What is mentalization supporting therapy (MST)?

A metacognitive-psychotherapeutic approach based on developmental psychology

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Abstract

Mentalization supporting therapy (MST) is a further development of the Strategic Behavioural Therapy SBT. Two new modules will be added to their therapy modules: Emotion Tracking - an adaptation of Albert Pesso's microtracking for use in cognitive behavioural therapy (CBT) - and Mentalization support - an adaptation of the MBT questioning technique. While the mentalization-based therapy MBT is a therapy method based on psychoanalysis within psychodynamic therapy, the mentalization module of the MST is a cognitive-behavioural instrument for building a reality-based theory of mind (TOM). These two modules have become the core of the MST and are therefore one general psychotherapeutic basic competence, which in our opinion should not be missing in any therapy. The treatment progresses from Module 1: Establishing a secure attachment in the therapeutic relationship to Module 2: Extracting the dysfunctional survival rule from childhood injuries and transforming it into a permission-giving rule of life, and then on to Module 3: Noticing and accepting feelings through mindfulness. Then come the two new modules mentioned (Emotion tracking and Mentalization support), followed by the two development modules (6. development from the affect level to the thinking level and 7. development from the thinking level to the empathy level, the goal of which is functional affect regulation and relationship skills in the sense of empathy and compassion.).

Keywords

Support of mentalization, emotion tracking, cognitive behavioural therapy, strategic behavioural therapy SBT, survival rule, security of attachment, survival rule, mindfulness, acceptance, development, affect stage, thinking stage, empathy stage, theory of mind TOM, metacognition.

Mentalization supporting therapy (MST) is the latest development of the research group Strategic Behavioural Therapy (SBT) and Brief Psychiatric Psychotherapy (BPP) (Sulz, 2020b, 2021, 2022, 2023; Sulz & Deckert, 2012; Sulz, Sichort-Hebing & Jänsch, 2015; Sulz, Antoni et al., 2012; Schober, 2018; Liwowsky, 2019). Through metacognitive training and emotion tracking, we achieve attachment, security, successful emotion regulation, self-efficacy and the ability to empathize. This means moving moments and steps in psychotherapy simultaneously in an experience-oriented mode (Barth (2024), Sulz & Schreiner (2024), Theßen & Sulz (2024a,b), Theßen et. al (2024a,b,c), Richter-Benedikt & Sulz (2024)). The list of sources of inspiration is long, starting with strategic short-term therapy (Sulz, 1994, 1995, 2020a) and dialectical behaviour therapy (DBT) by Marsha Linehan (1996, 2016a, b). The reception of acceptance and commitment therapy (ACT) by Steven Hayes et al. (2007) led to the completion of strategic behavioural therapy (SBT) (Sulz & Hauke, 2009). After 2000, several therapeutic approaches from the Anglo-American area followed: Young's schema therapy (1994), McCullough's CBASP (2007) and Albert Pesso's PBSP® (Pesso, 2008a,b; Pesso & Perquin, 2008; see also Bachg & Sulz, 2022). The strongest impulses came from Albert Pesso and Peter Fonagy's working group (Fonagy et al., 2008), whose therapeutic approach “Mentalization-based therapy (MBT)” has shown the greatest effectiveness to date in the treatment of borderline personality disorders. To avoid confusion, we do not use their term “mentalization-based.” MST and MBT (Schultz-Venrath, 2021; Schultz-Venrath & Rottländer, 2020; Schultz-Venrath, Diez Grieser & Müller, 2019; Schultz-Venrath, Staun, 2017; Schultz-Venrath & Felsberger, 2016) support mentalization, but in different ways.

MST was developed as a bridge between psychodynamic and cognitive-behavioural therapies. Thus it is based on

– developmental psychology (attachment theory by Bowlby (1975), developmental theories by Piaget (1995) and Pesso (Bachg & Sulz, 2022) and the mentalization approach by Fonagy and colleagues, 2008),

– neurobiology (including Damasio, 2003) and the psychological dual-process theories and system theories (Epstein, 2003; Grawe 1998, among others)

– cognitive behavioural therapy (cf. Hiller, Leibing & Sulz, 2019) and the third wave of behavioural therapy (e.g. DBT, Linehan, 2016a, b).

SBT had six therapy modules:

1. Relationship building
2. Rule of survival
3. Mindfulness
4. Symptom therapy
5. Skill training
6. Development

Two modules, symptom therapy and skills training, resulted in brief psychiatric psychotherapy (BPP) (Sulz, 2020b).

