Mentalization-Supporting Therapy for Adolescents MST-A – a further development of the Strategic Adolescent Therapy SAT/SJT

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Abstract: The following article describes the adaptation of Mentalization Supporting Therapy MST (Sulz 2021) to adolescence - grounded by Strategic Adolescent Therapy SAT/SJT.

Approaching adolescence from a developmental perspective, Mentalization Supporting Therapy MST-A, a therapy concept which combines individual and group components, first represents an attempt to adapt Strategic Behavioral Therapy SBT to this age group. In addition to symptom reduction, MST-A emphasizes effective emotion regulation and relationship building. Second it represents the adaptation of MST to adolescents. The theoretical foundations and the therapeutic foci as well as the concrete course of therapy will be outlined.

Keywords: Strategic Adolescent Therapy SAT/SJT, therapeutic relationship, therapeutic behavior, adolescents, affective-cognitive developmental theory, personality development, needs, fears, aggressive impulses, emotion regulation, relationship building, theory of mind, metacognition, mentalization, attachment, survival rule, emotion tracking, affect stage, thinking stage, empathy stage.

Disorder theory and therapy theory

Strategic Adolescent Therapy SAT/SJT was already a mentalization-supporting therapy for adolescence in a broader sense. Mentalization-supporting therapy for adolescents MST-A is a further development of SAT/SJT. It refers to developmental psychology (Kegan 1986, Pesso 2008a,b, Piaget 1978, 1995, Bischof-Köhler 2016, Oerter 2016, Sulz & Theßen 1999, 2024a,b, Walter 2016).

The focus is on the central needs of the young person, building on the need for a secure attachment. This focus corresponds to the mentalization-based approach of Fonagy et al. (2008), who view secure attachment as an indispensable prerequisite for healthy human development (Fonagy & Target 2001, Fonagy et al. 2004, Barth 2024, cf. Sulz & Milch 2012)

1.1 Attachment and autonomy

The concept of the above is derived from the developmental dynamics which are inherent in the “youth” phase of life. Based on the construct of the “developmental task”, adolescence is understood as a decisive episode for personality development in which the individuation process is given particular importance. In connection with functional or dysfunctional coping mechanisms, it is considered central to further development. Against the background of intra-individual physiological and psychological changes, the young person comes into an altered contact with the social environment around him: the increasing ability for self-reflection makes taking responsibility and self-regulation more and more possible.

Attachment and autonomy in the context of the interaction between young people and their parents are important for the (dys-)functional coping with all developmental tasks of adolescence or for the individuation process as an overall construct. The development of autonomy can only succeed if there is a secure attachment to the parents and if this results in

one's own ability to capability for attachment. Individuation requires a specific definition that cannot easily be equated with the emotional self-sufficiency of young people from their parents. Detachment becomes increasingly visible at the behavioural level, without of course the adolescents becoming emotionally distant from their parents. Successful detachment must rather be understood as a form of individuation process in which qualitative, albeit less quantitative, emotional changes occur while the attachment between parents and young people continues. In fact, emotional needs directed at parents appear to continue to exist, although their content seems to change.

Against the background of the attempt at differentiation, strategic adolescent therapy and mentalization-supporting therapy for adolescents MST-A assume here that in the phase of adolescence not only the need for autonomy but also the need for belonging are of central importance. The most important diagnostic tool for measuring attachment security is the VDS24 questionnaire “Frustrating parental behaviour”. The less their needs were frustrated by their parents, the better young people feel in their care and the more they appear to them as reliable attachment figures.

In this context, Sulz's cognitive-affective development model (1994, 2001, 2003) offers an explanatory approach according to which, depending on the individual's learning history and the associated level of development of the individual, specific needs, fears, forms of anger and personality patterns come to the fore. These represent central components or working hypotheses of SAT/SJT and MST-A, the observance of which, in addition to the concrete symptom therapy in therapeutic work, aims to promote salutogenic developmental tendencies or avert pathogenic ones.

