MST evaluation study 2 on the effectiveness of mentalization-supporting therapy

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ABSTRACT

Mentalization-supporting behavioral therapy (MST) is a variant of cognitive behavioral therapy (Sulz 2021a,b). The aim of mentalization-supporting behavioral therapy is to enable the patients/clients to develop their own theory of mind (ToM), which is still not realistic enough for forming relationships, to such an extent that they can look at their own motives, feelings and thoughts from the outside, comparing it to reality, and can put themselves in the shoes of their attachment figures in such a way that they can empathize with their needs and feelings. In 2021, the first MST evaluation study (Sulz, Brejcha et al. 2023) examined a short metacognitive training with the above mentioned seven modules.

The 2nd MST evaluation study reported here is based on this. The focus was to be on emotion tracking. The results correspond to the statements of the disorder and therapy theory of mentalization-supporting behavioral therapy (MST) (Sulz 2021a, b). This assumes that insecure attachment inhibits development and mentalization. Instead, the view of oneself and the world remains undeveloped and unrealistic (no realistic theory of mind). In central matters, the patients stay in the pre-mental affective stage. They make do with a dysfunctional rule of survival that sets commandments and prohibitions affecting the success of the way they lead their life. Even as an adult they still exhibit attachment insecurity. They do not develop enough functional personality traits with personal strengths. In contrast, attachment security in childhood allows a development towards the thinking and empathy stages. With the evolving ability to mentalize emotion regulation is not disrupted by a dysfunctional rule of survival but functional personality traits with personal strengths can develop.

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Despite the small sample size, clear to high correlations were found that were highly significant. The previous first MST evaluation study showed comparable results. The earlier studies were also able to make these connections visible.

Nevertheless, both larger samples and clinical samples comprising patients with mental and psychosomatic disorders are needed if generalizable statements are to be made.

Keywords

Mentalization-supporting behavioral therapy (MST), metacognition and theory of mind (ToM), attachment insecurity in childhood (VDS24 AI) and in adulthood (VDS20 AI), dysfunctional rule of survival (VDS35), emotion regulation & dealing with anxiety and anger (VDS32), functional personality traits – personal strength (VDS19+), mentalizing ability (VDS48), epistemic trust

Introduction

Mentalization-supporting behavioral therapy (MST) is a variant of cognitive behavioral therapy exhibiting many features of the behavioral third wave (Sulz 2021a, b). Like Aaron T. Beck's Cognitive Therapy (1979, 2004), it aims at changing dysfunctional emotions. Beck chose the path of changing dysfunctional cognitions through cognitive techniques such as Socratic dialogue, three-column technique and empirical hypothesis testing. MST does not stop at simple, cognition-triggered feelings in the situation, but goes to the metacognitive level. The patients take a bird's eye view and look at their motivational, emotional and cognitive processes from the outside, thereby gaining some distance and being able to see more clearly what the connections are due to the reduced intensity of their feelings. Their theory of the mental (Fonagy 1997) or theory of mind and thus their knowledge of human nature is elaborated through the constant reflection of the emotional triggers. The patients can better predict the behavior of their counterpart and thus achieve more satisfying transactions and experiences of self-efficacy.

Parallel to this metacognitive therapy, which in turn is based on the mentalization-based therapy of Peter Fonagy and colleagues (Fonagy & Bateman 2008, Fonagy et al 2008), conversations are conducted that are more reminiscent of the approach of Carl Rogers (1961, 1989) and very similar to the conversational style of Greenberg's emotion-focused therapy (Elliot et al. 2000, Greenberg 2007). We call this conversational style, according to Albert Pesso, emotion tracking (Sulz & Schreiner 2023): The patient talks about a stressful topic. The therapist observes the face and body of the patient and pays attention to after which statement (memory or visualization of a concrete event in an interpersonal situation) a new feeling occurs. He gives a twofold feedback:

a) He names the feeling (e.g. “I see how sad you are getting...”)

b) and adds the situational trigger (e.g. “...when you remember that your mother did not come back”),

c) he gives the patient time

d) to linger on the feeling and thereby perceive it more clearly

e) and to note the presumed causal statement about the trigger of the feeling.

