8. Emotion and mentalisation supporting therapy in the group (EMVT-G)

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Abstract
Publications on the new therapy approach of Emotion and Mentalisation Supporting Therapy EMVT will be available from 2021. It is a modular psychotherapy that remains completely focussed on the individual patient in terms of goal formulation and treatment plan. In the first module, attachment security is established in the therapeutic relationship. The second module aims to replace the dysfunctional survival rule as a maladaptive schema with a new permission-giving rule of life in order to reduce therapeutic resistance. The third module promotes acceptance through mindfulness. The fourth module uses Emotion Tracking dialogue techniques to keep track of feelings. The fifth module serves to promote mentalisation or metacognition in order to elaborate the Theory of Mind (Tom). The sixth module uses Piaget's stage theory to help the patient develop from the affect stage (where feelings and needs determine every action) to the thinking stage, where causal thinking and goal-orientation become possible. Finally, in the seventh module, the development from the thinking stage to the empathy stage takes place, in which a change of perspective leads to empathy and compassion (also with oneself). There are particularly many therapeutic possibilities when the treatment is carried out in a group setting (EMVT-G). This article reports on this.

Key words
Cognitive behavioural therapy - metacognition - Theory of Mind ToM - mentalisation support - emotion tracking - body level - affect level - thinking level - empathy level - change of perspective - dysfunctional survival rule - secure attachment - mindfulness - acceptance - ideal parenting exercise - emotion exposure - anger exposure - grief exposure - anxiety exposure AACES - group psychotherapy

Introduction

The long name "Emotion and Mentalisation Supporting Therapy" already reveals the threefold origin of this new therapeutic approach: Emotive therapy with the aim of promoting the handling of feelings, needs and relationships - metacognitive therapy to promote the development of mentalisation skills - cognitive behavioural therapy with the aim of self-efficacy and relationship skills.

The foundation is cognitive behavioural therapy in the special form of evidence-based strategic behavioural therapy SBT (Sulz & Hauke 2009). Body-oriented emotive therapy builds on this, in particular the microtracking of PBSP (Pesso-Boyden-System Psychomotor, see Bachg & Sulz 2022), which we call Emotion Tracking. It leads to the third floor of the therapy building, the metacognitive or mentalisation training to build a realistic Theory of Mind (ToM), which borrows a lot from MBT (mentalisation-based therapy according to Fonagy et al. 2008).
The combination of these three approaches results in the Emotion and Mentalisation Supporting Therapy EMVT (Sulz 2021), the final name of which has only now been decided in 2025. The reason for the name extension is that the emotional therapy component of the treatment takes up at least as much space as mentalisation support.
In this article, this is presented in its group form as EMVT-G.

1. Strategic behavioural therapy SBT

We start with the cognitive-behavioural foundation (Sulz 2017a-d), which is applied in practice as Strategic Behavioural Therapy SBT.

This is based on the affective-cognitive developmental theory of behaviour (Sulz 2017b, p. 86):

- Based on Grawe's (1998) theory of therapy, we assume that human self-regulation takes place through implicit homeostasis and homeodynamic processes, so that the psyche is constantly changing and at the same time constant enough for a stable identity to emerge.
- To this end, homeostatic target values of need fulfilment, relationship quality, inner norms and values are strived for.
- Encounters with people in the social environment initially take place through perception.
- It activates motivational schemata such as anger, fear and positive affection. These in turn generate reactions with feelings, thoughts and action components.
- These have an effect on the social environment, whose response is in turn perceived and compared with the target values.
- However, the interaction can also begin with the social environment mobilising desires and creating incentives.
- In the case of mental disorders, self-regulation is derailed so that a symptom must be added as an emergency measure.
- Psychotherapy attempts to restore the previous self-regulation in such a way that a symptom is no longer necessary.

"This is based on three assumptions:

1. The human psyche autonomously regulates human sensation, perception, feeling, thinking and action in the sense of homeostasis (self-regulation and self-organisation) (cf. Sulz, 1987; Bischof, 1995; Grawe, 1998). Autonomy means that consciousness, as an "arbitrary psyche", has no constant controlling influence on self-regulation (Kanfer, Reinecker & Schmelzer, 2012), but merely serves as a measurement and control variable in this control system in the sense of cybernetics. Behavioural goals are not only created by target values at higher system levels, but also bottom-up from the constitution of new patterns of order through the interaction of lower system levels.
2. Humans have an inherent tendency to develop their emotionality (Piaget & Inhelder, 1980) and their interpersonal relationships (Kegan, 1986) throughout their lives. This development takes place mainly before the onset of puberty, particularly at pre-school age. McCullough (2007) points out that people only develop partially. Their psyche operates at a lower level of development in difficult and important situations. However, development can be continued at any time, e.g. with the help of psychotherapy (Sulz, 2010, 2012). Development from one stage to the next follows the laws of self-organisation. The order parameter changes. A new attractor is formed.
3. Human life and relationships are shaped far more according to the principle of construction and self-organisation than according to that of causality. This is the hypothesis of constructivism of the Palo Alto school (Watzlawick et al., 1974). Strictly speaking, the homeostatic principle already contains this assumption in the sense of purposefulness and instrumentality and functionality (Sulz, 2012). However, new patterns of order emerge from the self-organisation of subordinate subsystems of the psyche, which also construct the external social world.

Re 1: In the first three years of life, human self-regulation functions as "somatopsychic" homeostasis, based on the primacy of somatic and then also psychological survival. A medium-term survival strategy is indicated for the child: "I have to get through my childhood reasonably well." This implies that the resulting considerable disadvantages must be accepted in adulthood. Adult psychotherapy has to deal with these disadvantages of a successful childhood survival strategy. These survival strategies also bring considerable advantages for adult life, and there are certainly quite a few people for whom the advantages outweigh the disadvantages - perhaps for life, but perhaps only until the end of an athlete's career, for example, or until the midlife crisis of the careerist who fails to make the breakthrough, or until the retirement of the truly successful professional.

One of the main damages to children's homeostasis is that they are forced into a "psychosocial" homeostasis far too early - the primary regulation of the well-being and satisfaction of their social environment, i.e. their parents and family. The child is far from being able to think and act in this way and must therefore regulate its own behaviour with the help

of aversive feelings such as fear, guilt, shame and disgust - not for its own good, but for the good of its social environment." (Sulz 2017b, p. 86f)

The first publications on the predecessor of SBT, namely Strategic Short-Term Therapy SKT (Sulz 2017a), were published from 1994 (Sulz 1994, 1995).
"Behavioural therapy was originally "the" short-term therapy. Today, not many therapists have mastered the art of brief therapy. More and more, behavioural therapy has become "depth-psychological" - not necessarily in the sense of Freud, but analysing the deeper motives such as needs, fears and interpersonal relationships. And that takes time. Strategic short-term therapy has shown that all of this can also be effectively addressed in a short-term setting.
The shorter the therapy, the more extensive and differentiated the therapy preparation, the more precise the diagnosis and the more actively the patient and therapist move through the therapy process (Sulz 2019a,b). We can observe something similar in the ever shorter inpatient stays in psychosomatic clinics.
Deep emotional experience occurs very early on in short-term therapy - based on a secure, trusting and sustainable therapeutic relationship (problem actualisation according to Grawe, 1998). If the process remains cognitive, it remains superficial and stagnates early on. In contrast, the emotional experience during the therapy session leads to a mental reflection on the causes and interactions of problem development, symptom formation and maintenance. The result is acceptance of one's own limitations and the motivation to change. This means that the active part played by the therapist has essentially already been achieved. Now the patient becomes the actor, accompanied by the therapist - emotionally, mentally and relationally.
In order to control a short-term therapy confidently, the therapist must be aware of the process in addition to the two important aspects of relationship and therapy content. The therapy process consists of a cascade of therapy steps that recur implicitly or explicitly in every therapy, not rigidly like a staircase, but dynamically with an interchangeable sequence. Each step can harbour the opportunity for a decisive turnaround, but also the danger of getting stuck or failing." (Sulz 2017a, p. 11).

