

Clinical Perspectives

Minding the Gap for Interconnected Villages: Mitigating the Youth Mental Health Crisis within an Attachment and Mentalization-Based Framework

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Objectives

This article demonstrates the clinical utility of attachment-informed and mentalization-based approaches in modern psychiatry, focusing on relationships as a primary source for healing and resilience.

Background

Rooted in the psychoanalytic tradition of Donald Winnicott, the framework emphasizes that the mind cannot be understood in isolation from its social environment. In the current youth mental health crisis, social and economic stressors fragmented the scaffolding necessary for healthy emotional development. These forces often result in impaired mentalization and the breakdown of epistemic trust, particularly among marginalized populations.

Methods

Through a theoretical review and a clinical case illustration of a young man navigating cumulative trauma and systemic inequity, the article explores the transition from nonmentalizing modes (psychic equivalence, teleological, and pretend modes) to reflective awareness.

Results

The authors advocate for a “mentalizing stance” characterized by clinician humility, transparency, and genuine curiosity. This approach moves beyond classical neutrality and purely skills-focused models, positioning the therapeutic alliance as a transdiagnostic vehicle for change. By modeling self-reflection, clinicians can foster the regaining of mentalization capacities and healthy emotional and social functioning.

Conclusions

Enhancing mentalization offers a robust pathway for addressing emotional dysregulation and trauma across various clinical settings and diagnostic groups, offering a promising avenue to mitigate the ongoing youth mental health crisis.

INTRODUCTION

Our aim is to demonstrate the value of attachment-informed and mentalization-based approaches in psychiatry. Our primary goal, for a target audience of child and adoles-

cent psychiatrists, is to demonstrate the use of mentalizing skills and their benefits on assessment and treatment outcomes. Central to this framework, rooted in the psychoanalytic observations of Wilfred Bion, Donald Winnicott, and others, is the relational space between 2 minds, where un-



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derstanding, containment, and trust can emerge and foster resilience and healing.

This gap between minds, between parent and child, clinician and patient, or author and reader, is an intersubjective space in which we may feel seen, held, and supported or, conversely, misunderstood, judged, or rejected. Winnicott, likely due to his pediatric training and sustained contact with children and caregivers, devoted exceptional attention to this space and its profound role in emotional development across the lifespan.¹

RELATIONAL SPACE AND THE EXTERNAL REALITY

A well-known story from the wartime meetings of the British Psychoanalytical Society illustrates a related sensitivity: attunement to the broader context shaping subjective experience. As bombs fell on London, analysts continued debating theory until Winnicott pointed to the explosions outside and suggested they seek shelter. His gesture reflected the simple truth that the mind cannot be understood apart from its social environment, nor can it grow without adequate scaffolding from that environment.

For children and adolescents' mental health, the erosion of community scaffolding, once provided by extended families, apprenticeships, and shared caregiving, has been as consequential as problems in reflective, attuned parenting. Winnicott's work with evacuated children separated from caregivers taught him that chaos and trauma can only be contained when someone is able to "keep thinking." His line, "It is a joy to be hidden, but disaster not to be found," highlights the dual human need for both protection and recognition, for a mind held securely in another's. His foster programs attempted to create such reflective environments, validating the children's fear while maintaining boundaries, constituting secure enough bases for growth and development.¹

SOMETHING IS WRONG WITH THE MODERN VILLAGE

The "raids" of our time are not *only* air raids but also social and economic forces that devastate poor and marginalized neighborhoods, brutalizing adults, separating children from families, and poisoning the springs of community life. These forces create conditions for adverse childhood experiences that predispose young people to lifelong emotional and physical ailments and facilitate the intergenerational transmission of suffering.^{2,3}

To speak about attachment without acknowledging this reality would, in mentalization-based therapy terms, fall into pretend mode, thinking that is disconnected from authentic emotional truth. Just as Winnicott's children bore the marks of wartime terror, many youths today endure chronic adversity, violence, displacement, and systemic inequity. These modern conditions fracture trust and undermine the capacity to mentalize.³

"WE-MODE" AND THE VILLAGE

In mentalization-based therapy, the "we-mode," supported by social evolution research, emphasizes that emotional development unfolds within communities that share values, norms, and trust. Such communities support social learning in all forms; physical, cognitive, emotional, and moral. These concepts offer a framework for clinical and advocacy efforts aimed at "bringing the village to the children."

Peter Fonagy has likened the erosion of social connectedness to the thinning of the ozone layer: urgent, dangerous, and potentially reversible through collective effort.⁴ Restoring our social fabric requires more relational laboratories of reflection in clinics, classrooms, consultation rooms, and residential programs, where minds can be mirrored and expanded. From this standpoint, child psychiatrists may adopt roles traditionally filled by extended kin or community figures: uncle, mentor, master craftsman, or caregiver.