This means that while the feeling is there, the event is mentally grasped.

This brings us to reflected affectivity, which, in Fonagy's understanding, constitutes the mentalization process. For us, mentalization and metacognition are roughly identical – the way we define both (Sulz 2021a, cf. Sharp & Bevington).

However, these therapeutic processes may only take place when the indispensable basis of secure attachment has been established in the therapeutic relationship. This can be achieved if the sequence of the seven MST modules is adhered to:

1. Secure attachment through a stable therapeutic relationship

2. Replacing the dysfunctional rule of survival (in analogy to the inner working model of Bowlby 1975, 1976) by a rule of life that gives permission, so that, for example, annoyed assertion is no longer forbidden

3. Regular mindfulness and acceptance exercises
4. Emotion tracking enables the conscious perception of central need frustrations in childhood and the emotional experience of relationships
5. Supporting mentalization through structured metacognitive interventions
6. Developmental support for the step from the body or affect stage to the thinking stage, which makes it possible to recognize causes and predict consequences of one's own behavior for more experiences of self-efficacy to take place
7. When a healthy egoism has emerged, a change in perspective can be encouraged (putting oneself in the other person's shoes), which creates empathy and compassion. The result is that the patient reports more frequently about relational episodes in which and after which both parties feel fine and a good relationship has developed.

The constructs of MST have been repeatedly confirmed empirically over the years. Theßen & Sulz (2024) and Theßen, Sulz et al. (2023) provide an overview. The report on the first MST evaluation study as an outcome test also contains a detailed presentation of the theoretical background with regard to disorders and therapy (Sulz & Schreiner (2024), Theßen & Sulz (2024a,b), Theßen et. al (2024a,b,c), Richter-Benedikt & Sulz (2024)).

In 2021, the first MST evaluation study (Sulz, Brejcha et al. 2023) examined a short metacognitive training with the seven modules mentioned above. The study included twenty psychology students from the Fresenius University in Munich as test subjects. The training comprised group sessions on seven evenings each lasting 90 minutes. The subjects first received a psychoeducational introduction to the respective module, followed by practical exercises. Because of the corona pandemic, live group sessions were no longer allowed to be held from the third evening of practice, so they took place online via Zoom. While in previous studies most of the time was devoted to emotion tracking, the topics and procedures in this study were evenly distributed among the seven modules. Accordingly, emotion tracking only played a minor role. The results were as follows:

a. The ability to mentalize was significantly improved (VDS38 (see Sulz, Esterbauer et al. 2022) and VDS48),

b. dysfunctional personality traits were reduced (VDS30) and

c. central anxiety could be better dealt with (VDS28).

d. The extent of frustration of children's needs were more intensely brought to awareness/reflected through the MST training (VDS24 AI).

The MST evaluation study 2 reported here is based on this. The focus was to be on emotion tracking, which is why in each of the six two-hour training sessions, after 60 minutes of psychoeducation on the seven MST modules, 60 minutes were devoted to emotion tracking (modules 6 and 7 were combined). All sessions took place on-site in a group therapy room. The group size was limited to ten. Six out of ten participants received an individual interview. The other participants were involved by playing the roles of caregivers who were of great significance in the reported problem context. If they were not asked to take on a role, they were given the task of practicing empathy by compassionately following the one-on-one conversation. While in the first MST study, the subject of the evening interventions was the metacognitive understanding of interpersonal problems by supporting mentalization (with little emotion tracking), the second part of the evening in this study was restricted to the emotional experience in emotion tracking with relatively little subsequent mentalizing.

The 2nd MST study

Sample

The study included 20 subjects (psychology students at the Fresenius University in Munich), aged 22 to 33 years (16 (80%) were female). 58 percent were in the first semester and 32 percent in the third semester. 65% were in a relationship, 20% still lived with their parents. They were offered handouts, videos and books/articles for rework. 60% made use of the handouts, 35% of the videos, and 25% of the literature.