For this purpose, the two new modules Emotion Tracking and Mentalization were added:

1. Relationship building: secure bonding in the therapeutic relationship
2. Rule of survival: from the dysfunctional rule of survival to the new rule of life that gives permission
3. Mindfulness and Acceptance: stress reduction and self-soothing
4. Emotion tracking: making the patient aware of suppressed feelings and needs
5. Mentalization and metacognition: deep understanding of feelings and needs
6. Development to the THINKING level: from affects and impulses to self-efficacy
7. Development to the EMPATHY level: building the ability to empathize and show compassion

The core theses of the mentalization approach (Barth, 2017; Fonagy et al., 2008) are:

1. attachment as the first achievement of life
2. the self as the originator: the child creates attachment
3. from equivalence to as-if mode to reflection mode
4. affect regulation through mirroring and marking
5. projective identification: blaming the other person

It should be noted that MBT (Fonagy et al., 2008) was primarily developed for the treatment of borderline disorders, like DBT (dialectic-behavioural therapy, Linehan, 1996, 2016a, b), TFP (transference focused psychotherapy - transference-focused psychotherapy for the treatment of personality disorders, Frank et al., 2016) and schema therapy (Young, 1994). These therapies are therefore also suitable for changing personality accentuations. However, in order to apply them to the much more common Axis I disorders, disorder-specific interventions must be added. In addition, they focus on borderline personalities, narcissists and histrionic persons. This means that their primary task is to help the patient capture and regulate their excessive feelings. However, this therapy problem does not occur so often in everyday outpatient psychotherapy. Failure to recognize their suppressed feelings is much more frequent among patients. This is exactly the primary approach of MST, based on the effective factors common to all therapies (see Wampold & Imel, 2015): the fit between patient and therapy, the quality of the therapeutic relationship, etc. Together with the pronounced exercise orientation, we are already in a Deliberate Practice (Rousmaniere, 2019).

To put it simply, MST can achieve seven therapeutic goals from seven problems via seven paths

.The seven patient problems are as follows:

1. Lack of connection: »NO ONE IS THERE! I'm alone."

2. Dysfunctional survival rule (inner working model): “I’m not allowed to defend myself,

assert myself…”

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 recognize why people behave the way they do and I don't realize what my actions lead to."

6. Development from the affect level to the thinking level (self-efficacy): “I cannot regulate my feelings and find a solution for the problem.”

7. Development from the thinking to the empathy level (empathy and compassion): "I cannot empathize with others."

Seven goals of the MST:

1. Attachment security: “I’M 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): TAKE THE REINS INTO YOUR OWN HANDS

7. Development from the thinking to the empathy level (empathy and compassion): BEING COMPASSIONATE

<u>Seven therapeutic paths to achieve your goals:</u>

1. Attachment security: secure attachment in therapy

2. From the dysfunctional survival rule (inner working model) to the permission-giving rule of life: making the new permission the rule of life

3. Mindfulness and acceptance: creating awareness

4. Emotion Tracking – deep emotional experience: becoming aware of feelings and understanding triggers

5. Mentalization - Metacognition: elaborate Theory of Mind (TOM) - why and for what purpose people act

6. Development from the affect level to the thinking level (self-efficacy): regulating affects and acting competently

7. Development from the thinking to the empathy level (empathy and compassion): empathetic communication

This corresponds to seven therapy modules, which will be briefly outlined here. Many therapy conversations consist of an interplay of emotion tracking (finding one's feelings) and mentalization (recognizing one's own motives for action and those of the other person), which means that the training sessions are not strictly separated.

Module 1: Attachment security in the therapeutic relationship

The use of this module requires familiarity with attachment research. The most important statements for us will be briefly presented here:

Attachment figure:

Emotional attachment to the primary attachment figure is an innate need of humans (Bowlby, 1975) and all mammals. Secure attachment is the essential prerequisite for successful development. The goal is to experience security. The experiences with the caregivers are psychologically represented and create expectations about the effects and consequences of one's own attachment behaviour, initially in the infant and later throughout life.

Attachment patterns and the inner working model (survival rule):

These expectations, combined with one's own behaviour, form the internal working model (Bowlby, 1975) or the rule of survival (Sulz, 1994, 1995, 2020a) within the framework of this homeostatic system of the child's orientation. Four different working models can be differentiated, which can be identified as behavioural attachment patterns:

The secure attachment: the child explores the play space in the presence of the mother. It behaves insecurely and reservedly towards strangers. When the mother leaves the room, he or she cries and immediately seeks closeness to her when she returns.

The insecure-avoidant attachment: when the mother leaves the room, the child is less worried and does not immediately seek closeness to her when she returns. In these children, emotional arousal is downregulated, so their response to separation is weak and only a little alarm occurs.

The insecure-ambivalent attachment: the child explores and plays only a little in the presence of the mother. If the mother leaves the room, the child reacts desperately and is difficult to calm down even after she returns. In this child, emotional arousal is upregulated and a great alarm is created that affects the mother.

The disorganized attachment: the child behaves seemingly aimlessly and wants to end the situation despite the mother's presence. The mother is a source of reassurance as well as of fear and frustration, which is why her presence triggers undifferentiated and unregulated arousal in the child. In the families of such children there are long and frequent separations, violent couple conflicts, neglect and abuse.

The inner working model (survival rule) is to be found less in autobiographical memory than in implicit memory, which is only accessible bottom-up, i.e. when a situation arises that requires the social behaviour in question. It has to be identified as emotional-motivational, not cognitive-linguistic and not in “talking about”.

Attachment is therefore an ability that develops in interaction with the primary caregiver and is tailored to influencing the child's individual social environment. It is a teleological instrument with the help of which a homeostatic goal is to be achieved: security in the relationship, which is characterized by the reduction of negative affects that signaled insecurity.

