanations offered. The emergence and dominance of social media in the lives of young people may be an important factor. Much has also been written about disproportionality concerning gender. There is no doubt that social pressures on young women are far greater (or have been at least until most

recently) with conflicting roles of educational and professional success and an effectively unchanged value system surrounding sexual roles in our society. Of course, there is likely to be intersectionality amongst these risk factors. Gender may have implications for social media use and women are far more vulnerable in relation to the visually dominated social media most present in youth culture than males.

Many of the general vulnerabilities associated with adolescence are brilliantly reviewed in the first part of this book. But of course, understanding development at both psychosocial and neurobiological levels does not explain why, in England at least, the number of young people presenting with mental health problems in 2019 alone increased by 15%. It doesn't explain why 50% of the young women who experienced diagnosable mental health problems have self-harmed or made a suicide attempt. It doesn't explain why suicide rates are rising in this age group. This shift takes on a catastrophic flavour if we fully recognise just how important adolescence is as the period which defines people's subsequent career, health and well-being trajectories. If 75% of mental health difficulties manifest by the age of 18, as some research suggests (Murphy & Fonagy, 2013), it is obvious that nothing short of a radical transformation is needed, working across disciplines and approaches to mental health to bring the best and most readily adapted evidence-based intervention to our communities, to young people and their families.

And this is where the wonderful collection of chapters in this book comes in. The editors are to be warmly congratulated for providing a comprehensive introduction to a common language which may be readily adopted by clinicians, regardless of their orientation or primary training, by families attempting to provide the best support to young people regardless of the specific problem, by young people trying to find their way through their increasingly complex social network and by the broader systems of schools, communities and social institutions which are so evidently failing in mitigating depression and anxiety in our young people.

This book proposes a generic, atheoretical and potentially extremely helpful conceptual framework that is simple and obvious that it is hard to understand why the clinical world of child and adolescent mental health services has been relatively slow in adopting it. It is in keeping with a paradigm shift in the world of psychosocial treatments that a number of us have noted (e.g., Fonagy & Luyten, 2019). This shift is characterised by a decreasing emphasis on *named therapies* defined by a set of technologies addressed to a particular clearly defined group of patients. Difficulties in scientifically validating these groups have contributed to this decline. Similarly, the idea of *schools of psychotherapy* has also lost some currency. It used to be enough to say that a therapist was psychodynamically or cognitive behaviourally trained and this would be a kind of passport both in terms of accreditation but also defining their "therapeutic nationality".

Meanwhile, balancing these declines, we can observe a rise in *testable models of intervention*. In the first trial of mentalization-based treatments for adolescents (Rossouw & Fonagy, 2012), we measured both a capacity for mentalizing and security of attachment as possible mediators of treatment effects. Assuming that mentalizing matters, enhancing this psychological capacity provides an experimental framework for placing MBT under a microscope. There should be and there will be more *mediation and moderation studies*. As several chapters in this book clearly identify, the conceptual frame of mentalizing provides a new form of diagnosis based on a kind of *mechanistic functional analysis*. Different forms of mentalizing failure may lead to different manifestations of mental disorder rooted in a common core of dysfunction of social cognition associated with patterns of adaptation in types of child-caregiver relationships. Mentalizing also represents an approach, in common with other orientations such as ACT (Hayes, 2015) and compassion focused therapy (Gilbert, 2019), where we may discern a *move from nomothetic to idiographic* approaches. We need more than an effect size coefficient associated with mean differences between two groups that differ principally in the treatment to which they were exposed. We know that beneath the group mean in a treatment trial are substantially different trajectories that correspond to individual paths often reflecting deteriorations alongside the recovery even when overall improvement predominates. All this opens the door to a kind of 'personalized medicine' approach to psychological therapies with elements of therapy being used in combination configured to best fit an individual's presenting difficulties, creating an approach that integrates, or perhaps bridges, different treatment orientations, settings and even cultures.

