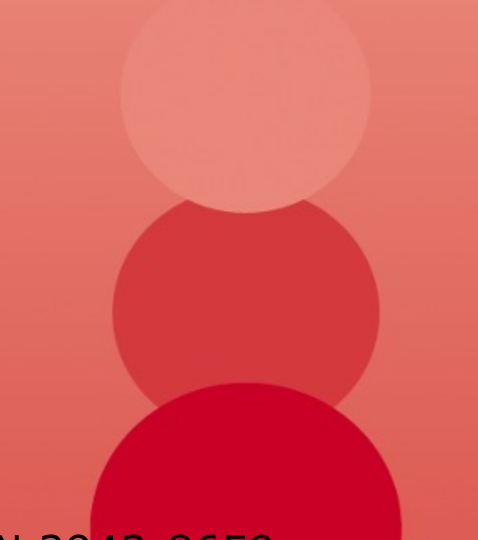
European Psychotherapy

Guest Editors
Annette Richter-Benedikt
& Maria Schreiner



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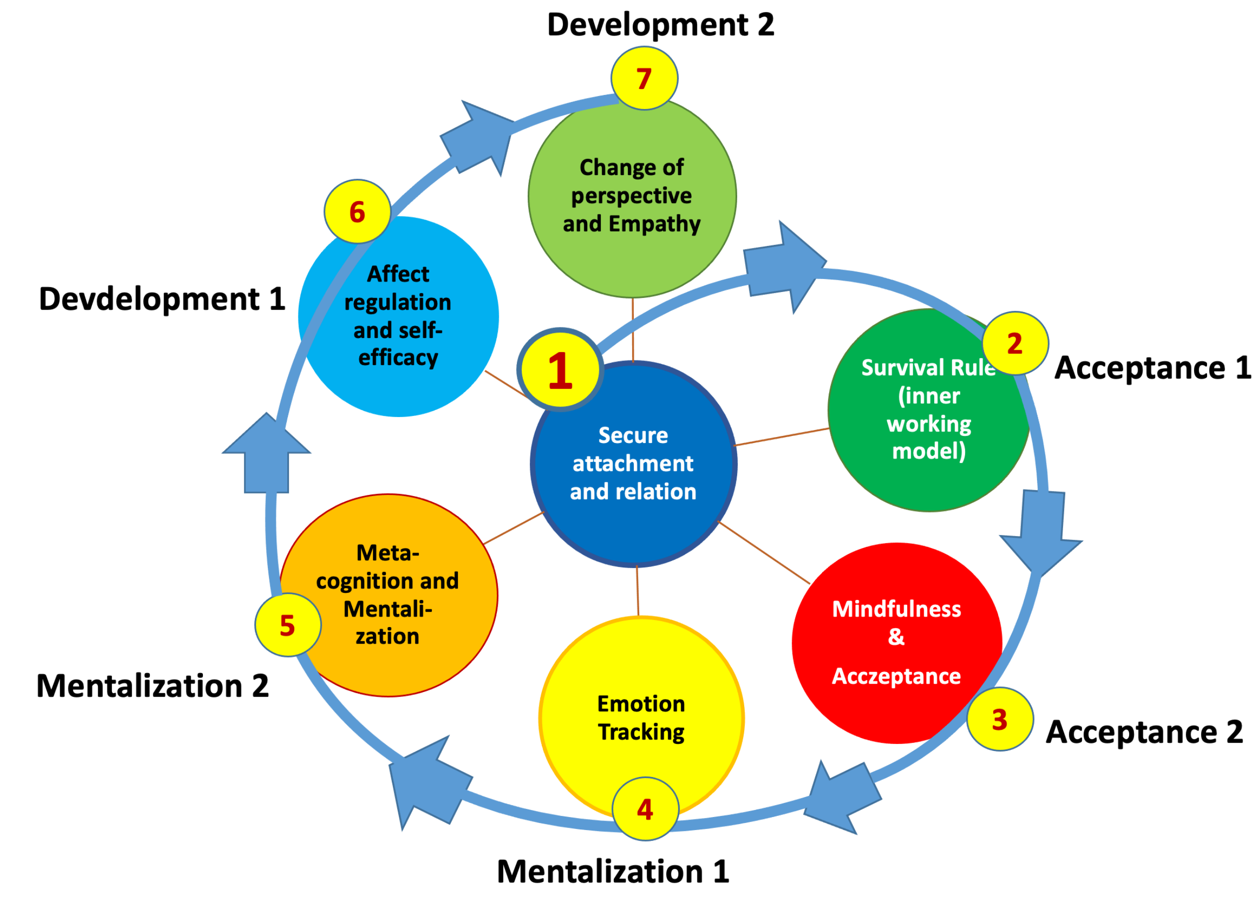
Special Issue: Mentalization Supporting Therapy MST



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1 Barth, D. (2024). Affect Regulation and Mentalization. *European Psychotherapy 2024* p. 11-14

2 Theßen, L., & Sulz, S. K. D. (2024a). Theßen, L. & Sulz, S. K. D. (2024). What is mentalization supporting therapy (MST)? A metacognitive-psychotherapeutic approach based on developmental psychology. *European Psychotherapy 2024* p. 15-35

3 Theßen, L., Sulz, S.K.D. (2024b) What is mentalization supporting therapy (MST)? A metacognitive-psychotherapeutic approach based on developmental psychology. European Psychotherapy 2024 p.36-69

4 Sulz, S.K.D. & Schreiner, M. (2024). Emotion Tracking - Healing and Growth of the Wounded Soul. *Psychotherapy 2024* p.70-89

5 Theßen, L., Sulz, S.K.D., Wedlich, K., Keim, P., Hofherr, L., Leiner, R., Schick, P., Wöhrle, K, Bohn, A., Rose, J. & Cozzi, I. *(2024).* Research on mentalization-supporting therapy MST - Attachment, mentalization, development and personality strengths. European Psychotherapy 2024 p. 90-135

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Special Topic:

Mentalization Supporting Therapy MST

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E D I TO R I A L

European Psychotherapy is published in the 15th year now. It arose from surveys of psychotherapy organisations of nearly all European states. The advisory board is one of the results of this cooperation.

In the first issue in 2000 we introduced the most recent psychotherapeutic developments of that time (Dialectic Behavior Therapy DBT, Acceptance and Commitment Therapy ACT, Functional Behavior Therapy FBT). It was followed by the consistent and radical accentuation of Davanloo's Short-term Dynamic Psychotherapy. In 2003 we dealt extensively with presenting the treatment of Posttraumatic Stress Disorder as it was developed in the work with war victims in the former Yugoslavia by Willi Butollo and coworkers. After this followed the Existential Analysis of Viktor Frankl, published by Alfried Längle, and Pesso Therapy PBSP which is on its way to become better-known in Europe only for a short time. Also not so well-known has been that since the beginnings of the 90th a third wave therapy has developed in Europe: Strategic Brief Therapy SBT which puts the work with emotions and the development of personality in the foreground. From here it is only a small step to the Emotion Focussed Therapy of Leslie Greenberg (2007) as a scientific further development of Gestalt Therapy and Client Centered Psychotherapy.

Next we had the pleasure to introduce Jeremy Holmes as a guest publisher. He is a topclass representative of Psychoanalysis himself and he succeeded in getting contributions of real value about the presence and the future of Psychoanalysis from authors who instigate a lively development of Psychoanalysis. In his Editorial 'towards a secure theoretical and evidential base for psychoanalytic psychotherapy' he gives an introduction and an outline of this collection of psychoanalytic writings which are not written for psychoanalysts but for all psychotherapists who want to know more about today's Psychoanalysis, who want to do notional steps towards it, maybe for to break with old prejudices, to become more open again for psychodynamic ideas or to ascertain similarities that are much bigger then assumed until now. We as the publishers of this periodical had to see thereby that not only communication between the schools of therapy are essential but also communication between the national groups of psychotherapists in Europe. And that exactly is our European project.

2010-2011, psychotherapists from all over Europe reported on psychotherapy training in their country:

Gerhard Lenz, Rafael Rabenstein, Vivian Görgen Austria
Martine Bouvard France
Serge Sulz and Stefan Hagspiel Germany
Evrinomy Avdi Greece
Bernardo Nardi and Emidio Arimatea Italy
Susan van Hooren Netherlands
Andrzej Kokoszka Poland
Celia Avila Fernández Spain
Bo Erik Sigrell & Rolf Sandell Sweden and
Jan McGregor Hepburn Great Britain.

2012-2013, body psychotherapy became a topic. Concentrative Movement Therapy CMT (KBT) was used for this purpose - an evaluated Body Psychotherapy for psychosomatic and psychic disorders.

2014-2015 topic, Austria – Home of the World's Psychotherapy – most
of the great psychotherapists in the early 20th century lived in Vienna or their career began there: Sigmund Freud, Melanie Klein, Michael Balint, Wilhelm Reich, Alfred Adler, Victor Frankl, Paul Watzlawick and Fred Kanfer.

2016-2017, Embodiment in Psychotherapy was topic (edited by Gernot Hauke) with absolutely innovative contributions – looking in the future of psychotherapy:

Wolfgang Tschacher, Mario Pfammatter: Embodiment in psychotherapy – A necessary complement to the canon of common factors?

Marianne Eberhard-Kaechele: Emotion is motion: Improving emotion regulation through movement intervention

Rosemarie Samaritter and Helen Payne: Being moved: Kinaesthetic reciprocities in psychotherapeutic interaction and the development of enactive intersubjectivity

Tania Pietrzak, Gernot Hauke, Christina Lohr: Connecting Couples Intervention: Improving couples' empathy and emotional regulation using embodied empathy mechanisms.

Andrea Behrends, Sybille Müller, Isabel Dziobek: Dancing supports empathy: The potential of interactional movement and dance for psychotherapy

Susanne Bender: The meaning of movement rhythm in psychotherapy

Gernot Hauke, Christina Lohr, Tania Pietrzak: Moving the mind: Embodied cognition in Cognitive Behavioral Therapy (CBT)

Lily Martin, Valerie Pohlmann, Sabine C. Koch, Thomas Fuchs: Back into life: Effects of Embodied therapies on patients with Schizophrenia.

And now 2023-2024, the latest integrative psychotherapeutic development - first published in 2021 - has not yet entered the evidence-based evaluation phase: Mentalization Supporting Therapy MST. That's exactly what it's about with EP: new important impulses, which of course only become evidence-based a few years after the approach was developed. Nevertheless, MST can build on a surprisingly broad empirical basis.

We can draw on more than thirty years of research tradition on the behavioral diagnostic system, strategic brief therapy and strategic-behavioral therapy. Because MST is actually not a new therapeutic approach. Similar to Fred Kanfer's self-management approach, it is a variant of cognitive-behavioral therapy, consisting of the evidence-based intervention strategies of behavioral therapy. However, the cognitive aspect focuses much more than Aaron T. Beck on metacognitions (thinking about thoughts, feelings and needs), so one can speak of metacognitive behavioral therapy. In addition, emotions have come to the fore. It's about the ability to regulate emotions - to be able to control one's emotions in such a way that they lead to stable and satisfying relationships. The third focus is needs orientation, based on John Bowlby's attachment theory. Insecure attachment in childhood as an elementary disposition for mental and psychosomatic illnesses. And therefore the bond between patient and therapist is an indispensable condition for successful psychotherapy.

The impetus for the development of MST came from Peter Fonagy and his working group with their Mentalization Based Therapy MBT, whose perspective Daniel Barth presents in the first article. This is followed by two articles by Lars Theßen and Serge Sulz, in which they describe the theoretical background, therapeutic conception and practical approach. The special type of emotion exposure in MST (Emotion Tracking), which was adopted by Albert Pesso, is described very clearly and impressively by Serge Sulz and Maria Schreiner.
This is followed by reports on previous research in the MST research laboratory by Lars Theßen, Serge Sulz and colleagues. Finally, there is an article by Annette Richter-Benedikt in which the use of MST in young people is described.
All articles are peer reviewed.
MST was only one example of innovative therapeutic development that others will follow.

Annette Richter-Benedikt & Maria Schreiner - Editors

Affect Regulation and Mentalization

Daniel Barth, Basel

ABSTRACT

This article highlights the importance and effect of affect regulation on the development of thinking. Psychoanalysts suppose the new-born to be overflood by feeling, to say affects and emotions. At the beginning the baby is not only bodily but also psychically helpless. As the baby needs a specially prepared milk it needs a specially adapted emotional food. But how does this emotional food of affect regulation looks like? The mother takes in affects of the baby and modulates the affects. She will mirror this subtly changed to her baby. This leads to a soothing and satisfaction of the baby. By these constant repetitions it learns more and more about him and internalises this experience in him. The mechanism of internalisation is explained in this paper. Also different possibility of the development of the self are touched. Depending on the experiences in childhood of affect regulation clinical pictures are described.

Keywords

Mentalization, Attachment theory, projective identification, hyperactivation of the attachment system, marked affect mirroring, affect regulation

Introduction

A newborn baby is completely helpless and at the mercy of death without outside help. This helplessness does not mean that a baby is not already very active in perceiving and interacting with its environment. Reference should be made to books such as “The Competent Infant” by Martin Dornes (1992), which lists scientific studies on how active a newborn is. However, a helping person is still needed, who is always a mother in utero and usually the mother after the birth. After birth, the father or any other person can just as easily take on this function. In English literature the

term “attachment figure” is used for this person. Since “attachment person” is a bit awkward and is not (yet) common in our vocabulary, I will use the expression “attachment person” in the following. The caregiver will create an external, stable climate that allows the child to develop. The intrauterine situation allows the psychological function of the caregiver to be explained. In psychoanalysis, different images are used for psychological functioning. Freud, for example, initially used images of the steam engine with his drive model. This explains that he thought in terms of drive, repression and repetition compulsion. Something is repressed and wants to become conscious again.

The digestive model

Fonagy, the founder of the mentalization theory, on the other hand, primarily needs the so-called digestion model, which was proposed by Bion (1962). This is best explained by the interaction between the intrauterine baby and its mother. Not only does the mother provide the baby with a constant temperature of 37°C, but she also feeds the baby. However, unlike conjoined twins, the blood circulation of mother and embryo are separate from the beginning. The mother consumes food like cow's milk, meat, fruits, grains, etc. and digests these foods in her digestive tract. Digestion involves, for example, the proteins ingested by the mother being broken down before they enter the placental circulation. Through the placental barrier, the mother “offers” these broken down proteins to the embryo or fetus, which serve as the basic building blocks for the child’s physical development. This also applies to carbohydrates, fats, vitamins, trace elements... The child cannot take over larger building blocks from the mother, but must reassemble the building blocks itself.

We humans have to walk this arduous path of disassembly and subsequent reassembly. Vampires, so the myth goes, have found another way: As is well known, vampires cannot digest human food. They therefore rely on sucking blood directly from humans. This makes them very dependent on people, but at least they are expected to live much longer. The child, on the other hand, can under no circumstances, or only to a very limited extent, directly absorb entire assemblies. In summary, it can be said: the mother digests food that is indigestible for the baby, breaks it down and offers the baby food that it can absorb in its still immature digestive tract. This happens intrauterine via the

bloodstream and the placental barrier, in the first months of life through breastfeeding and in the first few years through the preparation of special children's food. If the baby or toddler is offered something indigestible too early, this can have fatal consequences. For example, feeding a 2-month-old baby penne (tube-shaped Italian pasta) will cause intestinal obstruction. It is very likely that the baby will end up in the emergency room and can only be kept alive through surgical intervention.

The Attachment Theory

But now to the psychological apparatus. The picture of digestion is valuable, but it cannot explain all processes. Psychoanalysis deals with the question of how a baby learns from its caregiver and what traces are left in its psyche. In recent years, scientific findings (e.g. Londerville/Main, 1981) have shown that a stable, i.e. secure, attachment promotes the development of inner security, self-esteem and autonomy. Attachment theory goes back to the English psychoanalyst John Bowlby. He postulated a biological attachment system that was responsible for the development of the emotional relationship between mother and child. Bowlby also based his work on animal experiments such as the behavior of Konrad Lorenz's geese. Through the intensive relationship that the child naturally seeks, the child forms “internal working models” which are internalized. If the caregiver offers the child a good bond, the child will develop a good bond. However, if the caregiver offers too little attachment, the child develops an avoidant attachment model. If the caregiver is irregular in the relationship offered, the child will develop an ambivalent attachment model.

The caregiver observes the child and reflects his condition back to him. Over time, it learns to integrate the behavior of its caregiver and to be able to master future situations on its own. This means it acquires an “internal working model”. However, Bowlby did not describe exactly why and how this happens. Infant research has helped here by discovering new mechanisms.

Daniel Stern et al.

A major new discovery in neuroscience was the description of the mirror neuron system (Rizzolati et al. 2004) and its role in humans. An important point in learning is imitation. An example is feeding the children: the mothers open their mouths even though they are not getting anything themselves. Nevertheless, it is useful because the child imitates it immediately. Furthermore, Daniel Stern (1985) has shown that the interaction between the infant and its caregiver is shaped by both self-regulation and a sensitivity to the state of the other, which we today refer to as “attunement.” This interaction is supported by the innate abilities of the infant, who, for example, are able to imitate the facial expressions of adults in the first phases of life (cf. Metzoff, 1993).

Extensive empirical studies, e.g. by Beebe and her colleagues (Beebe/Lachmann/Jaffe, 1997), have shown that the interactions between infant and mother are complementary and occur extremely quickly. This interaction does not occur in a vacuum; rather, the mutual reaction to changes in facial expression obviously obeys expectations that both participants have regarding the other's reaction. Furthermore, Tronick (1989) showed that interactions between infant and mother are not perfectly coordinated. The failure of the “vote” is both unavoidable and conducive to development. Tronick's assumption is that restoring misaligned micro-interactions promotes the establishment of a viable human relationship. This is consistent with the experience of many clinicians who observe that restoring a broken therapeutic alliance often has greater long-term effects than the mere presence of empathic understanding. Getting through a crisis together strengthens the trust that we will be able to overcome difficult situations in the future.

To summarize: Bowlby described attachment as central; Rizzolati the mirror neurons; Stern, Metzoff and Beebe the dance of interaction; and Tronick the microrepair of these interactions. But what happens in the interaction between two people and what intentions do the two participants pursue and what traces do the interactions leave on the child (and his caregiver)?

Theory of mind

One way to understand the function of our brain is to assume that it serves to best understand our surroundings in order to make predictions. These predictions are important because they make our actions more efficient. This also applies to the footballer who wants to calculate the trajectory of a ball in advance, to the police officer who has to assess whether his opponent will attack him or not, as to a mother who wants to understand her crying baby. Since humans have the most developed brain on this planet, they are able to understand and influence their environment like no other living being. Together with the interest in understanding our environment and our fellow human beings, we also want to know our inner psychological states. We sometimes perceive ourselves as foreign and therefore experience ourselves as being influenced from outside. Emotions can be experienced as foreign bodies. It is therefore not surprising that attempts to influence one's own feelings or those of others in a desired direction are as old as humanity itself.

The Theory of Mind (ToM), also called native theory, was developed in 1978 by the philosopher Dennett. This allows the prediction of behavior from three different perspectives (quoted from Fonagy et. al. 2006, p. 33f): “from the physical perspective, the design perspective and the intentional perspective. Dennett uses predicting the behavior of a chess computer as an example. At the simplest level, it can rely on knowledge of its physical properties (the physical perspective). The design perspective would be based on knowledge of the construction of the computer, including the programming that went into the development of the device. Finally, the third option is to predict the presumably best, i.e. most sensible, move that the computer can make. Here we attribute certain beliefs and desires to the computer - in other words: regulation by intentional states. … A “theory of mind” is a construct of interrelated beliefs and desires that are attributed to a person in order to explain their behavior.”

In the theory of mind, the assumption is to recognize conscious processes in others and oneself, i.e. to assume feelings, needs, ideas, intentions, expectations and opinions." I further quote Fonagy et al (2006, p. 34): " Representatives of the philosophy of mind (Wollheim, Hopkins, 1992) have gone beyond Dennett's approach to also

explore unconscious processes. They showed that one of Freud's main contributions was to extend everyday psychology to unconscious mental states and to develop it into a theory of unconscious mental life. Man not only tries to predict how inanimate matter will behave, but also how his fellow human beings and himself will behave. This is done with the assumption that people have intentions, i.e. intentions. However, these are only partially conscious. From the very beginning, psychoanalysts assumed emotion or affect regulation. The defense mechanisms described by Sigmund Freud and later by his daughter Anna Freud, such as repression, denial or projection, are nothing other than affect regulation. These mechanisms are directed against unpleasant emotional states that are triggered by mental conflicts between different internal motives (such as desires or "drives" on the one hand and evaluations of reason or conscience on the other). But it was only Peter Fonagy and Mary Target (2002, German 2006) who included this affect regulation at the center of their theory with their mentalization theory. In particular, they managed to build a bridge between theory and clinical practice by seeking to understand the beginning of the development of the psychic apparatus.

Mentalization

Mentalization is a psychological ability to interpret one's own behavior or the behavior of other people by attributing mental states. Not only is the behavior considered, but above all an intention is attributed to this behavior. Intentions include qualities such as needs, desires, fears, feelings, beliefs, goals and others. Mentalization allows us to “read” from behavior what is going on in other people’s heads. However, most mentalizing functions are not conscious, intentional, and explicit, but rather automatic, intuitive, and implicit. So, as Fonagy emphasizes, it is less about knowing what is happening in the other's head than about grasping "with heart and psyche" what is happening "in the heart and psyche" of the other. Mentalization assumes that an intention is attributed to the other person in their actions and actions, i.e. in their behavior. The better we understand our counterpart's intentions, the more efficiently we can predict why they will behave the way they do.

But how does a baby learn to assign intention to another's behavior? Everyone agrees that this ability develops gradually, probably based on maturation processes that come to the fore between the ages of six and twelve months. At this age, infants apparently begin to think about objects and people in terms of their "goals" (end states as distinct from intentions) and to view their actions as "rational" or "appropriate" relative to such hypothetical goals. Gergely and Csibra (1996) have shown that the principle of rational action is applied by infants to human and nonhuman objects alike. For example, nine-month-old babies react with surprise when disks of different sizes appear to behave irrationally on a computer-controlled display. When a small circle, wanting to "reach" a large circle, chooses an unnecessarily long path (the same route that had previously been necessary to avoid an obstacle), the face reflects the infant's astonishment. This surprise is avoided when the small circle finds the direct route, even if this route differs from the previous one to which the baby had already become accustomed. The baby “assumes” the intention of the small circle, which if formulated would mean something like: reach the large circle as quickly as possible and do not run into any obstacles.

But is this “assumption” innate or did the baby learn this because its mother assumed intentions from the beginning by carrying a representation of the child’s psychological state? (Image 2)

How is it that young children learn abstract concepts such as true and false beliefs with such ease and that this step is mastered at about the same age? Baron-Cohen and Swettenham (1996) postulate, in the spirit of Chomsky, an innate learning mechanism to which they assign a specific location in the brain. Other theories, such as simulation theory, assume that when we want to guess someone else's intentions, we draw conclusions based on what we ourselves would do under the imagined circumstances. This simulation rarely remains just a thing that happens in the brain, but there is learning through motor imitation. Fonagy et al (2006, p. 37f) list a few more theories, all of which have in common that they largely ignore the child's emotional relationship with his/her caregivers. The mentalization theory assumes that the mother-child relationship plays a central role in the development of thinking. These functions are explained below.

How attachment is related to affect regulation

Anyone who has ever held a baby can attest to the fact that they have a hard time regulating their emotions on their own. This requires the adult to change his condition. "The baby learns that excitement in the presence of the caregiver does not have to lead to disorganization that overwhelms his or her coping skills. The caregiver will be there to restore balance. In uncontrollable states of excitement, the infant will ultimately seek the physical closeness of the caregiver because it expects them to provide comfort and the restoration of homeostasis." (Fonagy et al. 2006, p. 45) The mother-child attachment system is that for the baby and toddler system by finding a way to control its excessive emotions. In attachment theory, four different types of attachment are distinguished: the secure, the insecure-avoidant, the insecure-ambivalent and the disorganized child. The securely attached child approaches the caregiver because they have experienced that this can help them reduce their stress and calm them down again. The insecure-avoidant child will approach his caregiver less because he has experienced that he is often not understood and comforted by him. It will therefore try to over-regulate its affect in a pseudo-autonomous manner (because it is overwhelmed). The insecure, ambivalent child turns to his caregiver when the slightest disturbance occurs because he has experienced that the caregiver has little confidence in the child's autonomy and constantly offers himself to reassure him. The disorganized child is, as the name suggests, disorganized because he does not know whether to approach his caregiver or not. There are usually traumatic experiences with the caregiver (e.g. inconsistent behavior, physical or psychological violence).

