Can behavioural therapy support mentalization? For what reason?

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ABSTRACT

Interest in developmental psychology arose in behavioral therapy as early as 1994. This resulted in strategic short-term therapy and strategic-behavioral therapy SBT, based on Jean Piaget and Robert Kegan: “Only behavior that has already been developed can be modified through learning!” The top priority is therefore to promote development. Later, James McCullough also took up developmental support in behavioral therapy. However, the most comprehensive reorientation came from the psychoanalytic side: the mentalization-based approach of Peter Fonagy and his working group, which saw attachment theory as the absolute primary basis: “Without secure attachment, no mentalization and no successful affect regulation!” These two aspects became the cornerstones of the 2021 for the first time published mentalization-promoting behavioral therapy MVT, which made secure attachment and development of mentalization into a therapeutic concept with the aim of enabling affect regulation. In this article, the scientific background and the embedding in the current state of research are presented, in order to then move from the MVT disorder theory to the therapy theory and the therapy approach, operationalized through seven therapy modules: secure attachment, from the dysfunctional survival rule to the permission-giving rule of life, mindfulness and Acceptance, finding your feelings with emotion tracking, conversation that promotes mentalization, development from the affective to the thinking level with the aim of self-efficacy and development from the thinking to the empathy level - with example dialogues.

Keywords

Development, secure attachment, mentalization, affect regulation, dysfunctional survival rule, permission-giving rule of life, mindfulness, acceptance, emotion tracking, emotion recognition, antidote (satisfaction of central needs), affect level, thinking level, metacognition, theory of mind TOM, anger exposure, self-efficacy, Empathic communication, effect strength outcome

European Psychotherapy EP 2024 page 70-98

1. A metacognitive approach to the developmental psychological understanding of mentalization and mentalization disorders

1.1 Neurobiology: the development of the brain

When McCullough (2007) postulates that people are only partially developed in adulthood and do not reach adult levels of development in difficult relationship contexts, this statement is supported by neurobiology (Roth 1995, Roth & Strüber 2016). In highly problematic relationship contexts, we are at the developmental level of a preschool child who needs protection and someone to come to his aid and solve problems for him (Kegan 1986, Pesso 2008a,b, Piaget 1978, 1995, Bischof-Köhler 2016, Walter 2016).

The PFC (prefrontal cortex) does not become functional until around five years of age (McClure et al. 2004, Roth, 1995, Roth & Strüber 2016). It hasn't been developed before this stage. Causal thinking is missing because mentalization could not yet take place. Until then, we rely on the emotional brain (example: limbic system), which can fulfill its functions more or less from birth (Roth 1995, Roth & Strüber 2016). Our affects and impulses determine our reactions. It is not linear cause-and-effect thinking that controls our behaviour, but rather associative processes and the numerous conditioning aspects associated with them. Because of the partial developmental deficit sensu McCullough, this also applies to adults.

So we need to consider at least two levels of development: the pre-mental affect level and the mental level of causal thinking (Fountoglou et al. 2022). Piaget (1978) and neurobiology (Roth 1995, Grawe 2004) agree here.

Gollwitzer, Gawrilow, and Oettingen (2010) found that behavioural plans “are effective when they have become automatic (cf. Mischel 1972, 2004, 2015). This means that the prefrontal cortex no longer has to redirect and control behaviour in every situation, but that an automatic new behaviour has prevailed against the primary impulsive and uncontrolled behaviour - reflexively controlled by the limbic system, i.e. the hot system. So now the hot system is at the service of the cool system. The new behaviour is immediately available as a reflex.” (Sulz 2021, p. 63) Many therapies suffer from the fact that the interventions are ended too soon, which leads to a relapse.