In order for the affect mirroring to have a calming effect, it must accurately contain both the child's affect (and, in therapy, the patient's) as well as the information that the mother is not as worried as the child, but that she can master the affect well. The affect mirroring must be marked in this way.

Secure attachment frees the brain for cognitive development. As long as no secure attachment is established, the attachment system (security system in the sense of Bischof) works at full speed. Everything else is unimportant. Once a secure attachment has been established, the child no longer has to make any effort to create it but is freed up for playful development. It can and wants to turn to cooperative interaction games earlier in life such as the pretend games. They are good at tasks relating to mind reading and emotional understanding (Astington & Jenkins, 1995).

Fonagy (1997) was able to predict the cognitive development of the child in preschool age from the security of attachment with the mother at the age of twelve months and with the father at the age of 18 months. 82% of securely attached preschool children solved theory of mind tasks (being able to reflect that beliefs and desires predict their own behaviour and the behaviour of others), while only 46% of insecurely attached children were able to solve these tasks.

Another study (cited by Fonagy et al., 2008) also recorded the importance of the father: 87% of preschool children who had a secure attachment to both their father and mother solved theory of mind tasks. In comparison 63% of children who only had a secure attachment with one parent, and 50% of the children who did not have a secure attachment with either parent solved these tasks. This is in line with Walter Mischel's (2019) marshmallow studies.

The childhood attachment patterns become four adult attachment types:

1. dependent to clingy type -> fear of separation
2. detached type -> fear of closeness
3. provided type -> fearless due to perfect avoidance in the close relationship
4. autonomous type ->fear-free through perfect avoidance in autonomy

The following imagination exercise illustrates how attachment security can be supported in therapy.

Here you have reliable protection and are safe. Here you can feel liked without having to do anything for this and here you can be as you are. You don't have to adapt here. You have my understanding. I value you and recognize you. Settle down first of all, let go, relax and become calm. Observe your breath and notice the calm and relaxation as you breathe

out. Let go of everything that weighs you down and let go of everything heavy. Allow the stomach to soften so that the abdominal wall rises and falls as you breathe. Accept my support, as much or as little as is right for you. I'm just there, I don't demand anything, I don't judge and I'm in no hurry. My attention, my interest, my goodwill and my compassion are entirely there for you. You can let yourself be accompanied, supported, confirmed, recognized, comforted, encouraged. And in turn you can feel welcome, in good hands, protected and liked and understood again and again. You can trust, as much as is possible. And you are free to make your own decisions; you decide what happens when we are together, when, how and for how long. In this exercise you maintain your independence and your own will. And you can now decide to begin our conversation today by breathing in deeply through your nose and using your sense of smell, breathing in freshness and alertness, and opening your eyes again when you are ready.

Figure 1 shows how the relationship offering needs to change over the course of therapy.