In summary, it can be said that, contrary to what many cognitive scientists postulate, affect regulation occurs primarily within the mother-child (caregiver-child) relationship. Authors such as Lane and Schwarzt (1987) have postulated five stages of development in which the ability to perceive and verbalize one's own feelings is developed. These are seen as an emotional-cognitive ability, which, similar to the sensory-cognitive abilities defined in stages by Piaget, can reach very different levels of maturity individually but are fundamentally independent of the caregiver. However, it is clear from attachment theory that the caregiver plays a complicated role, as for many children they are not only a source of security, but also a source of stress and anxiety. The child gets to know himself in this

relationship. Winnicott was one of the first psychoanalysts to connect the development of the self with the caregiver. Winnicott ([1967] 1993) wrote: “What does the child see when it looks into its mother’s face? I guess generally what it sees in itself. In other words, the mother looks at the child, and how she looks depends on what she sees herself. [...] But I am of the opinion that one should not take for granted what mothers [...] naturally do. What I mean becomes even clearer when I ask directly what a child sees in a mother's face that reflects her own mood or, even worse, the rigidity of her own defenses! [...] You look - and don't see yourself again.« (p. 129)

The psychic self arises when a child can perceive themselves as a thinking and feeling being in the psyche of another person. The human psyche needs another person for its creation. A baby cannot feed itself any more than it can develop its psyche on its own. But what effect does the caregiver's psyche have on the baby's psyche? Bateman and Fonagy (2006) presented this graphically as follows.

The caregiver observes the baby and draws conclusions from the baby's behavior (inference). For example, if the baby cries, the caregiver will assume that the baby is hungry, scared, upset, bored, too cold or too warm, gassy, etc. - so they attribute an intention of communication to the baby's cry Yes, an intention is attributed to screaming. In fact, the infant does not know what is wrong with him, but is crying because he is stressed and cannot process the unbearable emotion himself. This is where the view of Fonagy et al. differs. radically by many more cognitively oriented researchers. Fonagy is of the opinion that the human psyche is absolutely dependent on another human psyche for its development; in short, “brains need brains”. The baby does not yet know what it means to be hungry, tired, bored, angry, ... This idea ultimately means that psychological self-development represents an intersubjective process in the course of which the caregiver's reaction to his statements becomes increasingly clear to the infant and organized perception of internal states. The research findings show that the infant initially experiences his emotional states as completely confusing. How should a baby, in which a physiological state of arousal is building up and whose behavior expresses avoidance, know that what he is perceiving is fear?

A clinical example may explain this. Patients with psychosomatic symptoms have great difficulty attributing an emotion to what is happening within them. An 18-year-old patient who was in therapy with me came to me one day

and said that his doctor had diagnosed a stomach ulcer and asked him if he was stressed. He told the doctor that he wasn't stressed at all. I look at him in surprise and say: “You have so much argument during your apprenticeship that you are on the verge of quitting, your relationship with your girlfriend is threatening to break down, you don't feel like you are being taken seriously by your colleagues and your mother wants you put on the street. What else does it take for you to say that you are under stress?" The patient says in astonishment: "That's right, when I listen to you, I'm really under stress, but I don't feel it." Here was the therapist the caregiver who drew conclusions (inference): a psychosomatic patient who is obviously under stress is suffering from a stomach ulcer. The patient felt pain, but he could not understand that his physical symptoms were an expression of multiple internal and external conflicts. A clinician naturally wonders whether such a patient is unaware of his or her stress due to incompetence or internal conflict. However, this does not play a clinical role at this point. It was important to first make him understand that he did not see his physical sensations as signs of stress. Later, the defensive aspects could also be addressed in therapy. Without going into the theory of psychosomatics too much, it can be said that he had no reference persons who discovered his psyche, his subjectivity. He learned that it wasn't just “something” happening to him, but that he had a way to influence and understand his condition. In this way it learns to perceive itself as a feeling and acting subject.

In the infant (as well as in the patient), the “discovery of subjectivity” leaves a trace that can be called the psychological core self. Parents who cannot think about their child's inner experience in an understanding manner and react accordingly are preventing him from developing the core psychological structure that he needs in order to be able to build a stable sense of self. But how does this core self come into being? The psychoanalytic term is “internalization.” Freud, Klein, Bion and also Winnicott were very imprecise and vague when they described exactly how this internalization should take place. It remained rather hypothetical. These mechanisms can be better described using infant research and the theory of mentalization.

Marked affect reflection

One of the most central discoveries of mentalization theory is marked affect reflection. What does that mean? Fonagy (1995, with Steele et. al.) were able to demonstrate that “mothers who are most successful in comforting their whining eight-month-old infants after an injection mirror the infant's feeling very quickly, but in doing so incorporate affective expressions into the reflection, that are incompatible with the infant's current feelings (smiling, teasing facial expressions, etc.). … [they enable] the infant to recognize that their emotion is analogous to, but not identical to, his or her own feeling. (Fonagy et al, 2006, p. 44) A mother who calms her baby, on the one hand, worsens the affect (“The injection hurt you so much that you now have to scream so much. Yes, my little one, that is real "horrible") and on the other hand she trivializes the situation ("It was just a small, harmless peck" or she distracts the child). The discovery by Fonagy et al. So it wasn't that mothers mirror their baby's current affective state. Rather, the mothers mixed in a foreign affect. They not only reflect the child's stress, but also offer him a way to deal with the pain of the vaccination. A mother can only offer a solution if she can empathize with her child and identify with the problem. In terms of the digestive model of the psyche, one could say that a mother absorbs (i.e. identifies) the psychological state of her child, “breaks it down” and then gives it back in a digestible form. In this case, this means recognizing the unbearable physical pain and giving it back in a modulated way. This leads to regulation of affect. The

mother comforts the baby by combining "mirroring" its affect with statements or behaviors that suggest different states.

This complex process has little to do with that of a simple mirroring. A simple mirroring poses the following question: how can a baby tell whether its mother is showing her own emotions or those of the child? Why do babies notice very early whether their mother is mirroring the emotional state of the mother or the baby? If a mother is actually very worried about her child (e.g. the baby is in severe respiratory distress), she will not say: “How terrible my little one”, but will look very worried and call an ambulance. The mother will forego a marked affect reflection (“How terrible my little one”) and will show and thus reflect her worry and fear directly. Marked affect reflection is reserved for states in which the caregiver empathizes with the baby and communicates with the baby through marked, i.e. exaggerated, mirroring. The infant learns that the caregiver can change stressful situations and identifies with them. This leads to internalization into the core self. It will be able to use what it has learned as part of a strategy for affect regulation. The growing ability to control (English contigency) helps the child to understand his inner experience as his own, subjective experience. He trusts that the caregiver will help him regulate his emotions. This is the prerequisite for later learning to understand itself and others as people whose behavior is organized by mental states - thoughts, feelings, beliefs and desires (Fonagy/Steele et al., 1995).

To summarize what has been written so far: The caregiver observes the child's behavior and tries to understand this behavior from the child's perspective. She assumes that this behavior is based on an inner logic and intention. Above all, it assumes that the baby is a personality that has its own, independent subjectivity and pursues goals. She therefore reacts to his behavior. Specifically, she will perceive his emotions and mirror them. This mirroring is marked, i.e. exaggerated. This allows the baby to recognize that the mother reflects his condition. Thanks to this mirroring, which involves affect regulation, the baby develops a psychological self. Mothers intuitively follow the following basic principles:

1 Attention regulation (control of arousal and impulsivity, even of excessive blockage, important also joint attention of mother and child). This is achieved through shared rhythm, pitch, speaking along, singing along, exaggerated affect reflection, clapping, etc.

2 Affect regulation (the psyche is in the body - but is influenced by interaction with the environment)

3 Mentalization and development of the psychological self.

The objection could be raised that the role of the caregiver is overestimated. After listing the behavior for good and bad mentalization, let's address this objection. It is shown that where the mother-baby interaction has gone wrong, specific psychopathological symptoms develop, which are an indication of the important role of this very interaction.

Level of mentalization

Mentalization, according to the definition, “is a psychological ability to interpret one's own behavior or the behavior of other people by attributing mental states.” People who are good at empathizing with others are more efficient in their behavior. In general, it can be said that the less stressed someone is, the more they are able to correctly assess a situation. But even a bout of hunger or lack of sleep reduces our ability to mentalize. These are the signs of someone who is good at mentalizing:

Taking someone else's perspective.

Genuine interest.

Openness to the unknown.

Acknowledge that assumptions are being made.

Absence of paranoia.

Ability to forgive.

Reliable behavior.

Poor mentalization, on the other hand, is associated with the following behavior:

hostility

Active evasion

Non-verbal reactions

Lack of integration and explanation, pseudo-explanations instead

Content is taken literally (concretism)

Pseudo-mentalization.

From the points above it becomes clear that this self-reflective position takes place not only in the cognitive area, but also and especially in the emotional area. At the same time, by definition, mentalization refers not only to the perception of cognitive and emotional content in other people, but also to the perception of corresponding content in oneself. Processes of affect regulation can take place consciously or unconsciously. People with a tendency

towards integrative emotion regulation generally have a higher level of well-being and better mental health than those with a repressive or suppressive style or only weak cognitive influences on emotion regulation.

Hyperactivation of the attachment system

So far, the main thing that has been described is the healthy development of the core self. In order to understand the pathological conditions that are primarily observed in personality disordered patients, it is necessary to see what can go wrong in the development of the core self. The theory of mentalization is particularly helpful in the treatment of severely disturbed patients in the area of personality disorders. Bateman and Fonagy (2006) initiated the so-called “mentalization based psychotherapy” and tried to manualize it. Although psychoanalytic concepts are helpful, they are also often confusing. Therefore, these authors attempted to use as few psychoanalytic concepts as possible to explain the behavior of personality disordered patients (PDD).

As already mentioned, the basic emotions such as joy, anger, fear, sadness, disgust and surprise are experienced without the baby being able to classify them. Bays, for example, cannot initially determine that they are “scared” themselves. The child must first develop this ability to distinguish between different emotional states. The baby externalizes his indigestible affect and hopes that someone will help him. It takes a bond with a person who feels addressed by the need. This is usually the caregiver: a helpful person absorbs the emotions that are indigestible for the baby. As described above, these will return the affect in a modified form via a variety of processes (attention regulation, affect modulation) so that the baby can calm itself down. This corresponds to the digestive process described above. But what happens if the caregiver cannot find a way to deal with the problem (e.g. unbearable affect)?

When this process goes wrong, it is often understood in psychoanalysis as “projective identification.” This consists of the “projection” of the baby and the “identification” of the caregiver. It is a condition in which the caregiver cannot regulate the baby's affect, but rather identifies completely with the indigestible projection. This mechanism can often

be observed in parents who, because of their own psychopathology, are unable to regulate their emotions, but rather feel specifically attacked by the child. The inability to help your child can be experienced as a reproach of the same child for being an incompetent and therefore no good person. This is originally the child's feeling, but the parent now experiences it as an intolerable reproach.

In a second course, the parent will project this “accusation” back into the child. The caregiver can no longer ifferentiate between their own distress and that of the child. This process is mostly unconscious. The child now has a double problem: not only is his original problem unresolved, but he also becomes a “victim” of a projective identification: he identifies (in this example) with his parent's insufficiency and now thinks for his part that it amounts to nothing is good.

If further interactions follow the same pattern, a vicious circle occurs that is difficult to break. The child feels not understood and the caregiver feels attacked. What can also be referred to as “hyperactivation of the attachment system” occurs. The more the child wants to be understood, the more the caregiver will feel attacked. There are variable attacks. The result is the insecure attachments described by Bowlby. The insecure-ambivalent child sometimes tries excessively to relate to the caregiver and sometimes withdraws abruptly because he notices that an escalation in the sense of projective identification is occurring. The insecure, avoidant child seeks to distance himself from the eternal conflict. However, because its vital conflicts are not resolved, it will repeatedly try to approach the adult. These interaction patterns become established in further development.

Depressive picture

Instead of there being a clear separation between two people, the child may internalize the caregiver's feelings of guilt. This results in a part of the (internalized) caregiver constantly attacking the core self. Depressive people, for example, overwhelm themselves with self-blame, which can be understood as a trace of accusations from a caregiver. The following illustration represents this situation:

What was once between two people becomes an internal conflict. The main complication with this constellation is that the boundaries between I and you are no longer respected. Instead of boundaries being maintained, the child is colonized by aspects of the caregiver. As a result, psychological mechanisms that help people deal with emotions better are no longer available. Instead, the child has to defend itself against constant internal accusations (which come from others). This leads to a false self that torments and wants to destroy the true self. This can lead to anything from depressive images to self-destructive behavior.

Violent image

The constellation with violent patients and with so-called argumentative relationships is different. The interaction between an attacker and the attacked from childhood is repeated. However, the false self will attack the true self in another person.

In this constellation, the previously misunderstood child becomes violent. He can push away the misunderstood child within him and can feel powerful and great as a violent partner. All weak, powerless parts of the self are attributed to the partner and thus enable emotional stability. However, this breaks down as soon as the relationship breaks down. This is a hyperactivation of the attachment system. Problems that should be solved intrapsychically are dragged into an interpersonal level and are therefore not accessible to a solution. In addictive relationships, the circle of argument is always maintained. However, a separation is not possible because the attacking partner (in marriages the spouses often alternate roles) would have to admit their own powerlessness. Violent patients react even more extremely, often reacting massively to separation, for example with self-attacks, emotional breakdowns or suicide attempts.

Victim state

Conversely, it can happen that the false, attacking self is projected into a partner. These are patients who repeatedly find themselves in destructive and violent relationships and become victims there. The inner false self, which always

attacks her from within, is experienced as so alien and terrible that it cannot be seen as a part of her own. The consequences would be too terrible, so this part is projected into another person. The prerequisite for this is an addictive relationship. When such relationships break down, the factor that has provided stability for a while collapses. Patients who become victims of violent partners often collapse, become depressed or hurt themselves. This can be understood when one becomes aware that the false, destructive self can no longer be projected, but is active within the person himself.

Clinical consequences

Three mental states in personality disordered patients with different clinical pictures were described here: self-harming or depressive behavior, the violent state, and the victim state. What they all have in common is that these conditions can be explained by the early relationship with the caregiver. The clinical interventions therefore follow the understanding of the pathology:

1 The therapeutic relationship offered should under no circumstances be too close, otherwise it will represent a repetition of the child-parent relationship, which is referred to as hyperactivation of the attachment system as described above. A general overexcitation occurs, which is hardly helpful.

2 Next, attention regulation is important. Kernberg, for example, suggests therapeutic goals (in TFP, transference focused psychotherapy), agreements. Bateman and Fonagy (2006) take a less directive approach, but controlling arousal and impulsivity is also important in MBT (Mentalization based treatment). This is achieved through clear agreements and not too close proximity. Patients have a relationship pattern in which they are usually either too far away or too close to their partner.

3 Only then can affect regulation take place. This is used in a similar way to how it is used by mothers with babies: on the one hand, the affect is dramatized (“You can never forget an event like that”), and on the other hand, it is

trivialized ("Steve Jobs was also given up for adoption by his mother"). . This dramatization and trivialization must be done carefully and tactfully.

4 Over time there is an increase in mentalization. Patients initially begin to look at themselves and others more realistically during rest periods. They learn to see that when they are stressed, they have a harder time assessing what is happening in others and themselves and they fall back into old patterns (e.g. paranoid, obsessive-compulsive, depressive, etc.).

5 This leads to the development of the psychological self. This also includes recognizing how limited our ability is to really know what is happening in ourselves, let alone in another person!

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What is mentalization supporting therapy (MST)?

A metacognitive-psychotherapeutic approach based on developmental psychology

Lars Theßen & Serge K.D. Sulz

Abstract

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

Keywords

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

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

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

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

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

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

SBT had six therapy modules:

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

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

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

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

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

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

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

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

<u>.The seven patient problems are as follows:</u>

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

2. Dysfunctional survival rule (inner working model): "I'm not allowed to defend myself, assert myself…"

3. Mindfulness and acceptance: “I’m not aware of a lot of things.”

4. Emotion Tracking – deep emotional experience: “NO ONE SEES what I feel – my pain.”

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

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

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

Seven goals of the MST:

1. Attachment security: “I’M HERE!”

2. From the dysfunctional rule of survival (inner working model) to the rule of life that gives permission: “YOU MAY…”

3. Mindfulness and acceptance: BEING AWARE

4. Emotion Tracking – deep emotional experience: “I SEE what you feel.”

5. Mentalization – metacognition: “WHY – FOR WHAT PURPOSE?”

6. Development from the affect level to the thinking level (self-efficacy): TAKE THE REINS INTO YOUR OWN HANDS

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

Seven therapeutic paths to achieve your goals:

1. Attachment security: secure attachment in therapy

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

3. Mindfulness and acceptance: creating awareness

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

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

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

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

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

Module 1: Attachment security in the therapeutic relationship

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

Attachment figure:

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

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

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

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

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

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

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

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

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

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

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

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

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

The childhood attachment patterns become four adult attachment types:

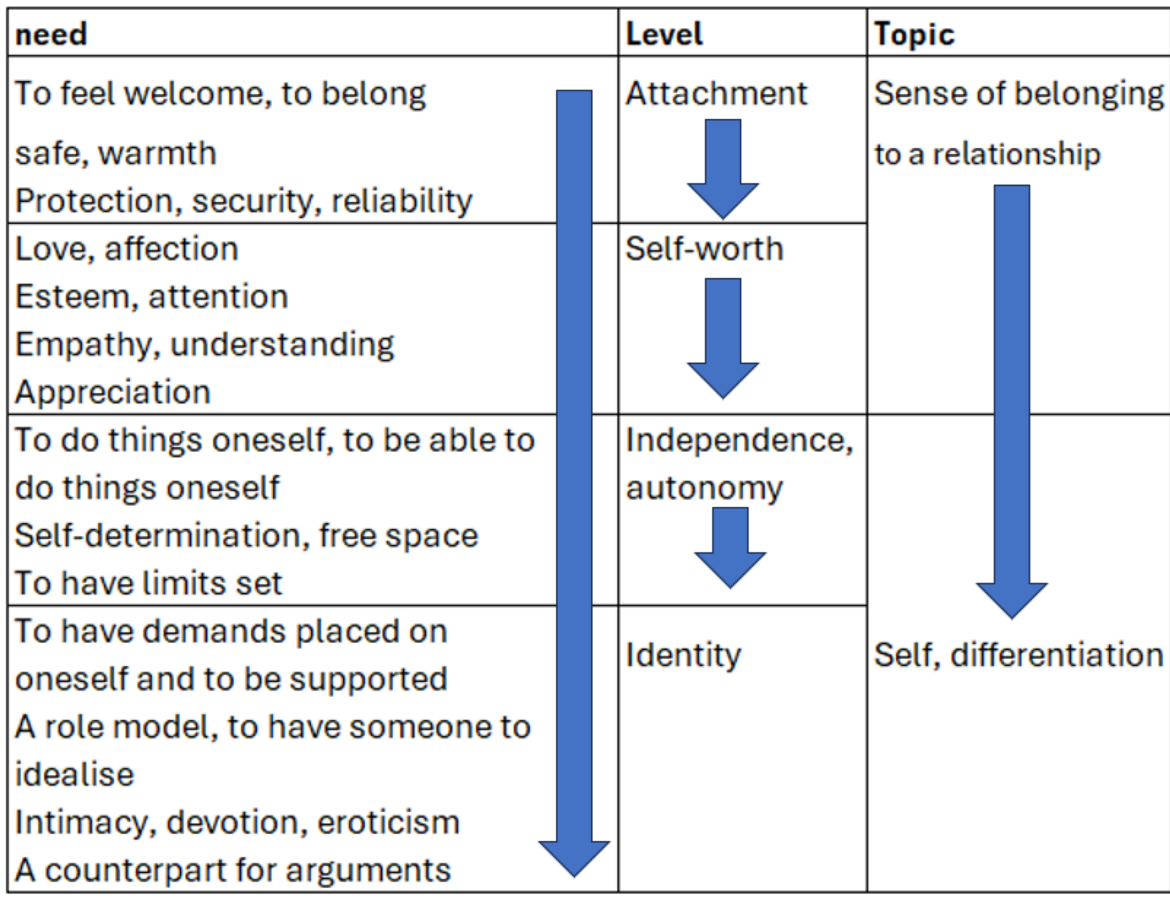
1. dependent to clingy type -> fear of separation
2. detached type -> fear of closeness
3. provided type -> fearless due to perfect avoidance in the close relationship
4. autonomous type ->fear-free through perfect avoidance in autonomy

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

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

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

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



need	Level	Topic
To feel welcome, to belong safe, warmth Protection, security, reliability	Attachment	Sense of belonging to a relationship
Love, affection Esteem, attention Empathy, understanding Appreciation	Self-worth	
To do things oneself, to be able to do things oneself Self-determination, free space To have limits set	Independence, autonomy	Self, differentiation
To have demands placed on oneself and to be supported A role model, to have someone to idealise Intimacy, devotion, eroticism A counterpart for arguments	Identity	

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

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

Module 2: Rule of Survival and Permissive Rule of Life

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

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

- **Self-image**
- On the one hand, I need

(need for dependency) warmth.

- On the other hand, I need

(need for autonomy) self-determination.

- What I need most is warmth
- I can't assert myself (yet).
- I can already adapt
- I (still) fear abandonment

- **World image**
- I only get warmth from my father/mother

if I adapt (desired behaviour)

- However, my father/mother threatened/frustrated me with abandonment

if I showed the following undesirable behaviour: defend myself defiantly

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

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

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

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

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

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

I give you warmth (need)

And I will not go away from you (fear)

A common survival rule is:

Only if I am always kind and compliant

And never attack in anger,

I maintain warmth and affection

And avoid being alone.

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

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

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

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

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

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

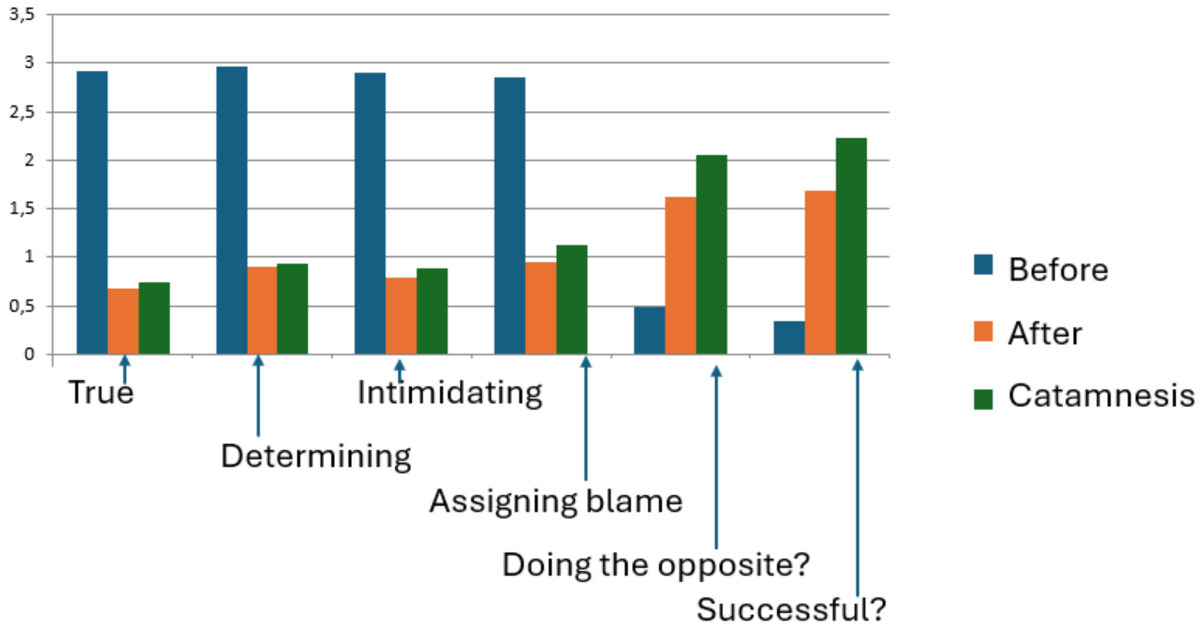


Figure 3: Present-day influence of the rule of survival on feeling, thinking and acting (from Sulz, 2014, p. 353).

The therapy process consists of three steps:

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

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

Even if I'm less often kind and compliant

And attack more often in anger,

I still maintain warmth and affection

And don't have to fear being alone.

What permission is involved?

It's about permission to stay as I am,

– not to have to bend over backwards for others,

– to be allowed to stand up for myself,

– to impose myself on others,

– to be allowed to go my own way,

– not having to be there for others,

– to be allowed to be weak,

– to be allowed to be strong,

– to be allowed to be alone, etc.

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

Module 3: Mindfulness and Acceptance – Stress Tolerance

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

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

We proceed therapeutically as follows:

The situation (by way of example): …

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

My MACES approach:

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

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

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

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

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

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

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

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

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

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

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

- perceiving, describing and participating

and the following three HOW skills:

-nonjudgmental, concentrated and effective.

