Title: Mentalization-Based Treatment for Adolescent Depression

Authors:

Patrick Luyten, Ph.D.
Faculty of Psychology and Educational Sciences, KU Leuven, Leuven, Belgium
Research Department of Clinical, Educational and Health Psychology, University College London, London, UK

Saskia Malcorps, PhD,
Faculty of Psychology and Educational Sciences, KU Leuven, Leuven, Belgium

Peter Fonagy, O.B.E., F.Med.Sci., F.Ac.S.S., F.B.A., Ph.D.
Research Department of Clinical, Educational and Health Psychology, University College London, London, UK

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Corresponding author:

Prof dr Patrick Luyten

Faculty of Psychology and Educational Sciences
KU Leuven
Tiensestraat 102 pobox 3722
Leuven
Belgium

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Abstract

Depression is a very common mental health problem in adolescence. Although over the past decades a number of psychological interventions for depression in adolescence have been developed and empirically evaluated, recent systematic review and meta-analyses suggest that there is considerable room for improvement of their effectiveness. This is particularly true for the treatment of adolescents with "complex" depression, that is, those where depression is embedded within broader personality and relational problems, often related to a history of attachment trauma. Mentalization-based treatment (MBT) may be particularly effective in these cases, as it has a strong focus on temporary or long-term impairments in mentalizing (i.e., the capacity to understand the self and others in terms of intentional mental states), which are very typical of adolescents with depression. This paper outlines a continuum of severity of depression as seen from a mentalizing perspective, ranging from the mild and moderate to the more severe end of the spectrum. This is followed by a summary of the mentalizing approach to the understanding of depression along the spectrum of severity, the empirical evidence supporting this approach, and a description of the basic principles of MBT for depression. We close this paper with some thoughts about the future of MBT in the treatment of depression in adolescents.

Depression is an extremely common mental health problem that can affect individuals at any age (Collins et al., 2011). Depression is therefore best considered from a developmental perspective (Luyten & Fonagy, 2018; Luyten & Fonagy, 2021). This paper focuses on the understanding and treatment of depression in adolescence, a pivotal developmental stage in terms of both prevention of, and intervention with, depression. Depression typically has its first onset in adolescence (Birmaher et al., 1996; Costello et al., 2006), with epidemiological studies suggesting that between 3% and 8% of children and adolescents meet criteria for clinical depression. Adolescence is also associated with the emergence of sex differences in the prevalence of mood disorders, with women being twice as likely as men to be diagnosed with depression from adolescence onward (see Angold et al., 2002; Birmaher et al., 2007).

Although a number psychotherapies for adolescents with depression have been developed and empirically validated (Cuijpers, Karyotaki, et al., 2020; Cuijpers, Stringaris, et al., 2020), a recent meta-analysis, comprising 40 randomized trials comparing psychotherapy for adolescent depression against control conditions, reported that only about 50% of adolescents with depression show clinically significant improvement, compared with 32% in control groups (Cuijpers et al., 2023). Recovery was achieved by 58% of adolescents in psychotherapy compared with 36% of those in control conditions .Hence, there is considerable room for improvement (Weisz et al., 2023), particularly in more “complex” cases, that is, those where depression is embedded within broader personality and relational problems (Weisz et al., 2017). For instance, studies suggest high levels of (attachment) trauma in adolescents with depression, with emotional abuse and emotional neglect demonstrating the strongest associations with depression (Humphreys et al., 2020). Mentalization-based treatment (MBT) may be particularly effective in these cases, as it has a strong focus on temporary or long-term impairments in

mentalizing that are typical of adolescents with these types of problems, including those with substantial personality disorder features and/or a history of attachment trauma (Luyten, Campbell, & Fonagy, 2020; Luyten & Fonagy, 2014, in press; Smits, Luyten, et al., 2022).