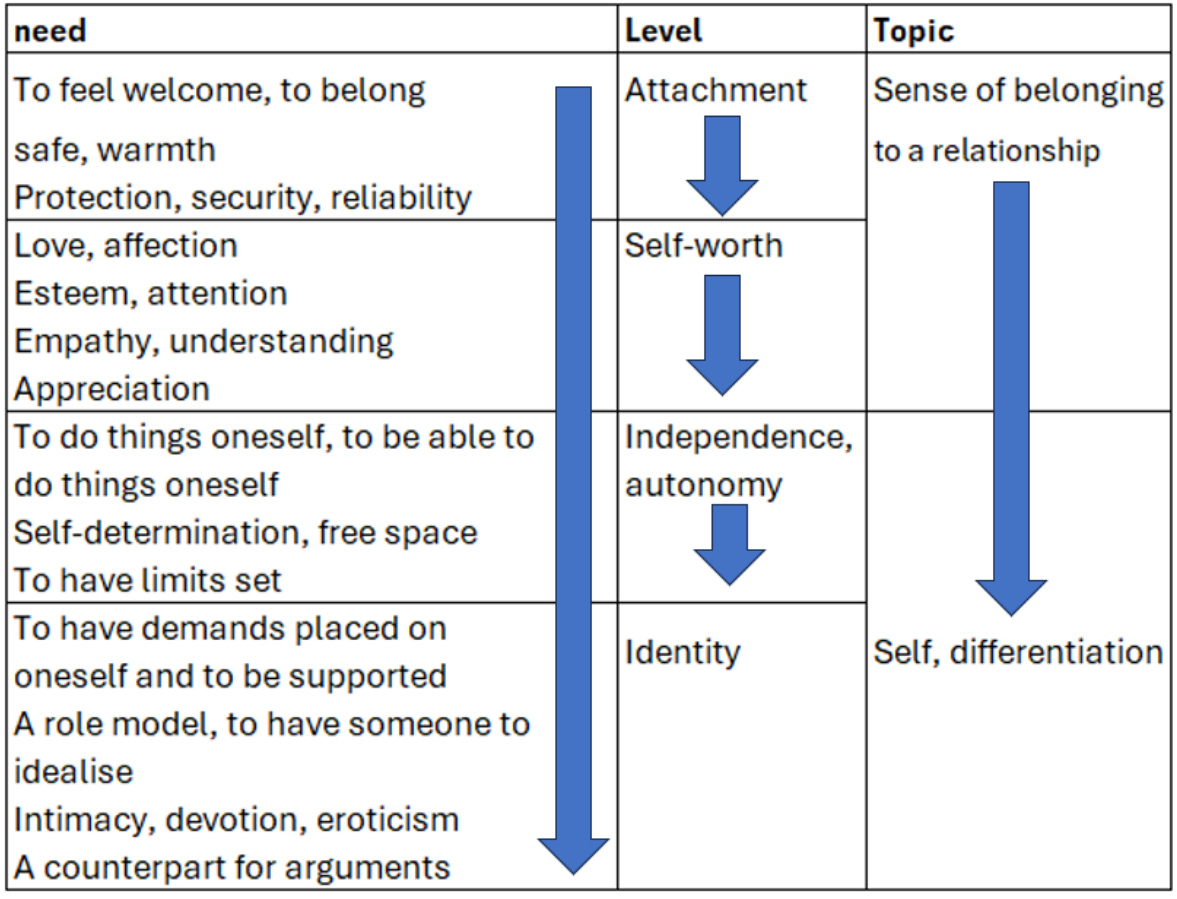

Figure 1: Patient needs in the phases of the therapeutic relationship (from Sulz, 2011, p. 53)

We have left all fourteen needs in the table, including the need for intimacy, devotion and eroticism, which can arise on both sides and which is sometimes not easy to deal with well. If it occurs, this topic is best addressed in supervision.

Module 2: Rule of Survival and Permissive Rule of Life

The inner working model, which serves to create the vital security of attachment to the people who are providing care, does not stop at this one need. With the inclusion of all central human needs (Sulz, 1994, 2017a), the inner working model embraces everything, which can lead to the sense of being in good hands with one's parents. Sulz (1994) called it the rule of survival. It becomes dysfunctional in adulthood because it is based on the all-or-nothing thinking of the small child (always or never) and because the people and living conditions in the adult world are completely different (the others are no longer so powerful, the dependence on them is much lower, their own abilities are much greater and the attachment figures are – unlike their parents – replaceable.

The processes that lead to the rule of survival are easy to see(Figure 2).

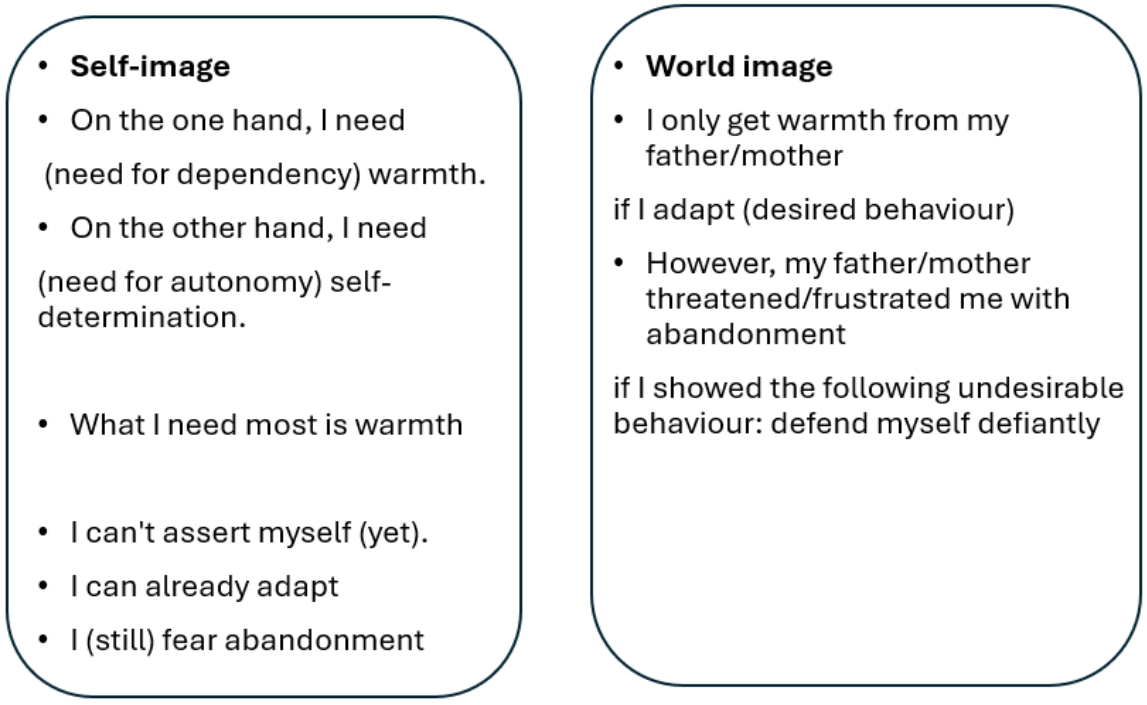

Figure 2: Self and World Image of the child during the first years of his life

At first there were spoken or unspoken commands and prohibitions from the parents, e.g.:

Only if you are ALWAYS nice /act nicely and are hard-working

You can do this if you always have secondary feelings (conscientious)

And if you never have primary feelings, e.g. anger, defiant

If you are NEVER rebellious/act in a rebellious way (primary self mode)

European Psychotherapy EP 2024 page 36-69

I give you warmth (need)

And I will not go away from you (fear)

A common survival rule is:

Only if I am always kind and compliant

And never attack in anger,

I maintain warmth and affection

And avoid being alone.