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

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

Module 4: Emotion Tracking: seeing, feeling, empathizing

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

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

Therapist behaviour consists of the following steps:

– recognize the feeling in the face

– name the feeling correctly

– identify and name the context (trigger).

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

– guide the ideal parent exercise.

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

»I see (perception of the therapist)

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

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

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

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

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

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

Patient: “I was never praised!”

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

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

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

1. Patient reports on the emotionally stressful relationship.

2. Therapist listens empathetically and observes the face.

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

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

5. Patient agrees or corrects.

6. Patient continues the story based on this feeling.

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

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

9. Patient confirms or corrects.

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

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

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

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

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

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

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

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

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

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

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

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

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

Module 5: Mentalization – Metacognition: Recognizing, Understanding

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

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

– Physical actor: “I am body”.

– Social actor: “I’m smiling at you.”

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

– Intentional actor: “You want this.”

– Representational actor: “You feel.”

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

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

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

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

Mentalization in conversation

A Working out affect and motive -> emotion tracking

1. Building up a secure attachment

2. Listening to emotional concerns

3. Mirror feelings markedly

4. Check which feeling has the highest energy (anger or sadness)

5. Feel the need empathetically and express it: “You would have needed …”

6. Guide fantasy of need satisfaction

B Joint reflection on affectivity-> mentalizing

1. “Which situation was frustrating?”

2. “What is the significance of the person?”

3. “What was frustrating about their behaviour?”

4. »What need was frustrated? What would you have wanted?”

5. “How did the person come to behave this way?”

6. “How could you have achieved what you wanted?”

7. “How does the idea of acting like that the next time feel?”

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

1. Establishing security in the relationship

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

3. Proceeding in a structured and supportive manner

4. Question-answer dialogue instead of free conversation

5. Columbo questions: not knowing

6. Asking specifically about motives for a type of behaviour

7. Value mentalization, question non-mentalization

8. Offering alternative interpretations for non-mentalized statements

9. Interrupting pseudo-mentalizing

10. Reflecting together

11. Thinking out loud as unfinished consideration

12. Saying when a thought was a mistake

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

14. Not imposing your own hypotheses

The result of the conversation may be that the patient

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

– can be more consciously aware of their feelings

– can accept their negative feelings

– can change how they feel

– can change their self-perception

– can perceive their therapist differently

– can give the relationship a different meaning

– feels less dependent and defined in the relationship

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

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

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

As a therapist, I pay attention to:

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

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

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

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

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

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

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

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

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

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

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

Affective system:

– I cannot help myself on my own.

– tends to be non-verbal

– associative thinking

– conditioned responses

– no self-distancing

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

Thinking system:

– I know how to help myself.

– tends to be linguistic

– concrete, logical thinking

– I make conscious decisions.

– I have psychological distance.

– I have a theory of mind (TOM).

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

Developmental therapy takes place in two steps.

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

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

What is not yet developed at the thinking stage:

– Thinking is still egocentric.

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

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

– There is no ability to empathize yet.

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

Module 7: Development to the Empathy Level: Empathizing

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

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

– putting myself in the other person's shoes,

– empathizing.

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

– so that the other person has a chance,

– being empathetic with myself,

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

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

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

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

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

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Can behavioural therapy support mentalization? For what reason?

Lars Theßen & Serge K. D. Sulz

ABSTRACT

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

Keywords

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

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

1.1 Neurobiology: the development of the brain

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

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

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

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

1.2 Biography: Childhood experiences shape people

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

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

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

1.4 Psychotherapy: Mentalization as the key to healing and growth

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

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

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

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

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

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

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

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

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

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

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

2. Therapeutic mentalization support

2.1 Attachment as a therapy goal?

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

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

2.2 Behavioural competence as a therapy goal?

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

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

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

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

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

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

2.3 Ability to regulate emotions as a therapy goal?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

P: Yes.

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

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

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

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

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

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

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

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

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

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

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

P: Yes, I´d like that very much.

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

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

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

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

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

P: In a kind, loving way.

T: What could he say?

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

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

P: Yes.

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

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

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

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

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

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

P: Really?

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

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

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

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

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

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

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

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

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

2.4 Development and mentalization as a therapy goal?

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

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

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

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

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

- Why will you be alone?

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

- Could this have been prevented?

I shouldn't have allowed it.

- What should you have done to prevent it?

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

- What stopped you from doing that?

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

- What fear prevented you from doing it?

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

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

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

- What prohibitions prevented you from doing it?

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

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

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

- What commands led you to do something else instead?

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

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

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

- Would these consequences have been bearable?

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

- If not, why not?

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

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

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

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

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

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

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

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

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

- How does it feel to have managed it?

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

- How does your body feel?

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

- Is it desirable for you to achieve this?

Definitely!

- Do you want to go ahead with this?

Preferably now.

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

Now I can really imagine doing it: tonight!

2.5 Permission for self-determination as a therapy goal?

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

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

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

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

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Emotion Tracking - Healing and Growth of the Wounded Soul

Serge K. D. Sulz & Maria Schreiner

Abstract: Most psychotherapies are far too intellectual and rational, especially in terms of conversation management. Creating the optimal mix of metacognitive reflection and emotive dialogue is an art. We aim to demonstrate that it involves professional therapist behavior that can be trained. However, Emotion Tracking is not as easy to learn as most psychotherapeutic interventions. For this purpose, we have adapted Albert Pesso's microtracking (Pesso, 2008a, b, see Bachg & Sulz, 2022) so that it can be repeatedly used in cognitive-behavioral and psychodynamic therapies. In Mentalization Supporting Therapy, Emotion Tracking is one of seven therapy modules. Just as Carl Rogers' client-centered conversation techniques have increasingly become part of psychotherapeutic basic skills over the decades, we believe that Emotion Tracking should also become a core competency of any psychotherapy alongside procedure-specific interventions.

Keywords: Emotion Tracking, antidote, somatic marker, body signals, metacognition, Theory of Mind, Mentalization Supporting Therapy(MST), anger exposure, need satisfaction, ideal parents

Introduction

Emotion Tracking (Sulz, 2021a, 2022a, 2023) is an adaptation of Albert Pesso's microtracking (Pesso 2008a, b, see Bachg & Sulz, 2022, Schreiner, 2017) for use in behavioral and psychodynamic therapies. The few available evaluation studies (Sulz, 2022b, c, Theßen, Sulz et al., 2024a-c, Richter-Benedikt & Sulz 2024) show a remarkably good effectiveness of this method. Moreover, the prominent trauma researcher, Bessel van der Kolk, has declared that microtracking is the best, if not the only effective intervention for trauma disorders. This statement complements our many years of clinical experience in a gratifying way.

It quickly becomes evident that modern therapies reach their limits exactly where Emotion Tracking begins. Be it Dialectical Behavioral Therapy, Mentalization-Based Therapy, Transference-Focused Therapy, or Schema Therapy—they all do not reach deep enough into the hidden, protected emotions. This is not surprising since these therapies were developed for borderline patients, where the goal is often the opposite: dealing with too intense, too long-lasting affects, and the resulting excessive actions. Therefore, it is unrealistic to expect these therapies to suddenly become just as competent and effective in addressing the opposite goal: bringing forth and working with feelings that are too rarely, too weakly, or too briefly felt.

Only methods like Focusing (Gendlin, 1998), Emotion-Focused Therapy (Greenberg, 2000), and Pesso Therapy (e.g., Bachg & Sulz, 2022) seem to provide solutions to this problem.

We chose Pesso Therapy, trained in it, and worked with it for many years. After ten years, we were ready to integrate the microtracking method into behavioral and psychodynamic psychotherapy. The adaptation required only a few changes, and thus, Emotion Tracking was born. We have been using it as an emotive conversation technique for another ten years, integrated into our main therapeutic approach, and now we have the courage to share it.

Emotion Tracking is now one of seven therapy modules of Mentalization Supporting Therapy(MST), which includes the modules: Attachment Security, Survival Rule and Life Rule, Mindfulness, Emotion Tracking, Mentalization and Metacognition, Development from Affect Level to Thinking Level, and from Thinking Level to Empathy Level (see Theßen & Sulz, 2023).

Mentalization Supporting Therapy MSTis an advancement of Strategic Behavioral Therapy (SBT) (Sulz & Hauke, 2009). It incorporates the mentalization approach by Fonagy et al. (2008) and Albert Pesso's microtracking (Pesso, 2008a, b, see Bachg & Sulz, 2022) and unfolds a developmental therapy based on Piaget's (1975) theory (Sulz, 2021b, 2022a, 2023).

Just as we do not constantly use the Socratic dialogue with our patients, we do not stick with Emotion Tracking all the time. However, there are many therapeutic situations where it is worthwhile to bring the underlying emotions to the surface and continue working with them.

For both patients and therapists, it is always impressive to see how Emotion Tracking can turn the tide and create deeply moving moments. Through this resource-oriented method, the patient is always guided from suffering and pain, from anger and grief, to well-being, contentment, and happiness. As a result, both patient and therapist usually leave the therapy session with a very good feeling.

Here, we want to describe the concept and procedure as clearly as possible. In the conceptual introduction, we adhere to the explanations of Sulz (2021b, 2022a) and the article by Theßen & Sulz (2023) published in this journal.

Emotion Tracking

Emotion Tracking is a form of dialogue that emerged from neurobiological and emotion-psychological approaches, focusing on emotions, making feelings tangible, identifying emotional triggers, understanding their formation, making need frustrations conscious, experiencing satisfying fulfillment, and, incidentally, serving as an excellent method for cognitive restructuring.

The Procedure of Emotion Tracking (Utilizing Somatic Markers)

The patient reports a problematic event. During the conversation, the therapist pays attention to which conversational contents trigger which feelings, which bodily reactions indicate which impulses, and which memories are associated with them.

What it comes down to is:

- Recognizing the feeling in the face
- Naming the feeling correctly
- Identifying and naming the context (trigger)
- Formulating an antidote: "You would have needed..."
- Guiding the Ideal Parents exercise
- Always being aware of why and for what purpose I, as a therapist, do something a certain way and not differently.

For example, if sadness becomes visible on the patient's face, even though they might not have noticed it yet, I reflect this feeling back to them. I tell them that I see how sad they become when they remember, for instance, how their father rejected their invitation. I see them with their feelings; they feel seen by me. I empathize with them, and they hear in my voice that I am with them in my feelings. At the same time, I point out that their feeling was triggered by the memory of their father's rejection. They recognize and understand the presumably causal connection. When the feeling is addressed, their consciousness remains in the emotional brain (limbic system). Hearing the context leads them to reflection (reflective affectivity in the sense of Mentalization-Based Therapy), that is, into the prefrontal cortex.

If desired, the feedback that reflects the emotion can be standardized: "I see (therapeutic perception) how desperate you become (emotion) when you remember (emotion-triggering consciousness process) that your mother stopped talking and just left (situational context)." We are free in our choice of words.

Antidote

I ensure that the patient perceives the problematic situation on all levels, focusing on their dysfunctional thoughts and the accompanying emotions and bodily sensations. This prevents merely talking about the problematic situation and allows me to form a precise image of the events: The patient continues to tell their story, and as a listener, I form an internal image of the events. I empathize with them, feel with them, and sooner or later, I sense what they would have needed instead. As soon as this becomes a certain feeling, I express it and reflect it empathetically to them. If the patient continues to talk without pause, I ask them to hold for a moment so that I can tell them what I feel, such as: "You would have needed your father to be happy about your invitation."

If my internal image is similar enough to their memory image, I can grasp what they really would have needed, what would have been the "antidote" to the real experience. As soon as I have spoken my sentence, they create an internal image in which they are given exactly what they longed for so much. Their face brightens, perhaps even radiates, so they don't even need to say that my assumption is correct. Their joy is validated: It would have felt so good; they would have felt seen and appreciated if their father had been happy about their invitation and accepted it.

With this, Emotion Tracking is essentially explained. It consists of the following steps:

1. Seeing what feeling is present and which context triggered it.
2. Sensing and saying what the patient would have needed instead.
3. Reflecting and validating the newly emerged feeling.

If I succeed in following the patient in this way instead of guiding them through an active conversation design, we make the most progress. In contrast to the metacognitive conversation of mentalization promotion, we almost never ask why and for what purpose questions. These questions lead the patient away from their feelings and toward thinking. The contact with their feeling is already lost.

If you want to try Emotion Tracking right away, you should stop reading here and only continue when it works and curiosity about refining the method arises. For those who continue reading, it becomes too easy to get the impression that everything must be done exactly as written here and all at the same time. The desire to do everything correctly quickly leads to losing contact with the patient.

As Theßen & Sulz (2023) suggest, we can imagine the sequence of the dialogue in 15 steps:

1. The patient reports on an emotionally burdensome relationship.
2. The therapist listens empathetically and observes the face.
3. Therapist: "I see how painful it feels,"
4. "when you remember how he treated you."
5. The patient agrees or corrects.
6. The patient continues from this feeling.
7. The therapist empathetically senses what the patient would have needed.
8. Therapist: "You would have needed someone to stand by you."
9. The patient confirms or corrects.
10. The patient can see the satisfaction of needs before their inner eye.
11. The therapist asks for a description of the imagined scene.
12. The therapist asks what the satisfying person might say.
13. The therapist speaks this sentence, lending their voice to the imagined person.
14. The therapist sees what feeling arises and reflects it.
15. The therapist asks where, from whom, and how to obtain this today.

16. The therapist asks what the patient would need to do to get it.

The question in step 12 is not a why-question that leads away from the feeling but an invitation to continue imagining the beautiful scene. The question in step 15 also stimulates the patient's imagination. Only the question in step 16 is no longer Emotion Tracking but stimulates reflection on available choices.

You can find two case examples in the already published MVT books, which give you a sense of how the dialogue flows. However, the conversation with Ms. N. in the practical guide (Sulz, 2022a, pp. 112-117) poses a challenge for beginners. The therapist constantly includes body awareness, playing almost with both hands, which can be overwhelming at first. The simplified dialogue without the body-dialogue component makes the principle clearer:

Case Example: Ms. N.

Ms. N. is 35 years old. Professionally, she is the owner of a successful clothing store. She hasn't had much luck with men so far. She is frustrated that they all end up resembling her father. Her father was rejected by her mother, so Ms. N. gave her love to her love-starved father. It was only later that she realized she was getting nothing in return. He took the love from his daughter that he needed from his wife.

Instructions for the Therapist:

- Listen carefully.
- Allow the patient's narrative to resonate with you.
- Fully engage with your own emotions.
- Do not get distracted by thoughts.
- Perhaps inner images of the reported events and the storyteller will emerge.

Ms. N.: I would like to talk about my father today and how I felt abused by him.

Therapist: Yes, you mentioned that this is a significant burden for you. Please start telling your story.

Ms. N.: My father accuses me of keeping him at a distance so vehemently. He didn't sexually abuse me but emotionally. I had to give him love and affection that he didn't get from my mother. But there was nothing left for me, though it took me a long time to realize that. (Tears in her eyes) I felt good when he felt good. Since he was very kind to me, I loved him very much. But in reality, it was all about him, his needs, and not about me. He needed something to love. He took that. And I didn't get what I needed.

Therapist: (Naming the emotion I see and adding the triggering context once again): You are very sad, and it hurts deeply that you didn't get what you needed from him.

Ms. N.: (Crying) Yes, it hurts so much that he didn't see me or my needs. I was the child, and he should have given me what I needed. That wasn't right!

Therapist: (Noticing the patient's face showing anger and hearing her angry tone): You realize that it wasn't right of your father. And now you're angry that he took something from his daughter instead of giving her something.

Ms. N.: I have such a great rage! I'm full of anger!

Therapist: (Observing her physical readiness to defend herself): You have so much rage that you can feel it physically. Where in your body do you feel it? Focus on it and notice this physical sensation as accurately as possible. Anger and rage may want to express themselves. What movement wants to happen? What does your rage want to do?

Ms. N.: I want to push him away, just get him away! He disgusts me.

Therapist: (Seeing her already making a pushing motion with her arms): He disgusts you. And out of anger over his selfishness, you want to push him away. Where do you see your father in the room? (The father is symbolized, for example, by an empty chair.) Look at him! Let your anger come into your eyes!

Ms. N.: (She stretches out her arms, palms facing outward as if to stop him): With all my strength, I want to push him away.

Therapist: You can stand up for that and imagine him standing in front of you, wanting to take your affection again. (She stands up.) Are you ready?

Ms. N.: Yes, I see him before me—disgusting—and I'm so angry that I just want him gone.

Therapist: (Standing beside the patient): You can do that now. You can stretch your arms and push him away with all your might. Imagine his face and his gaze. Look him in the eyes. Remind yourself that he wants to take something from you again, and that's not right. And that you can stop him now, with the energy of your anger, the strength you feel in your arms, and the will to draw a line.

Ms. N.: (Crying): You were needy; I had to take care of you. And I had no one to comfort me and really be there for me.

Therapist: (Noticing her tension diminishing and collapsing inward): It makes you infinitely sad to realize that you had no father who was there for his daughter, who felt what she needed and gave it to her so well that she felt seen, secure, and protected.

Ms. N.: (She remains with her sadness): I would have needed you to see how abandoned I felt by you and Mom, and to hold me in your arms to comfort me.

Therapist: (Focusing on the need and expressing empathetically what was missing for the patient): You would have needed a father who saw how lonely his daughter felt, and who came to her to comfort her. A father who didn't need his daughter to love him, who exchanged that with his wife and was happy with her. Did anyone see how you felt back then?

Ms. N.: No, I felt completely alone and helpless.

Therapist: How would it have been if someone had seen your helplessness? Someone who stood by you and saw how your father treated you. Someone who would have understood your helplessness? (Bringing in a contact person validates the feeling. It is felt to be right and justified.)

Ms. N.: That would have felt very good.

Therapist: I see how much longing (visible in her gaze and tone) you feel to have had someone by your side. Imagine this person, an ideal reference person, perhaps an uncle or aunt, as you would have needed them back then, and they were there, supporting you in standing up for yourself. Telling him what you really thought.

Ms. N.: It would have been wonderful. I would have needed such an uncle.

Therapist: Let's bring in this ideal uncle (symbolized by an empty chair). I will lend him my voice: “If I had been there back then, you could have defended yourself.” What would you have liked to tell him?

Ms. N.: I'm not responsible for making you happy! What you expect from me is unfair! I'm not the right person for that! (The ideal uncle encourages her to tell her father this, to express her anger and disappointment, so she can stay in her strength. Anger is a force that should be supported.)

After the Anger Exposure:

Therapist: If you want, we can, in imagination, bring the father you needed here (or as a symbol, for example, with a chair with a soft blanket on it. Or with a foam block).

Ms. N.: (First hesitant, then ready): Yes, I realize that I would like to feel that now.

Therapist: First, let an inner image of the father you needed form. What would have needed to be different from your real father? How does he look? What kind of person is he? How does he treat you?

Ms. N.: (Slowly getting into it): He is strong, self-confident, gets what he needs elsewhere, for example, with my mother as a couple. When he is loving towards me, I notice that it's not for him, but for me as his child.

Therapist: If he were in the room now, where should he stand or sit?

Ms. N.: I would like him to stand right behind me, his hands on my shoulders. (She can sit on the floor, lean back, feel the rolled-up blanket as the arms of the ideal father on her shoulders.)

Therapist: Would you like to imagine resting your head back so that he supports it?

Ms. N.: Yes, that feels good (head leaned back and supported from behind).

Therapist: How does that feel?

Ms. N.: I feel cared for, not alone, supported, and protected.

Therapist: What could the father you needed say?

Ms. N.: He should say that he is there for me. That he is doing well with Mom and they are both giving each other what they need. That I don't need to be there for him.

Therapist: I'll lend him my voice. But don't look at me while I speak: "I am here for you. I am doing well with your mother. We give each other what we need. I don't need anything from you. You don't need to be there for me." (I continue to speak for the father she needed): "I see when you feel alone. And I come to you and am there for you. You can lean on me and feel safe with me."

Ms. N.: (Relaxed and calm, fully immersed in the scene): So much tension is leaving, I can finally let go (Therapist reflecting the external signs observed).

Therapist: (Continuing to lend the ideal father my voice): "Your mother and I are here for you, not the other way around!" (Symbol for the ideal mother next to the ideal father—possibly a chair with a cushion on it.)

Ms. N.: (Tears again): And you two get along well too?

Therapist: (Again lending the ideal father's voice): "Yes, we have a beautiful man-woman relationship. I love your mother as my wife and you as my daughter."

Ms. N.: I feel really good with you two.

Therapist: (Speaking again for the ideal father): "Yes, we are a happy couple, and we are happy to have you as our daughter."

Ms. N.: (With tears and sadness): That's what I missed so much.

Therapist: (No longer speaking for the ideal father): It makes you so sad and hurts that it wasn't like that in your real life. Go back to the imagination, to the situation with the father you needed. With the experience of happiness and fulfillment.

Ms. N.: That you love me for who I am, without me having to take care of you.

Therapist: (Lending the ideal father my voice once more): "We love you just as you are. You are allowed to be demanding, reluctant, do things differently than we think. We love you for that too."

Ms. N.: Thank you, that is a relief.

Therapist: How does it feel physically? You can deeply imprint this father on your memory, with the experienced happy scene and your associated body posture, and recall it whenever you want. Just imagine that you had this father and still have him. A father who is there for you. While you take the body posture associated with this happiness once again.

Anger Exposure

When both sadness and anger are present in the patient, we are generally free to choose which emotion we continue to work with. However, there is an empirical rule: follow the feeling with the most energy. If the anger is still so strong that it constantly interferes, we should address it. For some patients, it is easier to allow anger than sadness. Only when anger has been dealt with is the way clear for the Ideal Parents exercise. Only then does the longing arise to receive what was missing.

There may be great anger towards a ruthless father who tormented his wife and children. While the child was full of terror and pure fear at the time, the adult patient looking back has an anger they would like to physically act out. We help them release their anger, whether purely in imagination or scenically in the therapy room. Their actions of anger must be permitted. Who has the authority to allow it? A therapist who can handle it well (providing a safe framework, with calm support and good boundaries). It is often helpful to offer a contact person who would have understood and supported the child at the time. The contact person must be effective, otherwise, the anger does not dissipate. The villain must receive the punishment they deserve. Satisfaction and a sense of justice indicate the effectiveness of the anger. We do not suggest to the patient how they can physically act against the imagined father. They let the impulses of anger arise from their bodily sensations. If they have been very active, they may be out of breath afterward but still feel powerful and free. With pure imagination, the experience is somewhat weaker but still liberating. Beforehand, we convey to the patient the knowledge that anger, when it becomes strong enough, always becomes physical. And we remind them that the anger exercise here does not hurt anyone and that relationships usually improve as a result. It may happen that the anger quickly turns into compassion for the other person, seemingly ending the exercise. We invite the patient to artificially separate the other person into a positive aspect (who is loved and deserves compassion) and a negative aspect. Only the negative aspect is brought into the anger exposure with a symbol. This aspect prevented a good relationship with the positive aspect. If the anger still disappears and great sadness arises, the perpetrator's guilt no longer matters. It is not uncommon for compassion for the perpetrator to develop (“They couldn’t help it. They didn’t have it easy as a child either”). Then it is only about the painful longing for what would have been needed from them, and after the needy child-part of the father or mother has been addressed, we can soon move on to the Ideal Parents exercise.

Ideal Parents

In the final step, a new stage is opened, where a hypothetical and synthetic childhood is staged, with ideal family (and social) conditions, with ideal parents, so that the patient can develop, out of their feelings, what they truly needed and how it would have felt to receive it—in imagination, with the help of symbols, or in groups through role players.

When it is clear that the patient imagines themselves as the child they once were and distinctly feels emotions and needs, the therapist suggests a role player or an imagined parent figure who represents the "ideal father," fulfilling the child's needs just as the patient requires.

For example, the therapist might say: "If I had been there as the father you needed when you were a six-year-old child, I would have said: 'I understand that it's not easy for you,' and I would have comforted you. I would have said: 'You have time, and I will help you.'"

If the subjunctive form is bothersome, it can be spoken in the present tense. However, it's worth considering that children naturally use the subjunctive in their play: "You would be the policeman!" or "You would be dead now!" Therefore, it's entirely up to you and the patient.

Unlike many imagination exercises, everything does not take place solely in the patient's mind (more precisely in their insula). Instead, they are encouraged to bring the ideal parents into the therapy room as role players or symbols, imagining them standing behind, in front of, or beside them. This makes a significant qualitative difference in the intensity of the experience.

If a thoroughly fulfilling experience arises, this becomes a real emotional experience with effects, despite the artificiality of the situation. The patient is invited to take this joyful situation with them in their memory, with all involved senses, so that they can recall and enjoy it anytime.

The happy experience in the imagination fills both the psyche and the body. The scene is emphasized, "photographed and videotaped," stored in memory with all perceptions, feelings, and sensations—as a resource that can and should be retrieved at any time. It becomes the vision of a fulfilled wish, helping to pursue goals that move in this direction (in an adult way).