Table 1 depicts a continuum of severity of depression as seen from a mentalizing perspective, illustrated with clinical vignettes in Box 1, divided into (a) the nature of depressive experiences, (b) the extent of mentalizing impairments, (c) the dominant attachment style (i.e., organized versus disorganized attachment strategies) used by individuals in response to adversity and distress, and (d) the severity of impairments in *epistemic trust*—the capacity to trust others as a source of knowledge. Although adolescents with depression toward the less severe end of the spectrum often require a focus on the recovery of their capacity for mentalizing, as discussed in more detail in this article, MBT approaches are likely to be most helpful for adolescents with more severe and chronic impairments in mentalizing and a high degree of epistemic mistrust (Luyten & Fonagy, 2018; Luyten & Fonagy, 2021; Luyten & Fonagy, in press). These individuals often not only lack the mentalizing capacities needed for the more interpretive focus that is typical of many psychodynamic approaches; they also typically find it difficult to establish a therapeutic alliance as a result of their problems with epistemic trust and trust in a more general sense (Fonagy et al., 1993; Luyten et al., 2013). Moreover, their mentalizing difficulties and problems with epistemic trust also impact the negotiating of developmental tasks both in the relational domain (i.e., the establishment of interpersonal relationships, including romantic relationships) and in the achievement domain (i.e., school and work) (for a more detailed discussion, see Luyten & Fonagy, 2018). Their combination of mentalizing difficulties and often high levels of epistemic distrust also compromises their capacities for (social) learning, including the social learning that is needed to allow them to use treatment effectively (see also Box 1). For

instance, in a recent prospective study in 377 students we found that impairments in mentalizing assessed as the start of the academic year were prospectively associated with increases in the prevalence and severity of depression at the end of the semester (De Coninck et al., 2021). Moreover, in another study we found that impairment in mentalizing and increased epistemic vigilance mediated the relationship between childhood adversity and acting-out behaviors in a large sample of adolescents oversampled for risk status for psychopathology (N = 451, mean age = 15.40 years), explaining about 40% of the total variance (Malcorps et al., in press). Taken together, these findings stress the importance of a focus on improving mentalizing abilities and lowering epistemic distrust in psychotherapeutic work with adolescents with depression, and particularly in those who have a history of childhood trauma. Hence, the recovery of mentalizing is a primary aim in the treatment of these adolescents and may also be helpful in addressing the high prevalence of acting out, including self-harm and parasuicidality among these patients. Consistent with these assumptions, MBT has been associated with medium to large effect sizes in reducing depression in patients with these more "complex" types of depression (Leichsenring, Luyten, Abbass, Rabung, et al., 2021; Leichsenring, Luyten, Abbass, & Steinert, 2021; Storebø et al., 2020) as well as self-harm (Motz et al., 2023). Finally, MBT has a central focus on engaging the social network and social environment of the adolescent more generally (Luyten, Campbell, Allison, et al., 2020). This approach is not limited to engaging caregivers in the adolescent's treatment, but includes actively reaching out to other key figures in their environment (e.g., teachers, neighbors, friends) as a key component of the treatment (Bevington et al., 2015; Vliegen et al., 2023). This approach is consistent with the view that therapeutic change should primarily foster *salutogenesis*, that is, the adolescent's capacity to derive benefit from their social environment (Fonagy et al., 2017; Luyten, Campbell, Allison, et al., 2020). This

often entails helping the adolescent to make changes to their social environment, which is also central in the Adaptive Mentalization Based Integrative Treatment informed care for adolescents (AMBIT) approach (Fuggle et al., 2023).

This paper first outlines the mentalizing approaches to depression. This is followed by a brief description of the basic principles of MBT for depression, illustrating this approach for adolescents with more severe complex clinical presentations, and those in the mild to moderate spectrum. We close with some thoughts about the future of MBT in the treatment of depression in adolescents.

Depression in Young People: A Mentalizing Perspective

Mood and Mentalizing

The mentalizing approach to depression is founded in views that consider depression to be an evolutionarily determined response to threats to attachment relationships (e.g., experiences of separation, rejection, loss, or failure), which tend to negatively influence and distort the capacity for mentalizing (Luyten & Fonagy, 2021). The depressed young person tends to become trapped in a vicious cycle in which depressed mood leads to increasing levels of internal conflict, distress, and arousal, which in turn lead to further impairments and distortions in mentalizing, culminating in an (often complete) loss of resilience.

The primary therapeutic task in the early stages of a mentalizing-focused treatment is therefore to interrupt this vicious cycle by restoring the adolescent's capacity to mentalize. This may take considerable time and effort, as depression not only impairs the adolescent's motivation to mentalize ("It is all useless, why should I talk about myself?") but also distorts this capacity ("It is simple: I am useless", or "The teachers at my school are causing my problems; they don't understand me"). At this stage, insight-oriented approaches are likely to do more harm

than good for the adolescent, as they rely on a capacity that is largely absent, either temporarily (because of the adolescent's depressed mood) or more chronically (because of a history of attachment trauma). Moreover, these types of interventions might communicate to the adolescent that the therapist does not understand them, which negatively impacts the therapeutic relationship, as demonstrated by a number of highly interesting qualitative studies of depressed adolescents' experience of psychotherapy (Housby et al., 2021; Li et al., 2022; Wilmots et al., 2020). Stated otherwise, particularly in the early stages of treatment, there is a focus on improving the *process* of mentalizing rather than attempting to provide insight into the *content* of the (interpersonal) dynamics involved in depression. This is achieved, as described in more detail later in this paper, through normalizing and validating interventions, in combination with the identification of so-called non-mentalizing modes of functioning.