The term "strategic" is defined as follows: "Here, "strategic" is a synonym for "functional". In a systemic context, the function of a behaviour can refer to its function in the family system, for example, or to its function in emotion regulation and self-regulation as an individual. The subtitle of my book: "Therapiebuch III - von der Strategie des Symptoms zur Strategie der Therapie" (Sulz 2011) points to the actual meaning: The psyche, more precisely the autonomous psyche of

the human being (Sulz 1994) pursues a strategy of survival and uses a symptom to do so. This unconscious strategy is pursued with great energy. Like an Asian martial art, short-term strategic therapy takes up this strategy and its energy and turns it into a therapeutic strategy. It is not the therapist who invents and develops a strategy, but (unconsciously) the patient's psyche. The therapist only takes up this existing strategy and gives it a new direction. But she can only do this if she has understood the strategy of the symptom." (Sulz, 2017a, p. 12).
As quite a few patients have a longer road to recovery ahead of them, the long-term variant of SCT was developed as Strategic Behavioural Therapy (SBT) (Sulz & Hauke 2009), the evidence-based nature of which was demonstrated by Hebing (2012). It is a modular psychotherapy, starting with the "therapeutic relationship" module, followed by the "from the dysfunctional survival rule to the permission-giving rule of life" module, in turn followed by the "mindfulness and acceptance" module. This is followed by the "symptom therapy" module, in which all the disorder-specific interventions of behavioural therapy are applied. The "skills training" module helps the patient to have masterful behavioural patterns available in previously symptom-triggering situations so that symptom formation is no longer necessary. As behaviour is not primarily conditioned but developed, a "development" module follows, based on Piaget's theory (1978, 1995), which promotes the development from the affective-impulsive to the sovereign-cognitive level and also accompanies the further development to the interpersonal empathy level. Based on the frustrated needs and central fears caused by learning history, the survival rule, which becomes dysfunctional in adulthood and represents the core of therapeutic resistance, is developed. This is overcome by reformulating it into a new rule of life that gives permission.

2. Pessotherapy PBSP

Although the cognitive behavioural therapy practised with SBT is effective, as the evidence-based study by Hebing (2012) shows, there are quite a few patients for whom this method does not succeed in reaching the actual control points of human behaviour - the needs and emotions. Cognitive-behavioural interventions do not succeed in fulfilling Grawe's (1998) demand for problem actualisation (emotional immersion in the problem) in as many sessions as possible. If you look at humanistic therapies such as Gestalt therapy, client-centred psychotherapy, etc., you will only find two approaches that really enable this actualisation: Greenberg's emotion-focused therapy (2000, 2007) and Albert Pesso's pessotherapy (PBSP) (Bachg & Sulz 2022). The latter has the great advantage of a pronounced resource-orientation and extensive body-therapeutic interventions.

"Far ahead of his time, Al Pesso and Diane Pesso-Boyden developed a now generally recognised dual process theory of the human psyche with an emotional and a cognitive-control system (pilot) from 1961 onwards. Pesso had a simple theory of the human psyche that is generally recognised today: **emotional** system (limbic system) and reflective system (prefrontal cortex), which he called **Pilot** (President of the United States of the Human Psyche). Whereby our experience today is completely coloured by our **memory**, especially our memories from our childhood years. These memories are **physical, pictorial,** emotional, associative (similar things belong together). Our pilot, on the other hand, is cognitive-linguistic, thinking causally (cause and effect belong together).

In his profoundly humanistic view of man, Albert Pesso sees the four innate tendencies or strivings of man as joy in life, fulfilment of basic needs, meaning in life and connection with people. Human life leads from the fulfilment of the basic needs for space, food, support, protection and boundaries to the integration of polarities that would otherwise drift apart, to the development of consciousness in order to recognise the meaning of life, to the development of the pilot in order to act consciously and responsibly and to the realisation of our uniqueness and our potential for development.

Three phases of development are distinguished:

- Phase 1: Parents must **satisfy** basic needs **in concrete interaction**, e.g. setting up a real physical space for the child
- Phase 2: Parents must **satisfy** the basic needs **symbolically**, i.e. give the child a fixed place in their heart
- Phase 3: Only then is it the child's turn to give themselves what they received from their parents as a child. **Self-care** needs a history of care in the relationship with and through the right caregivers at the right age. Only when this has happened can and should we move on to self-care. We now treat ourselves as well as our parents treated us.

In the Pesso structure (50-minute individual dialogue (individual work in the presence of the group), a "virtual symbolic stage" (Pesso, 2005, p. 307) is set up alongside the real here and now of the room in which the therapy takes place. This is located in the patient's past. It therefore has to do with the patient's memories, with events "that took place at different ages, in different places and with different people" (Pesso, 2005, p. 307). These are to be externalised and brought to life on the virtual stage. In this way, it also becomes visible how the neglect and violation of the child's needs

influences the present and disrupts the patient's actions and thoughts in the here and now. As mentioned above, the new synthetic and healing experiences should help the patient to positively balance the negative experiences of their own biography.

The trauma therapy concept is a speciality. The core of Pesso's **trauma therapy** is:
Trauma means

- Destruction of the protective shell that separates outside and inside.
- Powerful energy escapes to the outside without limits.
- Knees tremble, tend towards extreme opening,
- need limitation, to hold together.
- Unprotected seeking of help leads to repetition,
- as the "therapist" becomes directive and "the rapist".
- Instead, re-establish the pilot, not emotionally, but masterfully, controlling what is wanted and how, and where the boundaries are.

The play on words "therapist" verses "the rapist" is very drastically formulated. It points to the danger of repeating aspects of the trauma.

Bessel van der Kolk (2021) described pessotherapy as perhaps the most effective trauma therapy.

Before a structure can even be started, the therapist must first explain all the basic theoretical and practical principles of Pesso therapy to the group members. These include such concepts as form-fit, the basic developmental needs and their effects, the principle of accommodation and microtracking (cf. Schrenker, 2005, p. 347). At the end of the exercises, as at the end of a structure, there is a round of mutual sharing. The participants should report on the feelings they have experienced and not comment on or even interpret the exercises of the others (cf. Howe & Perquin, 2008, p. 147)". (from Sulz 2023, p. 419ff)

3. Mentalisation-based therapy MBT

Mentalisation is currently the hottest topic in psychotherapy. Peter Fonagy and colleagues (e.g. Fonagy et al. 2008, Schultz-Venrath 2021) developed MBT (mentalisation-based therapy) as a new psychotherapy for borderline patients, which can look back on the best results to date in the field of personality disorders. It is recommended as the first choice in the guidelines for borderline therapy. Application, research and publications spread explosively across the entire psychotherapy scene. In contrast, the hype surrounding dialectical behavioural therapy DBT (Linehan 2016a,b) and schema therapy (Young et al. 2005) was only a small fire.

However, what all these therapeutic approaches have in common is that they were initially only intended for borderline disorders. Although only a few psychotherapists worked with these patients to any significant extent, interest in the treatment of personality disorders was and remains huge. Perhaps because problems in dealing with emotions and close relationships affect us all and are therefore more exciting than depression or anxiety therapy. However, there are not yet many studies that show that these new borderline therapies are on a par with or even superior to the classic therapeutic approaches for Axis I disorders. The pioneering spirit and enthusiasm will certainly have an impact on the outcome results.

What is special about MBT is that it is a psychoanalytically based psychodynamic method of psychotherapy. However, it equally draws on Bowlby's attachment theory (1975, 1976). Psychotherapists who have no depth psychological or psychoanalytic training are explicitly encouraged to use MBT even without such training. This means that psychoanalytic metatheory and depth psychological therapy training are not required. Presumably this requires further in-depth discussion.

Following this invitation, I first turned to MBT and adopted the universal conception that applies to all therapies and all patients, in the sense that attachment theory became my theoretical basis and the therapeutic goal of mentalisation ability came first.

Another characteristic of MBT is that it is a group therapy (Schultz-Venrath & Felsberger 2016). It is also possible to help patients to mentalise more and more in individual sessions. But MBT as a method was intended for the group setting. Those who do not conduct group therapies were also invited to use the MBT concept for individual patients.

A final characteristic is that MBT was developed and recommended for day hospitals and outpatient clinics.

The clinical experience of many clinicians shows that MBT can be used for virtually all patients and all mental disorders in all settings (Sharp & Bevington 2024). Research results will not fail to materialise. While the core of MBT has remained, in

some respects it has developed in a similar way to, for example, schema therapy, which has greatly enriched its therapeutic repertoire by borrowing from other therapeutic approaches.
When this development has progressed, it is difficult to draw boundaries. People then say: We do that too.