1.2 Biography: Childhood experiences shape people

For a long time, behavioural therapy did not address the predispositions to mental illness that arise in the preschool years. It was rather an exception when the anamnesis went back to this age and also inquired about the relationships with the parents (Sulz 1992, Schönwald 2015). However, Aaron T. Beck's cognitive therapy, which only later combined with behavioural therapy to form cognitive behavioural therapy (CBT), traced the automatic depressogenic thoughts back to basic assumptions about the functioning of the child's social environment. Self-image and worldview came together to form basic assumptions about the parents' expected behaviour - later called the dysfunctional survival rule by Sulz (1994, 2017b). What was primarily used for emotional survival with parents is transferred to other people in adulthood, so that these commands and prohibitions result in dysfunctional personality traits such as insecure, dependent, obsessive-compulsive, histrionic, narcissistic or emotionally unstable. Thus Walter Mischel's (1972, 2004, 2015) if-then statements lead to an enduring behavioural signature that determines personality.

1.3 Symptom formation: Why who gets which mental illness at what moment

The tight corset of Beck's basic assumptions (Beck 1979, 2004) or survival rules (Sulz 1994, 2017a-d) does not allow competent (often defensive) behaviour in the situation that triggers the symptoms, so that the situation cannot be mastered. There is no choice but to resort to the symptom as an emergency measure. Sulz (2017a,b) sees for example in depression avoidance behaviour that is intended to prevent escalating arguments. Learned helplessness results (Seligman 1979). And the lack of urgently needed success in the effort to protect one's needs and interests (reinforcer loss) leads to the depressive affect (Lewinson, see Hautzinger 2013).

1.4 Psychotherapy: Mentalization as the key to healing and growth

Developmental psychology (Piaget 1978, Kegan 1986) suggests that the patient, who is still completely under the control of his emotional brain (hot system according to Mischel (2015)) at the beginning of therapy, is therefore still at the affect development stage, will be able to help himself if he manages to develop to the next level, to use his PFC for logical thinking and mentally reflect on his perception. Through mentalization he gains access to causal thinking and can anticipate the consequences of his behaviour. His behaviour becomes goal-oriented. If he succeeds in achieving his goal based on his realistic thinking and thus satisfying his needs, he experiences self-efficacy (Bandura 1975), which stabilises identity and self-worth. Learned helplessness turns into confidence, so that the depressive affect can be a thing of the past. Instead of impulsive acts or inhibiting behaviour due to fear, we find smart, prudent and relationship-maintaining behaviour.

1.5 Attachment, permission, awareness, mentalized affectivity, self-efficacy and empathy

Mentalization requires development and development requires secure attachment, both in the child-parent relationship and in the therapeutic relationship. Attachment is not a theoretical construct, but rather an elementary process at the beginning of life that is just as perceptible as the manifold disruptions to attachment and security (Bowlby 1975, 1976, Sroufe 1996, Rutter & Sroufe 2000).

In order to understand our patient and his symptom formation, we must explore his history of insecure attachment - with an empathetic and compassionate look at his childhood fate, which robbed him of the chance to develop further and become a stable person who can solve his life problems without the formation of symptoms (Brockmann & Kirsch 2010).

In order to be able to form a therapeutic alliance with our patient that makes therapy possible, we must create the most secure bond possible. Only then do further interventions make sense: without attachment, no therapy! Or it may be that therapy only consists of establishing more and more attachment security in small steps and helping the patient develop the ability to bond.

In order to feel that he or she is in good hands, the child needs the opportunity to idealize his parents. Idealization can also take place in the therapeutic relationship at the beginning, as this makes the bond more secure. The therapist is thus given the authority to lift the old commandments and prohibitions of the rule of survival (inner working model according to Bowlby, 1975, 1976) and to give permission to be the person they actually are. The person who doesn't have to suppress their needs for the benefit of other people. This permission is the second elementary therapy process after attachment security. Only when it has been granted and accepted can behavioural changes be sustainable without feelings of guilt stopping them again.

A first step towards mentalization is to create awareness of internal and external states and events. This is easily done through mindfulness exercises. The resulting self-perception, including its verbalization, leads in an infinite number of steps out of the reflexive, automatic affective acting that is controlled by the emotional brain. Anyone who does not expect these exercises from their patient makes their therapeutic work unnecessarily difficult and the patient also finds it much more difficult to take the step from affectivity to reflection.