Does the approach presented in this book provide a key to understanding the mental health problems our young people face? Mentalizing is rooted deep in our evolutionary history when becoming bipedal drove our species towards social living that in turn, required greater cognitive capacity (Dunbar & Sosis, 2018). Human babies are born markedly more immature than other primates. Birth itself is painful and dangerous and requires social support from kin (Hrdy, 2013). Our species require long periods of essential safeguarding and care and intense and protracted learning before the young human is ready to join the community of approximately 150 individuals engaged primarily in foraging with familiarity and reciprocal relationships between members of the group (Dunbar & Sosis, 2018). Everyone within the group, not just close relatives, has responsibility for protecting young humans. Relatives and other group members are present all the time and children can roam freely seeking contact, comfort, and play from whoever they choose.

Human sociality is explained by the unique capacity to share mental states with and of others (Tomasello, 2019). When people are poised to interact, they achieve interpersonal awareness through a meeting of minds. Mental states are assumed by individuals within a social system to be joined or shared by everyone. Philosophers of mind have named this category of mental events "jointly seeing

to it" (Tuomela, 2005). This feeling of we-ness underpins social collaboration. Being part of a set of thoughts and feelings that are beyond one's own is the essence of humanity. Thinking together in this way creates a collective form of social cognition called the "we-mode". This we-mode provides the context in infancy in which mentalizing develops. This is the context that spurs mentalizing on in toddlerhood and moves play from a solitary activity to social collaboration. This is the context in which peer relationships of middle childhood are formed and families acquire their unique systemic properties. We-ness permeates the social bonds of adolescence and the essential social support which peer groups provide young people transitioning from dependence to selfhood. This is also the core idea that runs through the therapeutic models and techniques described in this collection of excellent reviews. We-ness is the distillation of the mentalization-based approach to psychotherapy. Perhaps it goes beyond MBT and motivates other therapeutic approaches such as DBT or ACT as well.

But what of the increased prevalence of adolescent mental disorder? Our environment of biological adaptation, the social environment of the hunter-gatherer, where we acquired the capacity to jointly see to something and share our mutual understanding of mental states, is ecologically threatened in much the same way as the thinning of the ozone layer threatens vital facets of our physical environment. Mentalizing, according to this formulation, evolved in and for adaptation to a community rather than one on one relationships. In some ways, attachment theory may not have helped here. This theory, and our early writings on mentalizing, emphasised a model of parent/caregiver interaction that was essentially dyadic (Bowlby, 1969, 1973; Fonagy, Gergely, Jurist, & Target, 2002). Drawing on attachment research, we emphasised the dyadic: turn-taking, smooth completed interactions between infant and caregiver, the reflection in the caregiver's face of the child's emerging affect, etc. as the essential components or foundation stones upon which mentalizing was built. In other words, we supported a cultural ideal of the infant as an agent sensitised to use parental qualities and attributes as the primary referent of their actions. In this account, when infants recognised the mother's representation of them as the central agent, this generated the sense of self-recognition which was assumed to be at the heart of self-development not just in infancy but perhaps also through adolescence and of adulthood. There is little doubt about the reality of this, but it is a partial story. This dyadic experience might best be understood as a part of a broader category of we-mode: perhaps self-focused dyadic interaction is one special way of generating a sense of belonging and a sense of self? Perhaps among hunter-gatherers, different forms of we-mode were emphasised in developing these aspects of identity, and perhaps they still are in many non-Western societies. In societies more like hunter-gatherers' and different from ours, children and caregivers are engaged in multiple simultaneous ongoing activities and very rarely in dyadic interactions (Keller, 2018). These support a cultural ideal that is quite different from the one which prioritises the infant or child as the central agent, the focus of the caregivers'

attention. In this broader, multiply layered, constantly preoccupied interaction, the child is sensitised to attend to others' mental states, their wishes and their interests. It is the mental states of others, the social group, rather than their own, which can be used by the child as the primary referent for actions. It is the recognition of belonging, finding oneself similar to the central tendency of the group that creates and validates identity.