Although the situation ends with the exercise, the patient can imagine taking the ideal reference persons as inner companions, making them available at any time.

To illustrate the effectiveness of exceptions, we like to use a board with 1000 white mini squares—a huge area. Then we swap one small square for a black one and ask where the viewers look. Almost no one manages not to look at the black square. This one has more impact than the 999 others.

Just as we can't help but look at the one square, we cannot erase the one positive exception from our previous negative experiences from our expectations: We start with hope and confidence and thus become more positive people with a positive aura that has a positive impact on others, leading them to follow our positive invitation, creating positive encounters.

In training, practical tips are provided without thematic order or structure, which should be mentioned here.

Practical Tips

1. **Inner Image:** It is essential that an inner image of the events arises for both the patient and the therapist while the patient is telling their story. Ideally, these two images match well. The inner image triggers the feeling in the patient and leads to an empathetic reaction in the therapist:
    - **Image/Bodily Sensation ▶️ Emotion ▶️ Procedural Memory (bottom-up)**
    - **Language ▶️ Cognition ▶️ Declarative Memory (only top-down)**
2. **Learning to Perceive Subtle Signs:** We must learn to perceive subtle bodily signs of emotions in the patient's face and body (somatic markers in the sense of Damasio, 2003). We need to observe the patient with great attention and should not let ourselves be too distracted by the narrative.
3. **Awareness Processes in the Here and Now:** Similar to the mindfulness approach, Emotion Tracking attempts to focus the patient's attention on their awareness processes in the here and now—this is the moment of the conversation with the therapist. Which emotion, which thought, which bodily process (vegetative or motor), which imagination, which memory, which perception occurs right now in the present?
4. **Reading Feelings on the Face:** Training the ability to read feelings from the face is essential. Empathy alone is not enough. The trainer must train their ability to read feelings from the face.

5. **Empathy and Following the Narrative:** The therapist must empathetically follow the patient's story. The therapist's feelings must always be critically examined by the patient to determine whether they are truly perceived within them or simply a (false) assumption of the therapist.
6. **Letting the Patient Continue and Following Their Story:** Do not structure the conversation. Do not ask questions that divert from the focus. Do not ask questions that stimulate reflection. Do not introduce your own viewpoints.
7. **Taking Time and Being Error-Friendly:** It is always the same process. With frequent practice, it becomes smoother and no longer feels artificial. Without practice, it remains awkward and alien (for you as the therapist, not for the patient who is glad that you are working with them in this way). "It is okay to say the wrong emotion. And to not perfectly repeat the patient's words. I do it as well as I can. As well as I remember."
8. **Positioning to Observe the Patient's Face:** I position myself as a therapist so that I can see the patient's face and mimic changes well. I agree with the patient to talk about a very emotionally distressing topic that is of great concern to them. I say that as a therapist, I will focus on the feelings that arise during the conversation and will try to express them immediately (e.g., "I see how sad you are becoming").
9. **Encouraging Patient to Validate or Correct:** I ask the patient to always check immediately if the emotion I named is truly present in them and to correct me if it isn't, so that I don't lead the conversation in the wrong direction (e.g., "No, it’s not sadness; it’s despair").
10. **Identifying the Triggering Process:** I explain that I will add which awareness process (memory, visualization, reflection) triggered this feeling, giving the patient the opportunity to recognize what (context) triggers which feeling in them. This allows a deeper understanding of the emotional significance of the event (e.g., "I see how desperate you feel when you remember that your efforts to gain his recognition always went unnoticed").
11. **Interrupting Continuous Speech:** Some patients speak without pause, so I need to interrupt and state the emotion I see.
12. **Taking Time to Identify and Name Feelings:** If I don’t quickly find the right naming, I simply ask to stop talking because I want to reflect on which feeling has just emerged. I try to address each feeling and name its trigger. This slows down the conversation, which is necessary to perceive the feeling in the here and now.

13. **The Antidote Hypothesis:** The antidote hypothesis should not be omitted in Emotion Tracking. It is the goal of this emotional analysis, which unfolds in three acts. The first act was the emotional problem of the present. The second act was the misfortune of childhood. The third act of the drama is very rewarding in terms of resource-oriented goal finding.
14. **Aiming for a Positive Outcome:** The goal should not only be the liberation from negative emotions but a positive target state associated with very positive feelings such as satisfaction, relief, joy, and happiness. This state is experienced both physically and in imagination and is maintained as a vision that motivates goal-directed behavior more strongly than a mere thought-out goal.
15. **Introducing a Happiness Fantasy:** The therapist says: "I would like to invite you to a fantasy where you can bring in exactly the person you needed. You can imagine what kind of person they would have been, what they would say, how they would act—just so that you can experience the fulfillment of your most important needs back then. How old were you at the time? Imagine now being the child of that age. And imagine having exactly the person entirely for yourself who gives you that (e.g., feeling welcomed, secure, safe, loved, understood, appreciated, autonomous), as much as you want and need, so reliably lasting—and without you having to do or give anything in return."
16. **Allowing Tears:** Soon, the feeling of happiness will mix with sadness, so that tears may accompany the happiness. "Sadness is also coming up, the memory and pain that it wasn’t like that in reality. That is perfectly normal. Allow the sadness and redirect your attention to the fulfilling experience of this need-fulfilling person, who is like a good father or mother or could be the father or mother you needed back then."
17. **Marked Reflecting:** I do not react as intensely as the patient does. Therefore, I reflect the feeling "markedly" in the sense of Fonagy et al. (2008). Putting myself in their shoes, I feel anger like them, but I remain the external listener, and it is not as angering for me as it is for them. Therefore, my emotional expression is less angry, more understanding and affirming. Marked means that I empathize but do not feel as intensely (if the patient feels very intensely). They can then sense that I can handle their emotion and that they are in good and safe hands with me.

18. **Naming the Context:** When I name the triggering context, the patient temporarily and partially leaves the emotional state. While one part of them feels the anger, another part reflects on the new understanding: "Aha, the memory of my father's constant lecturing triggered my anger."
19. **Deep Emotional Experience:** This double process creates a deep emotional experience in the sense of Greenberg (2000). The feeling alone is an experience but not yet a learning experience. Only adding the triggering context brings the understanding that makes the feeling into an experience. It's about linking the narrative and the triggered feeling mentally in a causal way. In the brain, the place of feeling is the limbic system, and the place of understanding is the prefrontal cortex.
20. **Theory of Mind:** Over time, many such new experiences come together to form a Theory of Mind, so that behavior can be increasingly linked to intentions, and intentions can be traced back to needs and fears—both in oneself and in others.
21. **No Re-Parenting:** This should not be confused with the somewhat strained attempt of a beginner to avoid being like the negative aspects of the patient's parents. It is also not an attempt to provide the patient with a re-parenting experience as quasi-ideal parents. We do not leave our psychological professionalism to provide maternal or paternal care.
22. **Understanding Unmet Needs:** We do not fulfill unmet needs that the parents never satisfied, no matter how much they were longed for. We only empathize with how great the need and longing are, how much the frustration hurts the patient. We do not satisfy the central need for love, etc., but we accompany them in their pain of not being loved.
23. **Holes in Roles:** Gaps in central need fulfillment in previous generations generate compassion for the father or mother and lead to parentification—children taking on parental roles. The Holes-in-Roles technique creates a scenario where the father or mother has ideal parents themselves, is well taken care of, and the parentification can be reversed.

Conclusion

We have begun to learn a new dance, without the expectation of immediately mastering what professional dancers can only do after years of practice. Simple first steps that are enjoyable. And only much later do we dare to look at the advanced dancers. However, you can practice. There is a lot of practice material with which you can make great progress. You will experience that it becomes more and more fun—the more error-friendly you are.

The practice material can be downloaded or streamed from the website: https://eupehs.org/haupt/mentalisierungsfoerdernde-verhaltenstherapie-mvt/

We wish you much joy in dancing!

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Research on Mentalization-Supporting Therapy (MST)

Attachment, mentalization, development and personality strengths

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ABSTRACT

We report on a series of studies to validate the theoretical constructs of mentalization-supporting therapy (MST). Independent variables are developmental stage, attachment security in the strict sense, and overly frustrating parental behavior in childhood. Dependent variables are personality deficits *(VDS30)*, personality strengths *(VDS19+)*, mental resources *(VDS38 RDR)*, and mentalization ability *(VDS48)*. We find numerous highly significant correlations that support the validity of Sulz's affective-cognitive development theory (1994, 2017a,b). First results of outcome studies are reported.

Keywords

Affective-cognitive development theory, developmental stage, dysfunctional personality, personality strengths, mental resources, RDR resource deficit rating, mentalization ability, emotion recognition test, frustrating parental behavior *(VDS24)*, attachment security

Mentalization-supporting therapy MST (Sulz 2021, 2022a, 2023, Barth (2024), Sulz & Schreiner (2024), Theßen & Sulz (2024a,b), Theßen et. al (2024a,b,c), Richter-Benedikt & Sulz (2024)) is an integrative psychotherapy. Its foundation is cognitive-behavioral therapy and strategic-behavioral therapy (SBT) (Sulz 1994, Sulz & Hauke 2009). In both cases, as in almost all previous forms of therapy, attachment and mentalization were neglected. That is why Albert Pesso's emotion tracking (see Bachg & Sulz 2022) and the mentalization development of Fonagy and his working group (Fonagy et al. 2008, see also Schultz-Venrath (2021), Schultz-Venrath & Rottländer (2020), Schultz- Venrath, Diez Grieser & Müller

(2019), Schultz-Venrath, Staun (2017), Schultz-Venrath & Felsberger (2016)) were taken up, integrating them into the therapy concept consisting of seven modules (see Theßen 2012, 2016).

Now it is time to take a closer look at the constructs representing the scientific basis for mentalization support.
Comanns & Wedlich (2018) had already found in a study with 216 test subjects that the frustration of central needs in childhood can lead to dysfunctional personality traits and impairs the development of personality strengths. If the parents frustrate the child's needs too much, the children no longer feel comfortable and safe with them and have to develop compensatory emotional survival strategies, which are reflected in dysfunctional personality traits. Individuals who worked after completing their course of studies seem to stabilize their personality.
We examined the correlation between attachment, mentalization, development and personality with several hundred test subjects, finding very interesting results. First, I would like to present the five studies and then summarize the new findings.
The studies took place in the context of bachelor's and master's theses at the Fresenius University. I will therefore call them after the name of the graduate (although the conception of the studies was entirely in the hands of Lars Theßen and Serge Sulz, and the on-site supervision was assumed by Kurt Wedlich, Pia Keim and Lukas Hofherr).

Leiner study
(*ADE* stages, *VDS31*, *VDS19+*, resources *VDS38 RDR*, mentalization *VDS48*)
The focus of this study is cognitive-affective development. In addition to the *VDS31* development questionnaire (Sulz & Theßen 1999), for the first time three scales describing the experiences and actions of persons who, in their cognitive-affective development, are at the cognitive-affective stage, the thinking stage or the empathy stage were used. In contrast to previous stages, it was not the *VDS30* with its ten dysfunctional personality traits that was used, but the *VDS19+*, whose scales were intended to reflect the exact opposite of the respective *VDS30* scale as precisely as possible (Sulz & Maier 2009), as lastly this study is not about disturbed development.
Sample: The sample consists of n=49 female participants (65%) and n=27 male participants (36%) (a total of 76 subjects). The average age is 31 years (M=31.08, SD=11.477). The youngest participant is 18 years old, the oldest subject is 81 years

old. 28 subjects (37%; n=28) are single, 32 participants (42%; n=32) are currently in a relationship, 13 subjects (17%, n=13) are married and live together, two participants (2.60%, n=2) are married but live separately. Only one subject (1%, n=1) is widowed. 24 of the 76 participants (32%, n=24) have children, the number being between one and three children (M=1.17, SD=0.963).

Developmental stages A, D and E – correlations

We can apply three standards:

a) Mental resources in the resource deficit rating RDR *(VDS38)*

b) Personality traits representing personal strengths *(VDS19+)*

c) Mentalization ability and theory of mind (TOM) *(VDS48)*

It can be observed how mental resources, personality strengths and the ability to mentalize (Tables 1 and 2) grow with the development from stage to stage.

On a) Mental resources in the resource deficit rating *RDR VDS38*

The mental resources criteria of the *VDS38 RDR* are an important indicator of the development of mentalization skills.

Table 1: Mental resources at the three developmental stages (VDS38 RDR) – only significant variables listed

Correlations of *VDS38 RDR*	Affect stage	Thinking stage	Empathy stage
Functionality of emotion regulation	-0.04	0.249*	0.20
Self-awareness skills	-0.1	0.234*	0.351**
Self-control skills	-0.26*	0.269*	0.19
Social perception ability	0.04	0.15	0.287*
Ability to communicate	-0.06	0.365**	0.329**

Ability to differentiate	-0.04	0.15	0.276*
Ability to manage relationships	-0.01	0,17	0.334**
Utilization of resources	-0.06	0.20	0.266*
Dealing with crisis situations	-0.21	0.316**	0.21

While there are no mental resources yet at the affect stage (Table 2), at the thinking stage we find the ability to regulate emotions as well as self-awareness, self-control and crisis management skills and the ability to communicate.
At the empathy stage, social perception, delimitation, ability to manage relationships and utilization of resources come into play.

On b) Personality strengths *(VDS19+)*

Table 2 Correlation of developmental stage (D and E) with personality strengths *(VDS19+)*

Personality strengths are...	
At the thinking stage	**At the empathy stage**
Self-aware	Balanced
Confident	Community-oriented
Conflict-proof	Emotionally stable
Balanced	Impartial
Emotionally stable	
Entire personality	

On c) Mentalization ability and theory of mind *(VDS48)*

The third criterion for successful development is the ability to mentalize, which we capture by means of the *VDS48*. A distinction is made between understanding others (the world) and understanding oneself (Table 3).

Table 3 Means of "Total mentalization ability", "Mentalizing the world" and "Mentalizing the self"

VDS48 Mentalization	**Mentalizing the world**	**Mentalizing the self**	**Total mentalization ability**
Mean	0.78	1.09	1.87
Standard deviation	0.40	0.42	0.68
Minimum	0.09	0.05	0.14
Maximum	1.91	2.05	3.49

Overall, mentalization of the world (understanding others) was more pronounced than mentalization of the self (understanding oneself). The range of scores was from 0 (not) to 3 (very good).

In Table 4, we see that there does not yet seem to exist any ability to mentalize at the affect stage. However, this is clearly found at both the thinking and empathy stages.

Table 4 Correlation of developmental stages A, D and E with mentalization ability *(VDS48)* or theory of mind

Spearman's correlation of *VDS48* with *ADE* scales	**Affect stage**	**Thinking stage**	**Empathy stage**

Mentalizing the world (understand others)	-0.06 p=0.619	-0.34 p=0.003	-0.30 p=0.01
Mentalizing the self (understand me)	0.18 p=0.113	-0.45 p<0.001	-0.38 p<0.001
Total mentalization ability (theory of mind)	0.06 p=0.593	-0.50 p<0.001	-0.36 p=0.002

Thus, the question regarding a correlation between the ability to mentalize and personality strengths remains. Table 5 shows clear correlations between personal strengths and the ability to mentalize.

Table 5 Correlation of total mentalization ability *(VDS48)* with functional personality styles *(VDS19+)*

Self-aware	r=-0.40, p<0.001
Confident	r=-0.34, p<0.003
Flexible	r=-0.43, p<0.001
Conflict-proof	r=-0.31, p<0.006
Balanced	r=-0.42, p<0.001
Relational	r=-0.18, p<0.127
Community-oriented	r=-0.25, p<0.028
Emotionally stable	r=-0.56, p<0.001
Impartial	r=-0.44, p<0.001

Entire personality	r=-0.56, p<0.001

Thus, it could already be shown in this first study how closely development, mentalization ability, mental resources and personality strengths are connected.
The higher the developmental stage, the more pronounced are the ability to mentalize *(VDS48)*, mental resources *(VDS38)* and personal strengths *(VDS19+)*. In addition, the latter correlates with the ability to mentalize.
A therapy whose goal is to support the ability to mentalize could, in addition to this gain, also support the personal strengths necessary for managing life in general and thus reduce the tendency to develop symptoms and dysfunctional interaction patterns taking a toll on relationships.

Schick study
(*KADE* stages, dysfunctional emotion management (*VDS32 II*), mentalization *(VDS48)*)
This study also primarily deals with the developmental stages. In addition to the three stages of affect, thinking and empathy (ADE) from the Leiner study, the body stage K is added, especially because research has found that mentalization already takes place at the physical stage (see Schultz-Venrath, 2021). Our research is expanded by this study in two ways: attachment security and dysfunctional emotion management are added as an expression of lack of emotion regulation. Personality scales, however, are not used.
Sample: Of the 104 subjects, 74 (71.2%, n=74) were female, 30 (28.8%, n=30) were male. The age range of the sample is from 18 to 84 years (min=18, max=84). The average age is M=31.98 years with a standard deviation of SD=15.92. Most of the participants, 41.3% (n=43), were single. With regard to educational qualifications, 59% (n=62) had a general or subject-specific university entrance qualification.

The new developmental stages *KADE*
The evaluation algorithm runs over three cascades: First, it is determined whether the test subjects have checked enough items for this developmental stage to be significant for them. This is presumed if they have at least 30 out of 60 possible

points. Then, they are asked (in a more cognitive way) whether the stage in question describes them quite accurately. In the third step they are asked whether they also feel being emotionally affiliated with this stage.
At the K stage, the test subjects have an average total score of M=35.35, with a standard deviation of SD=9.58. A maximum total score of Max=59.0 and a minimum total score of Min=10 (of 60 possible points) was found. For 72.1% (n=75) of the test subjects, stage K is included in the developmental stage profile because they achieved at least 30 points in the total score. This did not apply to 29 participants (27.9%, n=29). Of the N=104 subjects, 67.3% (n=70) clicked the "I have at least 30 points on the K scale" field, while 32.7% (n=34) did not. "The scale K category describes me fairly well" field was selected by 32 (30.8%) subjects, while 72 (69.2%) did not check this statement. 97 (93.3%) of the participants did not select "I feel like being more of the K type", while 7 (6.7%) did.
For the A stage, the summed-up items resulted in a mean of M=24.3, with a standard deviation of SD=9.78. The lowest total score achieved by the participants is Min=10, the highest Max=56. 73. 1% (n=76) of the test subjects have a calculated total score of under 30 points, while 26.6% (n=28) exceeded this score. The "I have at least 30 points on scale A" category was selected by 22.1% (n=23), while 81 (77.9%, n=81) of the participants did not select this field. In addition, 86% (n=90) did not select "Scale A describes me quite well", while 13.5% (n=14) clicked this field. 11.5% of the test subjects (n=12) selected "I feel like being more of the A type", whereas 88.5% (n=92) did not.
On average, the total score of the D stage is M=37.45 (SD=8.91), ranging from Min=16 to Max=56. Of the test subjects, 79.8% (n=83) achieved at least 30 points, 20.2% (n=21) were below this score. In this sample, 68.3% (n=71) participants selected the "I have at least 30 points on the D scale" field, while 31% (n=33) did not. "Scale D describes me quite well" was not clicked by 59.6% of the subjects (n=62), while 42 (40.4%, n=42) selected this category. "I feel like being more of the D type" was selected by 15.4% (n=16), while 84.6% (n=88) did not click this statement.
The descriptive key figures for the E stage amount to an average total score of M=40.59, with a standard deviation of SD=7.99. The scores range from Min=16 to Max= 56. 90. 4% (n=94) of the participants achieved at least 30 points, 9.6% (n=10) were below this score. 76.9% (n=80) of the subjects clicked "I have at least 30 points on the E scale", while 24 (32.1%, n=24) did not select this field. Furthermore, "Scale E describes me quite well" was not clicked by 62.5% (n=65),

while 37.5% (n=39) selected this field. 18 of the test subjects (17.3%, n=18) selected “I feel like being more of the E type”, whereas 82.7% (n=86) of the total of N=104 did not.
Since you can decide in favor of or against each stage, regardless of the evaluation of the other stages, there are numerous simultaneous affiliations, as shown in Table 10. In these intermediate stages two stages are present, e.g. K+A or A+D or D+E.

15 questions about attachment disorder

The 15 questions about attachment disorders now add a completely new aspect. The question is how much insecure attachment causes development to stagnate and how much it blocks the development of the ability to mentalize.

1) Were you separated from your mother in the first two years of your life?
2) In the first two years of my life I was…
3) In the first two years of my life my mother was…
4) How did she react when she was stressed?
5) How did she react when she was angry with you?
6) What did she threaten to do when she was angry?
7) How was the physical contact?
8) What brought security?
9) How important was safety, protection and reliability?
10) Are you afraid of separation?
11) What would you like to do most if you are extremely angry with someone?
12) Are you more of an affectionate person?
13) How well can you be alone?
14) Do you prefer being up close or at a distance?
15) Would you rather be pampered or pamper others?

The descriptive evaluation of the 15 attachment disorder questions resulted in a mean total score of M=7.62, with a standard deviation of SD=5.58. The summed-up points ranged from Min=0 to Max=26, with a maximum of 41 possible points if you include all 15 questions, and a maximum of 34 points if you leave out only the last two items. Of course, we cannot answer the above question with correlative studies. But if necessary, further research can be carried out here.

Mentalization ability *VDS48*

The average total mentalization score of the sample is M=2.06, with a standard deviation of SD=0.42. The total mentalization score achieved by the test subjects in the present work ranges from Min=0.21 to Max=2.97. For mentalizing the self, there was a mean of M=1.96 (SD=0.47). For this scale, the scores ranged from Min=0.21 to Max=2.95. For mentalizing the world, the mean is M=2.24, with a standard deviation of SD=0.47. Here, the range was from Min=0.64 to Max=3.0. When also considering the different stages of the *VDS48*, the result for the stage of perception and feeling is a mean of M=2.0, with a standard deviation of SD=0.055. Here, the scores range from Min=0.38 to Max=3.0. For the stage of recognizing mentalization, the average score was M=1.96 (SD=0.44), ranging from Min=0.83 to Max=2.92. A mean of M=2.21 (SD=0.54) could be determined for the stage of understanding. The range was from Min=0.75 to Max=3.0. For the fourth stage of acceptance, the mean was M=2.24, with a standard deviation of SD=0.52. Here, the scores ranged from Min=0.83 to Max=3.0.

Correlation of attachment insecurity with total mentalization ability (*VDS48*)

A negative correlation was found between the severity of a person's attachment disorder (total score of the first 13 items of the 15 questions) and the total mentalization ability (r=-0.326, p<0.001). This means that the lower the security of attachment, the lower the ability to mentalize. We can differentiate the mentalization ability into perceiving, recognizing, understanding and accepting.

Again, we find high negative correlations in three out of four areas. This means that insecure attachment is associated with a poorer ability to mentalize (Table 6).

Table 6 Correlation of insecure attachment with mentalization stages

Spearman's correlation of insecure attachment with mentalization stages	**Mental_w perceive**	**Mental_w recognize**	**Mental_v understand**	**Mental_a accept**
Insecure attachment	-0.45 p<0.001	-0.016 P=0,874	-0.401 p<0.001	-0.473 p<0.001

Correlation of attachment insecurity with dysfunctional emotion management *(VDS32 II)*

The assumption that there is a correlation between dysfunctional emotion management and (total) mentalization ability is confirmed: (r (Pearson) = -0.189, p=0.027). The more pronounced attachment insecurity, the more dysfunctional is emotion management, i.e. the worse is emotion regulation.

In the present sample, the total score for dysfunctional emotion management is M=1.16 (SD=0.65), ranging from Min=0 to Max=2.92. The subjects rated number 1 as the most common emotion coping pattern (26%, n=27). The second most common coping pattern was number 2 (17.3%, n=18), the third most common type number 3 (15.4%, n=16).

The correlation (Spearman) between dysfunctional emotion management *(VDS32 II)* and the "insecure attachment" total score is 0.415 (p<0.001). There is a relatively close correlation here stating that insecure attachment is associated with a lack of emotion regulation and thus with dysfunctional emotion management. Here, a causal interpretation is more probable than with other variables.

Correlation of more dysfunctional emotion management with the *ADE* developmental stages

We expect that emotion regulation is not yet possible at the affect stage and therefore a dysfunctional emotion management prevails. The correlation (Spearman) is 0.291 (p=0.003). On the other hand, there is no correlation with the thinking and empathy stages (Table 7a).

Table 7a Correlation of developmental stages with dysfunctional emotion management in the *VDS32 II*

Correlation of *VDS32* dysfunctional emotion management with *ADE* developmental stages	**Affect stage**	**Thinking stage**	**Empathy stage**
Spearman's rho	0.29	-0,01	0.10
p (2-sided)	0.00	0.93	0.33

What does the Schick study tell us?