When it comes to discussing problems with the patient and finding a solution, problem updating in the sense of Grawe (1998, 2004) is absolutely necessary. The studies he cites show that a therapy conversation that remains cognitive has no therapeutic effect. A therapy session can only be effective when the problem is emotionally updated and the painful feeling resulting from the problem can be felt and identified clearly enough. However, since the corresponding feeling can only be evoked bottom-up, we encounter barriers that can be overcome, for example, by emotion tracking (microtracking borrowed from Albert Pesso (Bachg & Sulz 2022)). Pictorial memory of the problematic relationship leads to painful affect, naming and reflective recognition of the trigger is mentalization and the result is the mentalized or reflected affectivity or, in Greenberg's (2000) words, the deep emotional experience. The depth of this mental understanding leads to sympathy for the child at that time and for the person today and to self-compassion (Gilbert 2013).

But what is mentalization anyway? It is a synonym for metacognition (Flavell 2011, Leslie 2000) and this is a synonym for theory of mind TOM (Premack & Woodruff 1978, Astington & Jenkins 1995, Sodian 2007, Förstl 2007): thinking about thoughts, feelings and needs. Thinking not only about one’s own thoughts and feelings, but also about what is going on

in the other person, what they need, feel, and think (Sharp & Bevington 2024). As early as 1955, Kelly was able to show that people unintentionally and sometimes unconsciously form implicit theories about people. Sulz and Gigerenzer (1982a,b) examined this in the psychiatric diagnostic process. From the age of 4 to 5 years (once the PFC is functional), children form and continually refine a TOM, enabling increasingly accurate predictions of the outcome of a transaction. They also recognize that a thought is just a thought and not reality, whereas at the pre-mental stages of development the equivalence mode (Fonagy et al. 2008) still prevailed, which says that if I think something is like that, then it is also like that.

Once mentalization is achieved, the ability to empathize is not automatically present, which is why we assume, with Piaget (1978, 1995), two distinct developmental steps: Initially the child remains egocentric and uses its TOM knowledge about other people to satisfy its own needs. If empathy is demanded of it too soon, it will not be able to take care of itself well enough. Self-efficacy means: I can take good care of myself. Only when this experience has lasted long enough can the developmental step from an egocentric to a social person take place, for example at the beginning of primary school. Their self-efficacy means: I can handle relationships well. Piaget (1978) considers the ability to think abstractly and thus to change perspectives to be the necessary prerequisite for empathy and compassion. This is how he explains the delayed development of empathy. In psychotherapy, one should therefore wait a while before introducing empathy. A person who is not yet sufficiently developed to be able to take good care of themselves will obediently try to act empathetically but will only be able to do this with the help of feelings of guilt, without real empathy already being present.

2. Therapeutic mentalization support

2.1 Attachment as a therapy goal?

The current state of knowledge regarding attachment research (Fonagy & Target 2001, Fonagy et al. 2004, Sulz & Milch 2012) definitely means that the first therapeutic goal must be attachment security. Development is not possible without attachment security and psychotherapy is not possible without attachment security. We distinguish the patient's attachment needs from his or her (in)ability to attach. And we also look at both topics with the therapist. In this case,

their willingness to commit is also a topic and question. Since most patients have attachment disorders in their own way, the first priority is the attachment analysis, starting with the exploration of the child's attachment fate (parental behaviour that caused the attachment disorder) and leading into how he deals with attachment today and the profile of his attachment needs: What does the patient need today in his relationships and also in the therapeutic relationship - how much is needed? How does he or she make sure they get what they need? How does he or she prevent themselves from getting it? The therapist obtains the most authentic information by observing the patient in the therapy session. Here one can constantly see their efforts to ensure security in the relationship, which is peppered with transferences from his childhood relationships. McCullough (2007) shows how this can be worked with in an elegant way in a behavioural therapy setting (causal theoretical conclusions). His approach is very similar to Beck's (2004) empirical hypothesis testing: for example, checking whether the therapist really reacts, as my mother used to, by withdrawing love and being offended for a long time when I express my anger. In this way, step by step, the barriers that have previously prevented the patient from allowing secure attachment in the therapeutic relationship can be removed (Sulz 2022a-c).