1.2 Dysfunctional survival rule and permission-giving rule of life

SAT/SJT and MST-A are aimed at adolescents aged 13 to 18 years, although there is no specific disorder. The initial diagnoses of the patients treated at our institute according to this concept are primarily anxiety disorders (exam anxiety, social anxiety, panic disorders with and without agoraphobia), depressive symptoms with suicidal crises and self-harm, eating disorders, simple activity and attention disorders and social behaviour disorders or hyperkinetic disorders of social behaviour. Here some patients tend towards personality defects. It is not uncommon for underlying dyslexia or dyscalculia to exist in the background.

The theoretical background for strategic adolescent therapy and mentalization-supporting therapy for adolescents (MST-A) is the cognitive-affective development theory according to Sulz and its therapeutic implications (Sulz, 1994, 2001, 2003) as well as the general MBT concept (Sulz 2021a, b, 2022a ,b, 2023). Accordingly, in the biography of every patient - in addition to any possible protective factors - there are limiting risk factors that restrict individual psychological and social growth (socio-ecological limitations) and that are reflected in the personality development of the person affected (Schönwald 2015). Individually characteristic ways of dealing with needs, fear and anger emerge as central action-regulating factors or as a dysfunctional way of dealing with feelings. In addition, they develop dysfunctional personality tendencies, individual values, norms, resources and the patient's cognitive-affective development level increases. All of the listed components lead to the individual's personal survival rule. How rigid the individual survival rule is depends on how many stressors the person was exposed to during a development phase. What is important in this context is that people are not aware of the rule of survival in its function of regulating

actions and balancing individual psychological homeostasis and that it is not primarily expressed in language. It corresponds to Bowlby's internal working model (1975, 1976).To simplify matters, we can assume that most patients have only remained at Kegan's (1986) affect level (impulsive level) when it comes to dealing with feelings and relationships, or have slipped back down there in the face of the problem. The path to symptom formation and maintenance can thus be presented as follows: situations that trigger symptoms require problem-solving actions, which violate the rule of survival. The formation or maintenance of symptoms is therefore to be seen as a desperate attempt to solve the problem at the affective level, which is not possible there without the formation of symptoms, since the rule of survival must be strictly adhered to. Or in other words: symptom-evoking situations are usually associated with so-called (primary) feelings such as anger, disappointment, sadness, dissatisfaction. However, these feelings must not gain momentum if the appropriate survival rule is followed and their action-regulating function must be curbed. They are thus replaced by counteracting (secondary) feelings such as helplessness, fear, restlessness, self-doubt. At the same time, psychological and physical symptoms of stress occur. The formation of the symptom leads to a decrease in stress symptoms because the arbitrary psyche now has to deal with the symptom - and no longer with the underlying development-specific conflict - which saves the old psychological homeostasis. In addition, symptoms are usually formed in such a way that they are reinforced by the environment. They also protect the attachment figures close to them from unpleasant changes, i.e. the patient experiences protection, attention and (supposedly) the opposite of what he would get if he opposed his survival rule. But even without feedback from outside, the old self-image and worldview per se remains intact by avoiding new experiences.

The decisive direction-setting is made by formulating the new rule of life that gives permission, which only then helps to overcome the usually considerable resistance.

3. Mindfulness and acceptance

Young people learn mindfulness to get to know their feelings and needs better without judging them. This makes the therapy work and the necessary development steps considerably easier and both the perception of affect and its regulation are easier.

4. Emotion tracking – finding your feelings

After preparation through daily mindfulness exercises, the young people receive intensive dialogue offers in which the feelings they are experiencing at the moment are reflected - with information about the situational context that triggered the feeling. As a result, their theory of mind undergoes ongoing elaboration. After the therapist has listened for a while (with ongoing mirroring of feelings), her empathy helps her to feel compassionately what the young person would have needed in the reported situation - instead of the hurt that occurred (e.g. comfort after a defeat). This feedback is a great door opener for access to the patient's deeper feelings. “You would have needed your father to see how bad this defeat is for you and to comfort you instead of making derogatory comments.”

Finally, we work out what the ideal father and mother would have been like. In a setup with role players in group therapy and with figures in individual therapy, a happy state becomes possible - mixed with sadness because it wasn't like that in reality (Sulz & Schreiner 2024).