What is suggested here is that mentalizing is a product of social adaptation to collaboration in groups. As a result, it may be risky for this idea to be hijacked into a framework that emphasises the self as the central agent. We have for many years, cautioned against excessive self-reflection as a therapeutic approach for individuals whose sense of self is poorly formed. Perhaps we did not quite recognise the importance of our recommendation, rooted as it was in clinical experience rather than theoretical considerations. If we see mentalizing as essentially a signal of belonging, then one way of seeing difficulties in mentalizing is as an experience of loss of social cohesion and social belonging. I wonder if we should not see the increased prevalence of adolescent mental health difficulties as a limitation of resilience rooted in a vulnerability that arises out of a partial failure of social connectedness. I am not suggesting that social connectedness between young people is less intense now than it was in the past. I do think, however, that there is evidence to suggest that intergenerational contact has been on the wane since the Second World War and young people have in many respects become their own socialising agents. While the importance of peer groups for development is clear, I do believe that we have arrived at a human evolutionary mismatch in the way we have reconstructed adolescence in the late 20th and early 21st-centuries.

Humans now live in environments diverging rapidly from those in which they evolved - the so-called *environment of biological adaptation*, the contexts where certain functions fulfilled a selective advantage. The discrepancy between the current environment and the environment where the selective advantage was clear is referred to as an *evolutionary mismatch*. The mismatch is due to the *adaptive lag* that occurs because the environment that called forth a capacity or function with selection advantage changes more rapidly than the time needed for the evolved function to adapt to change. An evolutionary mechanism such as a preference for sweet things makes perfect sense in the context of scarce resources where sucrose will lead to a preference for fruits and honey that yield calories and vitamins. In the context where manufactured foods replaced those found in nature, this built-in preference for sweet things can lead to a preference for foods with little nutritional value and high-calorie content leading to an epidemic of childhood obesity. For 99% of human history, people lived as hunter-gatherers in small kin-based groups. The evolutionary mismatch for we-ness started perhaps 10,000 years ago when agriculture arose but the mismatch became worse again with the industrial revolution. We-ness, *jointly seeing to it* makes sense in the environment of hunter-gatherers. The viability of mutual understanding is increasingly tested

with the increasing complexity of social structures, particularly social hierarchies and the psychological complexities these bring with them.

I think that modern education has generated a similar adaptive lag by removing key features of the environment of biological adaptation. The environment of biological adaptation for adolescent development included supportive, vertically (intergenerationally) integrated groups. An evolutionary mismatch occurred when, for the best of social reasons, education was prolonged beyond puberty into late adolescence and young adulthood. The mismatch is rooted in the relative absence of adults within the groups where adolescent upbringing takes place. Adolescents spend less time with adult role models now than was the case when apprenticeships dominated the educational model. Adolescence is a period when we are biologically programmed to seek independence from our caregivers. The drive for independence should not preclude non-kin adults with an educational function. Yet socialising adults are remote in the large classes of most secondary schools. Young people do not feel they are known about as individuals. In modern adolescence, parts of our biological heritage are retained, such as the drive to take increased responsibility for one's actions; at the same time components designed to support enhanced responsibility, namely increased agency, have been compromised. Responsibility without agency is never a helpful combination. Having been brought up in a culture where self-agency is king, the lack of agency creates incoherence and a gap between the actual and ideal self that many cannot cope with. It is right that adolescents should push against parental involvement in their lives, but it is challenging that the current social structure also makes them excessively dependent at least financially on parental input. Social media may indeed bear some responsibility for increasing stress. But it is an underlying compromise of an intergenerational social network that may have additional significance.

Why are we in this situation where young people may rightly feel inadequately supported by the previous generation, while simultaneously being apparently overprotected from taking on the markers of adulthood responsibility? The driver for the modern prolongation of adolescence is the changed environment - the demands placed upon learning by the increased complexity of the human knowledge base. The increased complexity of tools we now use require longer learning and the adequate transmission of cultural knowledge simply takes more time. To counter the impact of the demands of this changed environment, we need to create natural protective adaptations which promote processes that enable connections, enhance agency and strengthen the social network. This is the touchstone of we-ness and a mentalizing informed approach.