In the therapy an agreement is made to do the opposite from now on (empirical hypothesis testing). A lot happens already during the planning phase:

Imagine: Now you have to decide to do the opposite of this rule from now on! What feeling arises?" - e.g. fear of abandonment

“What thoughts come?” - e.g. “Then my attachment figure will send me away” (partner, boyfriend)

“What are you afraid of?” - e.g. fear of being left alone

“What conflict are you in?” - e.g. either to give in (not a good thing) or to be abandoned (worse)

In this way we can check how powerful the rule of survival still is today. Hebing (2012) was able to show this in a sample of 100 psychotherapy patients (Fig. 3).

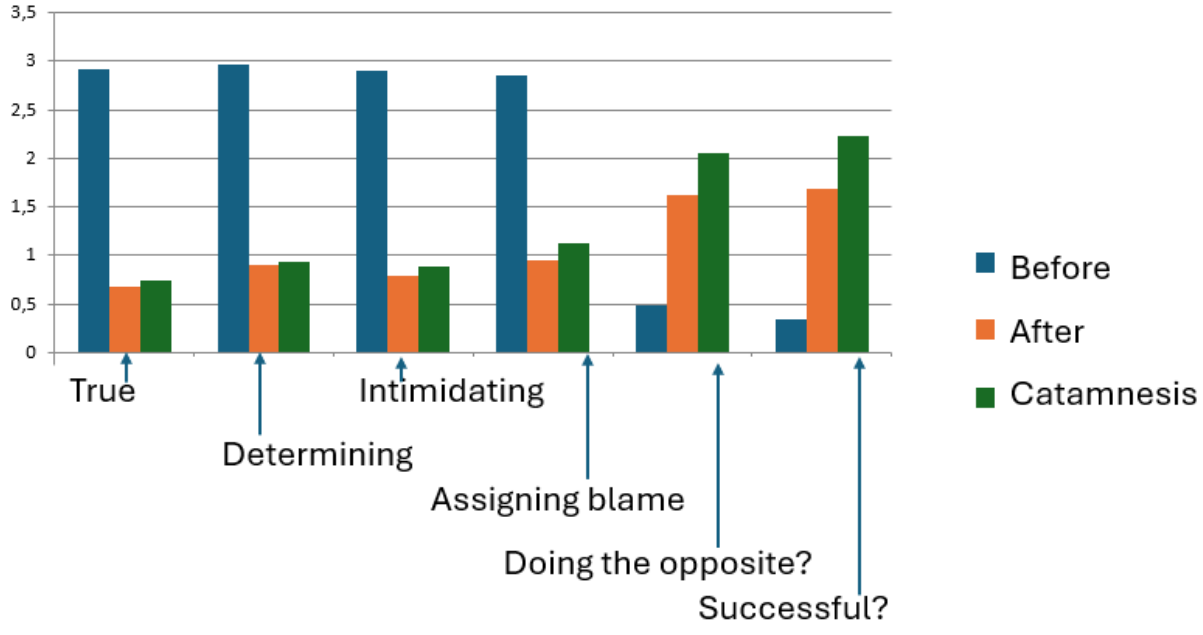

Figure 3: Present-day influence of the rule of survival on feeling, thinking and acting (from Sulz, 2014, p. 353).

The therapy process consists of three steps:

- Empirical hypothesis testing (“Do the opposite from now on!”)
- Contract (acting contrary to the rule of survival)
- Formulation of the new permissive rule of life

The permitting life rule has the same syntax and content as the survival rule, except that "only if you always" is replaced by "even if you less often" and "if you never" is replaced by "if you more often", e.g.:

Even if I'm less often kind and compliant

And attack more often in anger,

I still maintain warmth and affection

And don't have to fear being alone.

What permission is involved?

It's about permission to stay as I am,

– not to have to bend over backwards for others,

– to be allowed to stand up for myself,

– to impose myself on others,

– to be allowed to go my own way,

– not having to be there for others,

– to be allowed to be weak,

– to be allowed to be strong,

– to be allowed to be alone, etc.

Once the new permission is there, the patient can try out new behaviours and build skills. The therapeutic resistance has become so small that the patient is now doing what he can and what he did not dare to do before. From now on he will experience self-efficacy.

Module 3: Mindfulness and Acceptance – Stress Tolerance

The third MST module focuses on mindfulness and awareness. It's about breaking away from the automatism of purely emotion-driven experiences and actions. We rely on two tried and tested approaches: Jon Kabat-Zinn's (2013) stress reduction through regular mindfulness training and Marsha Linehan's (2016a,b) mindfulness in everyday life.