In adolescents with depression, the emergence of *psychic equivalence* functioning is extremely common, expressed in a lack of desire and/or inability to explore inner mental states. In psychic equivalence, the individual *is* beyond help, they *are* worthless, there *is* no future and things *are* what they are—bad. In addition, in psychic equivalence mode, psychological pain feels like physical pain, and emotional and physical exhaustion are equated, which in part explains the high comorbidity between depression and chronic pain and fatigue conditions (Luyten & Fonagy, 2020). This experience is primarily expressed in impairments in embodied mentalizing: worries feel like a painful weight on one's shoulders, criticism by others really hurts, depressive thoughts literally "press down on" the self, emotional conflicts seem to "paralyze" the patient. *Hyperembodiment* is typical in many young people with depression, as subjective experiences are experienced as "too real" and are felt in terms of bodily experiences. However, as discussed in more detail later, the adolescent is often barely aware of the connection

between these embodied states of mind and their presenting problems. Studies have shown impairments in neural circuits implicated in (embodied) mentalizing in patients with depression, including the medial prefrontal cortex, amygdala, hippocampus, and ventromedial parts of the basal ganglia, reflecting an imbalance between the cognitive and affective aspects of mentalizing (Luyten & Fonagy, 2018, in press).

As the symptoms of depression reflect responses to threats to attachment relationships, their interpersonal nature should not be ignored. For instance, rumination and self-criticism clearly have an interpersonal function, as they "call" for attention and help, and thus reflect attempts to co-regulate arousal and stress. Interventions that involve empathic mirroring of feelings of helplessness, hopelessness, or worthlessness can be particularly helpful in the early stages of treatment, as they may lead to the recovery of mentalizing by restoring feelings of agency and selfhood (as well as fostering epistemic trust). This was borne out by a recent qualitative study of the experience of therapy of adolescents with depression (Li et al., 2022). Such holding and containing interventions signal to the adolescent patient that even "unbearable" emotions can be discussed and reflected upon. Communicating the tolerability of affect is essential when working with depressed patients, particularly adolescents, as many of them are convinced that they should be able to bear painful feelings and/or are so ashamed of them that they do not want to admit to and talk about them. Psychoeducational interventions concerning the influence of mood on mentalizing may also be helpful, just as psychopharmacological treatment, exercise, improving sleep, and a healthier lifestyle in general may be helpful in the recovery of mentalizing.

Psychic equivalence functioning may also increase the risk for suicide in an attempt to silence psychological pain. Again, careful mirroring of unbearable feelings of psychological pain

typically lead the adolescent to open up about opposite feelings, that is, the wish to live, which decreases the risk of suicide, as such interventions restore the patient's mentalizing and reduce the "tunnel vision" that is typical of suicidal states of mind.

Teleological mode functioning in adolescents with depression is often related to the origins of depressed states, consistent with the mentalizing approach's assumption that depression is interpersonal in nature. For example, adolescents with depression often show frantic attempts to get attachment figures (including their therapist) to show that they care for or like them. For example, they may demand more or longer sessions, or ask their therapist to caress or hug them. Yet, in teleological mode, the adolescent may deny that there is any relationship between their depressed mood and relational problems, or try to limit the interpersonal origin of their problems to simplistic cause–effect relationships ("Depression runs in my family, it must be genetic", "I have been abused, I can't help it", "I am diagnosed with depression, which is why I feel so bad").

Extreme pretend mode or *hypermentalizing* functioning in adolescents with depression is very common too and can lead to hypomentalizing–hypermentalizing cycles that may confuse both the adolescent and their therapist, leaving them both feeling empty, frustrated, bored and helpless. In adolescents, hypermentalizing takes the form of very elaborate narratives involving the self and others. These narratives may at first appear to be fairly accurate accounts reflecting genuine mentalizing, particularly in patients who are higher functioning. Similarly, it is often hard for the therapist to distinguish between genuine reflections on existential questions that are often very central in adolescents' subjective experience, and those that are rooted in hypermentalizing.