4. Integration: Emotion and mentalisation supporting therapy EMVT

The reason why we didn't completely turn to MBT, which we were very enthusiastic about, was because Serge Sulz had previously completed training in pessotherapy PBSP (Bachg & Sulz 2022) and had been working with its concept for twenty years. This is a body and emotion-orientated humanistic therapy whose basic attitude and view of humanity corresponds to Carl Rogers and John Bowlby. If MBT used this approach via emotions and the body, it would no longer be MBT. MBT cannot remain with the physical and purely emotional experience for so long and so extensively. Pessotherapy enables a lot of mentalising, but the ratio of going into the depths of feelings and needs and taking the external perspective (seeing oneself from the outside) is the opposite of MBT. In other words, 80 % deep emotional experience and 20 % understanding reflection. Why we didn't stick with pessotherapy is this disadvantage of many humanistic therapies such as Gestalt therapy: getting out of the emotional whirlpool in such a way that as much lasting understanding as possible is made possible. Classical MBT, on the other hand, lingers too briefly in the whirlpool.
We try to achieve a 50:50 ratio with EMVT (Emotion and Mentalisation Supporting Therapy, Sulz 2021a,b, Richter-Benedikt, Schreiner, Sulz 2024).
EMVT is a variant of cognitive behavioural therapy (Sulz (2021a,b). In a similar way to how Fred Kanfer (2000) composed his self-management therapy, it orchestrates evidence-based behavioural interventions in such a way that optimal gains are possible for individual patients.

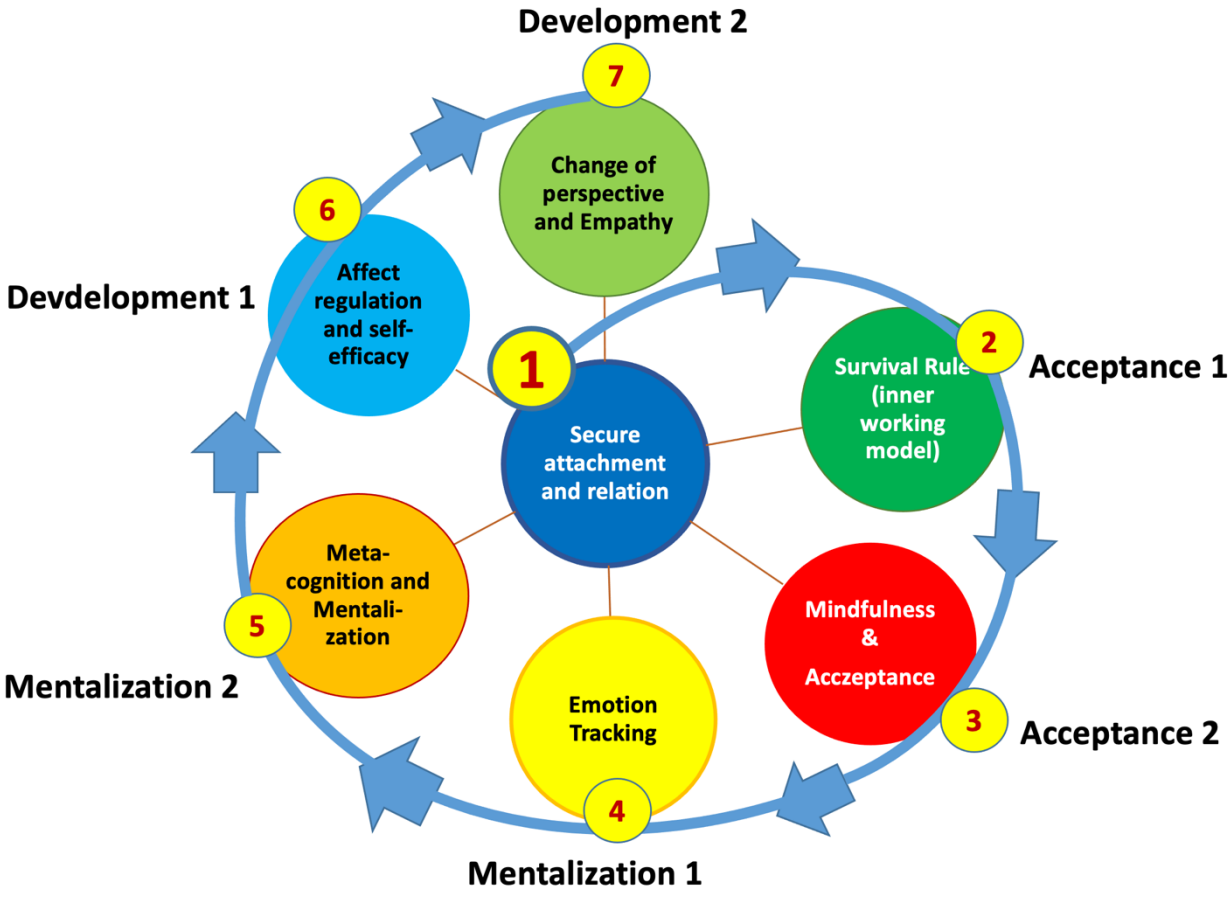

Figure 1 The 7 modules of Emotion and Mentalisation Supporting Therapy EMVT

EMVT consists of seven modules (Fig. 1), which are based on the patient's particular problem:

1. Lack of attachment: **NOBODY IS THERE! I am alone.**
2. Dysfunctional survival rule (inner working model) **I must not defend myself, claim ...**
3. Mindfulness and acceptance: **I am not aware of many things**
4. Emotion tracking - deep emotional experience: **NOBODY SEES what I feel - my pain**
5. Mentalisation - metacognition**: I don't recognise why people behave the way they do and not what my actions lead to**
6. Development from the affect level to the thinking level (self-efficacy): **I can't regulate my feelings - I can't find a solution to a problem**
7. Development from the thinking level to the empathy level (empathy and compassion)**: I cannot empathise with others**

The 7 therapy modules proceed accordingly:

1. Attachment security: **secure attachment in therapy**
2. From the dysfunctional survival rule (inner working model) to the permission-giving rule of life: **making new permission the rule of life**
3. Mindfulness and acceptance: **creating awareness**
4. Emotion tracking - deep emotional experience: **becoming aware of feelings + understanding triggers**
5. Mentalisation - metacognition**: elaborating the 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 level to the empathy level (empathy and compassion) **Empathic communication**

Strategic Behavioural Therapy SBT (Sulz & Hauke 2009) is the predecessor of EMVT. It already contains the majority of these modules. Modules 4 and 5 are completely new. Module 4 is emotion tracking borrowed from Albert Pesso (Bachg & Sulz 2022), which he called microtracking. And Module 5 is the explicit mentalisation supporting conversation technique. Working with Bowlby's inner working model (dysfunctional survival rule) and the two developmental therapy modules were already integrated into SBT.
As most therapists had not previously carried out group therapy, the EMVT concept was initially developed for individual therapy: a lot of psychoeducation, which was enriched with imaginations to enable emotional experience. Mindfulness

exercises to improve emotional awareness. Emotion tracking with chair exercises for anger exposure and with imagined ideal parents (possibly also Pessos Holes in Roles: ideal parents for the parents).
However, the ideal way to deal with emotions is to work in groups, which is presented in the EMVT-G concept.

5. What characterises EMVT-G group therapy to promote emotion and mentalisation?

EMVT-G is carried out with six to eight patients as modular psychotherapy. It is not intended for patients with personality disorders. Indications are Axis I disorders such as anxiety and obsessive-compulsive disorders, depression, somatoform disorders, etc. Approximately 20 sessions of two hours and 100 minutes each are planned.

In the first hour of an evening, an individual discussion takes place in the presence of the group: Emotion Tracking. The patient/protagonist reports on a current emotional problem and the therapist addresses it using the Emotion Tracking dialogue technique. The group members should adopt an empathic and compassionate attitude: go along with them emotionally. The therapist observes the body, especially the face, and addresses perceived feelings, which then become the common thread in the conversation. There may be exposure to grief or anger, which takes place in role play. Towards the end of the conversation, a constellation of ideal parents is made as an "antidote", which leads to very touching moments for the protagonist and the group. Finally, there is a debriefing using the conversation technique of mentalisation supporting questions, so that a deeper understanding is achieved and the Theory of Mind ToM (Sodian 2007) is gradually elaborated more and more. In 20 sessions, each patient receives three individual counselling sessions.

The second hour of an evening is psychoeducational. There is a lot of work with paper and pencil and role play. Thematically, we proceed along the series of seven modules (about three sessions per module).

This description makes it clear that although MBT and EMVT-G have the same goals, they are fundamentally different in their approach.
We can now move on to group practice.

6. The practice of EMVT-G groups

Preparation of the group leaders

You have an advanced or completed behavioural therapy training or further training.
And if you want to bill your group therapy with the health insurance companies, you also have additional group therapy training (VT). This includes 48 hours of theory, 120 hours of leading your own group therapy sessions with 40 hours of supervision.
So far, however, I have had no problem finding self-payers for the group. The costs for the individual are not high. You can charge 30 or 40 euros per evening. If there are six participants, you then have a fee of 240 euros per evening.