The increased impulsivity, risk-taking and the prioritisation of peer group interactions in adolescence represent an adaptation to facilitate moving away from reliance on caregivers towards becoming an individual that in turn necessitates complete reconfiguration of self-structures to encompass physical and sexual maturation. The task of adolescence is to integrate a vastly changed

body, to manage increased sexuality, to accommodate enhanced emotional intensity and to deal with a greater capacity for symbolic and abstract thinking in organising a sense of oneself and one's relationships at the same time as being equal to the massive pressures that the sometimes intensely competitive nature of peer relationships impose with additional psychosocial demands for creating separation and autonomy and developing a distinct adult sense of self. How can we expect young people to achieve this on their own? Within the historical context of hunter-gatherer socialisation, the function of the community around the individual was to manage the 'perfect storm' of adolescence: the neurodevelopmental progression of mentalizing brain circuits that are undergoing pruning and may therefore be less able to modulate arousal and emotion and respond to the demands of the limbic system. This, in turn, generates increasingly intense emotional experiences linked to a desire for novelty and stimulation. In brief, the adolescent without adult support may often be inadequate to the tasks that we require of them. Perhaps the hypermentalizing (Sharp et al., 2013; Sharp et al., 2016), the excessive theory of mind, the tendency to make groundless inferences about the mental state that go so far beyond observable data that others may struggle to see how they are justified is a signal of the evolutionary mismatch that we have created for our young people and the source of the mental health risk which young people in the early 21st-century face.

That they deserve better support and social networking than they currently receive is hard to deny. Yet there must be reasons for this gap in appropriate support, and these may point up a second, perhaps even more pernicious, social process. There is a clash of generations between baby boomers (and the children of baby boomers) and the adolescents and young adults of today. The increased focus on the parent-child interaction in the second half of the 20th century, the dyadic concern of parents for infants, focused on enhancing self-agency may have had many desirable social outcomes in the form of reducing the cognitive and psychological disadvantages of neglect but perhaps also had some undesirable social consequences when it comes to the capacity of the child of the baby-boomer parent to engage in their own parenting.

Transgenerational transmission of this enhanced dyadic focus, which seems well established by now, and has undoubtedly improved the early years of infants and toddlers across society. But has the same pattern improved these parents' capacity to empower the next generation to achieve independence and overtake them as well as taking over from them as is nature's template for all living beings? I believe that here we encounter a problem. The same developmental pressures that have placed the infant at the centre of the socialisation process taking energy and attention away from the we-mode of the community and the social network, that same psychological pressure for self-importance may make that individual when older be less willing to step aside and give over power and authority to the emerging young. A simpler account for or a separate contributor to the evolutionary mismatch is, of

course, increased longevity. As we live healthy lives for decades longer than has been the case in the environment of biological adaptation, evolution may not have prepared us to willingly relinquish our authority when perfectly fit and move over to our biologically prepared grandparenting mode. The narcissism of Western culture, probably rooted in the nuclear family and the valorisation of mother-infant interaction has perhaps served to undermine fresh opportunities for adolescents and young adults because of parents' attitudes to the challenge of the next generation of adults. It is generally recognised that the current generation of noughties is likely to be the first that is worse off than the generation that has preceded it, at least since we have focused on this particular indicator of transgenerational progression.

Our response to Covid-19 is perhaps an example of the way, for the most justifiable and humanitarian motives, the interests of the older generation have been prioritised across the globe over the interests of the young. Young people are less affected by the coronavirus than those in middle-age and above. In fact, under 45 excess deaths have decreased since Covid-19 in contrast to older adults whose lives are seriously at risk of being shortened by the virus. The public health initiative, at least in all Western cultures, appears to have prioritised the older generation against the young. As an adult in my late 60s, I have little to complain about. However, it is striking that rather than making my generation and a few above and below responsible for looking after ourselves and keeping ourselves safe, we forced young people to adopt an unnatural set of strategies of social isolation with the primary function of protecting the older generation from disease and a painful and uncomfortable death.

So, I see the increased prevalence of adolescent mental health less as a manifestation of the neurobiological changes, characteristic of that age group, and more of a consequence of social change consequent on preceding social changes that have prioritised the individual above the social group. It is hardly surprising that the sense of self-focus and the assumption of being of deserving of our central place might have translated at least in part into a way we treat the generation below us and in turn that generation experiences a sense of gloom, anxiety and hopelessness, feeling unsupported to some measure and abandoned by us to manage on their own in a social environment where competition has just become much harsher: they have all the 60-year-olds to contend with along with their peer group and beyond.