On the one hand, in this study the developmental stage concept is expanded by one stage: the body stage. On the other hand, attachment insecurity is now added as a new independent variable in the form of the 15-question questionnaire. The test subjects also completed the *VDS32 II*, indicating their dysfunctional emotion management.

We can now explore the characteristics of the developmental stages, such as the degree of mentalization at each stage, and we can examine how insecure attachment affects the ability to mentalize. Conclusion: The higher the developmental stage, the more pronounced are mentalizing ability and emotion regulation. The ability to mentalize and the availability of mental resources grow with attachment security. This result confirms the findings of previous research. It also shows that our measuring instruments capture the facts very well and are therefore suitable for research and practice.

Wöhrle study

(10 attachment questions, *VDS30*, mentalization *(VDS48)*)

The Wöhrle study is our second study (prior to the Schick study). In comparison to the Leiner study, it omits the developmental stages and instead includes the attachment questions, but not yet 15 multiple choice questions, but only 10 questions to tick – the first version of this questionnaire. What is also exciting is that it uses the *VDS30* dysfunctional personality questionnaire instead of the *VDS19+* personality strengths questionnaire. In addition, the four adult attachment types are examined.

Sample: This sample included 126 subjects. 72% (n=91) of the them were female, 27% were male (n=34). One person (1%, n=1) selected "diverse" as gender. The age of the test subjects ranged from 18 to 65 years. The average age was 30

years (M=30.20, SD=14.04). 37% (n=46) reported being single. 76% (n=96) reported having no children. The question about the highest educational degree was answered by 2% (n=3) with “lower secondary school leaving certificate/qualifying lower secondary school leaving certificate”. 13% (n=16) had a secondary school diploma, 12% (n=15) a technical college entrance qualification or a technical college diploma. 51% (n=64) stated having a general university entrance qualification.

TYPES OF ATTACHMENT

The total sample of 126 subjects was divided into attachment autonomy types (anxious-clingy, anxious-distant, secure-autonomous and secure-cared for). Since the first two types were only represented by one or two test subjects in the sample, this topic is omitted here.

QUESTIONS ON ATTACHMENT SECURITY (first version)

The questionnaire used here consists of 10 items to be ticked when appropriate (simple yes-no answer):

1. Parents lacked protection, security, reliability
2. Parents threatened to leave or send me away
3. I was very affectionate to clingy
4. I was separated from my mother for too long (clinic, home)
5. My central fear is fear of separation and loss
6. My central need is protection, security and comfort
7. My central anger is about separation
8. I cannot break up
9. I cannot stand disharmony
10. I am not good at being alone

The mean of the total score for the attachment questions questionnaire was 1.73 checked statements (M=1.73, SD=1.53). The number of checked statements varied between no checked statements and a maximum of six checked statements. One of the statements was checked most often. 28% (n=35) agreed with one statement, while 25% (n=31) agreed with none of the statements. Two of the statements presented in the questionnaire were ticked by 20% (n=25) and three

statements were ticked by 14% (n=17). 8% (n=10) agreed with four statements in the questionnaire, while 5% (n=6) agreed with five of the statements. 2% (n=2) considered six statements in the questionnaire to be correct. Thus, 72% (n=91) were classified as not insecurely attached, while 28% (n=35) were classified as insecurely attached. Many studies estimate that 35% of the general population are insecurely attached.

DYSFUNCTIONAL PERSONALITY QUESTIONNAIRE (*VDS30*)

This questionnaire is a standard tool for the diagnosis of outpatient psychotherapy patients. However, as it also shows great variability in non-clinical samples, it can be viewed as a helpful instrument for assessing general competence in relationship management.

The following correlations emerged:

a) between insecure attachment and personality (VDS30)

A positive, average correlation of 0.38 was found between insecure attachment and the "self-insecure/anxious" scale of the *VDS30*, with a significance value of $p<0.001$ ($r=0.38$, $p<0.001$).

The Pearson correlation also revealed a significant mean positive correlation of 0.48 between insecure attachment and the "dependent" scale ($r=0.48$, $p<0.001$).

With a value of 0.19, the "obsessive" scale correlated, to a small extent, significantly and positively with insecure attachment ($r=0.19$, $p=0.030$).

There was a significant median positive correlation between insecure attachment and the "histrionic" scale.

The results of the Pearson correlations for hypotheses H21 to H29 will also be discussed. A positive mean correlation of 0.38 was found between insecure attachment and the "self-insecure/anxious" scale of the *VDS30*, with a significance value of $p<0.001$ ($r=0.38$, $p<0.001$). The Pearson correlation also revealed a significant mean positive correlation of 0.48 between insecure attachment and the "dependent" scale ($r=0.48$, $p<0.001$). With a value of 0.19, the "obsessive" scale correlated, to a small extent, significantly and positively with insecure attachment ($r=0.19$, $p=0.030$). There was a significant mean positive correlation between insecure attachment and the "histrionic" scale of 0.35 ($r=0.35$, $p<0.001$). The results of the significant correlations between insecure attachment and the *VDS30* scales are shown in Table 7b.

Table 7b Correlations between insecure attachment and dysfunctional personality traits (Pearson coefficient)

	Insecure attachment
Self-insecure/anxious (SU)	0.38**
Dependent (DE)	0.48**
Obsessive (ZW)	0.19*
Passive-aggressive (PA)	n.s.
Histrionic (HI)	0.35**
Schizoid (SC)	n.s.
Narcissistic (NA)	0.28**
Borderline (BO)	0.31**
Paranoid (PR)	0.31**
∗ = The correlation is significant at the 0.05 level (2-sided). ∗∗ = The correlation is significant at the 0.01 level (2-sided)	

With the exception of “passive-aggressive” and “schizoid”, all dysfunctional personality traits are associated with insecure attachment. “dependent” is associated to a very large extent, “self-insecure”, “anxious” and “histrionic” to a large extent. Maybe the dysfunctional personality traits are individual ways of dealing with attachment insecurity – the answer to the parental inadequate offer of attachment, so to speak. Dependency is the clearest and most common result of insecure attachment.

b) between insecure attachment and total mentalization score

Attachment theory postulates that secure attachment is the prerequisite for the development of the ability to mentalize. Conversely, this means that insecure attachment impairs this development. As expected, a negative connection was found between the total score of insecure attachment and the total mentalization score (r (Pearson) = -0.19, p=0.032).

c) between mentalization ability and personality (VDS30)

If, with a realistic theory of mind, no sufficient mentalization ability can be developed, the experience and behavior in interpersonal situations cannot be sufficiently functional. This is reflected in dysfunctional personality traits *(VDS30)* (Table 8).

Table 8 Correlations between mentalization ability and dysfunctional personality traits (Pearson coefficient)

Spearman's correlation of *VDS30* with *VDS48*	**Mentalization ability**
Self-insecure/anxious (SU)	-0.33**
Dependent (DE)	-0.29**
Obsessive (ZW)	-0.24**
Passive-aggressive (PA)	-0.27**
Histrionic (HI)	-0.10 n.s.
Schizoid (SC)	-0.18*
Narcissistic (NA)	0.07 n.s.
Borderline (BO)	-0.26**
Paranoid (PR)	-0.28**

∗ The correlation is significant at the 0.05 level (2-sided). ∗∗ The correlation is significant at the 0.01 level (2-sided).

In the non-mentalized equivalence mode (Fonagy et al. 2008), projective identifications occur (cf. Sulz 2022a), leading to dysfunctional ways of reacting, which burden relationships and can be identified as an expression of dysfunctional personality traits. It is striking that the two personality traits that are associated with a comparatively pronounced self-efficacy (histrionic and narcissistic) do not seem to be associated with a lack of mentalization.

Conclusion of the Wöhrle study

The results suggest a correlation between attachment security, mentalization ability and dysfunctional personality. The more insecure the attachment or the more pronounced seven of the nine dysfunctional personality traits, the lower the ability to mentalize. Likewise, the more pronounced the ability to mentalize, the lower insecure attachment and the dysfunctional personality traits “self-insecure/anxious”, “dependent”, “obsessive”, “passive-aggressive”, “schizoid”, “borderline” and “paranoid”.

Bohn study

(*VDS19+SHORT*, 15 attachment questions, mentalization *VDS48*)

A special feature of the Bohn study is the very large sample size (N=269) allowing for much more reliable statements. The sample consists of n=225 female participants (84%) and n=44 male participants (16%). The data set covers an age range from 18 up to and including 27 years, with the average age being approximately 22 years (M=21.99, SD=2.24). The information on the socio-economic status of the test subject shows that 251 participants had a general or subject-specific university entrance qualification (93%, n=251). Another 6 participants (2%, n=6) achieved a secondary school diploma. One participant had a lower secondary school leaving certificate, one had not achieved any qualification at all (1%, n=2). 29% of the study participants stated that they attended a daycare center in early childhood (29%, n=77). Accordingly, 71% of the subjects did not attend a daycare center in early childhood (71%, n=192). In addition, 40% of the 269 participants stated that they come from a family in which the parents are divorced (40%, n=107). Accordingly, the parents of another 163 subjects were not divorced (60%, n=163). It was also shown that the quality of the parents' relationship is largely

harmonious (32%, n=85) or very harmonious (15%, n=40). 60 participants stated that harmony and conflict balance each other out in the parents' relationship (22%, n=60), and the remaining test subjects stated that the parents' relationship was conflict-ridden (17%, n=46) or very conflict-ridden (14%, n=38). When it comes to children of divorced parents, it is noticeable that the more conflictual a parental relationship is, the more likely it is that the parents are divorced.
Our considerations are based on the personality strengths as recorded by means of the *VDS19+*. In this study, a short version of the questionnaire was to be completed.

VDS48 Mentalization ability – theory of mind

For the "Total mentalization ability" dimension, scores between 1.17 and 3 are achieved. The mean is M=2.02, the median 2.03 (Mdn=2.03).
For the "Ability to mentalize the world" dimension, scores in the range of 0.91 to 3 can be determined. The mean is M=2.23, the median 2.27 (Mdn=2.27).
Again, the "Ability to mentalize the self" characteristic shows scores ranging from 0.79 to 3 points. Both mean and median are 1.89 (M=1.89, Mdn=1.89).

Connections – Correlations

A) Correlation of attachment insecurity with personality *VDS19+SHORT*

When examining the correlation between attachment insecurity and personality traits, significant results could be identified for 7 out of 9 personality traits (see Table 9a).

Table 9a Correlation of attachment insecurity with functional personality traits (Pearson coefficient)

	Ss	**Sst**	**Fl**	**Ks**	**Au**	**Bb**	**Go**	**eS**	**Uv**
Insecure attachment	-0.11	-0.13*	-0.03*	-0.19*	-0.25*	-0.19*	-0.21*	-0.39*	-0.16*

Mentalization ability	-0.39*	-0.35*	0.17*	0.15*	0.35*	0.26*	0.26*	0.32*	0.25*
* The correlation is significant at a significance level of 0.05.									

A negative significant correlation was found for the personality traits independent, conflict-proof, balanced, relational, community-oriented, emotionally stable and impartial (p<0.05).
This means that functional personality traits, i.e. personal strengths, are closely related to the attachment security experienced or existing. The more secure the attachment, the more developed are the personal strengths.

B) Correlation of mentalization with personality *VDS19+SHORT*
When examining the correlation between the functional personality characteristics and the ability to mentalize, all significant correlations were identified (see Table 9a All functional personality characteristics show a positive significant result (p<0.05), confirming hypothesis 3. Across personality dimensions, the results can be interpreted as follows: the higher the ability to mentalize, the higher the functional personality trait in question. Conversely, this means that a lower ability to mentalize is also associated with less pronounced functional personality traits.
All correlations between mentalization ability and personal strengths *(VDS19+SHORT)* are significant, i.e. these strengths go hand in hand with the ability to mentalize.

Interpretation of the correlation between mentalization and personality
A high score for “independence” is associated with secure attachment (i.e. a low total score on the attachment security scale) or a higher mentalization ability. The study provides initial insights into the correlation of the personality trait “independence” with “attachment security” or mentalization ability. The correlation can be explained by the results of the NICHD Study of Early Child Care (2004, see also NICHD (1997, 2002, 2019)), which emphasize, among other things, the relevance of supporting children's autonomy on the part of the parents. According to the results of the NICHD study (2004), children who were able to form a secure bond with their parents probably also received much support with regard to autonomous behavior in their childhood.

Individuals who, according to the results of the present study, have secure attachments tend to be considered as conflict-proof. Findings according to Vanza (2005) illustrated that the individual ability of a person to deal with conflicts arises from the personal awareness of his/her own emotions, i.e. mentalization. According to the present result, which postulates that the ability to mentalize is positively influenced by attachment security, there is probably an indirect or multifactorial correlation between attachment security and the personality trait of “conflict resistance”. The correlation between mentalization ability and conflict resistance can be directly confirmed based on Vanza's (2005) findings.
With regard to the characteristics “balanced” and “relational” it was found that persons with secure attachments tend to be more balanced and relational than those with insecure attachments. Kissgen's (2008) findings, which emphasized the relevance of affect regulation on the part of the parents, are thereby confirmed.
No scientifically based results with regard to attachment security or the ability to mentalize could be identified for the characteristics “community-oriented” and “impartial”. However, the present results demonstrate both a negative correlation between community-orientation and the scale for attachment security or mentalization ability, and a positive correlation between impartiality and the scale for attachment security or mentalization ability. The results of the personality trait “community-oriented” could have come about because the participants were able to gain many positive experiences in the social community, for experiences of secure or insecure attachment contribute to the development of attachment security (Rutter & Sroufe, 2000).
Furthermore, emotional stability is positively related to secure attachment. This result confirms findings by Rollett and colleagues (2009), who, based on a study, were able to determine the positive influence of the child's attachment security on emotional stability: in relation to the children's emotional stability differences in attachment security could be demonstrated. The correlation between emotional stability and attachment security can be explained as follows: assuming that emotional stability based, among other things, on a healthy internal working model, which in turn is formed on the basis of the average total attachment-related experiences with parents (Frischenschlager, 2007), a healthy internal working model usually results in a secure attachment. Emotional stability and a higher ability to mentalize also suggest a positive correlation. This is probably due to the fact that in the context of the social situations through which attachment security may form, the individual learns to mentalize (see Brockmann & Kirsch, 2010). Secure attachments are

formed on the basis of predominantly positive attachment, and therefore also on the basis of predominantly positive emotions. According to the results of Fonagy and colleagues (1997), Main (1991) and the present study, a secure attachment also has an impact on the ability to mentalize, which means that emotional stability could possibly be affected by the indirect influence of attachment security on the ability to mentalize.
Once again, this study confirms the results of our previous studies: Leiner had shown the correlation between personal strengths and the ability to mentalize. Wöhrle and Schick were able to show the correlation between attachment security and the ability to mentalize.

Rose study
(*VDS19+SHORT*, 15 attachment questions, *VDS24* frustrating parental behavior, *VDS48*)
The Rose study focuses on the effects of parental frustration on attachment security, the development of a stable personality or personal strengths and on the ability to mentalize.
It is based on the same data set (N=279) as the Bohn study.
The sample consists of n=231 females (82.8%) and n=48 males (17.2%). The average age of the test subjects is 22 years (M=22.23, SD=2.54), with the minimum age being 18 years and the maximum age being 31 years.
The majority of participants (92.8%, n=279) had a general or subject-specific university entrance qualification, n=8 (2.9%) achieved a secondary school diploma and n=1 (0.4%) had a lower secondary school leaving certificate (including a qualifying lower secondary school leaving certificate). The majority of the test subjects (90.7%, n=253) are students. Most students (68.5%, n=191) major in psychology. More than a third of those surveyed (39.4%, n=110) stated that they were a child of divorce or separation, which did not apply to 169 subjects (60.6%, n=169). On average, the quality of the parental relationship is rated as neutral (M=3.16, SD=1.29).
Almost one third of the test subjects (29%, n=81) stated that they had attended a daycare center as a child, with a mean starting age of 15 months (M=15.05, SD=9.66)). According to the test subjects, the minimum age when attending the daycare center for the first time was one month and the maximum age 38 months. Two thirds (71%, n=198) of the participants did not attend a daycare center as a child.

The measuring instruments used

Short form of the personality questionnaire *VDS19+KURZ*

This was already described in the report on the Bohn study.

15 questions about attachment insecurity

Again, this questionnaire had already been described in the Bohn study. A high score means attachment insecurity. For 13 items included in the evaluation, a maximum of 34 points can be achieved.

Questionnaire on frustrating parental behavior *(VDS24)*

When measuring frustrating experiences in childhood and adolescence due to insufficient or lacking satisfaction of central needs by the parents using the *VDS24*, the test subjects achieved a mean score of 1.06 (M=1.06, SD=1.25) out of five possible points for frustration of affiliation needs caused by the mother. With regard to the frustration of self-needs caused by the mother, there is a mean score of 0.91 (M=0.91, SD=0.95) out of five possible points. The test subjects rated the frustration of homeostasis needs caused by the mother as 0.95 (M=0.95, SD=1). The test subjects rated frustrating experiences in childhood and adolescence in the sense of a lack of satisfaction of affiliation needs on the part of the father as 1.78 (M=1.78, SD=1.56) out of five possible points on average. The average score for the frustration of self-needs caused by the father was 1.91 (M=1.91, SD=1.23), that for the frustration of homeostasis needs caused by the father 0.90 (M=0.90, SD=0.91). The subjects reported far more frustration of both the affiliation need and self- or autonomy needs caused by the father.

VDSD24: Children of separation and divorce, t-test

The expectation was that children of divorce or separation would differ from children of non-divorce or non-separation in terms of frustration caused by their parents in childhood and adolescence. A separate analysis is carried out based on the frustration caused by the mother and the father. An independent sample t-test is used to test the assumptions.

110 test subjects (n=110) stated that they were a child of divorce or separation, 169 test subjects (n=169) stated that they were not. In the sample examined, the frustration caused by the mother is higher among children of divorce or separation (M=1.33, SD=1.11) than among children of non-divorce or non-separation (M=0.74, SD=0.83). At a significance

level of $a<0.05$ as defined by Cohen (1988), this difference is significant, with the level of frustration caused by the mother of children with divorced or separated parents being higher by 0.59 units on average than that of children with non-divorced or non-separated parents, and the difference in the comparative population, with 95% certainty, being between 0 and 1 ($t(186.9)=4.8$, $p<0.01$, $d=0.71$, 95% CI [0.35, 0.83]). The effect size according to Cohen (1988) corresponds to a medium effect.

In the sample examined, the frustration caused by the father is on average higher among children of divorce or separation ($M=1.96$, $SD=1.17$) than among children whose parents are not divorced or not separated ($M=0.86$, $SD=0.86$). The level of frustration caused by the father is by 1.10 units lower for non-divorce or non-separation children. At a significance level of $a<0.05$ as defined by Cohen (1988), this difference is also significant, being 1 point in the comparative population, with 95% certainty ($t(185)=8.52$, $p<0.01$, $d=0.94$, 95% CI [0.85, 1.36]). The effect size according to Cohen (1988) corresponds to a high effect. Hypothesis 1A can therefore be presumed.

<u>Attachment security of children of separation and divorce: t-test</u>

Hypothesis 1B assumes that children of divorce or separation differ from children of non-divorce or non-separation in terms of attachment security in adulthood. To test this assumption, an independent sample t-test is performed. Within the sample, former children of divorce or separation are more insecure in attachment ($M=10.56$, $SD=5.63$) than individuals who did not experience parental divorce or separation in childhood ($M=6.87$, $SD=3.93$). At a significance level of $a<0.05$ as defined by Cohen (1988), this difference proves to be significant. The difference in the comparative population, with 95% certainty, is between 3 and 5 points ($t(177.6)=6.0$, $p<0.01$, $d=0.94$, 95% CI [2.47, 4.91]). According to Cohen (1988), the effect size corresponds to a high effect. Hypothesis 1B can therefore be presumed.

<u>*VDS24*: Correlation with personality *VDS19+SHORT*</u>

To test the hypothesis that there is a correlation between frustrating parental behavior and the respective functional personality traits, a Pearson correlation is carried out. One analysis is performed for the mother, one for the father. The relevant prerequisite tests have been checked (see above). The results are shown in Table 10.

At a significance level of a<0.05 as defined by Cohen (1988), the degree of frustrating parental behavior caused by the mother correlates significantly with the manifestations of self-confident, conflict-proof, relational, community-oriented and emotionally stable personality traits, with the correlations being negative and linear. The higher the mother's frustrating parental behavior, the lower the manifestation of the corresponding personality traits. According to Cohen (1988), the correlations correspond to weak to medium effects. There are no significant correlations (p>0.05) of the independent, flexible, balanced and impartial personality traits with the mother's frustrating parental behavior.
At a significance level of a<0.05 as defined by Cohen (1988), the degree of frustrating parental behavior on the part of the father correlates significantly with the manifestations of conflict-proof, relational, community-oriented, emotionally stable and impartial personality traits (Table 11). These are also negative linear correlations. The higher the father's frustrating parental behavior, the lower the manifestation of the corresponding personality traits. According to Cohen (1988), the correlations correspond to weak to medium effects. There are no significant correlations (p>0.05) of the self-confident, independent, flexible and balanced personality traits with the father's frustrating parental behavior. Hypothesis 2 can therefore still be partially presumed.

Table 9b Correlation between functional personality traits and frustrating parental behavior caused by the mother and the father (Pearson coefficient)

	Ss	Sb	Fl	Ks	Au	Bz	Gm	Es	Uv
FEV M	-0.13*	-0.08	0.01	-0.17**	-0.09	-0.21**	-0.14*	-0.31**	-0.08
FEV V	-0.05	-0.06	-0.10	-0.13*	-0.10	-0.21**	-0.13*	-0.23**	-0.20**

** The correlation is significant at the 0.01 level (2-sided). * The correlation is significant at the 0.05 level (2-sided).

Correlation of attachment security with personality *VDS19+ short*

Our hypothesis was that there is a correlation between attachment security and the respective functional personality traits. To test this assumption, the correlation is checked according to Pearson, with the corresponding prerequisite tests having already been checked (see Chapter 5.3.1). The results are shown in Table 9c. At a significance level of a<0.05 as defined by Cohen (1988), the degree of attachment security correlates significantly with the manifestations of independent, conflict-proof, balanced, relational, community-oriented, emotionally stable and unbiased personality traits, with the correlations being negative and linear. The higher the degree of attachment insecurity, the lower the manifestations of the respective personality traits. According to Cohen (1988), the correlations correspond to weak to medium effects. There are no significant correlations of confident and flexible personality traits with attachment security.

Table 9c Correlation between attachment security and functional personality traits (Pearson coefficient)

	Ss	Sb	Fl	Ks	Au	Bz	Gm	Es	Uv
BS	-0.10	-0.17**	0.07	-0.21**	-0.25**	-0.22**	-0.24**	-0.40**	-0.14*

** The correlation is significant at the 0.01 level (2-sided). * The correlation is significant at the 0.05 level (2-sided).

At last, we take a look at the connection between the total frustrations in childhood and the ability to mentalize in adulthood. The more the participants were globally frustrated as a child with regard to their central needs, the lower is their ability to mentalize in adulthood (Table 20).

Table 10 Correlation between frustration of the child’s needs and the ability to mentalize

Spearman's rho		**Mentalization**
Frustrations as a child	Correlation coefficient	-0.384
	Sig. (2-sided)	<0.001
	N	319

Interpretation

While most covariates do not yield significant results, there is a significant impact of frustration of affiliation and homeostasis needs caused by the mother on attachment security. The higher the frustration of affiliation and homeostasis needs in childhood, the more insecure the attachment from childhood into adulthood.

The first child is more insecure in attachment than the second.

Divorced or separated parents pose a higher risk of insecure attachment than parents who are not divorced or separated. The frustration of needs caused by the mother is higher among children of divorce or separation than among children who have not experienced parental divorce or separation. The frustration of children of divorce or separation caused by the father is even higher.

Children who have experienced a divorce or separation of their parents are later more insecure in attachment than children who have not experienced a divorce or separation.

There are negative correlations between self-confident, conflict-proof, relational, community-oriented and emotionally stable personality traits and the frustration of needs caused by the mother, i.e. the more a child's needs are frustrated by the mother, the weaker are the functional personality traits mentioned.

The frustration of needs caused by the father is negatively related to conflict-proof, relational, community-oriented, emotionally stable and impartial personality traits. It can therefore be said that these personality traits become weaker with the frustration caused by the father.

In summary, the Rose study provides us with insight or confirmation of previous findings:

- Fathers frustrate their children's affiliation needs far more than mothers. They also frustrate the child's needs for self or autonomy more.
- Children of separation and divorce have their central needs satisfied significantly less than children whose parents stay together.
- The more children's central needs are frustrated by their parents, the less they developed personal strengths in adulthood.
- The more insecure the attachment, the fewer personal strengths are present in adulthood.
- Finally, the frustration of central needs in childhood impairs the ability to mentalize in adulthood.