2.2 Behavioural competence as a therapy goal?

Can the overarching therapeutic goal of CBT be defined as behavioural skills? Or have we already reached the point where we are not just striving for successful behaviour, but rather the experience of self-efficacy (Bandura 1975)? This implies emotional states of satisfaction, happiness, pride, meaning, self-worth and inner attitudes of self-confidence and self-assurance (Barth (2024), Sulz & Schreiner (2024), Theßen & Sulz (2024a,b), Theßen et. al (2024a,b,c), Richter-Benedikt & Sulz (2024)).

“Thinking logically in concrete situations, not yet in abstract contexts, is perhaps the most important achievement in the first years of life. It is important for behavioural therapists that logical thinking as a skill was not learned, but rather developed. However, cognitive behavioural therapists rely on this ability in order to be able to treat their patients in an economical way. Because their activity no longer consists of conditioning, but rather the use of causal thinking in order to

be able to realistically assess the negative consequences of previous behaviour and the positive consequences of new behaviour.

The subsequent learning by means of success is partly based on contingent reinforcement, but partly also on the confirmation of the correctness of the expectation regarding the consequences of the behaviour (in the sense of Grawe's (1998) consistency theory and Piaget's (1978) assimilation concept and Mischel's (2015) If-then behavioural signatures." (Sulz 2021, p. 60)

At the developmental level of empathy (Sulz 2017a-c), as mentioned, the experience of self-efficacy includes the success of relationship formation. From the perspective of the person striving for autonomy, both types of success are of his own making and he can attribute them to his comprehensive behavioural competence, which gives him so much self-efficacy experience that he can feel secure in his life.

The more relationship-oriented person can also feel safe if they can rely on other people and their relationships and can devote themselves to them with full epistemic trust - embedded in a community of people who are there for each other (Sharp & Bevington 2024). Here the goal formulation of behavioural competence would be less applicable. Relationship skills with all their aspects would be more suitable (Sulz 2021, 2022) - including the ability to make and maintain secure bonds.

2.3 Ability to regulate emotions as a therapy goal?

The ability to regulate affects and impulses and to deal with feelings requires secure attachment and is the result of mentalization. In turn, it is a prerequisite for building behavioural skills.

This ability is not present in borderline disorders (Sharp & Bevington 2024). Loud feelings dominate the course of the relationship. Dramatic scenes line up one after the other. This is why forms of therapy have emerged that are aimed at emotion regulation skills: firstly, dialectical behavioural therapy DBT (Linehan 1996, 2016,b). Then there is transference focused psychotherapy TFP (Yeomans, Clarkin, Kernberg 2018), followed by schema therapy (Young et al. 2005) and finally

the mentalization-based therapy MBT (Allen 2008, 2010, Allen & Fonagy 2009, Fonagy & Bateman 2008, Fonagy et al. 2004, 2008, Schultz-Venrath 2021, Schultz-Venrath & Felsberger 2016, Schultz-Venrath & Rottländer 2020, Schultz-Venrath & Staun 2017, Schultz-Venrath et al. 2019, Sharp & Bevington 2024). These therapies focus primarily on patients who are constantly overwhelmed by their emotions. They try to modulate down the affects with the help of (meta)cognitions, but also to use reflection so that fewer false interpretations lead to inadequate anger or despair. The aim is that overemotional people reduce the amplitude of their emotions. So far this has best been achieved by the MBT (Fonagy et al. 2008). However, we cannot simply assume that these approaches to the treatment of emotion regulation disorders in overemotionally disturbed personalities will also best cope with the task of bringing suppressed feelings to conscious awareness. Figuratively speaking: Reducing sounds that are too loud is a different technique to making sounds audible.

If no extraverted personality disorder is present, other interventions to build affect regulation may be indicated as a priority. If a patient does not react emotionally too often and too much but does not have access to his or her feelings, interventions from emotion focused therapy EFT (Greenberg 2000), focusing (Gendlin 1998) and pessotherapy (Bachg & Sulz 2022) or emotion tracking (Sulz 2021, 2022) help as their adaptation for behavioural and psychodynamic psychotherapies. The aim here is to intensify feelings that are initially barely perceptible so that they correspond to the emotional meaning of a remembered event.