Measurements:

The measurement instruments used in this study are listed in Table 1.

Tab. 1: Questionnaires of pre- and post-measurement

Pre-measurement

VDS32 *Emotion analysis II*

VDS20 *AI parents*

VDS19+ *Plus personality questionnaire*

VDS24 *AI adults*

VDS48 *Mentalization – REB relationship-emotion-body*

VDS 31-*KADE developmental stages*

Post-measurement

VDS32 *Emotion analysis II*

VDS19+ *Plus personality questionnaire*

VDS48 *Mentalization – REB relationship-emotion-body*

VDS31-*KADE developmental stages*

VDS35b *Evaluation of change of rule of life*

The **VDS19+ *Plus personality*** *questionnaire* according to Sulz (2017) focuses on the functional personality traits and the associated strengths and abilities of a person. The questionnaire serves as a counterpart to the VDS30 *personality questionnaire* (Sulz, 2013c), which records the dysfunctions most frequently occurring in individuals. In the VDS19+, each of the nine dysfunctional personality traits can be compared with a functional personality trait. The distribution of the mean scores in this sample is shown in Figure 1. This is a resource-oriented personality diagnosis.

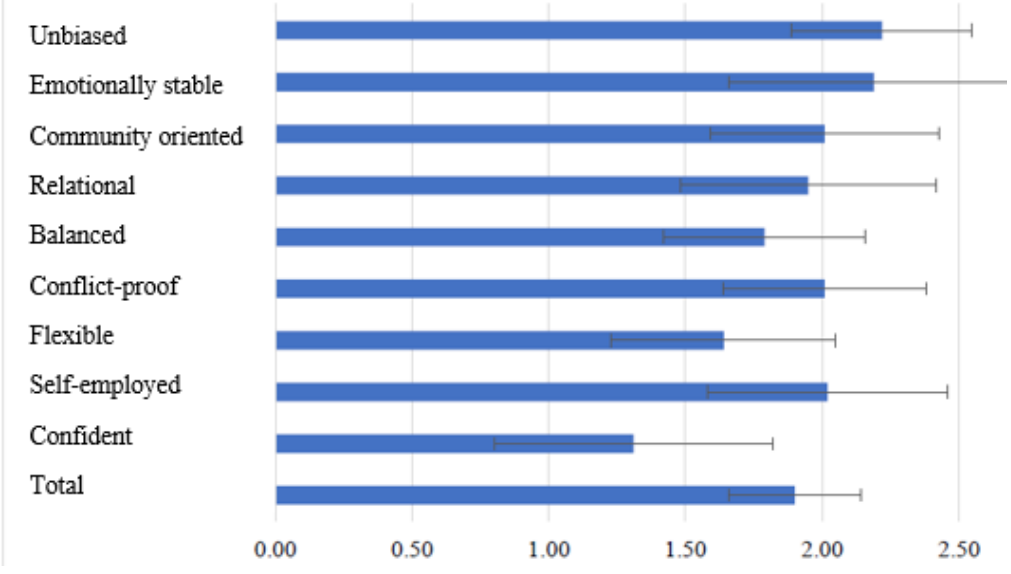

Figure 1 VDS19+ Personality (pre-measurement mean scores)

Attachment security is assessed using the **VDS20 *AI adults*** questionnaire according to Sulz (2022a,b). A higher score corresponds to an increased tendency towards insecure attachment behavior. The following questions are asked:

1) ( ) I was separated from my mother in the first two years of my life
2) ( ) I was very clingy in the first two years of my life
3) ( ) My mother was very stressed in the first two years of my life
4) ( ) She reacted very impatiently when she was stressed
5) ( ) She reacted furiously when she was angry with me
6) ( ) She threatened to leave me or send me away if she was angry
7) ( ) She provided little physical contact
8) ( ) She provided little emotional security
9) ( ) She provided little security, protection, reliability
10) ( ) I am still afraid of separation or loss of control
11) ( ) I want to walk away when I am extremely annoyed with someone
12) ( ) I am a rather clingy person or I find it difficult to commit
13) ( ) I do not like being alone or perceive being around people as tiring

A higher score corresponds to an increased tendency towards insecure attachment behavior. Even a total score of 4 indicates reduced attachment security.