Whether you have group therapy training or not. You should prepare yourself theoretically.
If you have completed training in Strategic Behavioural Therapy SBT, you are well prepared theoretically. And perhaps read up again:
In my easy-to-read (also for patients) popular science reader *"When Sisyphus let go of his stone. Or: Falling in love is crazy."* - The chapters describing the 43 most important feelings, the 21 basic needs, the seven basic forms of fear and anger, the nine dysfunctional personality traits and the six developmental stages are the most important theoretical framework for EMVT group management.
You can read the same at a scientific level in:
Sulz, S.K.D. (2017a). Learning and mastering good behavioural therapy - Volume 1: Behavioural therapy knowledge: How to achieve a deep understanding of people and their symptoms. Giessen: Psychosozial-Verlag
Sulz, S.K.D. (2017b). Learning and mastering good behavioural therapy - Volume 2: Behavioural therapy practice: Everything you need for good therapy. Giessen: Psychosozial-Verlag
Once you have learnt the basics in this way, you should read the EMVT book:
Sulz, S.K.D. (2021b). Mentalisation supporting behaviour therapy. Development of affect regulation, self-efficacy and empathy. Giessen: Psychosozial-Verlag.
Sulz, S.K.D. (2022a). Healing and growth of the wounded soul. The practice of mentalisation supporting behaviour therapy. Giessen: Psychosozial-Verlag.
However, your preparation can be even more thorough and differentiated if you make use of the free YouTube lectures and PowerPoint presentations that are part of the EMVT training programme. I highly recommend them. In this way, you will soon lose the uncertainty of the beginner.

This is how you can proceed:
Go to the EMVT website and browse through the many EMVT offerings:
https://eupehs.org/haupt/mentalisierungsfoerdernde-verhaltenstherapiEMVT/
Then get an overview of the extensive free pool of EMVT training courses, lectures, therapy videos, training materials and manuals:
https://eupehs.org/haupt/mentalisierungsfoerdernde-verhaltenstherapiEMVT/tetseite/
Now you can focus on **EMVT training in therapist behaviour:**
https://eupehs.org/haupt/mentalisierungsfoerdernde-verhaltenstherapiEMVT/uebungen-des-therapeutenverhaltens/

First you should practise learning to recognise feelings in the face of the person you are talking to. Then you can immediately do an exercise with photos of faces with a certain emotional expression, in which you practise mirroring the recognised emotion. The third essential exercise is the antidote exercise: you read a statement from a patient about an emotional problem. You give empathic feedback and tell them which need remained unmet and what they really needed.
This training provides you with the two **core competences of EMVT**:

a) Recognising and mirroring feelings in the face and naming the triggering context (promoting mentalisation)
b) Empathically and compassionately reporting back unmet needs, expressing their satisfaction and thus creating a click of closure (joyful anticipation and immediate visualisation of satisfaction)

The other exercises will also prepare you for emotion tracking:

- ET1a Mrs N Example conversation Emotion tracking without embodiment
- ET1b Mr C Whole therapy session Emotion Tracking with explanations
- E1c Ms N Example conversation Emotion Tracking with embodiment (body signals)
- ET2a Exercise Recognising the 43 feelings with photo: Learning to see feelings
- **ET2b Exercise Seeing feelings with context photo and naming and mirroring the triggers of the feeling**
- ET2c RMET Reading the Mind in the Eyes Test: Here is the link:
- -https://www.as-tt.de/assets/applets/Augentest_Erwachsene.pdf
- I can also send it to you on request.
- **ET3 Practising empathy with many examples: You would have needed ... (Antidote)**

Preparation of the group sessions

Ideally, your group room should be 20 square metres in size. You will need 10 chairs for 8 participants (lightly upholstered - one extra for chair work). Some people like flip charts, I prefer to hand out worksheets that you can download and print out before the session. Your patients will need their own paper with writing pad and pen. If there are ideal parents in the role play and the child wants to cuddle up to them, a small cushioned landscape as a sofa would be good. If anger is to be expressed with all your might, a cushion to absorb the blows would be helpful.
In the first hour of the group evening, the chairs are arranged in a circle. When the emotion tracking begins (2nd hour), we divide the room into a stage for role play and constellations and a room for the observers. The observers sit in a semi-circle around the group leader so that everyone can see the protagonist's face. A witness chosen by the protagonist can sit to the left or right for the emotion mirroring, but they only say exactly what the group leader has recognised, e.g. "I can see how sad you get when you remember that he didn't want to visit you."
After the emotion tracking, everyone sits in a circle again for the round of sharing and for the metacognitive reflection, which begins with a dialogue between the group leader and the protagonist that later opens up into a group round.
The terms mentioned here will be explained later.

This is how emotion tracking typically works:

1. Patient: reports on emotionally stressful relationship
2. Therapist: listens empathically and observes the face
3. Therapist: "I can see how painful it feels. (Emotion Recognition)
4. Therapist: ... when you remember how he treated you." (metacognition/mentalisation)
5. Patient: agrees or corrects
6. Patient: continues the story based on this feeling
7. Therapist: empathically senses what the patient would have needed
8. Therapist: You would have needed someone to stand by you (antidote)
9. Patient: confirms or corrects
10. Patient: can see the fulfilment of needs in their mind's eye
11. Therapist: asks where, who and how and asks for a description

12. Therapist: asks what the satisfying person could say
13. Therapist: repeats this sentence and sees what feeling arises
14. Therapist: asks where, with whom and how this can be obtained today
15. Therapist: asks what the patient would have to do to get it

The basic attitude of the group leader during emotion tracking

We compare the basic attitude of the EMVT group leader in emotion tracking or in the mentalisation supporting debriefing with conventional conversation in cognitive and psychodynamic therapies (Table 1). What is important is what we try not to do/say during emotion tracking (left column), compared with the behaviour we are aiming for (right column). The justification and discussion is recorded in the line below, starting with an asterisk (*).

Table 1 Basic attitude in emotion tracking - reasons for the approach (adapted from Sulz 2021, pp. 313-324)

	What I <u>don't</u> do as a therapist during emotion tracking?	**Instead, I will ...**
1	**<u>Not:</u>** As a therapist, suggest a topic to the patient	The patient brings in a topic themselves, based on their current emotional distress
	It is almost always a relationship problem that has often culminated in a stressful event or an oppressive feeling regarding the relationship with an important attachment figure. The patient determines what we address. We approach it with a client-centred attitude. We follow them with our full attention and give the patient as much time as they need to communicate their concerns clearly. The patient is the actor and not me as the therapist. As we meet them at eye level, they don't have to feel small.	
2	**<u>Not:</u>** Remain critically cool and objective	warm-heartedly attentive
	A secure attachment is an absolute prerequisite for immersing yourself in the complexity of your feelings and needs. The attachment system or security system as defined by Bischof (2001) should soon be able to calm down, feel secure and	

	make no further efforts to make the therapeutic relationship more secure. Otherwise, the patient is not so much concerned with the issue being addressed, but with getting me to form a secure bond with him as a new attachment figure. An objective, neutral to coldly analysing attitude as a therapist does justice to the issue, but not to the person. In the current situation, however, I can reach him through warm-heartedness. This gives the impression of being in good hands (security and protection). If this has been successful, the oxytocin level has increased in both patient and therapist.	
3	**Not:** Being open without intention	Interested and committed
	As a therapist, I could be open, inviting and available, while remaining unintentional and not engaging - so that it would correspond to the attitude of mindfulness. I can therefore welcome the patient in a mindful and accepting way without actively engaging with the patient. This is the first big step. The patient can feel welcome. But the patient's need for connection demands more. I am there, but not just for him. So that they can feel that I am actively engaging with them and that I only mean them now. He needs to feel my interest and commitment, to feel how important the encounter with him is to me.	
4	**Not:** Structuring the course of the conversation by asking questions Leading the conversation	Follow all of the patient's statements and expressions
	As a therapist, I deal with the interplay between leading and following very consciously and stick to following as long as the flow of the conversation allows. I leave out questions that create mental clarity and structure. This is because the choreography of emotion tracking already creates a high degree of structure. I pay close attention to the stories and the associative processes of consciousness they trigger - it is often inner images that trigger feelings whose somatic markers I recognise. I immediately reflect these in a marked way (much less agitated than the patient). I follow and accompany his feelings while I speak compassionately.	