However, hypermentalizing accounts can be distinguished from genuine mentalizing by a number of telltale features: (a) they are typically overly analytical, repetitive, and lengthy in nature, and are distorted by depressive themes such as self-criticism, guilt, and shame (e.g., excessive rumination); (b) they may be self-serving (e.g., to control or coerce others, or to picture oneself as the victim of neglectful others), which often leads to feelings of frustration or boredom in the therapist; (c) they have an imbalance between cognition and affect that is characteristic of hypermentalizing (i.e., they are either overly cognitive in nature or affectively overwhelming); and (c) the patient shows an inability to switch perspective from self to other or vice versa, or from cognition to affect, even when the therapist attempts to shift the young person's perspective using "contrary moves" interventions (e.g., shifting the focus from self to others or from cognition to affect).

In this context, it is also important to discuss the nature of *depressive realism*, meaning that some adolescents with depression may look at the world through less "rose-tinted glasses" than many adults and non-depressed adolescents, and thus their perception may actually be more accurate than that of non-depressed people. However, depressive realism is not always more "realistic" as it may reflect either hypomentalizing or hypermentalizing. Studies suggest that a positive bias is normative and conducive to healthy functioning (Moore & Fresco, 2012), and the loss of this positive bias seems to be implicated in vulnerability to depression.

Hence, from a more existential perspective, it seems there is a flip side to the capacity for mentalizing and increased self-awareness and self-consciousness, as both enable self-conscious emotions such as regret, shame, and guilt. The capacity for self-consciousness, which emerges more fully in adolescence, enables the awareness that there may be a difference between one's current self-state and one's wished-for self-state (Luyten et al., 2012). This difference may be

experienced by adolescents as very painful ("I am sitting here on the bus on my way to school for yet another boring day; is this how it's going to be for the rest of my life?"). It is well established that neural circuits involved in mentalizing undergo major structural and functional changes in adolescence; at the same time, mentalizing capacities are seriously challenged by increasing demands related to both achievement and relationships and increasing self-awareness (Luyten & Fonagy, 2018). The emergence of sexuality and new forms of aggression further challenge the adolescent's mentalizing capacities. As a result, hypermentalizing may develop ("What if I had different parents; what if I had been born in a different country?") or, conversely, the defensive avoidance of mentalizing (hypomentalizing) ("I am not interested in talking about myself").

The Role of Attachment and Personality in Explaining Heterogeneity in Adolescents with Depression

The attachment system plays a key role in the regulation of distress. Research has demonstrated difference in the use of so-called primary and secondary attachment strategies in this context. The primary attachment strategy involves seeking proximity to others to find relief, support, love, and understanding. Secondary attachment strategies are activated when the primary attachment strategy fails and/or when other people are not available to provide support (Mikulincer & Shaver, 2017, 2019). Secondary attachment strategies involve hyperactivating and deactivating strategies, or a combination of both. Attachment hyperactivating strategies entail desperate efforts to find support, love, and relief, and are typically used by individuals with preoccupied attachment styles. Attachment deactivation strategies involve the denial of attachment needs and assertion of one's own autonomy, agency, independence, and strength, as

used by individuals with fearful-avoidant and dismissive attachment styles. Individuals with disorganized attachment show marked oscillations between the two types of strategies, and typically present with more complex problems.

The role of these attachment dimensions in explaining vulnerability for depression is well supported by research (Brown et al., 2019; Dagan et al., 2018; Khan et al., 2020; Luyten & Fonagy, in press; Luyten et al., 2012; Spruit et al., 2020). Attachment hyperactivating and deactivating strategies also overlap both conceptually and empirically with the personality dimensions of dependency (or sociotropy) and self-critical perfectionism (or autonomy), respectively (Beck, 1983; Blatt, 2004; Blatt & Luyten, 2009; Luyten & Blatt, 2013). More than four decades of research suggest that these two attachment/personality dimensions are not only related to increased risk for depression but also may differentially impact on the therapeutic process and outcome. From a mentalizing perspective, two sets of findings are important here.