The following example shows how a gentle, compassionate mirroring of previously suppressed feelings that are just now becoming conscious gives them space and a name so that they are embedded in a mental horizon of understanding (Sulz 2021, p. 305f.):

Mr. C is an educational consultant for a non-profit organization – quite successful and very competent. He would have loved to study music but didn't have the confidence to do it.

P: Today I would like to talk about my father and how I never felt acknowledged by him.

T: Oh yes, this is a very important topic for you. Start telling me about it.

P: He visited me in Berlin last week. Now that he's retired, he's bored and calls me more often. That never happened before. There were always more important things than me. I always had to beg for some time and he never really listened.

T (sees pain in the patient's face and then repeats the context that triggers the feeling as accurately as possible using the patient's words): It hurts you a lot that in your memory you always had to beg for some time and he never really listened.

P (with tears in his eyes): That hurt so much! I'm surprised it still hurts so much.

T (repeating, adding triggering context again): And you're surprised it still hurts so much when you remember having to beg for some time and him never really listening.

P: Yes, I'm amazed at that and shake my head - also because I find it so unbelievable that a father would treat his son like that.

T (spotting anger on the patient's face and hearing the angry tone): You find it unbelievable that a father would treat his son like that and are now becoming very angry.

P: I'm really angry! I'm so angry!

T (seeing the patient's clenched fists): You have so much anger that the anger may want to do something, even if you would never do it. What movement wants to emerge, what does the anger want to do?

P: I want to grab him and shake him, so he finally understands what he's doing.

T: Your anger wants to grab him and shake him so that he finally understands what he's doing. Would you like to try this out in your imagination?

P: Yes.

T. You can do this by standing up and imagining that he is standing in front of you, preferring to focus on more important things and not really listening to you. Are you ready?

P: Yes, I see him in front of me and I'm so angry that I want to really shake him.

T (standing to the side of the patient): You can stretch your arms, grab him by the shoulders and start shaking.

P (hesitates, then starts to shake): Now you must feel my anger, you can no longer not listen or walk away.

T: Imagine his face and his eyes. Look him in the eyes. Imagine him looking at you and seeing the furrow of anger on your forehead and your determined angry look.

P: You didn't see me, you didn't realize that I have great musical talent. There was never any admiration, something that I needed so much from you.

T (hears the voice becoming brittle, sees the strength draining from the face and body and how the facial expressions show sadness): You are now becoming very sad when you realize how much you needed his admiration for how talented you are in music .

P (with tears and blowing his nose): Why didn't you give me what a father must simply give his son? That would have been so easy.

T (concentrates on the need and expresses empathetically what the patient was missing): You would have needed a father who took a lot of time for his son, who really enjoyed being with you and who listened to you with great interest. A father who admires you for your music.

P (his sad face brightens): Yes, exactly.

T: If you want, we can bring this father that you needed here in an imagination.

P: Yes, I´d like that very much.

T: Then you can start by first drawing a vivid inner picture of this father. What does he look like, what kind of person is he? What is he doing?

P (bursts out): He's not as big and rough as my real father. He is sensitive, loves music and knows this subject very well. He also teaches me a lot and plays music with me. He is warm-hearted and I don't have to constantly worry about doing something wrong.

T: Can we invent a scene in this room where you two are together?

P: Yes, he can sit here beside me on this chair.

T: Very good. So now you're both sitting here together. How does he look at you?

P: In a kind, loving way.

T: What could he say?

P: He should say that he has been looking forward to our meeting.

T: I can lend him my voice now. So he could say: I've really been looking forward to meeting you?

P: Yes.

T: When he says that in my borrowed voice, don't look at me, look at him. I will point at him with my outstretched arm so that it will be easier for you to stay with him.

T (I extend my arm towards the imagined "ideal" father sitting on the other chair): I've really been looking forward to meeting you.