5. Supporting mentalization and metacognition

This emotional therapy work is followed by the metacognitive analysis of interactions and relationships. The patient has just been helped to find his feelings and is now being forced to use his prefrontal cortex by consistently being asked questions about causes and consequences. This often happens due to the fact that our brain needs a lot of repetition before old automatic patterns are replaced by new ones. The result is a way of dealing with feelings that practises and consolidates metacognition.

6. Development from the affective to the thinking level

When it comes to problematic and conflictual relationship aspects, young people are at the affective level (impulsive level according to Kegan 1986). To that extent their thinking and actions are predominantly regulated in the right hemisphere by the limbic system - spontaneous impulses instead of metacognitively prepared actions, impatience, lack of perseverance and inability to help themselves. Instead of impulsiveness, there can also be a pronounced inhibition of impulses. The first step is to recapture your primary feelings and thus your vitality. Here exposure to emotions, especially anger, helps. Then anger at the thinking level (Kegan's 1986 sovereign level) is used for defensive assertion so that the young person can have self-efficacy experiences.

7. Development from the thinking to the empathy level

Since young people are capable of abstraction, after some practice they are able to change their perspective so that they can put themselves in the other person´s shoes, empathise and understand others (Piaget 1978, 1995). The relationship becomes more important than individual selfish goals. This makes compromises easy. The social self develops after the preceding period was devoted to the development of healthy egoism: finding and asserting one's place in the community (Kegan 1986). The need to be loved is accompanied by the need to love, and that there is someone who will accept my love. The empathy level corresponds to Kegan's (1986) interpersonal level.

Therapy goals and therapy strategy

Against the background of this understanding of the disorder, the MST-A goal is, in addition to specific symptom coping, the capturing of patient-specific effective intrapsychic and interpsychic dynamics. Processing these should enable the young person to deal with themselves and their environment in a more functional way, so that adolescent-specific development tasks can be addressed and ultimately development in the sense of the cognitive-affective development theory is possible.

MST-A assumes the following subjective problem situation:

1. Lack of attachment: **NO ONE IS THERE! I'm alone**
2. Dysfunctional survival rule (inner working model) **I am not allowed to defend myself, claim** ...
3. Mindfulness and Acceptance: **I'm not aware of a lot of things**
4. Emotion tracking – deep emotional experience: **NO ONE SEES what I feel - my pain**

5. Mentalization - Metacognition: **I don't recognise why people behave like they do and I don't realise what my actions lead to**
6. Development from the affective to the thinking level (self-efficacy): **I cannot regulate my feelings - cannot find a solution to the problem**
7. Development from the thinking to the empathy level (empathy and compassion) **I cannot put myself in the other person`s shoes**

This results in the MST-A goals:

1. Attachment security: **I AM HERE!**
2. From the dysfunctional rule of survival (inner working model) to the rule of life that gives permission: **YOU MAY** ...
3. Mindfulness and Acceptance: **BEING AWARE**
4. Emotion tracking – deep emotional experience: **I SEE what you feel**
5. Mentalization – Metacognition: **WHY – FOR WHAT PURPOSE?**
6. Development from the affect level to the thinking level (self-efficacy): **TAKING OVER THE REINS**
7. Development from the thinking to the empathy level (empathy and compassion) **BEING COMPASSIONATE**

MST-A gives parental work a central role here: parents are supported in acting as "co-therapists" against the development and maintenance of symptoms and in becoming more self-"aware" parents. The goal is therefore to create conditions that make symptom coping and development possible. For this purpose, the young people are treated in a combination of individual and group settings, with the methods used addressing the symptom level, the emotion level, the cognition level and the behavioural level. Parents are involved through family meetings, parent discussions and specific parent training.

Case study: Sarah – presentation of the MST-A therapy that promotes mentalization based on a specific therapy case

To make the concept of mentalization-supporting therapy MST-A clearer, we can follow Sarah's treatment.