First, with regard to the content of dynamics in adolescent depression, these personality/attachment dimensions are associated with distinct dysfunctional interpersonal transactional cycles (or self-fulfilling prophecies) in relationships, which also tend to re-emerge in the therapeutic relationship (Luyten et al., 2006). Adolescents with high levels of dependency/sociotropy/attachment anxiety tend to elicit frustration, resentment, and eventually rejection and abandonment by others because they are often overly anxious and clinging in interpersonal relationships; these responses by others simply confirming their underlying fears that they will be rejected and abandoned. Adolescents with high levels of self-criticism/autonomy/attachment avoidance tend to be critical and disapproving of others; this leads them to be perceived by others as distant and less likeable, which in turn confirms their beliefs that others are unavailable, critical, and distant.

Second, attachment/personality dimensions also determine to a large extent the quality of mentalizing, which is important from a more process-oriented perspective. More self-critical/avoidant adolescents with depression often have a strong tendency to defensively inhibit mentalizing, which leads to a derogation of mental life as such ("I can't see the relevance of talking about myself"). Cognitive mentalizing predominates, without much, or even any, affective grounding of experiences, and these adolescents often seem completely disconnected from their embodied psychic reality. By contrast, depressed adolescents with more dependent/anxiously attached features may be highly sensitive to signs of rejection and abandonment, and as a result they often have a low threshold for decoupling mentalizing. Their mentalizing is strongly affect driven, often leading them to relate overwhelming, hypermentalized narrative accounts of their interpersonal relationships.

In the early stages of treatment, the focus therefore needs to be on strengthening these adolescents' mentalizing capacity by an emphasis on issues that are congruent with their personality functioning (i.e., themes related to autonomy, identity, power, guilt, shame, and worthlessness in self-critical patients, and fears about rejection and abandonment in dependent individuals). Careful validation and normalizing of experiences and anxieties related to these experiences in particular (e.g., the fear that others will abandon or criticize them) is likely to strengthen these patients' capacities for mentalizing about these experiences and their roots in the patient's developmental history.

The micro-slicing of recent interpersonal events might play a particularly important role in this context, as this approach typically not only strengthens basic mentalizing but also leads the adolescent patient to experience feelings that they have difficulty admitting to, such as anxiety and vulnerability in self-critical individuals, or frustration and anger toward loved ones

in dependent individuals. A focus on improving embodied mentalizing by exploring the relationship between bodily experiences (so-called somatic markers of emotions) and unmentalized states of mind, using a "not-knowing", inquisitive stance, may be particularly helpful too, particularly when working with patients presenting with somatoform features (Luyten & Fonagy, 2020). Mentalizing the therapeutic relationship—identifying the adolescent's responses to the therapist in the here-and-now of the therapeutic situation—may further improve their basic mentalizing and relational mentalizing capacities. Finally, encouraging adolescent patients to experiment with new ways of relating to the self and others in their everyday life outside the treatment room is a central component of MBT for adolescents with depression as treatment progresses; this enables the patient and therapist together to monitor progress in the emergence of more robust mentalizing as well as the extent to which therapeutic changes have extended into the patient's life in general. This process may involve a systemic component, as explained in more detail in the section on mentalization-based interventions along the spectrum of depressive experiences.

Epistemic Trust

A considerable subgroup of adolescents with depression presents with difficulties in the capacity for epistemic trust, which is particularly the case for individuals with a history of early adversity and/or previous unhelpful treatments (see Table 1). Depression in itself is associated with social withdrawal, and epistemic mistrust only reinforces depressed adolescents' tendency to close themselves off from others and from salutogenic processes (including psychotherapy). Studies focusing on a general psychopathology factor which in itself is highly correlated with early adversity also bear this out (Laceulle et al., 2020).

A process focus is much more likely to counter these patients' feelings of often profound epistemic distrust than an insight-oriented or content focus. Careful validation and normalization in the context of marked mirroring of feelings of depression and despair is needed before any meaningful work can be done, as it signals to the patient that the therapist's mind is able to tolerate, contain, and reflect upon mental states that the patient believes to be unbearable. These experiences will not only generate for the patient a feeling of being understood, but also of agency and control, as a result of which their epistemic vigilance will be relaxed. This will also generate a sense of "we-ness" in the treatment, which not only increases the adolescent's mentalizing capacities but might also enable a shift toward a content or mental representation focus.