5	**Don't:** Stay completely with my empathy without paying attention to somatic markers	Both feeling empathy and seeing the somatic marker of the feeling*
	*During a phone call, we should rely entirely on our listening and empathy. In a face-to-face conversation (as in a video call) we have two channels of information at our disposal: auditory and visual. Listening to the narrative involuntarily creates an inner image or a film of the reported scene and we put ourselves in the patient's shoes, feel with them, perceive our empathy and thus recognise the patient's feelings. This is the first channel of information. We concentrate just as much on the somatic markers in the patient's face and body. Our mirror neurones help us here. Our own facial muscles generate a pattern that corresponds to the patient's - with a lower intensity than the patient's, so that a labelled mirror reflection takes place. Our body signals this emotional state to us, which helps us to decode the patient's emotional state. On the one hand, I am empathising with the patient and on the other, I am with myself and my proprioception. This is also a somatic marker, barely visible to the patient, but clearly perceptible to me. So my first reaction is to empathise with the patient, then I feel myself and my own feelings, then I go back to the patient. This is how we manage to become more and more accurate after practising for a long time.	
6	**Not:** Asking about the feeling that is there at the moment	See and express the patient's feeling*
	*As long as we are not sure, we simply ask the patient what they are feeling. However, they first have to feel it again because they may not yet be aware of it. So it's not easy for the patient to answer my question clearly. He is happy, when I offer him my perception and he can compare it with his perception and confirm that we both perceive the same thing. However, we should increasingly dare to say what we see or suspect. So that we can leave our initial uncertainty behind us. We do no harm if we name the wrong feeling. This is part of our learning process of "emotion recognition". It is not only allowed, but even necessary.	

	With every correct mirroring, the patient feels seen, which promotes rapport and bonding so that they can feel more at ease with me.	
7	**Not:** Mirroring a feeling without adding the context	Always mirror the emotion with the triggering context - add the aspect of the situation that triggers the emotion*
	*It is enough for the patient's emotional experience if, for example, I say compassionately, "That makes you very sad." He stays with his feeling and feels accompanied by me - he is not alone with it. I am there with him. I share his sadness with him to a certain extent. "I bring a small disturbance into the harmony by mirroring what he is feeling, i.e. by not being as sad as he is and thus returning the problem as manageable. But both being with him in his sadness and the fact that the pain that my marker signals can be limited alleviate the suffering and give hope. Now comes the second small disturbance. I do not leave the patient in a purely emotional experience, but express the contingent context. I add the trigger of the feeling: "It makes you very sad that he didn't come." I say that his feeling was triggered by the behaviour of his caregiver. More precisely, by the memory of their behaviour (not coming to him). The cause of his feeling is therefore the remembered behaviour of the other person. I am therefore making an if-then statement. This implies logical thinking, thinking in categories of cause and effect. The patient can only understand my statement if they activate their prefrontal cortex, which helps them to mentally comprehend what I have said. So in addition to the emotional processes in the limbic system, a metacognitive or mental process is set in motion in the cortex. The patient mentalises. This means that they think about their feeling and its cause. He realises what triggered the feeling. Adding the triggering context to the perceived and mirrored feeling is therefore a decisive step in the course of the patient's consciousness processes. I promote mentalisation. He practices mentalising. He elaborates his theory of mind, his theory of the mental. This helps him to attribute behaviour to inner causes." (Sulz 2021, p. 314)	

8	**Not:** Repeat in my own words what the patient has said	Repeat the patient's statements in their own words, pick up on their language*
	*We psychotherapists should listen more often to how much we use technical language that the patient has to try to translate into their own language. Technical terms, foreign words and a written rather than spoken language. To do this translation work, he has to switch from his feeling experience to thinking, i.e. from the limbic system to the prefrontal cortex. The thread of his emotional experience is already broken. That's why we should take up the patient's words as precisely as possible. To do this, I have to make the effort to memorise the words he has used as precisely as possible. In this way, we become an increasingly helpful companion.	
9	**Not:** What we do automatically: Concentrate on following the patient's thoughts or their further narrative and thus overlook the feeling that is currently present	Prioritise staying with the feeling without letting the patient drift off into thoughts or following the rapid progression of their story*
	*It's like knitting: don't skip a stitch. We have to slow down the storytelling. He wants to tell us his story. We, on the other hand, want to hold on to the feelings created by his story. In further rows, the feelings that have just flashed up quickly disappear again. Only if I interrupt the patient as soon as I notice a new feeling does it remain in his consciousness. We think we are rude, but the patient doesn't mind much. And so together we manage to recognise and understand the feeling and its meaning.	
10	**Not:** Mirroring a strong emotion - a strong feeling unlabelled	When an intense feeling arises in us, we do not respond in a reflexively sympathetic way, but only mirror it in a labelled way (with less intensity)*.
	*If the patient's story horrifies us, frightens us or makes us as angry as he is, we tend to spontaneously agree with him by expressing our great indignation. This can give him the feeling that he has won my support. But it's about the intensity of	

	my emotional expression. Am I suddenly caught up in this emotion like him? It helps if I only go in with one leg. My remaining leg helps us both to put what has happened into perspective and to be accessible for solutions.	
11	**Don't:** Address the patient's unconscious bodily reactions that do not indicate an impulse for action that we want to focus on next	If we see a physical nervous or stress reaction, e.g. intense redness in the throat area, we do not speak about it. This is because we do not name the somatic marker, but the feeling that it indicates/marks*
	*We can distinguish between two different bodily reactions. One is simply an expression or somatic component of the feeling. It is no help to the patient if we say that he is flushed or that he got red spots on his neck or that he started sweating. He even feels caught out or embarrassed. The second type of bodily reaction is movement impulses that may be held back. Clenching his fist, moving his legs as if he wanted to run, leaning forwards, leaning back, etc. We can address this: "You have become angry and clenched your fist a little." And we can add: "Pay attention and allow the movement that your body just started. Make it even clearer, even more so. As much as your feeling and your body want you to." The feeling intended an action that wants to become an interaction. "Your anger may want you to fight back. That's natural. You don't have to be afraid of automatically becoming violent if you let anger into your consciousness. But it is a clear signal of how angry you are about what you have just said."	
12	**Don't:** Introduce the reflection of the emotion so abruptly or coldly analysing that the patient is no longer aware of their feelings	Carefully add mentalising reflection to the emotion so that the emotion can remain while the context is heard and understood*
	*We empathically mirror the patient's feeling and relate it to their last statement. He often reports on the behaviour of his caregiver that triggered his feeling. We	

	refrain from a psychological analysis of the transaction and stay with the moment of the event in which the feeling arose. We name his feeling and only add the preceding behaviour of the other person very specifically. "You feel snubbed and angry when you remember that he simply left you standing there and turned to other people." In this way, he can keep the feeling in mind and also determine what exactly was so hurtful. We do not become matter-of-factly sober in our tone of voice, but remain empathetically compassionate.	
13	**Don't:** Ask the patient what they would have needed in the difficult situation reported	After just a few sentences, we can compassionately sense the patient's need, what they would have needed in order to be freed from their distress. We express this, e.g. "You would have needed you to be so important to him that he would have turned his attention to you." Within a second, his face brightens if our statement is correct*
	*The formulation of the antidote hypothesis is the dramaturgical climax of emotion tracking (antidote is antidote according to Albert Pesso, 2008a,b). What he experienced was poison for him. For example, his attachment figure humiliated him, let him down, attacked him aggressively etc. Often the opposite had been hoped for or even expected: that she would satisfy his central need, fulfil his great wish. The emotional damage caused to the patient was then even greater. At this point, our only task is to be empathic, to put ourselves in the patient's shoes in the situation described to such an extent that we can empathise with the need they had for the other person in this situation. At this moment, it is irrelevant if their expectations were deceptive. We listen until our compassion allows us to clearly state which need we empathise with. Sometimes the issue is obvious. Examples are: "You would have needed someone to protect you from his aggression" or "You would have needed your father to see how well you have succeeded" or "	

	You would have needed someone to take you by the hand and guide you on this difficult path" or "You would have needed your mother to stand up to your father" or "You would have needed your father to love you without you having to constantly perform at your best" or "You would have needed your parents to be loving to each other" etc. Should we dare to voice our antidote hypothesis, even if we are not quite sure? If we are completely unsure, we ask. But even a wrong guess is not very disturbing. If our sympathy was accurate, his face brightens (as already mentioned). Because he imagines that he will get what he has missed so much. He creates an inner image of a scene in which he receives what he longs for. Neurobiological studies show that the insula area of the brain is the place where the vivid inner images are generated. The patient appears happy and relieved. But if he visibly thinks about whether he needs what we have said, then we were wrong. Albert Pesso (2008a) called this moment the "click of closure". It is an aha experience. The arc of tension is brought to a relaxing conclusion. And it is the subjunctive: "Yes, that would be nice!". It is always surprising that even the subjunctive makes you feel so good.	
14	**Don't:** Start intervention steps without the patient's express consent	Once the patient has understood what is being done and why, ask whether they would like to accept the invitation*
	*In emotion tracking, we always offer an intervention that makes the topic more vivid (e.g. a protective person stands between the patient and a person who predicts failure in life) or chair work (imagine e.g. the father sits on a chair opposite and is now told for the first time how much the patient feels let down) or an anger exposure. The aim of the exercise is explained to the patient and he is asked whether he can imagine doing it. If so, whether they decide to do it now.	
15	Overcoming the patient's hesitation	We address the hesitation and clarify its origin*