3.1 Information on Sarah's symptoms and life story

Sarah began her therapy at the Centre for Integrative Psychotherapy (CIP) at the age of seventeen and a half. She was referred to the youth outpatient clinic through a counselling centre for eating disorders and in the first contact, where she is present with her mother, she appears very friendly and rather reserved. Her mother dominates the conversation and appears perplexed and very worried when describing her daughter's problem. As the reason for coming she states that about a year ago Sarah started putting her finger in her mouth after eating and vomiting. Sarah herself associates fear of falling behind academically and recurring negative comments about her weight, especially from her brother, with triggers for the eating disorder. Vomiting would give her a "good feeling of control."

The patient lives with her mother (42 years old, administrative employee) and her stepfather (32 years old, mechanical engineering technician). Contact with the biological father is sporadic and is viewed more as a "fulfillment of duty". The brother, who is two years older, is training to be a fireman and is only at home at weekends. Her parents separated when Sarah

was 7 years old. Her mother remarried when Sarah was 14 years old. The patient's mother mentions night terrors from the age of 5 to 8 years, fear of beetles and spiders from an early age until today, and sleepwalking from the age of 5 to 16 as earlier psychic ailments. Sarah has a secondary school leaving certificate and is currently attending nursing school in her second year of training. In terms of learning behaviour, she is now motivated and eager in her training, but had massive problems in mathematics in the ninth class. In her final year, she worked her way up significantly through special achievements in all subjects. When it comes to social behaviour, Sarah is still very popular with adults today. She can express herself well verbally and appears very mature. She tends to have problems with girls of the same age- she is seen as precocious and arrogant and is quick to devalue others. She has always been rather tense and shy towards boys. She had her first period at the age of thirteen, to which Sarah would have reacted happily because she felt “grown up”. Her first sexual contacts were at the age of fourteen.

Her kindergarten time from the age of 3 was unproblematic. Sometimes she didn't like going to elementary school because she “wasn't as well received by the others as her best friend was”.

3.2 Diagnosis, behaviour analysis, therapy goal determination

Due to the symptoms recorded in the diagnostic phase (no food cravings or massive craving for food; but self-induced vomiting and fear of being “too fat”), Sarah was diagnosed with atypical bulimia nervosa (F50.3) and the secondary development of a moderate depressive disorder episode (F32.1).

The associated working model which analysed the conditions and was developed at the end of the diagnostic phase (based on Sulz, 2000, 2017a-d) can be presented as follows:

S: As her success at school increased there was more and more devaluation on the part of the rivalling brother with underlying strong idealisation by the mother (“Sarah is sensible and mature. She can do it”). The stepfather was emotionally absent and the father was over-demanding and emotionally abusive ("You have to take care of me because I'm unwell." "When I'm dead, you have to take care of my gravesite").

O: Sarah is cognitively very reflective and mature, has a great need for harmony while at the same time being unable to perceive her own boundaries (especially with her father and brother), she has very strong feelings of guilt when distancing herself or expressing criticism. She has a strong need for warmth and security and clearly fears loss of love or loss of control and has strong inhibitions regarding aggression. The anger impulse is separation anger. She has histrionic and self-insecure personality traits. She has above-average talent (IQ of 124).

R: The primary emotion is anger at the frustrating environment (especially family-related). The expectation is: “Then I will be left alone, no longer belong, or I will get hurt”. . Angry impulses are replaced by a depressive mood in combination with compensatory eating and vomiting.

K: Fear of loss and the fear of being at the mercy of others are reduced and the feeling of control and warmth can be maintained.

The three specific therapy goals developed with Sarah against this background are:

1. To cope with the eating disorder

2. To feel more comfortable in relationships, i.e. that more comes back from the others and the patient does not constantly feel guilty ("What have I done wrong yet again?")