Mentalization-Based Interventions Along the Spectrum of Depressive Experiences

The current spectrum of mentalization-based interventions includes (a) Dynamic Interpersonal Therapy (Lemma et al., 2024), a brief (16-session) manualized treatment for depression that combines a mental process focus and a mental representation focus for patients in the mild-to-moderate range of the spectrum (Fonagy et al., 2020); (b) Dynamic Interpersonal Therapy for Complex Care (Rao et al., 2019), which is slightly longer (26 sessions) and has a greater process or mentalizing focus than brief Dynamic Interpersonal Therapy, which makes it more suitable for patients with more severe impairments in mentalizing and epistemic trust; (c) MBT for personality disorders, which has been shown to be particularly effective in reducing depression, self-harm, and suicidality in both adults (Bateman & Fonagy, 2008; Smits, Feenstra, et al., 2022) and adolescents (Feenstra et al., 2012; Rossouw & Fonagy, 2012); and (d) MBT for psychosis, which may be a suitable approach for patients with depression who also present with

psychotic symptoms (Brent et al., 2014; Debbané et al., 2016; Salaminios et al., 2024; Weijers et al., 2021). In the following sections, we briefly outline the treatment principles of MBT for personality disorders and Dynamic Interpersonal Therapy to illustrate some of the key principles of mentalizing-focused treatments for depression across the spectrum of severity.

Mentalization-Based Treatment for Patients with Moderate to Severe Depression

MBT is a highly structured treatment approach that combines individual and group therapy, and which has been offered as an outpatient program 2 days per week or a day-hospitalization-based treatment 5 days a week (Bateman et al., 2023; Blankers et al., 2023; Smits et al., 2020). Treatment typically lasts 9–12 months, and is followed by a less intensive treatment phase for up to 18 months after the start of treatment. A recent Cochrane meta-analysis, MBT in adults with borderline personality disorder, who typically present with more 'complex' depression, was found to be superior to treatment as usual in reducing self-harm, suicidality and depression with moderate to large effects at long-term (>12 months) follow-up (Storebø et al., 2020). Another meta-analysis showed that MBT was associated with large effect sizes (SMD=1.03) in reducing suicidality in persons with borderline personality disorder (Rameckers et al., 2021). A recent trial compared 5- and 14-month programs of MBT in adults with marked personality dysfunction and found no differences in treatment outcome, although within-group effect sizes were more modest than in most other trials (Juul et al., 2023). This was also the case in a trial of MBT in adolescents that examined only group treatment (in which there were high rates of non-attendance in the group therapy component) (Jørgensen et al., 2021). In studies of adolescents by Rossouw and Fonagy (2012), which combined weekly individual MBT with mentalization-based family therapy (MBT-F), and Laurenssen et al. (2014), which combined

individual and group treatment with monthly MBT-F, effect sizes were substantially larger and in line with findings in samples of adults. These studies point to the importance of both individual and family treatment, the possible role of treatment length and treatment adherence, implementation issues, and the interaction of all these factors in determining the effectiveness of MBT in adolescents.

As discussed in the previous sections, MBT for depression first and foremost focuses on improving the capacity for reflective functioning. This entails a focus on the near-conscious experiences in the here-and-now or recent past, based on a discussion of emotional and relational experiences (i.e, the affect-focus typical of MBT). This consistent focus on mental states driving behaviors and experiences (rather than aiming to offer insight into the developmental origins of these experiences) brings back meaning and coherence in the adolescents' internal world. Experiences of marked mirroring in particular are likely to restore feelings of agency and autonomy and as a result the capacities for mentalizing and epistemic trust. To achieve this, the MBT therapist adopts a not-knowing, inquisitive stance ("I cannot read your mind, but I am interested to learn about you and your mind"). Such a therapeutic stance counters the psychic equivalence functioning of many depressed young people, characterized by hypomentalizing and/or excessive certainty ("Everybody thinks I'm useless").

As is well-known, the starting point of MBT interventions is when there is a break in mentalizing (i.e., psychic equivalence, pretend mode, or teleological mode functioning) (e.g., psychic equivalence: "Nobody is interested in me"). The the patient and therapist then "rewind" to the moment when the break in mentalizing occurred, followed by a joint exploration of the adolescents' current affective state (affect focus) using elaboration, challenge and clarification ("You started talking about school, and suddenly you became very sad and self-critical, do I get

that right?"). In MBT, the potential contribution of the therapist to the loss of mentalizing is identified and acknowledged ("So when I then asked you how you felt at school, this only made you feel worse because you felt that I was criticizing you?"). The therapeutic relationship may be used in this context, not in an attempt to increasing insight, but to foster mentalizing and to communicate humility and the possible role of the therapist in the lapse in mentalizing ("So then things started to become more difficult between us, I apologize, this was my fault, I didn't realize when I asked you about school that you felt I was criticizing you. I should have realized this sooner").