	*The intervention we have just suggested to the patient is new and unfamiliar to them. We therefore describe the procedure and the goal in more detail. We say that we will accompany them through every step of the exercise. Then he can feel safe and will agree.	
16	**Don't:** ignore the patient's doubts	We make room for doubt and let the patient explain what it is all about*
	*Some patients have doubts as to whether the proposed exercise will be helpful for them. "What good will that do me? It feels uncomfortable." We ask about specific fears so that we can address them. "If I can't think of anything then!" is a common statement. "Then I'll help you" we say in a calm voice, signalling that we are a protective "mountain guide".	
17	**Don't:** Override the patient's reluctance	If the patient resists, pause and withdraw the suggestion*
	*We notice straight away if the patient is reluctant. "I don't want to do this. It's very unpleasant for me!" "Yes, I realise that you feel really uncomfortable at the thought of having to do that. I can understand that. You don't have to do it." We don't try to persuade the patient. They should be free to make their own decision. They should be able to express their wishes and needs in our relationship and experience that we take them very seriously. They should know that they can rely on us (epistemic trust). If it was just fear or uncertainty, we could still reach an agreement, but we firmly validate a clear 'no'.	
18	**Don't:** Keep my thoughts to myself	Think out loud*
	*On the one hand, we keep back thoughts that are not good for the patient or are not good for them now. Also theoretical considerations and psychodynamic interpretations. This can happen in a primarily mentalisation supporting session, but not during emotion tracking. Here, these thoughts also interfere with our own compassionate attitude. However, we speak out what comes to mind during the emotion tracking process and what belongs to it. I let such thoughts 'come out	

	loud' and share them with the patient. For example, "I don't know whether we should stay with your anger at your father or whether we should immediately look at what you would have needed instead of this frustration."	
19	**Not:** Leaving my error uncorrected and covering it up	immediately retract an error*
	*If we say straight away when our assumption was wrong, this is still part of "thinking out loud". Especially if we have assumed a wrong intention. E.g.: "Aha, you didn't want to be the best. I was wrong about that. You just wanted him to see how hard you were trying to get his attention and appreciation."	
20	**Don't:** Assume that my perception of his feelings is correct without the patient's agreement	Obtain confirmation from the patient as to whether my perception is correct*
	*We stay completely with the patient with our perception. We are not chasing a hypothesis, not looking for confirmation of our point of view. His face shows us immediately whether our mirroring of his affect was correct. A very subtle affirmative attitude. He feels seen, which we in turn can easily see. If instead we rush on to seek confirmation of our interpretation, we move away from the patient and do not realise that our mirroring was inaccurate. For example: "Then you got what you needed after all and he had to give it to you, albeit reluctantly." The patient might have corrected me and said. "I was just very sad. He realised that and then responded to me."	
21	**Don't:** Express my psychodynamic interpretations	It's best not to look for psychodynamic interpretations at all. They diminish perception in the here and now*
	*You can recognise the psychodynamic background of a patient's reaction, even if you have no psychoanalytic training. Functional analysis in behavioural therapy leads to the recognition of an unconscious intention. Even if a patient's expression	

	of helplessness has a very appealing effect on me, I don't say "I really wanted him to realise how much you need his help". Emotion tracking is easier if psychodynamic interpretations are not taken up. For the patient, they are sometimes an invalidation or labelling that they cannot or cannot yet classify in their self-image.	
22	**Do not:** Express a depth psychological interpretation	Do not interpret*
	*In an interpretation, an inner truth of the patient is expressed that is not accessible to their consciousness. If the patient still has to repress this fact because it contains a truth that is difficult to bear, an interpretation can cause damage. This is too often the case, which is why it has no place in the context of emotion tracking. For example, a great deal of jealousy can stem from one's own repressed desires for an extramarital adventure.	
23	**Not:** Communicating a theory	Only explain the purpose of what is happening*
	*We explain what is happening in our conversation, why and for what purpose, without referring to the underlying disorder and therapy theory. Only what serves to understand what is happening at the moment is explained, not the underlying theory. "We can now introduce a protective person (in the imagination or in role play) so that you don't have to master this alone and experience how it works." I don't say: "Being able to protect myself requires the experience that my attachment figure was initially there to protect me and that I was able to experience that they protected me effectively and reliably. That I initially experienced the powerful defence and protection in a relationship as a substitute so that I could do the same later on. And that we are now gradually making up for this missing childhood experience in the expectation that the patient will have more self-assertion available with her in the future."	

24	**Not:** Expressing my opinion on an issue raised by the patient	Do not express your own attitudes, opinions or comments*
	* The patient absorbs the therapist's values and norms. When we express an opinion or attitude, this has a normative effect on the patient. They learn what we approve of and what we reject. In endeavouring to establish a good attachment relationship with me, he uses this knowledge to adapt to me better and thus achieve a better quality of attachment. In this way, he falls into a repetition of old relationship patterns. This creates a conflict with the granting, accepting, permission-giving attitude of emotion tracking.	
25	**Not:** Expressing your own intense feeling	If the patient's story triggers an intense feeling in us, we do not express this unfiltered, but speak "about" this feeling.
	*As therapists, we do not have to hold back completely when dealing with our feelings. Because then we would be less authentic, less perceptible as a person and less of a relationship could develop. However, if intense feelings suddenly emerge on the therapist's side in a way that is unpredictable for the patient, this is very disturbing. So we will not give free rein to our emotional expression as we do in our private lives.	
26	**Not:** Setting my own value orientation or moral stance as a guideline (possibly only subtly)	I realise when and that my values and morals evoke an affective reaction in me, without talking about it now*
	* We don't have to hide our value orientation. It defines us as human beings. The patient uses fine antennae to sound out our values in order to gain orientation.	

27	**Not:** Conveying the norms (commandments and prohibitions) of my own world view between the lines	If my own norms bring a commandment or prohibition into my consciousness and urge me to follow them, this remains my private process, which I do not allow to influence the therapy*
	*At certain moments I allow him to do something that I would not allow myself to do. So it may be that in a certain situation it is necessary to shout out all his pain so loudly that "the whole world" hears it.	
28	**Not:** Bringing my own still dysfunctional survival rule into the conversation as a behavioural maxim	Communicate a permission-giving attitude that helps to overcome the limitations of the survival rules*
	*The patient adopts our own dysfunctional survival rule, even if it is not expressed. "He has long since established an introject of my personality as a psychological representation. He therefore not only communicates with me as a real counterpart, but also always with this introject. This helps him in many ways. But it would be better if it didn't contain my dysfunctional survival rule. The more I consciously confront my survival rule and catch myself following its guidelines again, the less danger there is of this happening." Sulz 2021, p. 321)	
29	**Not:** Imposing your own very similar topic on the patient	I differentiate between my topic and that of the patient and refrain from imposing projections*
	*If I know a patient's problem only too well from myself and it is still one of my "construction sites", I need to be extremely vigilant. The issue triggers my own feelings so much that I find it difficult to stay with the labelled mirror, which really only contains my own feelings (attenuated). The patient will realise how painful this is for me and it is no longer a marker. In other words, it is no longer his feeling. He should learn to differentiate between what he is feeling and	

	what the attachment figure is feeling. This is necessary so that he can build up a realistic theory of mind or theory of the mental." (Sulz 2021, 322)	
30	**Not:** Being like an ideal father or mother to the patient	Remain a very attentive and sympathetic listener*
	*We would like to alleviate the patient's suffering. And will be especially kind, patient and forgiving, a father or mother that he would have wished for (and that we would have needed ourselves?). This counter-transference is a completely natural process. It is our involuntary response to his transference. We catch ourselves without doing what we would prefer to do as a result of the counter-transference. We remain listeners with a basic attitude that is warm-hearted and accepting, but which does not fulfil the transference need. The desired fulfilment of needs by an ideal father or mother takes place later in the ideal parent exercise with role-players.	
31	**Don't:** Talk badly about the real parents	Do not express your own judgements about the parents*
	*We often get angry with the patient's real parents. However, our words then say more about us than about the patient's father or mother. And if someone from the outside speaks badly about the parents, the patient wants to defend them.	
32	**Not:** Expect or demand early understanding for the real parents	Do not suggest mitigating circumstances for the parents*
	*If the patient's anger seems too great, we tend to defend the parents and try to make the patient understand them. For the time being, however, he should be able to stand up for himself completely, regardless of the neediness of the father or mother. The only thing that matters at first is what the father has done, for example, what heavy burden he has passed on to his son. We are completely on the patient's side in order to allow him his emotional energy, e.g. his anger. He can take his time in understanding his parents, he can keep his anger for a while longer.	