3. To change in dealing with feelings, i.e. not to be sad all the time without knowing why, but to recognise causes and learn to act more confidently

The therapy goals derived according to SAT/MST-A are:

1. Sarah should learn to establish a balanced eating pattern and avoid vomiting with appropriate reaction prevention measures

2. Sarah should learn to perceive and articulate better her needs and feelings

3. Sarah should learn to set boundaries -even with her fear of loss and her striving for harmony (especially with her father and brother)- to reduce the associated feelings of guilt or to deal with her anger constructively instead of showing depressive processing mechanisms and compensatory eating or vomiting

4. Sarah should learn to engage with peers and maintain their friendships instead of devaluing them in a fearful-avoidant way

5. Sarah should learn to increase her self-esteem

6. Sarah should learn to build up an affirming self-image (especially with regard to her own gender identity) and to reduce her fears towards the opposite sex, i.e., ultimately to partially revise her image of men.

3.3 Therapy course and parent work in individual mode

The time window of the therapy, which took place in individual mode, extended over approximately nine months and included the mother and stepfather. At Sarah's request, the now 48-year-old father (an electrical engineering technician), who does not live with Sarah, is not taking part in the therapy, which in this case is due to Sarah's limited ability, which is plausible, to differentiate herself from his heavy alcohol abuse and his boundary-overstepping behaviour.

In terms of the therapeutic process, after a general psychoeducational part on the topic of "eating disorders and the development of symptoms" for Sarah and her mother or stepfather, the structured eating behaviour that had already been initiated by the Counselling Centre for Eating Disorders was adopted in individual mode and methods were tested to stop self-induced vomiting (reaction prevention by means of jogging, listening to music, PMR). What was central to the emotional work here was that Sarah perceives her symptoms as a mouthpiece. For this purpose, the eating disorder was personified by Sarah writing the following letters to the eating disorder as an enemy/burden and as a friend:

Dear eating disorder, my enemy,

You! You, you are so, so stupid. Do you actually know what you're doing to me? Of course you're always there, but you take me over. You settled in with me without really asking. This is really the last straw. Without you, this "Help, I have eaten too much!" wouldn't even exist. You determine my - rubbish - your ideals. You see, I don't even know anymore whether it's mine or yours because you take over my entire self far too often. When fearful, you bring me down even more. You don't know anything about boys. You make me avoid them. Stop it! Let me be Sarah. You eat up all my courage and hope. Do you know something like happiness? That's what I

want. But you are selfish and only fake happiness. I don't want you anymore. Where do you actually live? In my head, in my stomach, in my heart or where?

I want you to leave. Become part of my past. I don't want the little, false moments of happiness anymore.

AND

Dear eating disorder, my dear friend,

You are always with me and never leave my side. You are unwavering. I don't have to make an effort to contact you. You are the way, the help when I have eaten too much. You create a way out of it. You impressed me. You are so simple. For you, one doesn´t need a strong will to lose weight. You take care of me and pay attention to what ideals I have. You give me refuge from my fears. You create ways out when I get hurt. You want me to get along with boys because you really do pursue the ideals. You're there when I'm feeling bad. You belong only to me, only to me...

Supported by the emotion tracking conversation (tracking down feelings), Sarah was increasingly able to sort through the perceived "emotional chaos" and also to allow feelings to arise without resorting to vomiting when frustrated.

The therapist's main attention was on Sarah's face and body. What emotion arises? What had she just said? "I see how angry it makes you when your brother makes a derogatory comment." And: "I see how sad you become when your mother leaves you alone with your painful feelings."

This was preceded by the reformulation of the prohibiting and commanding rule of survival into a new rule of life that gives permission:

Even if I less often hold back in a controlled manner and put up with a lot

and if I show my anger more often and defend myself effectively,

I maintain love and affection

and don't have to fear being alone.

Only this permission made the perception of anger and angry assertion possible - with the experience that the relationship did not get worse.

At this point, therapeutic non-verbal material was also used, with the help of which Sarah learned to differentiate and grasp the feelings that were avoided with the eating disorder. Sarah painted a picture in which the "mouth of the eating disorder" eats up feelings such as love, sadness, hope and longing. With the help of the drawing, Sarah recognizes and feels the importance of perceiving, articulating and enduring feelings. In the process, she develops new, comforting thoughts to counteract the old thoughts that promote the eating disorder and depression. During the course of this, it was possible to reduce the depressive processing mechanisms in individual mode by working on the patient's feelings and relationship issues. The vomiting no longer occurred for a certain time and only appeared again briefly in group mode against the background of an acute crisis. In her individual work, Sarah also began to increasingly deal with her father's frustrating behaviour, to define her boundaries and to evade his influence by reflecting on the frustrating situations or using corresponding imagination exercises. In relation to her brother, she was able to express needs better and also to set boundaries with the help of role plays. Sarah made the leap towards partnership and

relationships. Before the parent training, Sarah described her relationship with her mother and stepfather as rather difficult because neither of them understood her.