Particularly in adolescents with depression, the MBT therapist needs to be alert to avoid the need to understand everything the adolescent relates, as pretend mode functioning is quite common in adolescents with depression ("I am sorry, I am not sure what you are talking about, can we go back to what you felt when you were visiting your friend?"). Similarly, the MBT therapist needs to be aware that depressed states of mind typically tend to undermine the therapists own mentalizing, leading to psychic equivalence functioning in the therapist ("There is nothing I can do or say to help!"), often leading an urge to intervene teleologically (e.g., "I need to *do* something, otherwise he might kill himself").

Finally, as noted, MBT for depression includes a systemic component, as many adolescents with more "complex" depression need to be actively supported in bringing about changes in their own interpersonal environment. This may entail actively involving the adolescents' social system (e.g., parents, peers, teachers, mentors, pediatricians) in the treatment, as is typical of MBT in adolescents with marked personality disorder features (Remeeus et al., 2024). Family therapy is therefore a core component of MBT in adolescents towards the more

severe end of the spectrum, as are out-reaching interventions entailing work with the adolescents' social support system outside the treatment setting.

A Mentalization-Informed Approach to Mild and Moderate Depression

Dynamic Interpersonal Therapy (DIT) may be more suited for adolescents in the mild to moderate spectrum as it combines a mental process or mentalizing approach with a more insight-oriented approach (Lemma et al., 2024). In these adolescents, mentalizing problems are often less marked and persistent (see Table 1), and as a result more insight-oriented work is often possible. This is typically achieved in Dynamic Interpersonal Therapy by the joint formulation between the patient and therapist in the first phase of treatment of a so-called Interpersonal Affective Focus, a largely unconscious repetitive pattern of relating to self and others which is associated with the onset and course of their depression. The Interpersonal Affective Focus consists of four components: (a) a representation of self (e.g., "I am useless"), (b) a representation of others ("Others are unavailable"), (c) particular affect(s) linking self and other representations (e.g., depression, anxiety, loneliness, despair), and (d) the defensive constellation of the Interpersonal Affective Focus (e.g., the adolescent has become submissive and placating to defend against underlying feelings of aggression). This pattern is then taken as the focus of the treatment and increasingly reformulated as an understandable adaptation strategy that unfortunately is also associated with high interpersonal costs. Dynamic Interpersonal Therapy has originally been developed as a 16-session time-limited treatment. A more extended 28-session format (consisting of 20 weekly sessions followed by 6 fortnightly sessions and 2 monthly follow-ups) may be more suitable for patients with more marked problems with

mentalizing and epistemic trust (Lemma et al., 2024; Rao et al., 2019). As in "traditional" MBT, the emphasis in Dynamic Interpersonal Therapy, particularly in the final phase, is on helping the adolescent to bring about changes in their environment and empowering them to consolidate changes that have been achieved in treatment. In Dynamic Interpersonal Therapy, this process is initiated by the therapist by writing a "goodbye" letter for the adolescents. This letter contains the reasons for seeking treatment, the initial agreed formulation (i.e., the Interpersonal Affective Focus), and both the progress that has been made during treatment as well as the work that remains to be done in the ending phase and after the end of treatment. This goodbye letter is then discussed in the final sessions to initiate the ending phase.

Conclusions

Depression is ubiquitous in adolescence. At the same time, there is a pressing need to develop and evaluate more effective treatments for adolescents with depression given the relatively low response rates associated with many current treatments. This is particularly the case for adolescents with more complex clinical presentations. The focus in recent years on brief treatments combined with spending cuts to mental health services has unfortunately resulted in longer-term treatment becoming increasingly unavailable for these adolescents. Similarly, there is a need to increase the effectiveness and availability of psychological treatment for those with milder problems. Findings concerning the effectiveness of internet-delivered psychodynamic treatments in adolescents (Lindegaard et al., 2020; Lindqvist et al., 2020; Mechler et al., 2022; Midgley et al., 2021) are very promising in this regard. Future research efforts should focus on investigating the effectiveness of the full range of mentalization-based interventions in adolescents with depression, including internet-delivered MBT (Luyten, 2024). In addition, more

research is needed concerning their cost-effectiveness and more efficient ways to implement these treatments in routine care should further evidence for their cost-effectiveness be found.