33	**Not:** Putting myself above the patient	I remain humble in my non-knowledgeable attitude and treat the patient with respect as an equal*
	* We see ourselves as the knowledgeable and strong ones and feel superior to the patient. The patient feels this and feels inferior and weak. Our mindfulness helps us to allow this feeling to be there and then to return to humility and feel appreciation for the patient again.	
34	**Not:** Exude the self-confidence that I am a very good therapist	I remain the one who is in the process of learning from the patient and understanding something*
	*Maybe it's good that our therapies don't often lead to the best results. We can therefore remain humble and see him as the one who knows much more about himself than we do. We learn from him, we try to understand him and his story and let him help us.	
35	**Not:** pretending to be so knowledgeable that everything the patient tells me has long been familiar to me	Even if I have understood a lot, I remain in the non-knowing position (like Columbo)*.
	*As therapists, we remain the potential non-knower who learns from the patient - and remain authentic in the process. Being able to remain authentic is our most important therapeutic competence.	

The basic attitude of the group leader during the mentalisation supporting conversation (e.g. metacognitive review in an emotion tracking session)

"The MBT working group (Allen 2010) has formulated criteria that define mentalisation supporting conversation very well. We can also apply these to behavioural therapy with a few modifications and reductions. They show how much the

nature of the conversation differs, for example, from a competent psychodynamic and also from a cognitive-behavioural style.
As this is very unfamiliar, it needs to be trained and practised.
Sufficiently effective mentalisation support can only be achieved if there is little deviation from these guidelines.
Learning through insight is not enough. The process of mentalisation/metacognition must take place continuously, like a constant drop in the ocean, so that the necessary pathways can take place and remain in the brain." (Sulz 2022b, p. 217)

The 14 most important aspects of mental/metacognitive dialogue (Sulz 2022b, p. 218)

1. Creating **security** in the relationship
2. Close **guidance** of the reporting person's awareness processes
3. **Structured** and **supportive** approach
4. **Question-answer dialogue** instead of free conversation
5. **Columbo questions**: not knowing
6. Ask specifically about **motives** for behaviour
7. **Appreciate** mentalisation, **question** non-mentalisation
8. Offer **alternative interpretations** to non-mentalised statements
9. **Interrupt** pseudo-mentalising
10. **Reflect** together
11. **Thinking aloud** as an unfinished consideration
12. Saying when a thought was a **mistake**
13. **Do not** give **metatheoretical** explanations of what is happening
14. **Do not impose** your own hypotheses

A stage model of group development (Sulz 2011, p. 406-416)

We can distinguish the following six stages in the development of a group from the beginning of treatment to the last group session:

- Receptive stage (orientation, affiliation)

- Impulsive stage (need fulfilment)
- Sovereign stage (influence, power)
- Interpersonal stage (cohesion)
- Institutional stage (rules)
- Supra-individual stage (integration)

Reception and orientation stage

a) Orientation:

The individual enters the group, which thus begins to exist. Everyone else is still a stranger to him, he does not yet have a feeling for the group and does not yet feel like a member. He hopes to be welcome, to belong. Everything he has learnt that could help him feel welcome and reduce his insecurity is done so carefully that he can take it back at any time. It is not actually purposeful action. Rather, action serves perception. It is a literal reaching out: contact through perception, seeing, hearing. Although there is hardly any physical contact, it is a sensing of others, a smelling and tasting - albeit with eyes and ears. In favourable cases, the alarm subsides and he does not feel endangered. I can be there, and the others can be there.

b) Recording:

If the perception has shown that no vigilance or mistrust is necessary, you can enter the receptive mode. The individual now assimilates the group and allows himself to be assimilated by the group by following his need to be welcome and to belong. To be among the others, to be indistinguishable from the others, to be inside, to be surrounded by the others. The group fills up with members like a belly with food or a sack of apples. There has not yet been any differentiation of the individuals and no structuring of parts of the group. It is still a set of individual parts whose boundaries tend to blur, so that individuality disappears. Joining together, fitting together, fitting in by giving up one's own contours, one's own profile.

Threat and fear is destruction. The group can break apart, then it no longer exists. Anger is destruction. Those who are hit by anger are threatened with annihilation. Or destructive rage

destroys the group.

Only **tasks** that are individual work and do not yet require group co-operation can be mastered. This stage can be **disturbed** by schizoid isolation of the members or by voracious incorporation of the group by individuals or by voracious incorporation of individuals by the group. Or through voracious consumption of external supplies. Or through anorexic refusal to incorporate and be incorporated.

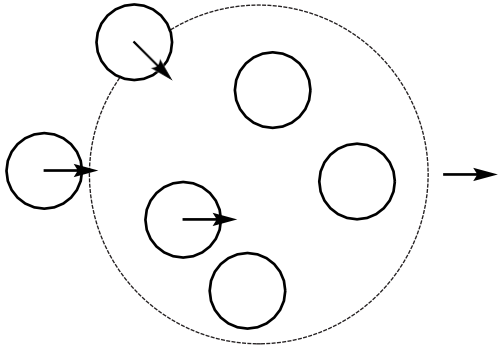

Figure 2: Absorbing stage

Stage of impulses

The group is supposed to provide a sense of security, warmth, protection, safety and reliability and the members act like a flock of sheep by being close to each other. They are afraid of separation from the group. The group offers them a playground to satisfy these needs, it is a guardian, a shepherd, without making demands on the individual, without imposing duties. The individual can now move around in the group, can take and get something, can go to someone in the group, can live their feelings and impulses fully under the wings of the group. Laughing,

being happy, being carefree is possible. The group is there to fulfil needs. It is assumed that the group will be available and accepting. The participants feel comfortable, safe and secure in the group. The individuality of each person has not yet awakened. They also do not yet have a sense of belonging to a group, they do not yet identify with the group. They are in the group and the group is there for them.
Their fear is separation. When they are angry, they want to separate themselves from the group. The group fears that members will separate from it. Group anger is separation from the individual.

Everyone can be given a task, co-operation is not yet developed.
Disruption can be caused by the threat of losing a member or by the tendency to separate aggressively from a member.

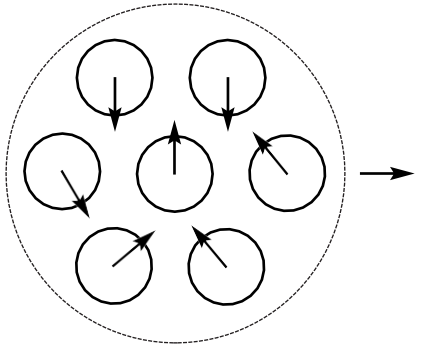

Figure 3: Impulsive stage

Stage of sovereignty, differentiation and power struggles

Being different, having different opinions, having different needs make it difficult to assert one's own interests. It has to be fought for. Once the experience has been made that impulses can be safely lived in the group, the desire arises to do this even more for one's own benefit. The others are now discovered - as

competitors seeking their own advantage. Their behaviour must therefore be controlled, one's own behaviour must no longer follow momentary desires, but must be placed in the service of a strategy. I exert influence, I manipulate, I gain power. I gain a position in the group. I secure my domain in the group. Since less power is possible alone, people join forces. Like-minded people form cliques in order to better assert their common interests in the group. Less powerful people choose a powerful person as their leader and benefit from his strength. In return, they subordinate themselves to him. Dissenters are fought against. Those who cannot be influenced are threatening and must also be fought against. This process of group structuring ends with the group finding and accepting its sovereign as leader. He must be so strong that identification with him is attractive. Identification with the sovereign leader ends the narcissistic imbalance that has arisen because one's own position is not so powerful. As a group member, I do not experience myself as powerless, but as part of the powerfully led group.

The central need is for power, influence and control. The central fear or threat is loss of control. Anger is explosive or sadistically empowering.