References

Bowlby, J. (1969). *Attachment and Loss, Vol. 1: Attachment*. London, UK: Hogarth Press and Institute of Psycho-Analysis.

Bowlby, J. (1973). *Attachment and Loss, Vol. 2: Separation: Anxiety and Anger*. London, UK: Hogarth Press and Institute of Psycho-Analysis.

Dunbar, R.I.M., & Sosis, R. (2018). Optimising human community sizes. *Evolution and Human Behavior*, *39*(1), 106–111. doi: 10.1016/j.evolhumbehav.2017.11.001.

Fancourt, D., Bu, F., Mak, H.W., & Steptoe, A. (2020). *UK covid-mind study: Results Release 3* (pp. 1–23). London: University College London.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York, NY: Other Press.

Fonagy, P., & Luyten, P. (2019). Fidelity vs. flexibility in the implementation of psychotherapies: Time to move on. *World Psychiatry*, *18*(3), 270–271. doi: 10.1002/wps.20657.

Gilbert, P. (2019). Distinguishing shame, humiliation and guilt: An evolutionary functional analysis and compassion focused interventions. In C.-H. Mayer & E. Vanderheiden (Eds.), *The Bright Side of Shame* (pp. 413–431). Cham, Switzerland: Springer Nature Switzerland.

Hayes, S.C. (2015). *The Act in Context: The Canonical Papers of Steven C. Hayes*. New York, NY: Routledge.

Hrdy, S.B. (2013). The 'one animal in all creation about which man knows the least'. *Philosophical Transactions of the Royal Society of London, Series B: Biological Sciences*, *368*(1631), 20130072. doi: 10.1098/rstb.2013.0072.

Keller, H. (2018). Universality claim of attachment theory: Children's socioemotional development across cultures. *Proceedings of the National Academy of Sciences of the United States of America*, *115*(45), 11414–11419. doi: 10.1073/pnas.1720325115.

McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (Eds.). (2016). *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds, UK: NHS Digital.

Murphy, M., & Fonagy, P. (2013). Chapter 10: Mental health problems in children and young people. *Our children deserve better: prevention pays: Annual report of the Chief Medical Officer 2012* (pp. 176–188). London, UK: Department of Health.

Rossouw, T.I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(12), 1304–1313. doi: 10.1016/i.jaac.2012.09.018.

Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., & McManus, S. (2018). *Mental Health of Children and Young People in England, 2017: Trends and characteristics*. Leeds, England: Health and Social Care Information Centre. (NHS Digital).

Sharp, C., Ha, C., Carbone, C., Kim, S., Perry, K., Williams, L., & Fonagy, P. (2013). Hypermentalizing in adolescent inpatients: Treatment effects and association with borderline traits. *Journal of Personality Disorders*, *27*(1), 3–18. doi: 10.1521/pedi.2013.27.1.3.

Sharp, C., Venta, A., Vanwoerden, S., Schramm, A., Ha, C., Newlin, E., … Fonagy, P. (2016). First empirical evaluation of the link between attachment, social cognition and borderline features in adolescents. *Comprehensive Psychiatry*, *64*, 4–11. doi: 10.1016/j.comppsych.2015.07.008.

Tomasello, M. (2019). *Becoming Human: A Theory of Ontogeny*. Cambridge, MA: The Belknap Press of Harvard University Press.

Tuomela, R. (2005). *We-intentions revisited*. *Philosophical Studies*, *125*(3), 327–369. doi: 10.1007/s11098-005-7781-1.

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Introduction

Trudie Rossouw, Maria Wiwe, and Ioanna Vrouva

The following dialogue between teenager Agnes and her father Olof is an excerpt from the Swedish movie 'Show me love' (the original Swedish title being 'Fucking Amal'), written and directed by Lukas Moodysson (1998). Olof, a caring father, is trying to comfort his daughter Agnes, who is feeling lonely and isolated following friendship struggles.