The **VDS24 *AI parents*** questionnaire according to Sulz (2022a,b) examines the content of frustrated needs in a person's childhood and the associated attachment insecurity in childhood. It refers to the frustration of central needs (Sulz, 2013a).

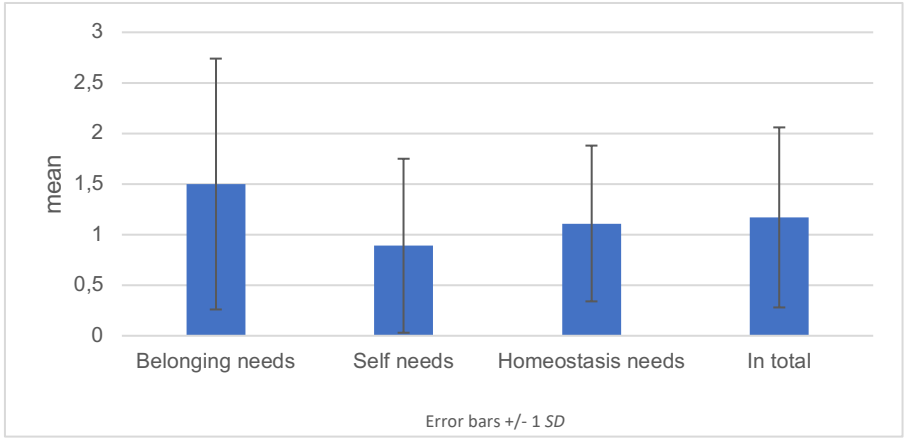

Figure 2 VDS24 AI parents Attachment insecurity in childhood – mean scores of frustration in need groups

VDS31-KADE developmental stages: The development questionnaire according to Sulz (2022a, b) records four stages of emotional and relational development (Sulz, Comanns et al. 2022). The present classification goes back to the work of Piaget (1978, 1995, Piaget and Inhelder 1980) and Kegan (1986). The questionnaire is made up of four dimensions: body, emotions, thinking and empathy (Fig. 3). We did not find any significant change in the postmeasurement.