Tasks can be taken on by homogeneous subgroups in a division of labour, provided they are not blocked by competition.
Disruptions arise from endless power struggles as long as no definitive leadership structure has been established. Only when everyone in the group has their fixed place and there is no longer any chance of improving their position in the short term, do these struggles subside. Some members only know two ways to survive - as a leader or as an outsider. They cannot integrate into the group as a simple member. If they do not succeed in gaining power, they remain outside. Because integration would be a loss of self and a surrender of the self. They prefer to wait outside for their chance to take power at the right moment. Their outsider status is also an opposition to the current leaders. They do not submit to their regime, which makes them less powerful.

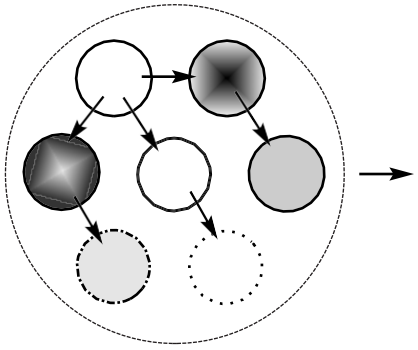

Figure 4: Sovereign stage

Interpersonal stage (cohesion)

If the power structures have been in place long enough, the desire arises to satisfy one's need to belong through the group. Self-interest takes a back seat. The group becomes a social organism that is loved and whose love is needed. Identity becomes group identity. I am a member of the group. I do not feel my own needs, but I feel and satisfy the needs of the group. Harmony and affection are the central needs.

There is fear of rejection and loss of affection. Anger is expressed through withdrawal of affection, through rejection.

Tasks can be given to the whole group. Conflicts within the group are minimised - by setting aside self-interests.

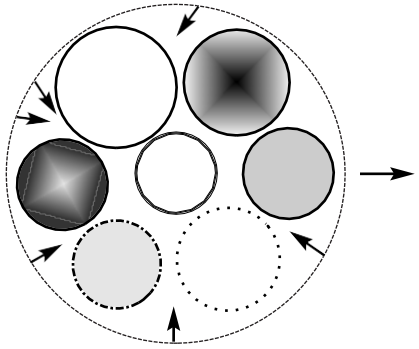

Figure 5: Stage of cohesion

Institutional stage

The needs directed at the group are significantly reduced. The group remains important as a cosmos and living or working space, the identity remains that of a group member. However, the pursuit of self-interest is no longer abandoned. The principle of fairness and norms of behaviour regulate the balancing of interests and also the duties of the individual. The smooth functioning of the group is important. This functioning is guaranteed by laws that must be observed by everyone. Friction is therefore just as low as in the previous stage. Individuals think for themselves in order to monitor the norms and to resolve conflicts through new rules and norms. The interaction is objective and less emotional. Benevolence is shown to those who obviously support the functioning of the group. The group is designed to function on a permanent basis and can go on like this for a long time.

The central need is for recognition and appreciation. The central threat is the destruction of this order, is chaos or, in the case of attacks, counter-aggression. Central anger is counter-aggression.

Task-orientation is very high at this stage, group performance is very high when it comes to productivity, performance that is best when precise, smooth task allocation is required.

Disruptions can be: Individuals identify little with the group and increasing peer pressure must be exerted, i.e. stricter standards, higher penalties for violating standards. This can go so far as to create a quasi-police-state dictatorship with underground fighters and an underground organisation that focuses all its energy on disempowering the leadership. If the work continues to be constructive, this can consist of undermining the power of the powerful or boycotting the group's performance.

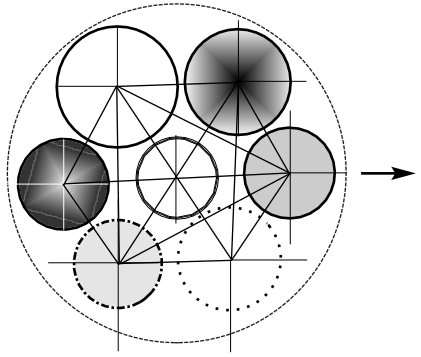

Figure 6: Institutional stage

Stage of supra-individuality (integration, balance between individual and group)

This group stage can only occur if the individuals themselves have reached a level of personal maturity that allows this. Otherwise, the institutional stage ends with a rebellion, with revolution and destruction of the group. Unless the previous stage is frozen.
The group is now redefined. It is no longer the sole source of identity. There are no longer any rigid normative or tenacious emotional ties between the group and the individual. The

individual is left with self-responsibility, with considerable degrees of freedom in relation to the group. They can adjust their own balance between self and group. However, this is not a step towards individualism or a forced separation from the group. No energy is expended to separate oneself from others and from the group. Rather, this simply happens. It is a solution in both senses of the word. With the increased degrees of freedom, the cohesive moment has become the intrinsic value. The group is no longer a prerequisite for existence, a refuge of secure survival, an opportunity to distinguish oneself and gain power, an emotional need or a quasi-state structure with normative shackles. It has become a **value.** The individual has inner self-sufficiency and autonomy, is no longer dependent on this one group, but it is valuable to him in the sense of an individual value orientation. This value-orientation is what constitutes the step from the individual to the supra-individual. Without inner need and without external constraints, the group remains intact. It no longer serves to relieve anxiety, nor to satisfy, nor to dispose of aggressive energy. It is not set up for eternity, but with the freedom to change and also to end. This means that the group structure is not fixed. It is subject to a fluid equilibrium. The roles do not necessarily change, but if they do not change, this would be a sign that the group has not developed to this stage.

Group activity is driven by a shared **vision**. This vision is the motor that generates task-orientation.

Central needs and fears take a back seat. Instead, value orientation is the guiding principle. Individual motives and the group's motives are balanced, differently for everyone. This results in a group that is strongly characterised by the personalities of the individuals.

Work orientation is guaranteed by values. It can take time to harmonise these values and goals, so the group cannot be deployed as quickly and effectively as a well-trained police force. Negotiations and agreements lead to consensus and co-operation. Without this communication, there is no group performance.

Overall, there is an integration of group and individual concerns, a balancing of group and individual needs, a pursuit of both individual and group goals. The group and the individual benefit equally from the group process.

Disruptions can occur when there are no longer enough shared values and the group eventually disintegrates. Or value violations cause so much aggression that the group regresses to the institutional level. Or external circumstances demand a different mode of functioning in order to continue to exist as a group. A threatening state of emergency may require strictly hierarchical leadership, so that the group has to adopt the institutional mode or even that of sovereign leadership.

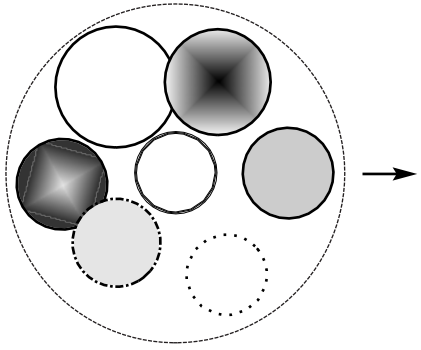

Figure 7: Supra-individual stage

If the therapist is not the only one to reflect on the group stages/group levels, but also repeatedly explores with the group the question of where the group currently stands and what stage the group is at, then the patients get a much better sense of the fact that it is not just individuals who are changing, but the group as a whole. Also what significance this has for the development of the individual. And vice versa, how individual developments affect the group and its development.

7. Discussion

Group therapies have many advantages over individual sessions. The new therapy approach of EMVT (Emotion and Mentalisation Promoting Behaviour Therapy) in particular benefits greatly from the group setting. The individual work that takes place in the presence of the group (analogous to Pesso's structures) becomes an intense experience through role play and constellations, which achieve exactly what Grawe (1998) called problem actualisation or deep emotional experience in the sense of Greenberg (2020). The feedback from the group members in the round of sharing is invaluable. In addition, each group member, even if they remain in observer status, can take away new insights and deeper understanding for themselves and their own biography. From this perspective, the group is an intensive training in empathy and the elaboration of the Theory of Mind (ToM). The experience of attachment security in the group forms the basis for individual personality development. The group is the reference for the new permission-giving rule of life, which helps to loosen entrenched resistance to change. This allows emotional regulation to heal and relationships to become more sustainable in the future. The new way of dealing with anger and rage also leads to the experience of self-efficacy. The repeated metacognitive analysis of current group events serves to build up the ability to mentalise.
An empirical study is currently being conducted to analyse the therapeutic effectiveness of EMVT groups.

For more information see Sulz, S.K:D. (2022b): Praxismanual Mentalisierungsfördernde Verhaltenstherapie – Anleitung zur Therapiedurchführung. Gießen: Psychosozial-Verlag

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