The ideal parent exercise was very helpful here. Sarah accepted the invitation to imagine having the parents she needed: “My ideal mother would have been sensitive and able to accept and support me even when I was sad and angry. She would have stood by me reliably, given me warmth and security, and would have supported myself-determination and independence. My ideal father would not have stopped loving my mother and both would have stayed together. He would have had strength and would never have abused her emotionally.”

These parents were brought into the therapy room in the imagination. They were seated on empty chairs to the left and to the right, holding each other`s hands. The therapist lends them her voice and lets them say literally, for example: “When you are sad, I am completely with you.” and “It is good if you show me how annoying that is for you.” Other statements that Sarah wants to hear from them are expressed, the physical togetherness and looking after each other are further developed so that Sarah can completely immerse herself in this wish-fulfilling imagination and staging and enjoy it. She is then invited to recall this scene often and to enjoy the remembering.

The new rule of life allows anger to be felt and expressed. It was possible to let Sarah experience this directly by playing a dialogue with the negative aspect of the biological father. She imagined him facing her. He won't say anything, he will just accept her annoyance and anger. She looks him in the eyes with an angry and determined expression and tells him how bad his behaviour was for her, how angry it makes her and that she won`t put up with it anymore. She underlines each sentence by hitting a cushion with her fist, as if she were angrily hitting the table. She knows that this exercise is not a blueprint for real encounters with her father, but only serves to clarify her inner feelings. In order to deal with him in real life, role-plays with socially competent behaviour are planned.

As far as the parallel parenting work in individual mode was concerned, the mother initially appeared to be avoiding problems and invalidating the daughter's emotional crises or being barely able to endure them. The principle was “Everything is fine”, “It will be okay” and “Close your eyes and get on with it”. In a similar way, the stepfather trivialised Sarah's psychological problems and here her mother`s and the stepfather`s helplessness towards Sarah was very noticeable. The stepfather did not want to question his “safe and secure home that was shielded from the outside world” at any cost, which is why the attachment figure conversations with both parents were primarily about intensified psychoeducation, de-trivialisation, and raising sensitisation to Sarah's needs.

3.4 Course of therapy in combined individual and group mode

What represented a central theme for Sarah in continuing content in the group mode was, on the one hand, the fear of loss that she felt, especially in the partnership she was living in at the time. On the other hand, it was clearly also how to deal with frustrations of the central needs for warmth and understanding. The challenge in the group was to endure disharmony or discord and also to be defensive, which Sarah managed better and better. Sarah learned to express criticism in the group and to be defensive against the verbal overstepping of boundaries by a young person with social behaviour disorders. At the end of the group phase, Sarah articulated clear gains from the group processes.

3.5 Course of parent training

As far as parent training is concerned, the patient's mother can be described as defensive at the beginning. In the course of the process, however, she was able to recognise her position in the family with the self-awareness parts “My Rule of Survival” and “Frequent/Strong, Feared and Rejected Feelings”, where she “covers up” problems, brushes them away and hardly allows them. Especially in her relationship with Sarah, the mother was able to develop alternative reactions when Sarah was feeling bad. Instead of “It’ll be okay” and “It’s not that bad”, the mother increasingly accepted her daughter’s search for help and took on a supportive, more understanding role. Especially when it came to desperation or sadness, the mother - as she herself recognised - used to ward off her daughter out of helplessness in dealing with it. It was now possible to allow comforting physical contact more easily. The mother is currently trying to get a feeling for how much support Sarah needs and where she has to refrain from providing it in the service of individuation. What is particularly healing for the mother-daughter relationship is that conflicts can now be allowed. Both sides perceive this as a cleansing thunderstorm which eases their burden - anger is allowed and does not destroy the relationship.