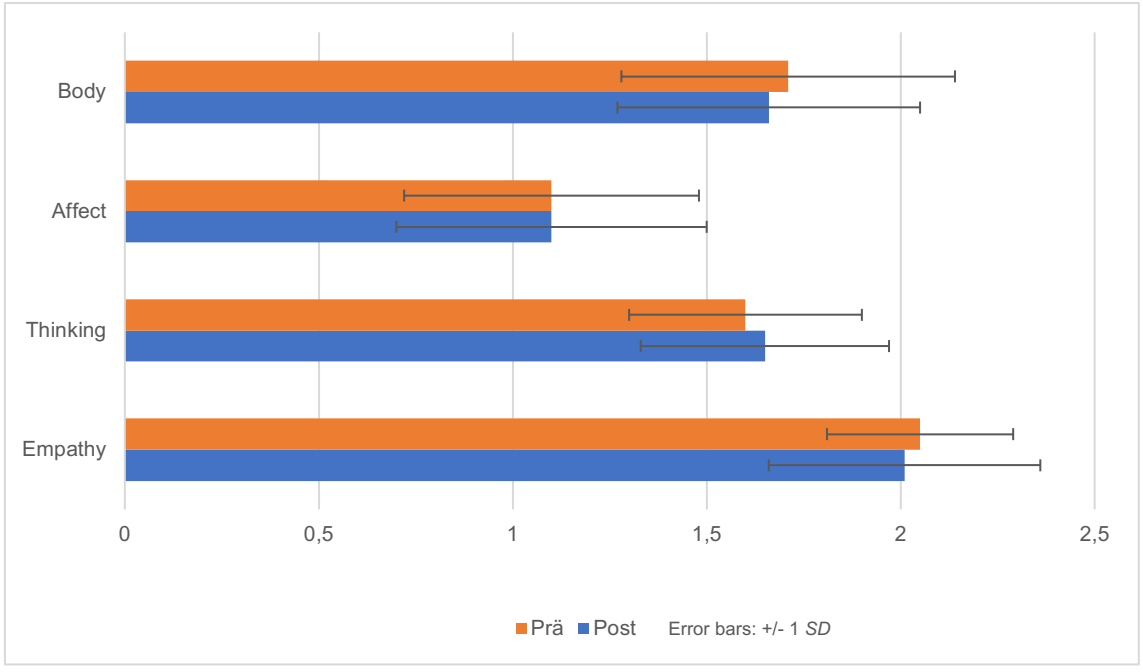

Figure 3: Mean scores of the VDS31-KADE developmental stages (pre- and postmeasurement)

The **VDS32 *Emotion Analysis II*** questionnaire according to Sulz & Schmalhofer (2010) and Sulz (2022a, b) considers an excerpt from the comprehensive VDS32 *Emotion Analysis* questionnaire (Sulz & Sulz 2005a, b). This includes the analysis of the experience with and acceptance or rejection of certain feelings, how to handle these feelings, and the reaction of others to your dealing with these feelings. In the context of this work, the focus is on the dysfunctional handling of feelings, which is why only the corresponding questionnaire excerpt is used.

Table 3 Items of the VDS32 Emotion Analysis II Dealing with Feelings (based on Sulz & Sulz 2005a,b)

1 I cannot do anything about my emotion, it is so intense and controls me.

2 I simply do not notice the emotion, even though I know that I have reason for it.

3 I just feel the emotion very weakly.

4 As a precaution, I take good care that no situation arises in which I feel this emotion.

5 I perceive a completely different emotion than the one that actually fits the situation.

6 I react more physically than emotionally.

7 I distract myself, tell myself that there is no reason for this emotion.

8 I give nothing away, I react more matter-of-factly or cautiously.

9 My emotion turns into a mood or upset that lasts for some time.

The questionnaire **VDS35b – *Evaluation of change of rule of survival*** according to Sulz (2020d) is the continuation of the VDS35a – *Dysfunctional rule of survival* according to Sulz (2013e). After developing the dysfunctional rule of survival, the patient/client is asked to consider its emotional meaning and answer the following questions (Tab. 4):

How does your rule of survival still affect you?

Table 4 The questions of the VDS35b Impact of the dysfunctional rule of survival

0 = not true 1 = somewhat true 2 = quite true 3 = very true

1	How true is your previous rule of survival for you? How much do you believe in its accuracy?	0 1 2 3

2	How much does your rule of survival determine your experiences and behavior?	0	1	2	3
3	How much do you fear negative consequences if you break your rule of survival?	0	1	2	3
4	How often do you act contrary to your rule of survival?	0	1	2	3
5	How strong are the negative feelings when the rule of survival is violated?	0	1	2	3
6	How well do you manage to act against your rule of survival?	0	1	2	3

The answers are very meaningful (Sulz 2020d).

The **VDS48 *Mentalization*** questionnaire according to Sulz (2022a,b) records the ability to mentalize. It surveys the increase in perception and understanding of one's own feelings and physicality, one's own development and to what extent recognition and understanding of the parents' characteristics have changed. For example:

Assess myself realistically in comparison with other people, i.e. as I really am

Assess other people realistically, as they really are

Expose restrictive/inhibiting commandments and prohibitions that I have assumed from childhood and transfer unchecked to my life today

Expose restrictive/inhibiting “wisdom” about the functioning of the interpersonal world that I have assumed from childhood and transfer unchecked to my life today

Recognize that today's behavioral pattern originates from childhood, trying to get what I did not get in childhood

Recognize that today's behavioral pattern originates from childhood, attempting even today to minimize a past threat

Recognize that today's behavioral pattern originates from childhood, trying to minimize my rage and anger

The evaluation leads to the following summary:

I can do better today...