The previous studies showed that there is a positive correlation between personal strengths and the ability to mentalize. Since personal strengths correspond to self-efficacy in shaping life and relationships, training the ability to mentalize can help to reduce existing deficits and develop more life skills.

Cozzi study

This study focused entirely on the ability to mentalize and examined whether this has an impact on recognizing emotions on a person's face.

161 subjects were included in the study. Originally, at least 20 test subjects were supposed to come from each country. In fact, 67% came from Italy, 8% from Germany and 4% from the USA. All other countries were represented by only one test person each or not at all. The age ranged from 18 to 69 years. 103 subjects were female.

***VDS48*: Questionnaire to assess the ability to mentalize**

The test subjects were asked to complete the *VDS48* mentalization ability questionnaire. The distribution of moderate, good and very good mentalization ability is shown in Table 11a.

When examining the two aspects of “mentalizing (perceiving, recognizing, understanding and accepting) the self” and “mentalizing the world”, there were no significant differences between children with siblings and only children with regard to mentalizing the self, while the only children performed significantly better in mentalizing the world.

Significance tests: Within the s-item category, both groups did not differ significantly from each other (only children: M=2.28, Mdn=2.0, SD=0.56; children with siblings: M=2.23, Mdn=2.0, SD=0.49). However, there was a significant difference in the item category w (only children: M=2.13, Mdn=2.0, SD=0.52; children with siblings: M=2.1, Mdn=2.0, SD=0.37).

Table 11a: VDS48: Frequencies of moderate, good and very good mentalization ability in mentalizing the world, mentalizing the self and total mentalization score

	Very good (3)	Good (2)	Moderate (1)
S = Mentalizing the self	45 (28%)	110 (68.3%)	6 (3.7%)
W = Mentalizing the world	23 (14.3%)	132 (82%)	6 (3.7%)

No gender differences were found with regard to the ability to mentalize.

Emotion recognition test – recognizing emotions on a person's face

The emotion recognition test presented the subject with a picture and various emotions from the four main emotion groups of happiness, sadness, fear and anger. The first 15 emotions listed belong to the first group of emotions (joy). In contrast, the eight emotions from sadness to sympathy belong to the second group of emotions (sadness). The eleven emotions from anxiety and fear to terror belong to the third main group of emotions, and the last nine from anger to jealousy were part of the fourth main group of emotions (anger) (for reference, see Fig. 2).

Each picture showed a different emotion, and only one of the answers listed was the correct emotion. As the test comprised 43 different image-emotion pairs, the scoring system was X correct answers out of 43. Each answer was marked either 1 for a correct answer or 0 for an incorrect answer. The final score was converted into a total emotion recognition score and percentage.

The general results of the emotion recognition test are shown in Fig. 1.

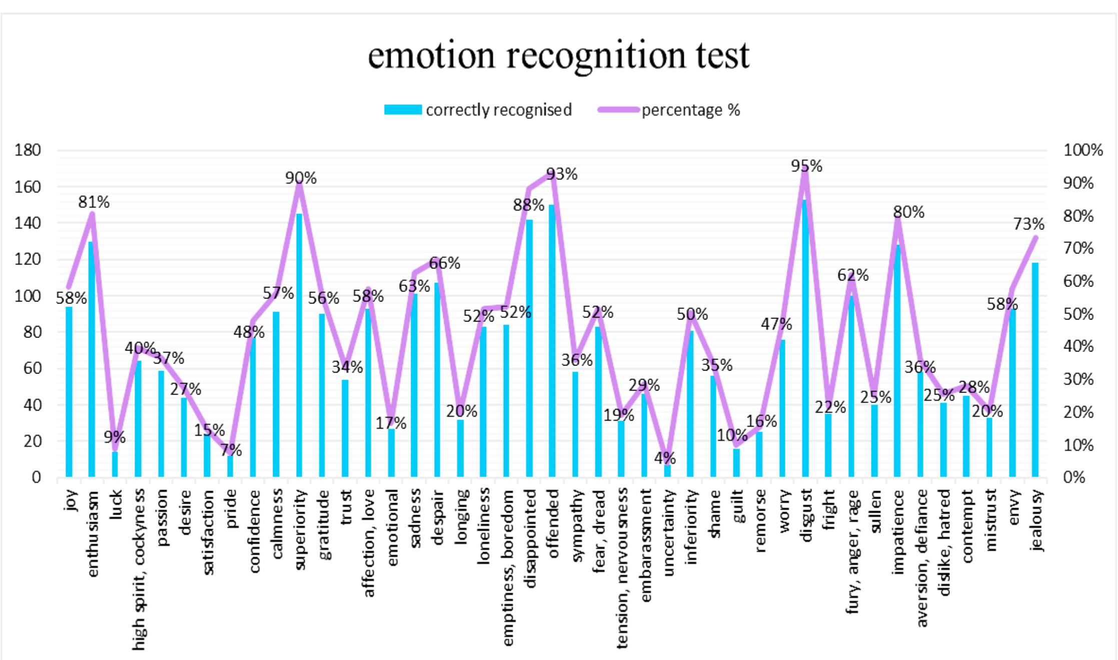

Figure 1 Distribution of correct answers in the emotion recognition test

The graphic shows how many individuals selected a correct answer (1) for each of the 43 emotions presented in the test. This data includes the entire sample of 161 participants and does not exclude individuals who chose not to disclose their gender. The five best identified emotions were disgust (95%), offended (93%), superiority (90%), disappointed (88%) and impatience (80%). The five least correctly identified emotions were uncertainty (4%), pride (7%), happiness (9%), guilt (10%) and contentment (15%).

Then, the results of the emotion recognition test were calculated for each participant, and total prevalence was calculated based on the number of correct answers (M=18.8, Mdn=19, SD=3.88). There was no significant difference (ANOVA) when testing group results by gender (female: M=19.02, Mdn=19, SD=4.11; male: M=18.75, Mdn=19, SD=3.5). Only about 15% of the test subjects recognized more than half of the emotions. In many cases there were 15 to 22 recognized emotions.

One question was whether a higher ability to mentalize facilitates emotion recognition. A chi-square test was performed using the results of the *VDS48* and the results of the emotion recognition test as variables. In the Pearson chi-square test, the score for mentalizing the self was 20.348. 44 (77.2%) cells showed an expected number of less than 5. The expected minimum number is 0.04. The score for the item "mentalizing the world" was 36.849. The expected minimum number is 0.04. Therefore, the numbers observed and the numbers expected did not differ significantly with regard to the s or w items and the results of the emotion recognition test (s items: p=0.983; w items: p=0.429). The data suggests that the variables "mentalization" and "emotion recognition" are not associated with each other.

This is also shown by Spearman's correlations (Table 11b).

Table 11b: Correlation of emotion recognition with mentalization

	(Spearman's coefficient)		**N = 161**
Correlation between emotion recognition and mentalization	**Mentalization_total**	**Mentalization of the self**	**Mentalization of the world**
Correctly recognized emotions	0.054	0.049	0.004

	n.s.	n.s.	n.s.
Mentalization_total		0.895	0.704
		<0.001	<0.001
Mentalization of the self			0.366
			<0.001

Accordingly, the hypothesis that a higher mentalization ability facilitates emotion recognition can be rejected. Research into emotion recognition, empathy and theory of mind has grown in recent years. It is known that these three topics are congruent, and successful studies measuring the brain regions activated during such processes have been performed. The aim of this work was to investigate whether theory of mind and empathy, also known as mentalization ability, have an impact on emotion recognition. Specifically, it was examined using statistical analysis whether cultural differences could be determined. In this context, theory of mind and empathy were viewed as multidimensional constructs and associated with each other. They represented the ability to sense the other person's emotions and understand that the other person's perspective may differ from your own, which has an effect on your actions and feelings. However, this study could not prove that the ability to mentalize has any influence on facial emotion recognition. Perhaps this is a pre-mental ability, and mentalizing is just the metacognitive processing of these perceptions.

Conclusion of the five studies – evaluation of the basic constructs of MST

These five studies were carried out in the context of MST development (Sulz 2021, 2022a, 2023, see also Sulz 2017a-d). They served the empirical evaluation of important constructs that, on the one hand, form the theoretical basis of MS and, on the other hand, are used in MST.

It is about

a) Attachment security (attachment in the narrower sense: not being without parents)

b) Satisfaction of needs in childhood (attachment in the broader sense: being in good hands)
c) Mentalization: metacognition and mental resources
d) Personality strengths as life and relationship skills

The following measuring instruments were used for this purpose:
1. Frustrating parental behavior in childhood *(VDS24)*
2. Attachment security (15 attachment questions)
3. Personality strengths *(VDS19+)*
4. Dysfunctional personality traits *(VDS30)*
5. Developmental stages *VDS31* and *KADE*
6. Mental resources *(VDS38 RDR)*
7. Mentalization ability *(VDS48)*
8. Empathy: recognizing emotions on a person's face *(emotion recognition test)*

Even if correlation studies cannot make any causal statements and the results above were reported accordingly, we can definitely say that they do not speak against our therapeutic theory. We can express it like this:
In childhood, central affiliation needs and self-needs and often also homeostasis needs are persistently frustrated by parents. As a result, the child does not feel securely attached. The total score of the *VDS24* corresponds to the extent of attachment insecurity.
As early as in their first year of life, children form an internal working model (according to Bowlby 1975) and soon afterwards a survival rule, which later leads to the development of dysfunctional personality traits. As, at the same time, it prevents the development of mental developmental stages, the individual remains, for example, at the body or affect stage. A sufficient mental grasp of the self and the world is not yet possible there. Projective identifications occur, leading to unsatisfactory transactions in important relationships.

MST positions the lever (efficient interventions) at several points:
– New experience of attachment security in the therapeutic relationship

– Replacing the dysfunctional rule of survival by a rule of life that gives permission
– Making previously suppressed emotions accessible and learning successful emotion regulation
– Supporting the development of mentalization and a realistic theory of mind
– Forming personal strengths with the experience of self-efficacy
– Supporting the development to the empathy stage

Outcome studies on the efficacy of mentalization-supporting therapy

Sulz (2022b,c) reports on two studies on the efficacy of emotion tracking as a derivative of Albert Pesso's microtracking, on the one hand (see Bach & Sulz 2022), and as a fourth module of mentalization-supporting therapy (MST) on the other hand.

Let us continue the series of study reports with these two studies.

Emotion tracking study 1

Implementation of the MST intervention "Emotion tracking" (Module 4)

Four 8-hour days of self-awareness training were offered. A group consisted of 9 participants. After an introduction and preparatory exercises, each participant was given individual work lasting 90 minutes. Group discussions supplemented the individual work.

Sample: A relatively small non-clinical sample (N=36) was chosen for this pilot study including a total of four self-awareness workshops (19 students studying pedagogy in the 5th to 8th semester and 17 psychotherapists in training (depth psychology and behavioral therapy)).

The average age was 24 years (21 to 41 years). There were 23 female participants and 8 male participants.

Pre-measurement:

– *VDS24*: Frustrating parental behavior
– *VDS27*: Central needs
– *VDS28*: My central fear

– *VDS29*: My central anger
– *VDS30*: Personality
– *VDS32*: Emotion analysis I and II
– *VDS48*: Mentalization ability and TOM

Post-measurement:
– *VDS30*: Personality
– *VDS32*: Emotion analysis I and II
– *VDS48*: Questionnaire on mentalization ability and TOM

Table 12 *VDS48* questionnaire, means of dimensional scales

VDS48	Self-perception	Recognizing how childhood shapes me	Self-acceptance	Acceptance of others	Sensing childhood injuries	Acceptance of parents
Pre	1.54	1.44	1.43	1.3	1.78	1.11
Post	3	2.94	2,85	2.56	3.52	2.22

The highest score can be found in the “Ability to sense childhood injuries” scale (Table 15). At the same time, the ability to reflect on this topic improved most as a result of the interventions. The lowest score is found in the “Acceptance of parents” scale. This is also where the least improvement was achieved. Table 13 shows the individual stages of mentalization ability in the *VDS48*.

Table 13 Correlation of the *VDS48* questionnaire with emotions and needs

***VDS48* scales AFTER** **resulting from factor analysis**	Improved self-perception	Improved ability to recognize how childhood shapes me	Improved self-acceptance	Improved acceptance of others	Improved sensing of childhood injuries	Improved acceptance of parents
***VDS48* total Change after**	0.90	0.46	0.76	0.59	0.67	0.68

Summary and conclusion of the emotion tracking study 1

There were significant improvements in the ability to mentalize and the theory of mind.

Overall, it can be stated that there were consistently positive, significant correlations of the *VDS48* questionnaire on relationship, emotion and body perception with frustrating parental behavior, central needs and emotion analysis. This means that subjects who previously reported negative starting situations, such as much anxiety or more frustration of the needs for affiliation, autonomy and homeostasis, were able to improve their awareness of personality development, emotions, relationships and their body.

In the subjects' statements about the quality of the structure only a few positive and negative significant correlations can be identified (in the questionnaire on how to approach the goal). No clear change in cognitive and emotional attitudes can be determined, since a high score for the criteria for structural quality improves the approach to the second goal (= feeling empathy for others), but at the same time improves the approach to the fourth goal (= experience antidote in role play).

Emotion tracking study 2

The aim of this study was to include the biographical determinants (*VDS24*: frustrating parental behavior). When it comes to personal experience and behavioral tendencies in adulthood, we were interested in dysfunctional personality styles

(VDS30) and the type of dysfunctional emotion regulation (*VDS32*: emotion analysis). Finally, the changing impact of the dysfunctional rule of survival on experience and behavior (*VDS35*: impact of the rule of survival) and personal gain through increasing metacognitive skills (*VDS48*: theory of mind and metacognition/mentalization) were examined again.
Sample and implementation: The sample consisted of 50 participants from several groups. Doctors completed 140 hours and psychologists 120 hours of group self-awareness training distributed over a period of one year. These were multi-day blocks of 2.5 to 4 days.

Results

VDS24: Frustrating parental behavior was very common in the participants' childhood; above all, there was a lack of appreciation and a counterpart. Often feelings of guilt were induced, having an impact on today's needs.
With regard to affiliation needs (dependency needs), lack of understanding and appreciation from parents was most common. Lack of attention and security was also frequently mentioned (Fig. 12). With regard to autonomy needs (or self-needs/differentiation needs), there is a counterpart missing for discussion and self-determination. Parents also provided too little physical contact and were too rarely a helpful role model.
With regard to homeostasis needs, a parent made some individuals too angry or too often angry or was too fearful, so that their fear became contagious. Other parents made them feel guilty too often.
The dysfunctional personality styles were also of interest. The *VDS30* scales of self-insecure, obsessive and histrionic are the most pronounced, and there is a high neuroticism score (Fig. 15). The degree of dysfunctionality decreased in the following personality traits: self-insecurity, obsessiveness, emotional instability. In addition, the neuroticism score (total score) was significantly lower afterwards (t-values 5% level).
When examining the dysfunctionality of emotion regulation *(VDS32)* the following was found: There are numerous forms of emotional dysregulation – most commonly emotion avoidance (I don't let on, I make sure I don't get into a situation like that, I distract myself, I just feel the emotion very weakly, my emotion turns into a mood).
In the t-test for dependent samples, the difference in means just missed the 5% significance threshold, i.e. the improvement in emotion regulation was only just insignificant (Table 14).

Table 14 Differences in means of dysfunctional emotion regulation before and after self-awareness training

	Mean	**Mean**	**95% Confidence interval**		**T**	**df**	**Sig. (2-sided)**
N = 38	Pre	Post	Lower	Upper			
*VDS32*EmoMan	12.8684	11.2105	-0.0428	3.35859	1.975	37	0.056

The influence of the dysfunctional rule of survival showed similar trends as in study 2.

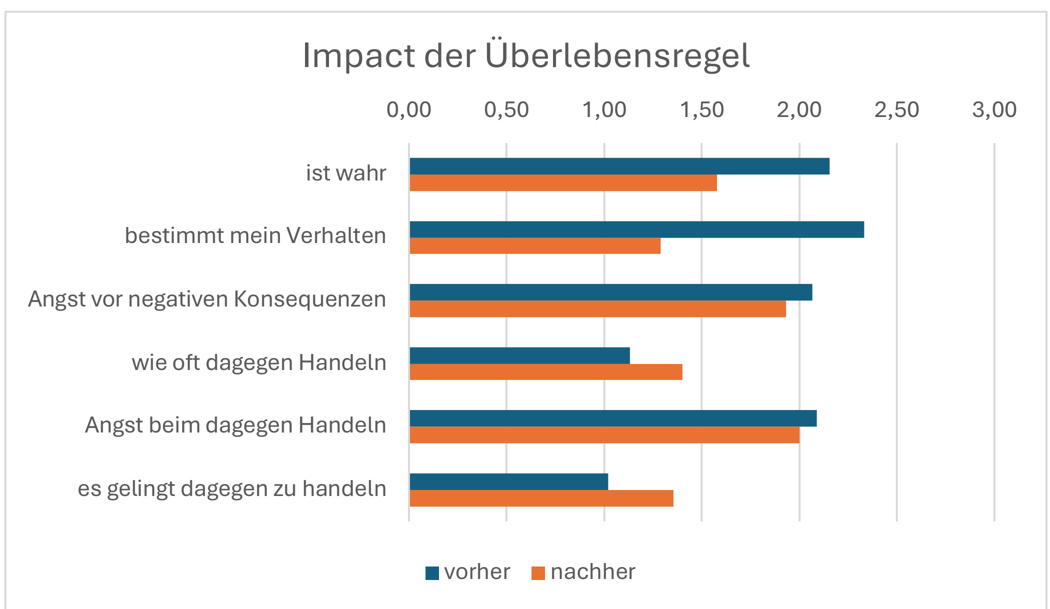

Figure 2 The dysfunctional rule of survival affects experience and behavior (from Sulz 2022c, p. 482).
Impact of the rule of survival

Is true
Determines my behavior
Fear of negative consequences
How often acted against
Anxious when acting against
Successful in acting against
pre – post
At the beginning of the self-awareness training, the rule of survival was largely believed to be true and determined behavior in difficult situations towards important individuals (Fig. 1). It was difficult to act against it. This changed significantly over the course of the self-awareness training (t-test for dependent samples).
The characteristics of a functional theory of mind were approximately captured using the *VDS48* questionnaire: metacognitive development and mentalization. The conscious perception of the body, emotions and needs, the recognition of the commandments and prohibitions of the child's rule of survival, the understanding of the biographical conditions and the acceptance of oneself and the caregivers (including parents) increased. Since the questionnaire directly enquired about the changes, there was no pre/post comparison.
Although significant changes occurred here as well (Table 15), psychological and psychosomatic symptoms were mild (very mild anxiety symptoms, depression symptoms).

Table 15 Psychological symptoms and their changes

N = 45	**Mean**	**Mean**	**95% Confidence interval**		**T**	**df**	**Sig. (2-sided)**
	Pre	Post	Lower	Upper			
VDS90 total	0.1877	0.1402	0.0135	0.08132	2.817	44	0.007

VDS90 anxiety	0.2644	0.1822	0.03086	0.13358	3.227	44	0.002
VDS90 depression	0.306	0.2444	-0.01148	0.13455	1.699	44	0.096

Conclusion and outlook

What the five diagnostic studies tell us:

– Leiner study: During the transition from a pre-mental stage (affect stage) to the mental stage (thinking or empathy stage), mental resources, mentalization ability and personal strengths arise, which in turn are closely related to each other.

– Schick study: Before the affect stage comes the body stage. At these two pre-mental stages there is still no functioning emotion regulation and no mentalization. Both are only possible at the mental stages (thinking and empathy) where mental resources are also available. Insecure attachment impairs these developmental steps.

– Wöhrle study: Dysfunctional personality traits can be seen as a result of insecure attachment and developmental stagnation. As, when remaining at the pre-mental affect stage, mentalization is missing, projective identification must be relied upon, which is an implicit component of dysfunctional personality.

– Bohn study: Personality strengths and the ability to mentalize are closely related. The greater the security of attachment, the sooner these two characteristics that are necessary for successfully shaping life and relationships can develop.

– Rose study: Lack of satisfaction of central needs in childhood and especially attachment insecurity impairs the development of mentalization skills and personal strengths.

– Cozzi study: Mentalization ability as a result of metacognitive development can be divided into mentalizing the self and mentalizing the world. Only children do better in the latter. There are no gender differences. Contrary to expectations, it was not found that good mentalization skills lead to more successful recognition of emotions on a person's face. It is possible that this ability is not a pure expression of empathy, but rather an ability that emerges earlier in development.

This means that behavioral therapy supporting mentalization already has a scientific basis. However, it needs to be continually expanded, especially by means of outcome studies.

– Emotion tracking study 1 (outcome): It can be seen that the use of emotion tracking has at least partially changed the cognitive and emotional attitudes of the test subjects – as much as can be expected from a single four-day workshop. If the therapy is continued over a longer period of time, it can be assumed that these results may become even more pronounced in terms of changes in cognitive and emotional attitudes and mentalization.
– Emotion tracking study 2 (outcome): Frustrating parental behavior has an impact on today's needs (*VDS27*: homeostasis needs). Self-insecurity, obsessiveness, emotional instability and neuroticism decreased. Emotional dysregulation tended to decrease. The dysfunctional rule of survival has less of an impact on experience and behavior. The commandments and prohibitions are more often violated. Improvement of mentalization, theory of mind, empathy and awareness (perceiving, recognizing, understanding, accepting, communicating) increases. Anxiety symptoms and depression symptoms tend to decrease.

– This also includes the first MST evaluation study (Sulz, Brejcha & Koch, unpublished), which examined the effect of seven MST training sessions on the ability to mentalize and strengthen the person’s personality. There was a highly significant increase in the ability to mentalize and a reduction in dysfunctional personality traits as well as an improved management of central anxiety. In the MST training, an improved awareness of the extent of frustration of children's needs was created, enabling the participants to reflect on the emergence of the dysfunctional rule of survival and the dysfunctional personality traits and making it easier for them to develop a new, permissive rule of life. Perceiving and expressing anger was part of this permission.

Finally, we can basically summarize our procedural understanding of the mind and its options for development as follows, based on Albert Pesso (see Bachg & Sulz 2022):

We assume
– that behavior arises from a *basic need*

– that behavior is always *interaction in relationship*
– that development always comes from and with *relationships*
– that *every emotion expects an answer*
– that emotions only gain *meaning* through a counterpart
– that automatic thoughts *become a voice that comes from outside*
– that automatic thoughts *become an interaction in a relationship*
– that this in turn provokes *a response that comes from within* (instead of being rationally functional)
– that what is central, however, is the *metacognition (mentalization)* of the "pilot": thoughts about thoughts (as well as emotions and needs)
– and that its development *leads to effective emotion regulation and empathy*

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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.

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.

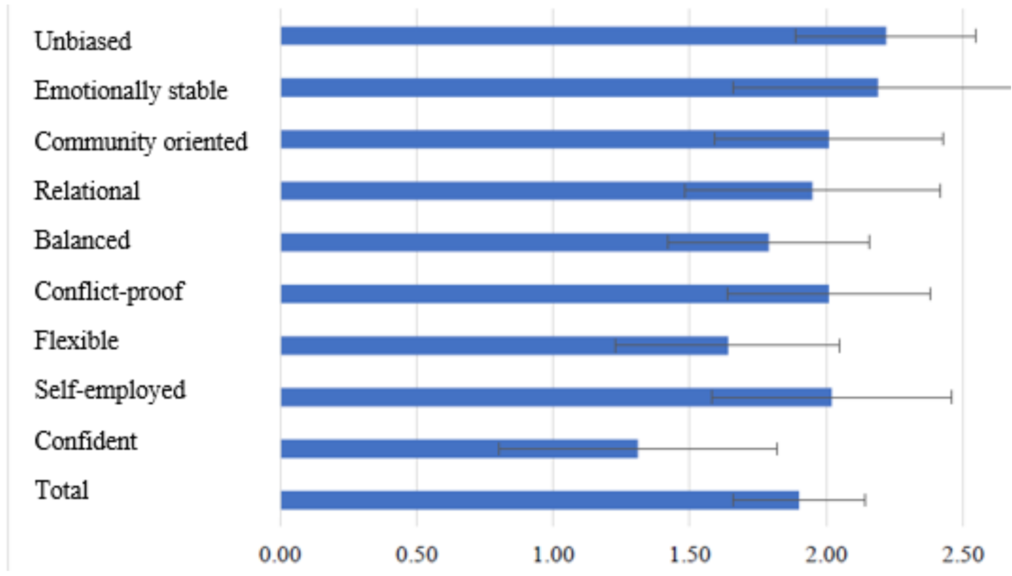

Figure 1 VDS19+ Personality (pre-measurement mean scores)

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).