Before we do this, however, we focus on stress and self-soothing (Wagner-Link, 2002). From birth onwards the child experiences stress reduction and reassurance from the mother. Gradually he or she learns to calm himself or herself the way their mother did (if their mother was able to do this). In the worst case scenario, we have not yet acquired this ability and we have to bring in others.

We proceed therapeutically as follows:

The situation (by way of example): …

»My feeling is a false alarm! So now I can practice dealing with it."

My MACES approach:

M Mindfulness: »I pay attention to early signals from my feeling of ... and in this way I learn to recognize how my feeling of ... begins. I say to myself: 'Now my feeling of ... is back.'"

A Acceptance: »I accept my feeling of ..., let it be there, let it get to me. It's understandable that at first my feeling ... is still there ."

C Commitment (deliberate decision): »I decide to let my feeling ... be there without doing what it wants (because it is a false alarm). I want to learn to stop following this feeling when making decisions. But I want to learn to handle my feeling.

E Exposure in the situation: I give myself self-instructions:

e.g. "After she/he said/did ... and didn't ..., I am full of my feeling of ..."

At the same time, I invite my feeling of ...: »(My feeling) ..., come here to me, take up as much space as you need. You can become stronger. You can stay here as long as you want. And you can disappear again when you've exhausted yourself. When the false alarm ends."

S Self-reinforcement afterwards (self-evaluation and self-praise): »It wasn't easy, but I stuck with it. I was able to let my feeling of ... be here. That was good. The only thing that mattered was that I did it, not how I did it."

This is an exposure (Sulz, 2017a,c) that can be used for all emotions and involves a slightly more active approach to stress, fear or another emotion. Accordingly, it provides a very helpful experience of self-efficacy (Theßen, 2016).

The mindfulness exercises can be started with a body scan in order to resort to the collection of Kabat-Zinn (2013) as the practice progresses.

Mindfulness in everyday life is based on Marsha Linehan's very large collection of exercises (2016a, b).

For her mindfulness consists of six core skills. These are the following three WHAT skills:

- perceiving, describing and participating

and the following three HOW skills:

-nonjudgmental, concentrated and effective.

There is a large number of exercises for each of these skills. However, what is practiced, when and how often, must be communicated and evaluated in a friendly manner.

In the context of MST, mindfulness has the special significance that it often only makes emotion perception and regulation possible through non-judgmental awareness. A purely cognitive-behavioural approach would not bring us any further here.

Module 4: Emotion Tracking: seeing, feeling, empathizing

Emotion tracking is an adaptation of Albert Pesso's (see Bachg & Sulz, 2022) microtracking to the behavioural therapy treatment setting. This transforms cognitive behavioural therapy into affective-cognitive behavioural therapy (Woolfolk & Allen, 2013). With the exception of emotion focused therapy (Greenberg, 2000), no therapy approach has succeeded so reliably in getting to the patient's feelings and making his needs, which are not reconstructed, but felt, come alive (cf. Theßen, 2012, 2016). Neither DBT, TFP, MBT, nor schema therapy have penetrated as deeply into the humanistic approach to working with feelings as is necessary. With emotion tracking/microtracking, beneficial resource orientation is added specifically for this therapeutic approach. What was sorely missing is experienced very movingly and imaginatively as wish fulfilment and need satisfaction. This is where Klaus Grawe's (1998) statement comes into play: therapy sessions in which only a feeling is talked about without being able to experience it at the moment provide little therapeutic benefit.

In summary, emotion tracking is a form of dialogue that arose from neurobiological and emotion-psychological approaches, makes feelings tangible by focusing on emotions, identifies feeling triggers, makes it possible to understand how they come about, makes patients aware of need frustrations and allows patients to experience satisfaction that makes them happy.

Therapist behaviour consists of the following steps:

– recognize the feeling in the face

– name the feeling correctly

– identify and name the context (trigger).

– formulate an antidote: "You would have needed …"

– guide the ideal parent exercise.

Syntax (structure) and semantics (content) of the dialogue:

»I see (perception of the therapist)

how desperate it makes you (patient's feeling),

when you remember (consciousness process in the here and now),

that she didn't say another word and just walked out" (situational context).

This sentence is mentalizing, i.e. applying the theory of mind (TOM). This is where mirroring and mental reflection about the trigger of the feeling take place. The sentence does not leave the patient exclusively in the experiencing of the feeling, but rather stimulates mental recognition, so that this is already about supporting mentalization.

There comes a point in the conversation where the patient has explained his suffering and distress so comprehensively that I, as the therapist, have a vivid inner picture of the circumstances and events. Now I can empathetically mirror what the patient would have needed instead, what antidote (antidote in the sense of Pesso, 2008a, b) would have been needed to end the suffering or prevent it from occurring in the first place. The somatic marker that immediately bubbled up (face beaming!) and shortly afterwards the words “Yes, that’s right!” confirmed that I was able to sense the real antidote (the central need satisfaction) and mirror it.

Antidote – What would really have been needed: “You would have needed …”

Patient: “I was never praised!”

Therapist: “You would have needed someone to tell you how good you are.”

Patient (face brightens): “Oh yes, that’s exactly what I missed so much.”