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Box 1. Clinical vignettes of adolescents with depression on the severity spectrum

Mild to moderate: Barbara recently broke up with her boyfriend. Her parents are very concerned about her as ever since the breakup Barbara seems to have lost all interest in life; she stays up very late, scrolling through social media on her smartphone in bed until very late, she doesn't want to eat anymore or go out with her friends, and has difficulties concentrating at school. One of her teachers recently called her mother to say that she was also worried about Barbara, as she fell asleep during one of her classes and didn't seem to care when the teacher woke her up and everyone in the class was making fun of her. During the first couple of sessions in treatment, Barbara admits feeling very lonely and anxious, and she comes to realize that she hates it that her parents are so worried about her: "I have always been the 'good daughter', I have never needed any help, but the guy I was seeing thought I was too distant and even aloof and then he broke up with me. To me, this meant that there was something fundamentally wrong with me". She was very interested to hear her therapists' thoughts about what was happening to her, and together with her therapist she relatively quickly began to realize that she tended to hide herself behind a façade of self-sufficiency, whilst in reality she desperately missed love and attention from others, and particularly from her parents. She began to be more open towards her parents and friends, which led to a notable change in how she related to herself and others. At the end of treatment, she felt more comfortable with what she called her "real self" and her relationships with others, which now also felt more genuine to her and others.

(Moderate to severe: As a child, Miley witnessed much verbal and physical violence between her parents, who separated when she was a teenager. In the first treatment sessions, she expressed her doubts about therapy and therapists in particular, as "my parents taught me that you can never trust anyone in life, so why should I trust you?". When she entered high school,

Miley began to consume alcohol excessively and had several problematic relationships in which she was emotionally abused and neglected. This made her increasingly feel empty, lonely, and frustrated as “nobody seems to love me or care for me, it’s always been like that and it will always be like that”. She also dropped out from high school, and began a job in sales, but was fired after a few weeks after she had a conflict with a colleague. In treatment, it took a long time before she began to trust her therapist. However, once she started to have the feeling that her therapist was genuinely interested in her, she began to open up about her feelings, her childhood and how difficult it was for her to grow up in a home where there was a constant threat of violence. She realized that, on the one hand, this resulted in her being constantly “on her guard” towards others, but that she also desperately longed for closeness, love and warmth. This led her to idealize the men who showed interest in her, and to become overly credulous towards them, until she realized they abused her. As her mentalizing capacities grew and her epistemic vigilance relaxed, she was able to establish a number of friendships and also entered into a stable romantic relationship with a man. She then decided to resume her studies and later found a job as a nurse which gave her much satisfaction.

Severe to very severe):. Michael recollects feeling very different and lonely as a child. For instance, he was interested in insects as a child and vividly remembered spending hours reading about them and collecting them. In early adolescence, he began to develop the delusional idea that he was not human, and as a result that he would not be able to lead a normal life. He had a profound distrust in and dislike of other people, although he could also show a naïve believe in others, of which they then often took advantage (e.g., by convincing him to buy something for them). When he turned 16, Michael became severely depressed and suicidal as he believed the world would soon end. After a brief stay at a psychiatric hospital, treatment

consisted of a combination of medication, providing structure and support, and a focus on improving his mentalizing and embodied mentalizing in particular, which enabled him to find a steady job and more stability in life, although he still felt that he was an "outsider".

Note: To protect patient confidentiality, all clinical vignettes are based on composite cases where clinical material from several patients were combined and presented as a single case.

Table 1. A spectrum of severity of depression in adolescence.

	Severity		
	Mild to moderate	**Moderate to severe**	**Severe to very severe**
Nature of depressive experiences	Mild-to-moderate severity of depression symptoms	Marked depressive symptoms, feelings of emptiness, high levels of shame and worthlessness	Delusional feelings of guilt or poverty delusions of poverty or guilt
Mentalizing impairments	Mentalizing capacities are impaired, but can be relatively easy restored	More severe impairments in mentalizing	Severe impairments in mentalizing
Nature of attachment problems	Most adolescents in this category are securely attached, but show an overreliance on attachment strategies in	Most adolescents in this category have a history of attachment problems; disorganization of the attachment	Most adolescents in this category show attachment disorganization

	response to current problems	system may be present	
Impairments in epistemic trust	Typically, secondary to depressed mood	Premorbid problems with epistemic trust	Severe problems with epistemic trust