In the case of the stepfather it was possible to achieve a somewhat more hesitant development. For a long time he stuck to trivialities even in training. It almost seemed as if he was competing with Sarah for her mother and therefore wouldn't allow any change. It is only in the last third of the training, when the relationship between mother and daughter improves significantly, that the stepfather first articulates the feeling of feeling excluded and he is only just beginning to reflect on his options for shaping relationships alternatively. He currently wants to try to give Sarah more understanding.

4 Final assessment of mentalization-supporting therapy for adolescents

Based on the previous results on the evaluation of strategic adolescent therapy (Richter-Benedikt, 2016; Sedlacek, 2015, Peukert 2020) and on the evaluation of mentalization-supporting therapy (Sulz, Richter-Benedikt & Sichort-Hebing 2012, Sulz 2022b,c, Theßen, Sulz, Wedlich et al. 2024, Sulz, Brejcha et al. 2023, Theßen, Sulz, Birzer et al. 2024, Theßen, Sulz, Patsiaoura & Feder 2024) it can be said that, in addition to symptom therapy, working on the central relationships or the associated needs, fears and anger impulses appears to be important and supports health and mentalization. Over the course of the therapy, the young people learn to differentiate feelings, sense and regulate needs, and largely show an improvement in their psychological well-being. In our opinion, the combined individual-group concept and the very intensive parent work have proven to be particularly effective. Changes within families and among individual parents and young people are particularly evident in the areas of “dealing with one's own boundaries” and “dealing with frustrating situations”. Some of the young people have emotionally unstable characteristics that can be addressed well with the intensive emotion regulation component. Self-injurious or self-damaging behaviour can definitely be reduced and, in many cases, eliminated completely. The youth groups are a big challenge for the patients. However, the young people can use the group’s feedback and our observations after the group frame to learn to cope with things among themselves and with each other. According to the patients, the group was often experienced as supportive. The group can offer relief, especially when it comes to shame about one's own symptoms. In the

spirit of peer dynamics during adolescence, young people also learn to get into contact more with their peers and to deal with difficult situations amongst each other.

Another argument in favour of the strategic adolescent therapy and mentalization-supporting therapy approach (MST-A) is that the adolescents and their parents can be involved in the long term and that we have relatively few discontinuations of therapy. The joint parent-child discussions that follow the groups also suggest a learning effect. The feedback from many parents is positive, although there are clear teething problems at the beginning of the parent training (talking about your own issues in front of others, etc.). After the parent training, the parents report being less helpless and more empathetic when dealing with the children and being able to reflect better on psychological processes in themselves and others. The parent group also seems important, especially when dealing with feelings of guilt towards one's own child. By dividing the parents into different groups, it was also possible to address and deal with couple conflicts and lack of parental alliances. Some parent groups continue to run privately and after the training several parents decided to undergo couples counselling or their own individual therapy.

It is conceptually problematic if the young people do not want their parents to be present during the therapy or if both parents refuse to cooperate. In such cases, we try to get the young person and/or parents to cooperate or motivate them, but we do not continue the therapy if there are no changes. This may sound radical to some, but it is related to our understanding of disorder and recovery. It also becomes difficult if the parents themselves have severe psychological disorders and we cannot convince them to start their own therapy. For some parents, it takes a lot of persuasion and also pressure at the beginning of the training (see comments like “But my child is in therapy, not me”). There are parents who “cannot take part in parent training because of other important appointments”. In such cases, the lessons are made up individually. In this context, it appears to be central to the implementation of the SAT/SJT that the parent training takes place in the second phase of the therapy and is preceded by joint preparatory work or collaboration in individual mode. In other cases, the parents may be overwhelmed by the group situation and the large amount of personal experience. The training situation can be a great support, but in individual cases it can also be a very frightening situation for the parents. Due to their comprehensive approach strategic adolescent therapy and mentalization-supporting therapy are certainly reaching their limits with regard to the implementation of hourly allotments which have been approved by health insurance companies, but so far they have proven that they are largely efficient and can be executed well in practice.

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