We can summarize the procedure in a 15-step guide:

1. Patient reports on the emotionally stressful relationship.

2. Therapist listens empathetically and observes the face.

3. Therapist: “I see how painful it feels”

4. Therapist: “when you remember how he treated you.”

5. Patient agrees or corrects.

6. Patient continues the story based on this feeling.

7. Therapist empathetically senses what the patient would have needed.

8. Therapist: “You would have needed someone to stand by you.”

9. Patient confirms or corrects.

10. Patient can see need satisfaction in his or her mind's eye.

11. Therapist asks where, who, how and asks for description.

12. Therapist asks what the satisfaction-giving person might say.

13. Therapist repeats this sentence and sees what feeling arises.

14. Therapist asks where, from whom, and how this can be obtained today.

15. Therapist asks what the patient would have to do to get it.

The ideal parents are experienced imaginatively in individual sessions and, if possible, in a group setting using role players.

If it becomes clear that the patient is the child from back then in his imagination and clearly feels feelings and needs, the therapist suggests a role player or an imagined parent who represents the "ideal father" who satisfies the child's needs in exactly the way that the latter needs this. He says: "If I had been there at that time as the father you needed when you were a six-year-old child, I would have said: 'I understand that it is not so easy for you' and would have comforted you. I

would have said: 'You have time and I'll help you'." This can but does not have to be said in the subjunctive. It is extremely astonishing how well patients can achieve a moving experience and are full of happiness.

This experience is so gladdening that this work is not just clarification, but already a clearly resource-oriented method that creates a new memory including intensive somatic markers, which remains available as a permanent resource and influences future behaviour (competing with biographical memory).

The patient cannot eliminate this one positive exception to his previous negative experiences from his expectations: it gives him a spark of hope and confidence. This makes him a more positive person with a positive charisma who has a more positive effect on others, so that they follow his positive invitation, and positive encounters arise. This is a valuable opportunity to transform the art of making yourself unhappy and making others treat you badly into a new art: to ensure that others treat you well.

Over time, many such new experiences come together to form a theory of mind or theory of the mental, so that behaviour can be traced back to intentions in an increasingly better way and the latter to needs and fears - in oneself and in others.

The patient’s theory of the mental or theory of mind tells him: "I feel and I know why I feel this way and you feel and I know why you feel this way."

Module 5: Mentalization – Metacognition: Recognizing, Understanding

In difficult situations and important moments, our patients' psychological processes are guided by emotions. Everything happens in the emotional brain (limbic system) and patients have no access to the logical thinking of the prefrontal cortex. This causes them to misjudge situations and react inappropriately. In an attempt to orient themselves, they resort to the aid (defense mechanism) of projective identification and do not recognize how they themselves are unconsciously orchestrating the misfortune.

To make this understandable, Fonagy et al. (2008) use a theory of developmental stages (from birth to five years of age) derived from Piaget (1995):

– Physical actor: “I am body”.

– Social actor: “I’m smiling at you.”

– Teleological actor: “I want to go there”.

– Intentional actor: “You want this.”

– Representational actor: “You feel.”

In the first three stages (premental stages) the child is in equivalence mode: "I see it like this; therefore it is like this." The last two (mental) stages include the as-if mode: "In my imagination it's like that" and then the reflection mode: "Aha, that's how it works" or "Maybe it's different to what I think."

Mentalizing is logical thinking (cause and effect). However, it is more than that: it is an attribution of mental activity to oneself and to others, especially that human behaviour is intentional. Behaviour arises from needs, desires, feelings, beliefs, goals, intentions and insights. To this extent, mentalizing corresponds to metacognition or the theory of mind (TOM): thinking about thinking (and feelings, etc.).

We have already got to know emotion tracking as the first method of supporting mentalization, as it leads to a deep understanding of the feeling experienced. Now we come to the second method that we adopt from MBT - really just a consistent questioning technique.

The principle is to ask the patient such questions that he can only answer if he activates the cognitive processes of his PFC (brain area: prefrontal cortex). The questioning takes place incessantly. The two methods of supporting mentalization are compared below:

Mentalization in conversation

A Working out affect and motive -> emotion tracking
1. Building up a secure attachment
2. Listening to emotional concerns
3. Mirror feelings markedly
4. Check which feeling has the highest energy (anger or sadness)
5. Feel the need empathetically and express it: “You would have needed …”
6. Guide fantasy of need satisfaction
B Joint reflection on affectivity-> mentalizing
1. “Which situation was frustrating?”
2. “What is the significance of the person?”
3. “What was frustrating about their behaviour?”
4. »What need was frustrated? What would you have wanted?”
5. “How did the person come to behave this way?”
6. “How could you have achieved what you wanted?”
7. “How does the idea of acting like that the next time feel?”