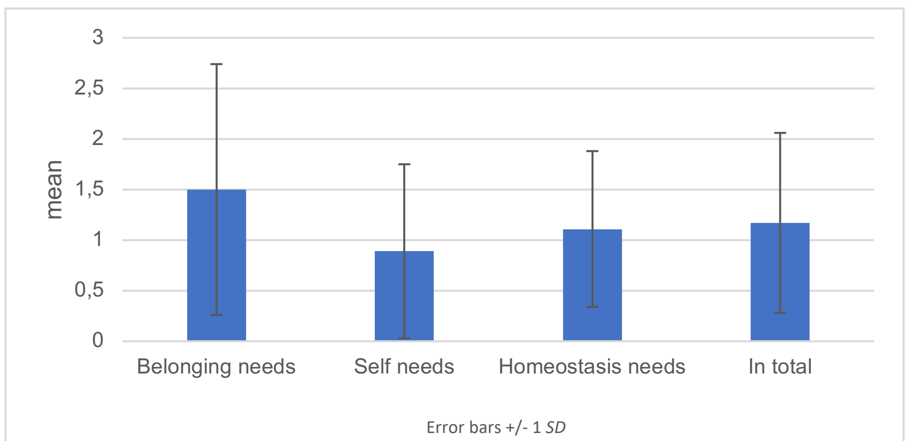

Figure 2 VDS24 AI parents Attachment insecurity in childhood – mean scores of frustration in need groups

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.

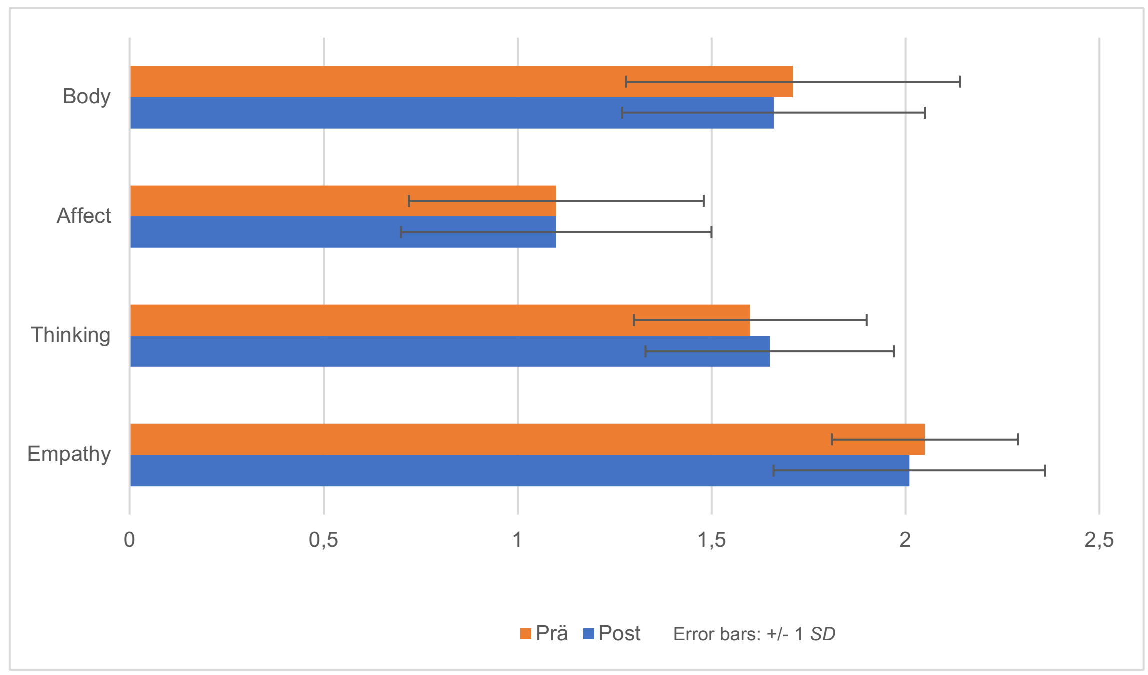

Figure 3: Mean scores of the VDS31-KADE developmental stages (pre- and postmeasurement)

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 uncertainty childhood total**	VDS24 AI parents Attachment uncertainty childhood belonging	VDS24 AI parents Attachment uncertainty childhood self	VDS24 AI parents Attachment uncertainty 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.

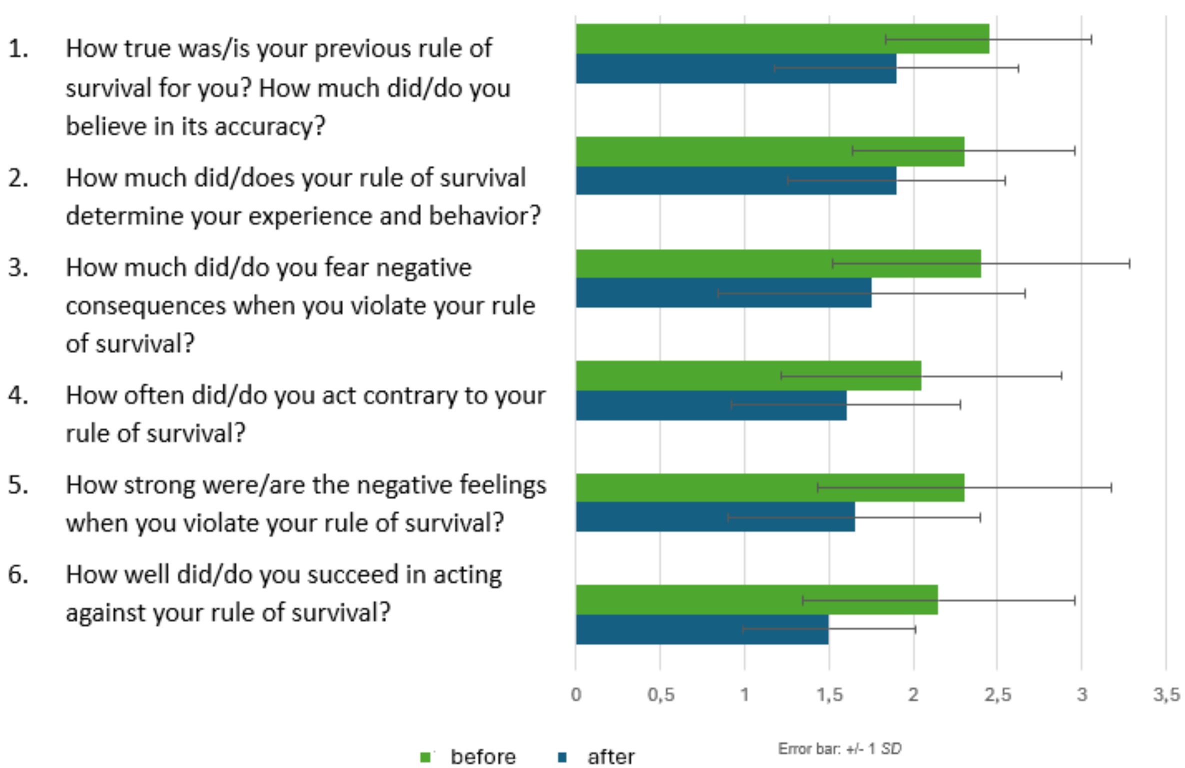

Figure 4 Impact of the dysfunctional rule of survival before and after MST training

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).

<u>Functional personality VDS19+ (personal strengths)</u>

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 ($rs = -0.478$, $p = 0.03$, $n = 20$), self needs ($rs = -0.561$, $p = 0.01$, $n = 20$) and homeostasis needs ($rs = -0.568$, $p = 0.01$, $n = 20$). 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 ($rs = -0.446$, $p = 0.05$, $n = 20$). 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 $rs = -0.315$. Accordingly, high values in VDS19+ are associated with low values in VDS32. However, this connection is not statistically significant ($rs = -0.315$, $p = 0.18$, $n = 20$).

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 ($rs = 0.466$, $p = 0.04$, $n = 20$). 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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AACES - MST evaluation study 3 on the effectiveness of mentalization-supporting therapy

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ABSTRACT

Mentalization Supporting Therapy (Sulz 2021a, b), 2022a-c, 2023) is a metacognitive therapy approach (Sulz 2017a-c) for the treatment of Axis I and Axis II disorders. Anxious patients have no access to their ability to mentalize in a fearful situation. This is exactly where the anxiety therapy of Mentalization Supporting Therapy (MST) comes into play. This paper deals with the question of the effectiveness of AACES training in the context of Mentalization Supporting Therapy. This will be tested first with a non-clinical sample in a pilot study. 21 test subjects (students who were offered online anxiety management training over five evenings) received AACES (Mindfulness, Acceptance, Commitment, Exposure, Self-reinforcement) training on five evenings, which was first practiced in dry runs and then applied between sessions in the fearful situation. Anxiety symptoms (VDS90-anxiety) improved significantly after AACES training. The effect size is high. The decrease in clinical anxiety/anxiety symptoms (VDS90) is also associated with a decrease in trait anxiety (VDS28) (-VDS90-anxiety). Individuals with higher neuroticism scores showed more clinical anxiety (VDS90-anxiety) and more trait anxiety (VDS28) prior to the training. The more pronounced the overall mentalization and the mentalization of the world are, the more do the anxiety symptoms subside (pre-post difference VDS90-anxiety). The correlation analyses suggested that neuroticism had a negative impact on the effect of anxiety training, while the ability to mentalize led to a better outcome.

In the moderation analyses, we also found a moderating effect for neuroticism: Neuroticism decreases the reduction in anxiety symptoms. Likewise, the moderating effect of attachment insecurity was a decrease in anxiety reduction through AACES training.

The result encourages us to take the next step: controlled randomized trials with a clinical sample. Until then, the statements cannot be generalized.

Keywords

Phobia, anxiety therapy, AACES anxiety training, Mentalization Supporting Therapy (MST), secure attachment, mentalizing ability, neuroticism, mentalization of the world, outcome of anxiety therapy, effect size

Introduction

Mentalization Supporting Therapy (Sulz 2021a, b), 2022a-c, 2023) is a metacognitive therapy approach (Sulz 2017a-c) for the treatment of Axis I and Axis II disorders. It includes a transdiagnostic concept that can be easily adapted for individual psychological disorders. Just as cognitive behavioral therapy puts thinking before action and changes it therapeutically, a metacognitive approach puts metacognition at the beginning – thinking about thinking, feelings and needs, both your own and others' (Allen 2008, 2010, Allen & Fonagy 2009, Fonagy & Bateman 2008, Fonagy et al. 2004, 2008, Schultz-Venrath 2021, Schultz-Venrath & Felsberger 2016, Schultz-Venrath & Rottländer 2020, Schultz-Venrath & Staun 2017, Schultz-Venrath et al. 2019, Sharp & Bevington 2024). Metacognition, theory of mind (Premack & Woodruff 1978, Astington & Jenkins 1995, Sodian 2007) and mentalization are closely related terms, but can only be used as synonyms in certain contexts (Main 1991, Brockmann & Kirsch 2010). Almost all patients having psychotherapy suffer from emotional dysregulation (Hoenes et al. 2014a,b, Gräff-Rudolph & Sulz 2017, Sulz & Gräff-Rudolph 2017). Either they are flooded with feelings or they have no access to them. Bowlby's attachment theory (1975, 1976) and clinical developmental psychology (Bischof-Köhler 2010, Walter 2010, Barth 2017, Bachg & Sulz 2022) assume that an indispensable prerequisite for successful emotion regulation is a sufficiently secure attachment to primary caregivers (Gergely & Watson 1999, Kissgen 2008, cf. Mischel 1972, 2004, 2015). Our patients were not fortunate enough to experience attachment security with their parents. Therefore, the child's second developmental task after establishing attachment security could not be successful (Gergely & Watson 1999, Sulz & Milch 2012). Without a secure attachment, the child's brain cannot take the crucial developmental step of mentalization (Sroufe 1996, Rutter & Sroufe 2000, Strüber 2016). The emotional brain continues to dominate all experience and behavior, even beyond the age at which the prefrontal cortex (PFC) has matured and its functions are available (4 to 5 years, see Roth 1995, Roth & Strüber 2016, see also Damasio 2003).

Metacognitive understanding of interpersonal interactions is not possible (Fountoglou et al. 2017). Anxiety, anger and other affects control the course of transactions (NICHD Early Child Care Research Network 1997, 2001, 2004, 2019). Instead of reflective restraint within a well-developed theory of mind (ToM), anxiety helps to control behavior (Sulz & Müller 2000, Sulz & Sulz 2005, Sulz & Hauke 2009, Sulz & Maier 2009). The radar of our anxiety signals keeps us away from situations similar to previous threatening events. However, many situations are no longer threatening for adults. But if the situation is consistently avoided in a phobic attitude, there will be no all-clear (Sulz 2017a). The person resorts to the early inner working model (Bowlby 1975, 1976, Frischenschlager 2007) or the child's rule of survival (Sulz 1994, 2017a, b, 2020) predicting danger. Thus, an association with threat becomes indelible. Phobia remains, e.g. anxiety of final loss of love when fighting back, or discomfort in the presence of obese bearded men.

In this context, anxiety exposure is a very effective approach: allowing the anxiety-triggering stimulus to affect me until the anxiety reaction subsides on its own and finally disappears. To ensure and increase the effectiveness of this procedure, various aspects can be taken into account. On the one hand, there is the perception of early anxiety signals, which is easier to achieve with mindfulness. In addition, there is the willful decision to remain in the fearful situation in order to take advantage of the opportunity to practice. And in the situation itself there is no distraction, but the attention remains entirely on the perception of one's own anxiety reaction (rather than the anxiety situation). It can be named and described through an inner dialogue, adding a conscious reflective component. After the situation has passed, its meaning is reflected and the reality of anxiety reduction is secured. As a result, the theory of mind or theory of the mental becomes more and more reality-related.

AACES anxiety exposure

An example of a metacognitive approach to anxiety therapy is Mentalization Supporting Therapy (MST). Anxious patients have no access to their ability to mentalize in a fearful situation. There is only one thing: anxiety signals danger and this must be countered by flight or, if possible, avoidance. Thinking is dominated by the principle of equivalence (if I think so, then it is true). If I recognize a situation as dangerous, then it is dangerous; there is no doubt about that. That is why

there is only one solution to the problem: escape/avoidance. Mentally reflecting on whether things could be different than I think is a luxury that only costs time. This is exactly where the anxiety therapy of Mentalization Supporting Therapy comes into play. It goes back to Sulz (1987, 1994, 2014). The therapist negotiates with the patient (prior to the situation) and a consensus is reached that there is no danger. Thus, the anxiety reaction signals a danger that does not exist. It is a false alarm. This statement is the metacognitive framework for further action. It is only as long as this framework applies that the subsequent anxiety exposure is appropriate. The decisive step is the mentalization-promoting intervention. The patient abandons his pre-mental certainty that there must be a real danger when his anxiety tells him so. He initially considers that there is no danger and ultimately, together with the therapist, comes to the conclusion that the anxiety is a false alarm and therefore the situation no longer needs to be viewed vigilantly. He can now focus more on his anxiety reaction. Since exposure is the most effective intervention, he decides to perceive the anxiety and let it be there until it disappears on its own.

AACES training (Sulz, 2017a,c) consists of five steps:

- A: Mindfulness – I pay attention to early anxiety signals
- A: Acceptance – I accept my anxiety
- C: Commitment – I decide to stay on my way to the goal
- E: Exposure – I clearly feel my anxiety in the fearful situation
- S: Self-reinforcement – Afterwards I reinforce myself for having dealt with the anxiety properly

This paper pertains to the question of the effectiveness of AACES training in the context of Mentalization Supporting Therapy (MST). This will first be tested with a non-clinical sample in a pilot study. It is the third MST outcome study.

Study design and methods

This is the third of three MST outcome studies.

1st evaluation study:

– 20 participants – psychology students from the Fresenius University

– 7-week mentalization promotion training with pre- and post-measurements (on site and online)

– The effect of 7 MST training sessions on mentalizing ability and personality strength was examined

– *Key results:* Significant increase in the ability to mentalize, reduction in dysfunctional personality traits and better dealing with central anxiety (Sulz et al. 2023)

2nd evaluation study:

– 20 participants – psychology students from the Fresenius University

– 6 double training sessions (on site)

– Focus: emotion tracking

– *Key results:* Correlation between attachment security and mentalizing ability, significance of the effectiveness of the training regarding the increase in mentalizing ability (Sulz et al. 2024)

3rd evaluation study:

– 23 participants – psychology students from the Fresenius University

– 5 double training sessions (on site)

– Focus: AACES anxiety training

– *Key results:* AACES was effective, including correlation between attachment security, mentalizing ability and effectiveness of training *(this study is reported about here)*

Study design

- quantitative, experimental, single-arm longitudinal study
- 3 measurement points (before, during and after intervention)
- Recruitment of test subjects via:

  – social media (Instagram, Facebook)

  – notice board of the Fresenius University

  – SONA test subject system

  – website of Psychologie heute

  – forwarding by email to the Catholic University of Eichstätt-Ingolstadt

  – flyer notice

Participants/sample

- 20–40 years old, suffering from recurring anxiety/phobia in certain situations, no psychotherapy
- Incentive: 12 test subject hours, €50 Zalando voucher
- Participants had to register by email and were then added to a WhatsApp group

- Number of participants set to 20 (minimum 10, maximum 25)
- 17 female, 6 male
- Mean age 23.6 years (SD = 3.44, Min. = 20, Max. = 35)
- 19 students (82.6%), 2 employed (8.7%), 2 unemployed (8.7%)
- 65% simple phobia (n = 15), 26% social phobia (n = 6), 1 panic attack (4.3%), 1 generalized anxiety (4.3%)

Anxiety content of the test subjects:

- Driving a car
- Deep waters
- Sharks and orcas
- Fear of heights
- Spiders
- Long distance
- Birds
- Wasps
- Emetophobia
- Pain
- Social anxiety

Experimental/therapeutic intervention:

- Subjects take part via Zoom in a total of 5 double sessions of group exercises with the aim of reducing the anxiety reaction.
- Mentalization-promoting intervention: **AACES training** (Sulz, 2017b)
    - A: Mindfulness – I pay attention to early anxiety signals

- A: Acceptance – I accept my anxiety
- C: Commitment – I decide to stay on my way to the goal
- E: Exposure – I clearly feel my anxiety in the fearful situation
- S: Self-reinforcement – Afterwards I reinforce myself for having dealt with the anxiety properly

- In addition to AACES → progressive muscle relaxation (Jacobson, 1934, cited by Hoyer & Knappe, 2020)
-

Survey instruments

- General questions on anxiety to record the phobic content (Sulz, 2017)
- VDS scales of the behavioral diagnostic system (Sulz 2017d):
    - VDS20 (new version) – attachment insecurity
    - VDS28 – central anxieties
    - VDS30 – personality questionnaire
    - VDS48 – relationship-emotion-body (mentalizing ability)
    - VDS90 – complete symptoms list
    - VDS90 – questions on anxiety

Independent variables are

Attachment insecurity (VDS20)

Central anxieties (VDS28) before

Dysfunctional personality traits (VDS30)

Mentalizing ability (VDS48)

Psychological complaints/symptoms (VDS90) before

Anxiety symptoms (VDS90 questions on anxiety) before

<u>Dependent variables are</u>

Psychological complaints/symptoms (VDS90) after

Anxiety symptoms (VDS90 questions on anxiety) after

Central anxieties (VDS28) after

Pre-post difference of these three variables (see Fig. 1)

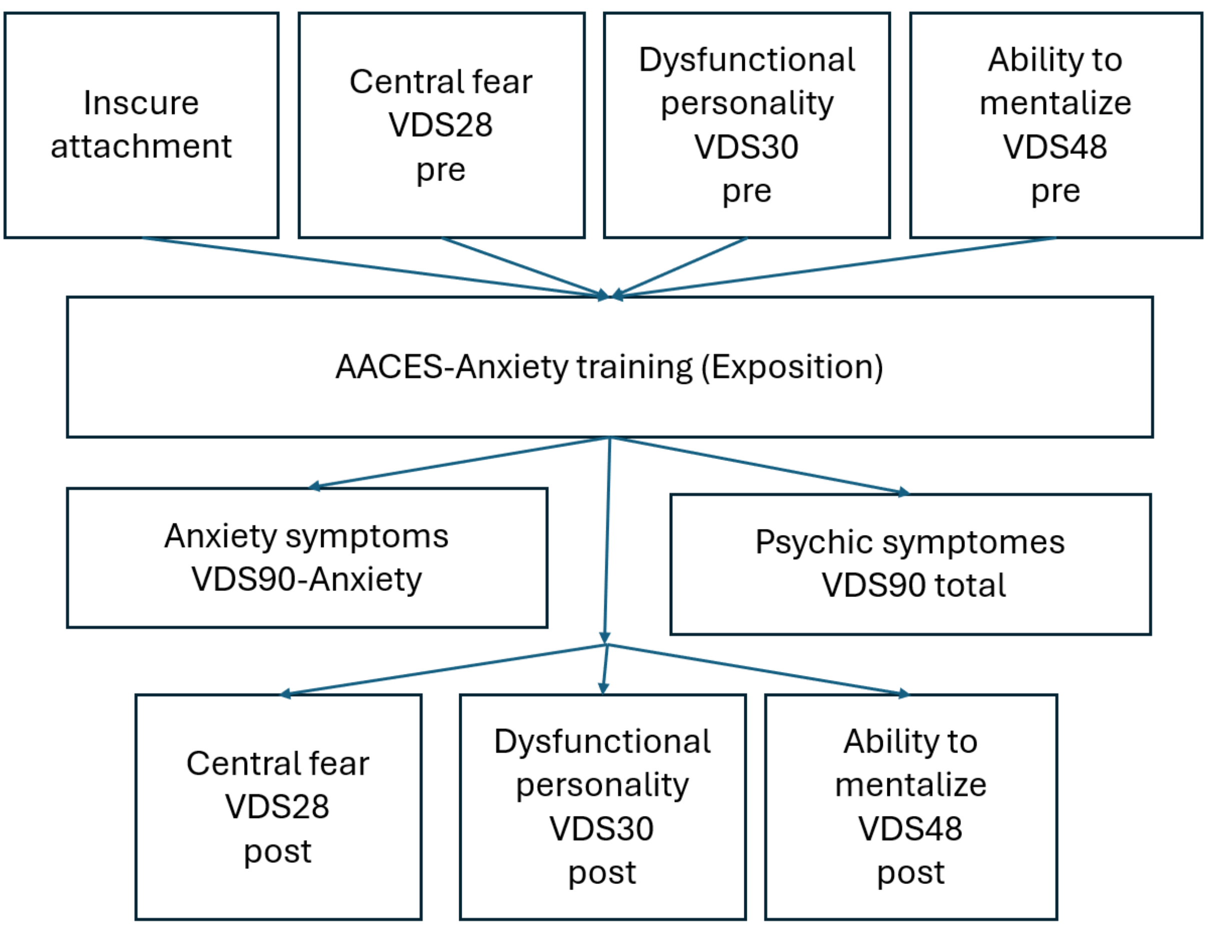

Figure 1. Study design of the 3rd MST evaluation study

The five practice evenings:

1. Introduction and practice of AACES training
2. Reports on the application, refining the approach
3. Reports on the application, refining the approach
4. Reports on the application, refining the approach
5. Final discussion in the group

The first evening comprised psychoeducation (psychology of anxiety), personal reports on the individual anxiety problem (with emotion tracking and mentalization promotion) and AACES dry exercises. The subjects agreed on how, how often, when and where to practice until the next training evening to experience the anxiety and practice dealing with it. Protocols are intended to make the exercises transparent. On the second evening, the concept of anxiety exposure was introduced theoretically (taking up a relatively short time) after initial experiences with it had already been made. The rest of the evening consisted of individual reports on attempts to apply the AACES training. Participants received feedback and advice on how to make their training more effective. It was decided together how to continue practicing. Particular attention was paid to emotional and physical experience, and metacognitive considerations were made.

The same procedure was followed on the third and fourth evening, and the individual course of the exercise process was also analyzed. Moreover, it was recommended that progressive muscle relaxation be used once daily to reduce baseline tension levels. The fifth evening comprised final reports, observations with regard to the training as a whole and decisions on how to continue practicing independently after the end of the training.

The content of the AACES training was as follows:

- **A Mindfulness – I pay attention to early anxiety signals**
    - You may have denied the onset of anxiety and acknowledged it only when it was so severe that it was too late to manage it cognitively.