Mentalizing the self (myself, feelings, needs, body, me as a child)

Mentalizing the world (mother, father, caregivers, biography)

s Feel, perceive

e Recognize

v Understand

a Accept

Total mentalizing ability

Results

VDS20-AI Attachment insecurity today

Mentalization-supporting behavioral therapy begins with examining the patients' attachment security. What resources do the patients have to create secure attachments today? How do they try to create a bond and to what extent do they fail? What recurring experiences do they make regarding secure or insecure attachments? And to what extent are

these experiences the result of their projective identifications (DRIBS) in the sense of a compulsive repetition as a transfer of insecure attachment experiences in childhood to relationships today?

For our test subjects, we can assess the last question by correlating today's attachment insecurity (VDS20-AI) with the experience of attachment insecurity with their parents in childhood (VDS24-AI) (Table 5). The latter occurs when parents constantly or repeatedly fail to satisfy their child's central needs and thus cause the child not to feel in good hands with them.

Table 5 Connection between today's attachment insecurity (VDS20-BU) and attachment insecurity with parents in childhood (VDS24-AI)

Correlation between today's attachment insecurity (VDS20-AI) and attachment insecurity with parents in childhood (VDS24-AI)		**VDS24 AI parents Attachment uncer-tainty childhood total**	VDS24 AI parents Attachment uncer-tainty childhood belonging	VDS24 AI parents Attachment uncer-tainty childhood self	VDS24 AI parents Attachment uncer-tainty childhood homeostasis
VDS20 AI adults Attachment uncertainty adults	Spearman Rho	**0.548****	0.466*	0.537**	0.506*
	Sig. (1-sided)	**0.006**	0.019	0.007	0.011

N	**20**	20	20	20

* The correlation is significant at the 0.05 level (1-sided). ** The correlation is significant at the 0.01 level (1-sided).

Table 5 shows that the correlation between today's attachment insecurity and frustration of central needs caused by the parents is highly significant (r = 0.548). The less the parents were able to provide secure attachment to their child, the less able is the person as an adult to establish attachment security.

Mentalizing ability as an adult (VDS48)

The aim of mentalization-supporting behavioral therapy is to enable the patients/clients to develop their own theory of mind (ToM), which is still not realistic enough for forming relationships, to such an extent that they can look at their own motives, feelings and thoughts from the outside, comparing them to reality, and are able to put themselves in the shoes of their attachment figures in such a way that they can empathize with their needs and feelings. The resulting metacognitions (thoughts about thoughts, etc.) allow the patients, for example, to recognize and understand why another person behaves in a certain way and what the likely consequences of their own behavior will be.

If we go back in the patient’s biography, we can try to capture the effects of attachment insecurity with parents as a child (VDS24 AI) on the ability to mentalize as an adult.

Table 6 Correlation according to Spearman: Individual dimensions of the VDS24 AI parents and VDS48 in the pre-measurement

			VDS24 AI parents Attachment uncertainty childhood belonging	VDS24 AI parents Attachment uncertainty childhood self	VDS24 AI parents Attachment uncertainty childhood homeostasis
Spearman Rho	**VDS48 Mentalization world (pre)**	Correlation coefficient	-0.692**	-0.604**	-0.658**
		Sig. (1-sided)	< 0.001	0.002	< 0.001
		N	20	20	20
	VDS48 Mentalization understand (pre)	Correlation coefficient	-0.622**	-0.536**	-0.579**
		Sig. (1-sided)	0.002	0.007	0.004
		N	20	20	20
	VDS48 Mentalization	Correlation coefficient	-0.525**	-0.574**	-0.603**

	accept (pre)	Sig. (1-sided)	0.009	0.004	0.002
		N	20	20	20

** The correlation is significant at the 0.01 level (1-sided).

While the total scores of VDS48 (pre) and VDS24 AI were not significantly correlated, numerous partial aspects of mentalization and attachment insecurity in childhood were highly significant (Table 6). The less parents were able to provide attachment security to their child with regard to the needs for belonging, autonomy and homeostasis, the lower is the mental ability to understand the world and to understand and accept as a partial function in adulthood.