P (moved and grateful): And I'm very happy about that. It's unusual. Have you really been looking forward to it? And do you really have time?

T (lending my voice to the ideal father with my outstretched arm): Yes, I have really been looking forward to it and I have endless time.

P (his eyes moisten): That's nice. That feels so good. What do you think of my music?

T (again lending his voice to the ideal father): You are so good, really good. I admire you for that.

P: Really?

T speaks again for the ideal father: Yes, I'm really impressed and I think you're really good!

P (with tears and sadness): I never, ever, never heard that from my father. And that hurts so much.

T (no longer speaking for the ideal father): It makes you so sad and hurts so much that you were never able to hear from your real father that he is thrilled and thinks you are really good.

T: Return once again to the imagination, to the encounter with the father you needed. Are there any other sentences you would like to hear from him?

P: Yes, that he loves me and that I am always welcome.

T (lending my voice to the ideal father with my outstretched arm): You are my beloved son. I love you very much and am so glad that you exist. You are always very welcome.

P: I love you too and look forward to our next meeting.

T: You can memories this encounter and remember it again and again as often as you want. Just imagine that you had this father and still have him.

As contradictory as this approach is, both the borderline and personality disorder therapies (DBT, TFP, schema therapy), as well as the approaches that help to make emotions that are too weak become perceptible (EFT, focusing, pessotherapy, emotion tracking), are all about ultimately empowering the patient to modulate his feelings in such a way that they can help him make his relationships satisfying for himself and others. That is, neither uncontrollably loud nor uncontrollably quiet. Without the basic skill of affect regulation, further therapeutic goals cannot be tackled.

2.4 Development and mentalization as a therapy goal?

Neither DBT nor schema therapy take the developmental aspect into account. Although they address biographical deficits in childhood, they do not address the gradual normal psychological development and its potential for disruption. McCullough's CBASP (2007), strategic short-term therapy or its long-term form (Strategic-Behavioural Therapy SBT, cf. Sulz 2017a-c) and MBT (Fonagy et al. 2008), in a modification of Piaget's developmental psychology, use a step model from which they determine therapy goals and derive interventions that would be more difficult to justify without these heuristics. It is not primarily about changing behaviour or experiences, but rather about the patient, who was previously only partially developed (and in whom affects still dominated in difficult relationship contexts) developing to the next higher mental level so that he can have a realistic TOM and have the ability to control his emotions. This part of the therapy is not primarily concerned with coming to terms with the quasi-traumatic experiences of childhood. Nor is it about correcting behavioural deficits in adults through systematic behavioural training. It is solely about enabling the patient to make the developmental step from the pre-mental (Piaget called this pre-operative) to the mental level.

The MBT approach has proven to be the best. By means of consistent and endless questions as to the whys and wherefores, the patient is forced to activate their PFC when they want to answer a question (Sharp & Bevington 2024). We know that our brain needs not just hundreds of repetitions, but thousands if its ability with regard to plasticity is to be stimulated to the point where lasting structural changes can occur. This catching up on development can be viewed as a neuropsychological intervention if one starts from the neurobiological perspective (Grawe 2004, Sulz 2021, 2022).

In the behavioural therapy setting, mentalization-supporting questions can be asked, as in the sample conversation below (Sulz 2021, p. 346f.). It becomes clear how different the two forms of conversation are (emotion support versus mentalization support). Above is the conversation that aims to help the patient find their way to suppressed feelings (emotion tracking) and below is the conversation that aims to lead the patient to reflection from the feelings so that feelings can be controlled:

A 35-year-old patient reports that she and her husband both have to take their holidays at the same time for work reasons, but her husband is going on a bike ride with two friends while she sits at home and has no friend who could do

something with her this week. He refuses to postpone his bike ride and go on holiday with her. She can`t stand being alone, but she also doesn't manage to gather friends around her often enough that the time alone only lasts a few hours.

- Why will you be alone?

Because my husband refuses to cancel his trip with his friends and go away with me for a week.

- Could this have been prevented?

I shouldn't have allowed it.