The fourteen most important aspects of mentalization supporting conversation are (modified according to Fonagy et al., 2008):

1. Establishing security in the relationship

2. Tight guidance of the conscious processes of the person reporting

3. Proceeding in a structured and supportive manner

4. Question-answer dialogue instead of free conversation

5. Columbo questions: not knowing

6. Asking specifically about motives for a type of behaviour

7. Value mentalization, question non-mentalization

8. Offering alternative interpretations for non-mentalized statements

9. Interrupting pseudo-mentalizing

10. Reflecting together

11. Thinking out loud as unfinished consideration

12. Saying when a thought was a mistake

13. Not giving any meta-theoretical explanations of what is happening

14. Not imposing your own hypotheses

The result of the conversation may be that the patient

– understands their problem attitude, accepts it and can finally give it up or put it aside

– can be more consciously aware of their feelings

– can accept their negative feelings

– can change how they feel

– can change their self-perception

– can perceive their therapist differently

– can give the relationship a different meaning

– feels less dependent and defined in the relationship

– does not have to maintain so much avoidance in dealing with themselves and others

– has practiced and improved their mentalization ability (metacognitive ability).

As long as the patient is at a pre-mental stage of development, his emotional brain searches for and finds the relationship patterns of his childhood in the present. There is often nothing more than the transference. Not infrequently, a countertransference initiates projective identification, which can become a perpetuum mobile (a self-perpetuating control loop), thus perpetuating the self-inflicted misfortune. Once you have reached the mental level, you can think and act realistically.

<u>As a therapist, I pay attention to:</u>

1. I let the situation be described to me in such a way that I can vividly imagine it.

2. Asking questions often changes the meaning of what was actually said in the situation.

3. Only then do I ask what that did and is doing to the patient (what was frustrating about it).

4. The ways of behaving reported by the patient show in what way he or she was not effective or was not behaving appropriately to the situation.

5. I let the patient tell me the process right to the end, what the actual outcome was.

6. Only then do I ask what need was there and what he or she actually needed or wanted instead of what was given.

7. Finally, there is the question why it probably went wrong. I help with ideas if the patient cannot find a cause, through Socratic questioning or by directly stating my assumption.

8. The most difficult thing for the patient is to imagine effective competent behaviour, because this is forbidden by his survival rule.

Module 6: Development to the THINKING level: self-efficacy

In addition to emotion tracking and the MBT questioning technique to support mentalization, other heuristics and interventions are helpful when it comes to raising the patient from a pre-mental to a mental level.

We postulate that here it is not only a question of behaviour change, but of development (Sulz & Höfling, 2010). In the first year of life we are at the physical level, in the second and third years of life at the affect level and only in the fourth year of life do we reach a mental level with the thinking level, followed by the empathy level. The awareness processes are qualitatively different:

Affective system:

– I cannot help myself on my own.

– tends to be non-verbal

– associative thinking

– conditioned responses

– no self-distancing

– I don’t have a theory of mind (TOM).

Thinking system:

– I know how to help myself.

– tends to be linguistic

– concrete, logical thinking

– I make conscious decisions.

– I have psychological distance.

– I have a theory of mind (TOM).

Development stagnates due to unfavourable parental behaviour. The mental levels are not reached. Some remain in an overemotional mode (borderline, histrionic, narcissistic), others in an emotionally inhibited mode (insecure, dependent, compulsive, passive-aggressive).

Developmental therapy takes place in two steps.

1. Out of stagnation (hiding in the development hole under the stairs of development) onto the unprotected plateau of affects (Theßen, 2016) and impulses in order to regain the energy of natural vitality (emotion exposure)

2. The step from the affect level to the thinking level (causal thinking, goal orientation, perseverance) in order to be able to advocate one's own interests effectively and experience self-efficacy (competence training)

What is not yet developed at the thinking stage:

– Thinking is still egocentric.

– The other person is still an object that serves to satisfy needs.

– It is indeed established that the attachment figure thinks and feels differently, but their needs are not yet of interest.

– There is no ability to empathize yet.

– There is still no desire to understand the other person or concern that the other person is doing well.

Module 7: Development to the Empathy Level: Empathizing

When moving from the thinking to the empathy level, the egocentric person becomes a social being. Now the focus is on how the relationship is doing - a relationship in which the other person also feels comfortable. In order to achieve this goal, empathy is required, which, according to Piaget (1995), is only possible when abstract thinking and thus a change of perspective are achieved. With Piaget we assume a double empathy:

On the one hand: – taking on the other person's perspective,

– putting myself in the other person's shoes,

– empathizing.

On the other hand:– showing and expressing my feelings,

– so that the other person has a chance,

– being empathetic with myself,

– the other person can put himself or herself in my shoes.

A) When looking at situations together, the therapist repeatedly directs by means of questions the patient's attention to:

B) what the attachment figure may have felt, thought, needed, and feared. And to what extent the patient's own behaviour influenced this or could influence it.

An effective intervention for developing the ability to empathize is "empathetic communication" (less demanding and assertive, more pleading and expressing the need): saying which behaviour triggered which feeling because which need was frustrated. Requesting new behaviour that leads to satisfaction and joy. This is very similar to Non-violent Communication (NVC) by Rosenberg (2016).

In conclusion - development is possible by supporting mentalization. Our wealth lies in the fact that we can choose: sometimes we can be completely body, sometimes we can be completely feeling, sometimes we can be completely thinking and again and again completely relationship (Sulz, 2021a, b).

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