CLINICAL ILLUSTRATION: JOSEPH

Joseph, a young Caribbean American man, presented to a public urban hospital with chronic low mood, conflict at home and work, and history of cumulative trauma including immigration stress, parental violence, neglect, and sexual abuse.

He attended sessions inconsistently and struggled with mistrust. A turning point occurred when he asked his therapist directly: "What have you done to increase equity in health care for diverse patients?"

Instead of reacting defensively, the therapist responded with humility: "I care about equity and work on an initiative in this city, but I still have a lot to learn. I also get nervous about what to share. I'm glad you asked, it's clearly important to you."

This exchange marked a shift from defensiveness to mentalization. By acknowledging their own internal state, the therapist modeled the curiosity and self-reflection Joseph had rarely experienced. "I needed you to answer," he replied. "Time will tell. I ask that question to everyone."

Over time, Joseph's certainty about others' hostility softened. Statements like "They all hate me" evolved into more reflective observations: "When your eyebrows tense up, I feel unsafe. I'm not saying you want to hurt me, but could you watch for that?"

This shift from psychic equivalence to reflective awareness illustrated growing mentalization.

A later incident involving a forgotten umbrella deepened their bond. Joseph returned to find the door closed and felt abandoned. Rather than interpreting symbolically, the therapist validated his feelings before exploring meaning. Through this stance, Joseph internalized that others could hold him in mind despite misunderstandings.

By the end of treatment, Joseph had formed new community connections through a clubhouse and achieved greater independence. In their final session, he offered a succulent to his therapist: "I care about this plant. I know you'll take good care of it, like you took care of me."

The gesture, somewhat teleological but also symbolic, reflected his internalization of a more stable attachment: one involving roots, nourishment, growth, and continuity.

MENTALIZATION: FROM THEORY TO CLINICAL PRACTICE

Mentalization builds on early theory-of-mind research and extends it into the interpersonal and affective domains. It refers to the capacity to understand one's own and others' behavior in terms of underlying thoughts, feelings, intentions, and desires. This capacity develops within secure attachment relationships and is compromised by trauma, neglect, and inconsistent caregiving.¹⁻⁴ Joseph's story illustrates how the development of mentalizing can become disrupted while also highlighting clinical strategies that may help restore this capacity. Research shows that children who mentalize well are more likely to become mentalizing adolescents and adults. Deficits in mentalization contribute to emotional dysregulation and interpersonal conflict across diagnoses, including borderline personality disorder, posttraumatic stress disorder, depression, anxiety, and obsessive-compulsive disorder. Enhancing mentalization offers a transdiagnostic route to resilience.⁵ Youth like Joseph, who have trauma histories and complex psychiatric presentations, often exhibit overlapping internalizing and externalizing symptoms that resist neat diagnostic classification, underscoring the clinical importance of transdiagnostic frameworks.

THERAPEUTIC RELATIONSHIP AS A VEHICLE FOR CHANGE

This vignette highlights features that distinguish mentalization-based approaches from classical analytic neutrality and from purely skills-focused models such as cognitive behavioral therapy. Rather than interpreting or correcting, the clinician adopts a stance that is curious, collaborative, and transparent, reducing misattributions of hostility and fostering mutual understanding.

Empirical evidence consistently shows that therapeutic alliance is among the strongest predictors of treatment outcomes, particularly for patients with attachment trauma. A mentalizing stance strengthens this alliance and restores epistemic trust, the trust required to learn, both of which may be common factors responsible for the effectiveness of different psychotherapy modalities.^{6,7}

CLINICAL APPLICATIONS

Key principles for clinical work include the following:

1. Curiosity and empathy elicit richer clinical information and deepen understanding.
2. Feeling understood enhances the therapeutic alliance, a major predictor of outcomes across treatments.
3. Mentalizing others promotes their ability to mentalize in return, extending reflection, interpersonal

trust, growth, development, and change beyond the clinical setting.

Mentalizing difficulties can be elicited via clinical assessments or research-based tools such as the Child and Adolescent Reflective Functioning Scale (K. Ensink, M. Target, and C. Oandasan, unpublished data, 2013), Reflective Function Questionnaire for Youth,⁸ Parental Reflective Functioning Questionnaire.⁹ They often appear as rigid, excessive use of nonmentalizing modes of psychic equivalence (certainty about others' minds), teleological mode (demanding actions as proof of mental states), and pretend mode (detached or pseudoreflective thinking). Please see [Table 1](#) for explanations and examples of prementalizing and mentalizing responses that can be provided by clinicians in real-world settings.

Mentalizing interventions, such as empathic validation, curiosity, checking understanding, and marking and reinforcing mentalizing, can strengthen reflective functioning. The clinician must hold genuine curiosity and openness while navigating power dynamics and the weight of professional expertise, an inherently humbling and challenging task for those trained to "know" and to present themselves as experts.