- What should you have done to prevent it?

I should have said that I wouldn't put up with being pushed aside like that. My holiday week is just as valuable as his.

- What stopped you from doing that?

There would have been an argument. He would have been angry.

- What fear prevented you from doing it?

I'm afraid of losing him, afraid of him leaving me.

- Which competing need was more important so that you refrained from doing it?

I need a close relationship that gives me warmth and security.

- What prohibitions prevented you from doing it?

I am not allowed to declare or even enforce my own wishes. That is forbidden.

- Do you forbid it for yourself or does the ban come from other people?

I had to experience this from a young age. My mother ignored me when I defended myself against her. And then I was afraid that she would send me to the home.

- What commands led you to do something else instead?

I have to adapt, I have to be docile and well-behaved so that he stays happy and doesn't become annoyed.

- What would have really happened if you had done it anyway?

I know that he won't leave me. And sometimes he gave in and wasn't angry with me for long.

- Would these consequences have been bearable?

If I knew that he wouldn't leave me and that he would only be mad at me for half a day, I could handle it.

- If not, why not?

But because I always think that he's going to leave me now, I can't stand it.

- What would it have taken for you to do it anyway?

I need someone by my side to remind me that my fear is a false alarm and that my husband will definitely stay with me.

- What kind of person would have been able to help you achieve this?

Someone who is an authority and who I believe and trust.

- What would this person have had to do for you to succeed?

Take me by the hand, calm me down, radiate that nothing will happen and give me courage.

- Would you like to imagine going in the company of this person to your husband and demanding that you want him to cancel the trip with his friends?

Yes, that is a tempting and exciting idea. I'm imagining this now. I tell him and he is surprised and impressed that I really mean it and am willing to follow it through.

- How does it feel to have managed it?

Really strong! With the support of my companion it is surprisingly easy. And achieving that is a great feeling!

- How does your body feel?

Powerful, upright, with good tension – with a kind of resilience

- Is it desirable for you to achieve this?

Definitely!

- Do you want to go ahead with this?

Preferably now.

- If this person is there as an inner invisible companion (you can decide that), will you do it?

Now I can really imagine doing it: tonight!

2.5 Permission for self-determination as a therapy goal?

Although the transformation of the prohibiting and commanding rule of survival into a rule of life that gives permission is the second therapeutic step in the therapeutic approach after establishing attachment security (Sulz 2021), it comes last in the considerations of this article: They are to free the inner working model as an emotional rule of survival that has become dysfunctional in adulthood from its dysfunctionality. To ensure that skills that were previously prohibited by this rule become part of the active behavioural repertoire. To ensure that over-adapted behaviour that was previously enforced by the imperatives of the rules or working model can be avoided. The working model is not linguistic-cognitive and not conscious. In therapy it is brought into consciousness and raised to a linguistic level so that it becomes accessible to change. The dysfunctional rule of survival can thus become a new rule of life that gives permission, e.g. “Even if I am less often friendly and compliant, and if I more often angrily demand what is due to me, I still maintain warmth and love and do not have to fear that I will finally lose the love of my attachment figures and be left alone.“ Before I can give

myself this permission, I have to get permission in a central relationship, which already happens implicitly or also explicitly in therapy, for example with imagination exercises or chair work. This intervention also makes therapies less laborious, as previous prohibitions are lifted and less resistance remains.

The resulting therapy theory puts attachment security first (Sulz 2021, 2022). Then the second step is to replace the old inner working model with a new rule of life that gives permission. This is followed by emotion regulation skills as well as behavioural and relationship competence. And all of this from the perspective of a heuristic that assumes that development from the affect level to the mentalization level is the main therapeutic change process (cf. Sharp & Bevington 2024).

Thus from a behavioural therapy perspective, we can begin to build a bridge between psychodynamic and cognitive-behavioural therapies. Despite all the differences, the common basis of knowledge and understanding (neurobiology, developmental psychology, emotional psychology, attachment research) is so large that the therapeutic procedure can approach each other in small steps, in so far as an understandable fear of contact can be overcome.

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