Table 7 Correlation between the increase in mentalizing ability (VDS48) and attachment insecurity as adults (VDS20 AI adults) and attachment insecurity in childhood (VDS24 AI parents) in the pre-measurement

Correlation between today's mentalizing ability (VDS48) and attachment insecurity with parents in childhood (VDS24 AI)			**VDS24 AI parents Attachment insecurity childhood total**	**VDS20 AI adults Attachment insecurity adults**
Spearman Rho	**VDS48 total mentalization difference**	Correlation coefficient	0.678**	0.381*
		Sig. (1-sided)	< 0.001	0.049
		N	20	20

There was a highly significant correlation in the effectiveness of MST training with regard to the increase in the ability to mentalize (r = 0.678). The more insecure the attachment in childhood was, the more did the training increase the

overall ability to mentalize (Table 7). This result seems contradictory. However, it can be interpreted such that the increase in mentalizing ability is greatest when this ability was previously low. If you were already good before, you cannot gain that much.

VDS35 Impact of the dysfunctional rule of survival

The second step of supporting mentalization in MST consists in analyzing the functionality of the inner working model according to Bowlby (1975, 1976) or the rule of survival according to Sulz (1994, 1995, see Sulz & Hauke 2009). We assume that, in the absence of a realistic theory of mind, the child wants to ensure its emotional survival through a rule of survival that becomes dysfunctional in adulthood.

For example, a dependent person may have kept the following rule of survival from childhood:

Only if I am always friendly

and never contradict,

I keep my relationship

and avoid being abandoned and alone.

The more problematic the conditions in childhood were, the more consistently is the rule of survival maintained. Its validity is not questioned, and it also determines adult experiences and behavior in difficult situations or relationships. The adult fears threatening consequences of a violation and rarely acts against the commandments and prohibitions. If he does, immediately strong negative feelings arise that prevent the behavior from being sufficiently competent and effective and the person from repeating it. The questions in the VDS35 capture the impact of the dysfunctional rule of survival on adults (Table 8).

Table 8 Impact of the dysfunctional rule of survival VDS35b before and after. t-test for dependent samples

	M diff	Standard deviation	t-vlue	df	p
How true is it?	0,55	0,826	2,979	19	0,004**
How much does it determine me?	0,4	0,503	3,559	19	0,001**
How great is the anxiety when I violate it?	0,65	0,745	3,901	19	<,001**
How often do I act against it?	0,45	0,945	2,131	19	0,023*
How bad do I feel if I violate it?	0,65	0,671	4,333	19	<,001**
How can I counteract it?	0,65	0,671	4,333	19	<,001**

Figure 4 illustrates the extent of these changes.

Figure 4 Impact of the dysfunctional rule of survival before and after MST training

Developmental stage

After insecure attachment, dysfunctional rule of survival (which blocks effective emotion regulation) and a lack of mentalizing ability (which is necessary to be able to regulate emotions), the developmental stage at which the patient still is or repeatedly returns to, at least in very difficult situations, is a very decisive factor for the success of self- and relationship regulation. Both Fonagy et al. (2008) and Sulz (1994, 2021a) are oriented towards Piaget's (1995)

developmental psychology. In simple terms, we can differentiate between a physical stage in the 1st year of life, an affective stage in the 2nd and 3rd years of life, a thinking stage in the 4th year of life and an empathy stage from the 5th year of life upwards. Affect control is only possible from the thinking stage onwards, and a change of perspective and compassion is almost reliably achieved at the empathy stage.