Olof: 'When our class met, I think it was our 25-year reunion, then they all found out that I had done very well for myself. Bengt, who was then the class king, he hadn't amounted to anything at all, really. Also, the girls who were considered the prettiest, they were not special any longer. You see, I think you should be glad that you do not have it so easy. Because those who have it easy often become quite uninteresting people in the end'.

Agnes: 'But you're speaking about 25 years' time. I'm sorry Dad, but I'd rather be happy now than in 25 years'.

Well, who would want to wait 25 years for better days? Adolescents, with their intense and highly present way of viewing life, can be rightly sceptical of adult advice and "wisdom". They long for connections with peers that will help them develop their sense of self and identity, but as many of us can still quite vividly remember, this process is far from painless, fraught with experiences of confusion, rejection, and humiliation. Understandably, adapting to the changing and often contradictory needs of adolescents presents their parents (and teachers) with multiple challenges. And when it comes to being an adolescent's therapist, pressures such as establishing an alliance in the face of high ambivalence, negotiating ruptures, preventing treatment dropout and managing multiple risks can test the most experienced clinicians. At the same time, the opportunity to follow these fascinating young people in their endeavour to connect with the people around them and find themselves and their place in life can be among the most rewarding experiences of our professional life.

The adolescent phase is tremendously significant and presents every young person and family with unique vulnerability, as well as opportunity. With every

aspect of the adolescent mind and being under construction, and simultaneous changes in their neurochemistry, bodies and psychosocial worlds, the adolescent years, now understood to continue into our 20 s, is an uncertain, unsteady and often unsettling period of life. Changes associated with brain development leave the young person more prone to strong affect storms, but with an underdeveloped capacity to regulate and navigate them. Adolescents are uniquely sensitive to the facial expressions of other young people (Moore et al., 2012) and perceived rejection, and present with higher risk-taking behaviour as they seek stimulation and peer approval (Steinberg, 2008).

It has long been established that adolescents often feel lost and torn between their dependence on, and their disdain for their parents and other adult authority figures coupled with their pull to their peer group, amidst significant anxiety about not fitting in, not knowing who they are and what they want. Changes in social understanding and increased self-conscious awareness can result in the insecurity and anxiety of childhood being replaced by feelings of shame and self-hatred in adolescence. It is no wonder that 50% of adult mental illness originates in adolescence (Kessler et al., 2005), and internalising and externalising mental health problems such as depression, eating disorders, substance abuse, conduct disorder and psychosis typically first present in this period of life.

However, adolescence is not just a period of increased vulnerability, but also a time of great opportunity. Many great minds emerged in their adolescent years, such as Michelangelo, Mary Shelley and Ada Lovelace, whereas more recently a once struggling teenager, Greta Thunberg, succeeded at inspiring and mobilising people in all age groups worldwide to take protective action for the future of our planet.

So, what are the factors that can turn vulnerability into opportunity and strength? What are the essential components of mental health and personal growth in adolescence? At the heart of this book is the tenet that strengthening mentalizing development in this neurobiologically and psychosocially critical period of life not only alleviates distress, but also increases resilience (Fonagy, Luyten, Allison, & Campbell, 2016). The term mentalizing, first used by Peter Fonagy in 1989, refers to our ability to understand behaviour in terms of mental states, namely attribute psychological meaning to actions, and also make sense of our own internal and interpersonal experiences. Conceptualised as a developmental construct (Fonagy, Gergely, Jurist, & Target, 2002), mentalizing was applied clinically by Peter Fonagy, Anthony Bateman and their colleagues in the development of mentalization-based treatment for adults with borderline personality disorder (Bateman & Fonagy, 2004). MBT was further developed by clinicians and researchers worldwide for several other mental health conditions in adults (Bateman & Fonagy, 2019), with mentalizing becoming a transdiagnostic concept (Luyten, Campbell, Allison, & Fonagy).

MBT was also developed for interventions with young people (Midgley & Vrouva, 2012), including children (MBT-C; Midgley, Ensink, Lindqvist,