PLAIN LANGUAGE SUMMARY

This work highlights that mental health is built on human connection. It advocates for mentalization-based psychiatry and a focus on understanding the thoughts and feelings driving behavior. Healing occurs in a supportive relational space where people feel truly seen and "held" by another. Social and economic stressors have eroded interconnectedness, making it harder to foster trust in children and adolescents. Mentalizing is a multidimensional social-emotional-cognitive "muscle" that allows us to see ourselves from the outside and others from the inside. Trauma and early life adversity often weakens this capacity. Using a collaborative, relational approach, mental health clinicians can act as humble, curious beholders rather than distant experts, using transparency and empathy to restore trust, growth, learning, and access to better coping strategies with transdiagnostic benefits.

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Table 1. Clinical Examples

Clinical scenario	Prementalizing mode and definition	Example	Clinician experience	Clinician response	Why it works
Eight-year-old male accompanied by his mother for a brief medication management appointment. You try to ask about specific feedback from teachers, but it is difficult to interrupt mom who “just knows” that the teachers are biased against her son. She does not seem to have any doubt that teachers are united against her efforts to support her child.	<i>Psychic equivalence:</i> Internal experience is equated directly with external reality. What is imagined or felt is assumed to be absolutely true, with no separation between thoughts and the outside world and no place for uncertainty or curiosity for alternative perspectives.	“No, there isn’t a single teacher who understands what my son is going through. I just know that they are talking behind my back and thinking that I am lying about his conditions. I feel like there is no point trying to work with them at this point. And their feedback is useless.”	You may feel fed up and/or confused with the caregivers’ reports. It may be tempting to want to disagree, argue on facts, and try to convince the caregiver to think differently about the issue at hand. The certainty can feel overwhelming, and you may not know what to say or suggest.	“It is normal to feel like you are all alone in the world when you are trying to help your child with all these complex academic problems. Communication and collaboration can also easily break down in the school setting for so many reasons. That is a tough spot to be in.”	Validating the affect and the caregiver without colluding or agreeing/disagreeing on all the facts is a good way to respond to <i>psychic equivalence</i> . Other options are expressing curiosity and confusion or distracting and returning to the matter when the emotional temperature is down.
Fourteen-year-old female who was admitted to the inpatient unit after a suicide attempt. You were able to build trust during her first week in the inpatient unit, but she presents increasingly fixated on discharge, questioning her treatment team’s intentions of “getting her” and “helping her.”	<i>Teleological mode:</i> Mental states are understood only through physical, tangible actions rather than thoughts or emotions: the belief that “actions speak louder than words.” Emotions are managed by doing, and only physical changes to the environment or body (self-harm, drug use, or impulsive acts) feel real.	“I told you that I am not getting better in this place. It gets loud and scary. I barely see my therapist, and the groups suck. You all seem nice and say that you care. But you would discharge me if you really cared about how I am doing. I need to know that you are working on my discharge and that you are not fake if I am going to continue to trust you.”	You may feel pressure to do things for the patient, to prove your feelings and intentions, to show that you care. This can lead to ambivalence, anxiety, and uncertainty about what to do next. You may also feel helpless and guilty and that you are unable to satisfy your patient.	“It is not easy being here, and I understand your need to see proof of true care. It can be frustrating when it looks like you are here for no reason. I am doing my best to make sure you receive the best care here before you go home. Would you mind telling me more about this feeling about your team not really caring about you. I wonder if there was something else earlier today that led to these feelings.”	You are validating the need or the feelings underlying the demand without giving into the demand. Reflection is promoted instead of problem solving or other quick fixes. Transparency about your thoughts and curiosity about their disappointment invite reflection on negative affects and processing of real or perceived interpersonal triggers.
Thirteen-year-old adolescent female is lying down comfortably on a hospital bed after intentional ingestion of her supply of selective serotonin reuptake inhibitor medication after a verbal altercation with her parents. She appears distracted as you try to review the events prior to her being brought into hospital by emergency medical services, making jokes about having the worst memory of all time.	<i>Pretend mode:</i> Internal experience is completely detached from external reality. Thoughts and feelings are experienced as play, fantasy, or excessive intellectualization that has no bearing on actual life.	“I am fine. I am not one of those kids who are writing notes about shooting themselves or shooting up the school. Life is just fine; I am not like depressed or suicidal. I don’t even know why I took the meds, but it did not mean anything. So, can you tell them I am fine so I can get my phone back?”	Clinicians may experience annoyance and boredom due to lack of true reflection by the patient. Avoidance is more common for younger children; older children and adolescents may also engage in pseudomentalizing, which is lots of intellectual talk without true self-reflection.	“You seem happy, and it is good to see that you are doing well right now. I just can’t help but point out that you are on a hospital bed after 24-hour monitoring to make sure that all your heart is working as it should be. And here we are now, thinking about your overdose yesterday and making sure that you are safe to go home. I know these are not easy things to talk about, but do you think we can go back to yesterday?”	Probing for real affects, and gently confronting patient, making use of the real here and now and being transparent about dilemmas at hand are good ways to respond to pretend mode.

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