Table 1 Correlation between developmental stages VDS31 and mentalizing ability (VDS48) in the pre-measurement

		VDS31 Affect stage	**VDS31 Thinking stage**
VDS48 total mentalization (pre)	Spearman Rho	-0.035	0.451*
	Sig. (2-sided)	0.883	0.046
	N	20	20

* The correlation is significant at the 0.05 level (2-sided).

The higher the measured values for the thinking stage are, the more pronounced is the ability to mentalize, while the affect stage does not correlate (Table 9).

Functional personality VDS19+ (personal strengths)

A person's positive development results in his/her personal strengths, which we measure with the VDS19+ questionnaire. It is the exact counterpart to the VDS30 questionnaire, which records dysfunctional personality traits and is based on the ICD10 and DSM IV classification (Sulz 2017). Functional means that these personality aspects promote the success of forming relationships and creating a way of life. We can examine to what extent attachment security and the ability to mentalize contribute to this, or to what extent attachment insecurity and a lack of mentalizing ability impair the development of these positive personality traits as personal strengths. Again, we can start in childhood. Though one might expect that childhood experiences no longer have a significant impact, the opposite seems to be the case:

We calculated correlations between total functional personality score (VDS19+) and attachment insecurity in childhood (VDS24 AI). The results show significant correlations between functional personality (total) and belonging needs ($r_s = -0.478$, $p = 0.03$, $n = 20$), self needs ($r_s = -0.561$, $p = 0.01$, $n = 20$) and homeostasis needs ($r_s = -0.568$, $p = 0.01$, $n = 20$). The more the needs for belonging, self and homeostasis are frustrated in childhood, the lower is the level of functional personality (personal strength) in the present.

We find something similar in the connection between the total value of functional personality (VDS19+) and the attachment insecurity of adults (VDS20 AI). The Spearman-Brown correlation is significant ($r_s = -0.446$, $p = 0.05$, $n = 20$). The lower the attachment insecurity as an adult, the higher the total value of functional personality (personal strength).

The correlation between functional personality (total) and dysfunctional handling of feelings is $r_s = -0.315$. Accordingly, high values in VDS19+ are associated with low values in VDS32. However, this connection is not statistically significant ($r_s = -0.315$, $p = 0.18$, $n = 20$).

Finally, correlations are calculated between the total functional personality (VDS19+) and the different developmental stages (VDS31). Here, a significant connection could only be found between the total functional personality and the developmental stage of thinking ($r_s = 0.466$, $p = 0.04$, $n = 20$). The more clearly a participant is at the thinking stage, the greater is his/her personal strength.

There is a particularly strong connection between mentalizing ability and functional personality ($r_s = 0.705$, $p < 0.001$, $n = 20$). Higher values in the VDS19+ questionnaire are associated with higher values on the VDS48 scale. The greater the ability to mentalize is, the greater is the personal strength (total value VDS19+).

Discussion

The results correspond to the statements of the disorder and therapy theory of mentalization-supporting behavioral therapy (MST) (Sulz 2021a, b), which assumes that insecure attachment inhibits development and mentalization. Instead, the view of oneself and the world remains undeveloped and unrealistic (no realistic theory of mind). In central matters, the patients remain at the pre-mental affective stage. They make do with a dysfunctional rule of survival that sets commandments and prohibitions affecting the success of the way they lead their life. Even as an adult they still exhibit attachment insecurity and do not develop enough functional personality traits with personal strengths.

In contrast, attachment security in childhood allows a development towards the thinking and empathy stages. The individual is now able mentalize, and as a result emotional regulation is not disrupted by a dysfunctional rule of survival but functional personality traits with personal strengths can develop.

Despite the small sample size, there were clear to high correlations that were highly significant. The previous first MST evaluation study showed comparable results. Even the earlier studies were able to make these connections visible.

Nevertheless, both larger samples and clinical samples comprising patients with mental and psychosomatic disorders are needed if generalizable statements are to be made. The evaluation process reported here is also an example of internal quality assurance in the sense of Sulz (2005, 2007, 2008, 2009, 2011).

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