  - Paying attention to early anxiety signals gives you the opportunity to begin managing anxiety when the feeling of anxiety can still be well controlled.
- **A Acceptance – I accept my anxiety**
  - So far, you have been reluctant to the approach of anxiety that can no longer be kept out of your consciousness. You tensed, staring or listening paralyzed as the anxiety grew, expecting it to continue to grow and you to be at its mercy.
  - If you allow and admit that you are (still) afraid, you will be much more able to focus on the actual task of overcoming anxiety. This is the hardest part to begin with. If you finally succeed, it will be easy from then on.
- **C Commitment – I decide to stay on my way to the goal**
  - Until now you have had only escape and avoidance in mind. You looked for ways to escape and avoid things. When no external escape route was visible, you chose cognitive avoidance (e.g. distracting thoughts).
  - If you decide with all your will to stay in the situation, these efforts are no longer necessary. You can use your energy to face anxiety. You have taken a second step to take control.
- **E Exposure – I clearly feel my anxiety in the fearful situation**
  - Until now, when external escape was not possible, <u>on the one hand</u>, all the finesse of internal anxiety avoidance had been applied: distraction, shallow breathing, tension, anger. "The situation will be over in a moment, I can just about hold out for that long!", "This time, my husband is there, but if I were all alone, then..."
  - <u>On the other hand</u>, thoughts of anxiety and catastrophe had fueled your anxiety. Now you just focus on your anxiety reactions, sense them and study them.

From this, you can establish your own self-instructions and write them, preferably in your own language, on a piece of paper and take them with you in the fearful situations:

- <u>Example of AACES self-instruction:</u>

- My anxiety is a false alarm! I feel a pressure in my chest, I feel slightly dizzy, my eyes water and I start shaking (*mindfulness*). My anxiety is there. It is there and it can stay (*acceptance*). I stay in the situation and do not run away. I want to face my anxiety (*commitment*). I feel my anxiety increasing. I do not want to stop it. I want to face it until it disappears (*exposure*). I took the opportunity to practice. I did it! Well done! This time I did not avoid the anxiety-triggering situation (*self-reinforcement*).

All individual self-instructions were checked by the therapist and returned with suggestions for changes.

Results

In this study, the 21 subjects (students who were offered online anxiety management training over five evenings) received four sessions of AACES (Mindfulness, Acceptance, Commitment, Exposure, Self-Reinforcement) training that was first practiced in dry runs and then used between sessions in the fearful situation. From the third evening onwards, they could also use progressive muscle relaxation to lower the baseline levels of their arousal, reducing the peaks of the anxiety reaction and keeping the anxiety within manageable limits. Before and after the training, the level of anxiety in the fearful situations was determined. In this way, it was possible to assess how much mean anxiety had decreased after the AACES training. In addition, the type and extent of psychological and psychosomatic symptoms before and after were evaluated using the VDS90 to determine whether the overall psychological complaints had decreased after the AACES training. Finally, it was also assessed whether the trait anxiety (VDS28), which represents the basic form of anxiety as a disposition for reacting anxiously in social situations, had decreased.

The participants were very committed and tried to benefit personally as much as possible from the anxiety training. In the debriefing, they were happy to have been able to acquire the skills to deal better with their anxiety in the future and, looking back on their own experience, to having been able to apply the training and overcome the difficulties that arose, and to having experienced anxiety decreasing. It was important that they were able to understand the origins of their anxiety and no longer had to devalue themselves because of it (the shared fate of the group members also helped here).

Outcome 1: Decrease in anxiety symptoms after AACES training (VDS90-Anxiety)

Table 1: Decrease in anxiety symptoms after AACES training (VDS90-Anxiety)

Means	N	Mean	Std.-deviation	Standarderror of Means
Pre Anxiety_VDS90	21	,93	,57	,13
Post Anxiety_VDS90	21	,54	,43	,09

t-Test		df	Significance 1-sided p	Significance 2-sided p	Mean Difference	95% Konfidenz-intervall der Differenz Lower value	95% Konfidenzintervall der Differenz Upper value
PreAnxiety_VDS90	7,5	20	<,001	<,001	,93	,67	1,19
PostAnxiety_VDS90	5,8	20	<,001	<,001	,54	,34	,73

Effektgrößen

		Standardiser[a]	Point estimation
Pre Anxiety_VDS90	Cohen's d	,57	1,6
	Hedges' correction	,60	1,6
Post Anxiety_VDS90	Cohen's d	,43	1,3
	Hedges' correction	,44	1,2

[a]The denominator used in estimating effect sizes.
Cohen's d uses the standard deviation of a sample.
Hedges' correction uses the standard deviation of a sample and a correction factor.

Result: Anxiety symptoms (VDS90-anxiety) improved significantly after AACES training. The mean dropped from 0.93 to 0.54 on a scale of zero to three. The effect sizes are high.

Outcome 2: Decrease in symptoms overall after AACES training (VDS90 total)

Table 2: Decrease in symptoms overall after AACES training (VDS90 total)

Means	N	Mean	Std.-deviation	Standarderror of Means
Pre Total_VDS90	21	,56	,37	,08
Post Total_VDS90	21	,33	,19	,041

t-Test		df	Significance		95% confiden	95% confidencei

			1-sided p	2-sided p	mean Differenc e	ceinterv all f Differenc e Lower value	ntervall f Difference Upper value
Pre Total_VDS90	6,9	20	<,001	<,001	,56	,39	,72
Post Total_VDS90	7,8	20	<,001	<,001	,33	,24	,41

Effect size		Standardiser[a]	Point estimation
Pre Total_VDS90	Cohen's d	,37	1,5
	Hedges' Korrektur	,38	1,6
Post Total_VDS90	Cohen's d	,19	1,7
	Hedges' Korrektur	,20	1,6

Result: Symptoms ovrall (VDS90 total) improved significantly after AACES training. The mean dropped from 0.56 to 0.33 on a scale of zero to three. The effect sizes are high.

Outcome 3: Decrease of anxiety (trait) after AACES-training (VDS28)

Table 3: Decrease of anxiety (trait) after AACES-training (VDS28)

Means

	N	Mean	Std.-deviationg	Standarderror des Means
Pre-Total_VDS28	21	.9921	.67245	.14674
Post-Total_VDS28	21	.5952	.54743	.11946

t-Test

	Test value = 0				
			Signifikance		
	T	df	1-sided p	2-sided p	Mean Difference
Pre Total_VDS28	6.761	20	<.001	<.001	.99206
Post Total_VDS28	4.983	20	<.001	<.001	.59524

Effect size

		Standardiser[a]	Point estimation	95% Confidence intervall	
				Lower value	Upper value
Pre Total_VDS28	Cohen's d	.67245	1.475	.843	2.090
	Hedges' Korrektur	.69905	1.419	.811	2.011
Post Total_VDS28	Cohen's d	.54743	1.087	.536	1.622
	Hedges' Korrektur	.56908	1.046	.515	1.560

[a]The denominator used in estimating effect sizes.
Cohen's d uses the standard deviation of a sample.
Hedges' correction uses the standard deviation of a sample and a correction factor.

Result: Basic anxiety/trait anxiety (VDS28) was significantly lower after AACES training. The mean dropped from 0.99 to 0.60 on a scale of zero to three. The effect sizes are high.

Correlation analysis: Factors that influence the outcome. Correlations of pre-post differences with mentalization and neuroticism

Beyond the direct comparison of means before and after training, we were interested in whether other variables influenced this result. In particular, dysfunctional personality traits were assessed using the VDS30. Previous studies have repeatedly shown high correlations with anxiety. In particular, the personality traits “self-insecure, dependent, obsessive-compulsive, histrionic, and emotionally unstable” were associated with high trait anxiety. Here, only the total score of the VDS30, which can be described as neuroticism, was to be examined. High scoring suggests a personality disorder, which was not the case in the test subjects of this sample.

The second variable of interest was the ability to mentalize, which was measured using the VDS48. Mentalization is seen as a prerequisite for the ability to regulate emotions (Fonagy et al. 2008). It therefore helps to downregulate any anxiety that may arise.

Table 4: Correlations of pre-post differences with mentalization and neuroticism

Korrelationen Pearson N=21, Signifikanz zweiseitig	Difference_Anxiety_VDS90	Difference_VDS90 total	Difference_Total_VDS28	Mentalization World_VDS48	Mentalization Self_VDS48	MW_Total_VDS48
Difference_VDS90	.539*					
	0,012					
Difference_VDS28	0,059	0,296				

	0,800	0,192				
Mentalization world_VDS48	.550**	0,309	0,319			
Mentalization self_VDS48	0,010	0,172	0,159			
Mentalization total_VDS48	0,120	0,117	0,167	0,215		
	0,603	0,613	0,469	0,350		
Mentalization world_VDS48	.436*	0,300	0,295	.793**	.729**	
Mentalization self_VDS48	0,048	0,187	0,194	0,000	0,000	
Mentalization total_VDS48	0,301	0,271	.591**	0,388	-0,059	0,230
	0,185	0,236	0,005	0,083	0,801	0,315

** The correlation is significant at the 0.01 level (2-sided).

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

Result:

The decrease in clinical anxiety/anxiety symptoms (VDS90) is also associated with a decrease in basic anxiety (VDS28) (-VDS90-anxiety). Individuals with higher neuroticism scores showed more pre-training clinical anxiety (VDS90-anxiety) and trait anxiety (VDS28). The more pronounced the overall mentalization and the mentalization of the world are, the more do the anxiety symptoms subside (pre-post difference in VDS90-anxiety).

Correlations of values for anxiety symptoms (VDS90), psychological findings (VDS90-total) and basic anxiety (VDS28) prior to training

Table5: Correlations of values for anxiety symptoms (VDS90), psychological findings (VDS90-total) and basic anxiety (VDS28) prior to training

Spearman 2-sided	Neuroticism_VDS30	Pre Anxiety VDS90	Pre Total VDS90
Pre Anxiety_VDS90	.544*		
	0,011		
Pre Total_VDS90	.677**	0,413	
	0,001	*0,063*	
Pre Total_VDS28	.714**	.493*	.733**
	0,000	*0,023*	*0,000*

Result: Pre-training clinical anxiety symptoms correlate with neuroticism, pre-training basic anxiety and pre-training overall psychological stress. In addition: self-insecure and dependent individuals showed more severe anxiety symptoms and more overall psychological distress (VDS90).

Analysis of moderator variables moderating the effect of AACES training on the reduction of anxiety symptoms

Even if there is no significant correlation, a variable can have an indirect effect and then acts as a moderator that changes the relationship between two variables. Accordingly, we could not find a significant correlation between attachment

insecurity and the pre-post difference in clinical anxiety (VDS90 anxiety scale). So the question remained whether attachment insecurity has a moderating effect. For neuroticism, it was examined whether there was a moderator effect in addition to the correlation. The moderating effect of these two variables on anxiety reduction was examined:

a) Neuroticism (total score of the VDS30 questionnaire to record dysfunctional personality traits)
b) Attachment insecurity (15 questions about insecure attachment)

Ad a): Neuroticism (total score of the VDS30 questionnaire for recording dysfunctional personality traits) influences many reactions. In this respect, it was obvious to examine whether it influences the ability to benefit from AACES training. Regression analysis revealed no significant moderating effect of neuroticism:

ΔR^2 = 8.02%, F(1.17) = 2.42, p = 0.1382, 95% CI[-0.2150, 1.2421]

Ad b): Attachment insecurity (operationalized by 15 questions about insecure attachment) is primarily seen as an obstacle to development and learning, so it can also be assumed that the effect of AACES training is inhibited. In fact, there is a significant moderation of the training effect. Insecure attachment impairs the effectiveness of AACES:

ΔR^2 = 19.66%, F(1.17) = 15.46, p = 0.0011, 95% CI[0.0312, 0.1115]

Summary of results

The outcome of the experimental study on the effectiveness of AACES training in Mentalization Supporting Therapy was examined with regard to three variables (comparing pre-post means):

a) Anxiety symptoms (VDS90 anxiety)

b) Psychological findings (VDS90 total)

c) Central anxiety as trait anxiety (VDS28 total)

The t-test for dependent samples revealed highly significant differences. After AACES training, anxiety symptoms and psychological well-being as a whole were significantly improved. The effect sizes were high. Trait anxiety as an indicator of general anxiety was also significantly lower. While neuroticism did not influence these results, attachment insecurity had a moderating effect, reducing the effectiveness of the training. However, individuals with higher neuroticism scores showed more clinical anxiety (VDS90 anxiety) and trait anxiety (VDS28) prior to the training.

The influence of other variables on the outcome was examined in two ways: first by a direct correlation analysis and second by an (indirect) moderation analysis. The correlation analyses suggested that neuroticism had a negative impact on the effect of anxiety training, while mentalizing ability led to a better outcome.

In the moderation analyses, we also found a moderating effect for neuroticism: Neuroticism decreases the reduction in anxiety symptoms. Likewise, the moderating effect of attachment insecurity consisted in decreasing the anxiety reduction through AACES training.

Discussion

Mentalization Supporting Therapy (MST) is a transdiagnostic approach that can be used for anxiety and obsessive-compulsive disorders as well as for depression, psychosomatic disorders and also for cluster C personality disorders according to ICD 10 (Dilling et al. 1999). The present experimental study is not based on a clinical sample, but involved volunteers with a simple phobia or social anxiety. They had neither an Axis I nor an Axis II disorder. They took part in an online group training on five evenings where they learned how to apply the AACES training: be mindful of early anxiety signals, accept that the anxiety is still there or keeps coming back, decide to face the anxiety without fleeing or avoiding it, observe the anxiety during the exposure and watch it gradually exhaust itself and diminish, and eventually, encourage yourself that you have practiced and that it was a good start.

The participants worked hard to deal with their anxiety in a new way, got to know its origins, understood why the anxiety remained and what they can do to leave the phobia behind them. Conceptually, the training consisted of two

approaches: on the one hand, the exposure procedure and, on the other hand, a metacognitive approach that led to mentalization, reflection and a deeper understanding of the origins of the symptoms and thus also to a more elaborate theory of mind, from which the best possible way of dealing with anxiety and phobia resulted.

The experimental design raised the question of whether even minimal MST group training can bring about a significant reduction in anxiety symptoms. We found a highly significant decrease in anxiety symptoms with a very high effect size. In addition, improvement of psychological well-being was highly significant, and the trait anxiety “central anxiety” improved as well (Sulz 2017a-c). Dysfunctional personality traits affected an improvement, while a pre-existing mentalizing ability appeared to facilitate the effect of AACES exposure training. Attachment insecurity as a moderator variable also had an unfavorable effect on the improvement of symptoms. As this was an initial pilot study that lacked a control group, generalizations are not possible. The next step must be randomized studies including control groups.

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Mentalization-Supporting Therapy for Adolescents MST-A – a further development of the Strategic Adolescent Therapy SAT/SJT

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Abstract: The following article describes the adaptation of Mentalization Supporting Therapy MST (Sulz 2021) to adolescence - grounded by Strategic Adolescent Therapy SAT/SJT.

Approaching adolescence from a developmental perspective, Mentalization Supporting Therapy MST-A, a therapy concept which combines individual and group components, first represents an attempt to adapt Strategic Behavioral Therapy SBT to this age group. In addition to symptom reduction, MST-A emphasizes effective emotion regulation and relationship building. Second it represents the adaptation of MST to adolescents. The theoretical foundations and the therapeutic foci as well as the concrete course of therapy will be outlined.

Keywords: Strategic Adolescent Therapy SAT/SJT, therapeutic relationship, therapeutic behavior, adolescents, affective-cognitive developmental theory, personality development, needs, fears, aggressive impulses, emotion regulation, relationship building, theory of mind, metacognition, mentalization, attachment, survival rule, emotion tracking, affect stage, thinking stage, empathy stage.

Disorder theory and therapy theory

Strategic Adolescent Therapy SAT/SJT was already a mentalization-supporting therapy for adolescence in a broader sense. Mentalization-supporting therapy for adolescents MST-A is a further development of SAT/SJT. It refers to developmental psychology (Kegan 1986, Pesso 2008a,b, Piaget 1978, 1995, Bischof-Köhler 2016, Oerter 2016, Sulz & Theßen 1999, 2024a,b, Walter 2016).

The focus is on the central needs of the young person, building on the need for a secure attachment. This focus corresponds to the mentalization-based approach of Fonagy et al. (2008), who view secure attachment as an indispensable prerequisite for healthy human development (Fonagy & Target 2001, Fonagy et al. 2004, Barth 2024, cf. Sulz & Milch 2012)

1.1 Attachment and autonomy

The concept of the above is derived from the developmental dynamics which are inherent in the “youth” phase of life. Based on the construct of the “developmental task”, adolescence is understood as a decisive episode for personality development in which the individuation process is given particular importance. In connection with functional or dysfunctional coping mechanisms, it is considered central to further development. Against the background of intra-individual physiological and psychological changes, the young person comes into an altered contact with the social environment around him: the increasing ability for self-reflection makes taking responsibility and self-regulation more and more possible.

Attachment and autonomy in the context of the interaction between young people and their parents are important for the (dys-)functional coping with all developmental tasks of adolescence or for the individuation process as an overall construct. The development of autonomy can only succeed if there is a secure attachment to the parents and if this results in

one's own ability to capability for attachment. Individuation requires a specific definition that cannot easily be equated with the emotional self-sufficiency of young people from their parents. Detachment becomes increasingly visible at the behavioural level, without of course the adolescents becoming emotionally distant from their parents. Successful detachment must rather be understood as a form of individuation process in which qualitative, albeit less quantitative, emotional changes occur while the attachment between parents and young people continues. In fact, emotional needs directed at parents appear to continue to exist, although their content seems to change.

Against the background of the attempt at differentiation, strategic adolescent therapy and mentalization-supporting therapy for adolescents MST-A assume here that in the phase of adolescence not only the need for autonomy but also the need for belonging are of central importance. The most important diagnostic tool for measuring attachment security is the VDS24 questionnaire "Frustrating parental behaviour". The less their needs were frustrated by their parents, the better young people feel in their care and the more they appear to them as reliable attachment figures.

In this context, Sulz's cognitive-affective development model (1994, 2001, 2003) offers an explanatory approach according to which, depending on the individual's learning history and the associated level of development of the individual, specific needs, fears, forms of anger and personality patterns come to the fore. These represent central components or working hypotheses of SAT/SJT and MST-A, the observance of which, in addition to the concrete symptom therapy in therapeutic work, aims to promote salutogenic developmental tendencies or avert pathogenic ones.

1.2 Dysfunctional survival rule and permission-giving rule of life

SAT/SJT and MST-A are aimed at adolescents aged 13 to 18 years, although there is no specific disorder. The initial diagnoses of the patients treated at our institute according to this concept are primarily anxiety disorders (exam anxiety, social anxiety, panic disorders with and without agoraphobia), depressive symptoms with suicidal crises and self-harm, eating disorders, simple activity and attention disorders and social behaviour disorders or hyperkinetic disorders of social behaviour. Here some patients tend towards personality defects. It is not uncommon for underlying dyslexia or dyscalculia to exist in the background.

The theoretical background for strategic adolescent therapy and mentalization-supporting therapy for adolescents (MST-A) is the cognitive-affective development theory according to Sulz and its therapeutic implications (Sulz, 1994, 2001, 2003) as well as the general MBT concept (Sulz 2021a, b, 2022a ,b, 2023). Accordingly, in the biography of every patient - in addition to any possible protective factors - there are limiting risk factors that restrict individual psychological and social growth (socio-ecological limitations) and that are reflected in the personality development of the person affected (Schönwald 2015). Individually characteristic ways of dealing with needs, fear and anger emerge as central action-regulating factors or as a dysfunctional way of dealing with feelings. In addition, they develop dysfunctional personality tendencies, individual values, norms, resources and the patient's cognitive-affective development level increases. All of the listed components lead to the individual's personal survival rule. How rigid the individual survival rule is depends on how many stressors the person was exposed to during a development phase. What is important in this context is that people are not aware of the rule of survival in its function of regulating

actions and balancing individual psychological homeostasis and that it is not primarily expressed in language. It corresponds to Bowlby's internal working model (1975, 1976).To simplify matters, we can assume that most patients have only remained at Kegan's (1986) affect level (impulsive level) when it comes to dealing with feelings and relationships, or have slipped back down there in the face of the problem. The path to symptom formation and maintenance can thus be presented as follows: situations that trigger symptoms require problem-solving actions, which violate the rule of survival. The formation or maintenance of symptoms is therefore to be seen as a desperate attempt to solve the problem at the affective level, which is not possible there without the formation of symptoms, since the rule of survival must be strictly adhered to. Or in other words: symptom-evoking situations are usually associated with so-called (primary) feelings such as anger, disappointment, sadness, dissatisfaction. However, these feelings must not gain momentum if the appropriate survival rule is followed and their action-regulating function must be curbed. They are thus replaced by counteracting (secondary) feelings such as helplessness, fear, restlessness, self-doubt. At the same time, psychological and physical symptoms of stress occur. The formation of the symptom leads to a decrease in stress symptoms because the arbitrary psyche now has to deal with the symptom - and no longer with the underlying development-specific conflict - which saves the old psychological homeostasis. In addition, symptoms are usually formed in such a way that they are reinforced by the environment. They also protect the attachment figures close to them from unpleasant changes, i.e. the patient experiences protection, attention and (supposedly) the opposite of what he would get if he opposed his survival rule. But even without feedback from outside, the old self-image and worldview per se remains intact by avoiding new experiences.

The decisive direction-setting is made by formulating the new rule of life that gives permission, which only then helps to overcome the usually considerable resistance.

3. Mindfulness and acceptance

Young people learn mindfulness to get to know their feelings and needs better without judging them. This makes the therapy work and the necessary development steps considerably easier and both the perception of affect and its regulation are easier.

4. Emotion tracking – finding your feelings

After preparation through daily mindfulness exercises, the young people receive intensive dialogue offers in which the feelings they are experiencing at the moment are reflected - with information about the situational context that triggered the feeling. As a result, their theory of mind undergoes ongoing elaboration. After the therapist has listened for a while (with ongoing mirroring of feelings), her empathy helps her to feel compassionately what the young person would have needed in the reported situation - instead of the hurt that occurred (e.g. comfort after a defeat). This feedback is a great door opener for access to the patient's deeper feelings. “You would have needed your father to see how bad this defeat is for you and to comfort you instead of making derogatory comments.”

Finally, we work out what the ideal father and mother would have been like. In a setup with role players in group therapy and with figures in individual therapy, a happy state becomes possible - mixed with sadness because it wasn't like that in reality (Sulz & Schreiner 2024).

5. Supporting mentalization and metacognition

This emotional therapy work is followed by the metacognitive analysis of interactions and relationships. The patient has just been helped to find his feelings and is now being forced to use his prefrontal cortex by consistently being asked questions about causes and consequences. This often happens due to the fact that our brain needs a lot of repetition before old automatic patterns are replaced by new ones. The result is a way of dealing with feelings that practises and consolidates metacognition.

6. Development from the affective to the thinking level

When it comes to problematic and conflictual relationship aspects, young people are at the affective level (impulsive level according to Kegan 1986). To that extent their thinking and actions are predominantly regulated in the right hemisphere by the limbic system - spontaneous impulses instead of metacognitively prepared actions, impatience, lack of perseverance and inability to help themselves. Instead of impulsiveness, there can also be a pronounced inhibition of impulses. The first step is to recapture your primary feelings and thus your vitality. Here exposure to emotions, especially anger, helps. Then anger at the thinking level (Kegan's 1986 sovereign level) is used for defensive assertion so that the young person can have self-efficacy experiences.

7. Development from the thinking to the empathy level

Since young people are capable of abstraction, after some practice they are able to change their perspective so that they can put themselves in the other person´s shoes, empathise and understand others (Piaget 1978, 1995). The relationship becomes more important than individual selfish goals. This makes compromises easy. The social self develops after the preceding period was devoted to the development of healthy egoism: finding and asserting one's place in the community (Kegan 1986). The need to be loved is accompanied by the need to love, and that there is someone who will accept my love. The empathy level corresponds to Kegan's (1986) interpersonal level.

Therapy goals and therapy strategy

Against the background of this understanding of the disorder, the MST-A goal is, in addition to specific symptom coping, the capturing of patient-specific effective intrapsychic and interpsychic dynamics. Processing these should enable the young person to deal with themselves and their environment in a more functional way, so that adolescent-specific development tasks can be addressed and ultimately development in the sense of the cognitive-affective development theory is possible.

MST-A assumes the following subjective problem situation:

1. Lack of attachment: **NO ONE IS THERE! I'm alone**
2. Dysfunctional survival rule (inner working model) **I am not allowed to defend myself, claim ...**
3. Mindfulness and Acceptance: **I'm not aware of a lot of things**
4. Emotion tracking – deep emotional experience: **NO ONE SEES what I feel - my pain**

5. Mentalization - Metacognition: **I don't recognise why people behave like they do and I don't realise what my actions lead to**
6. Development from the affective to the thinking level (self-efficacy): **I cannot regulate my feelings - cannot find a solution to the problem**
7. Development from the thinking to the empathy level (empathy and compassion) **I cannot put myself in the other person`s shoes**

This results in the MST-A goals:

1. Attachment security: **I AM HERE!**
2. From the dysfunctional rule of survival (inner working model) to the rule of life that gives permission: **YOU MAY** ...
3. Mindfulness and Acceptance: **BEING AWARE**
4. Emotion tracking – deep emotional experience: **I SEE what you feel**
5. Mentalization – Metacognition: **WHY – FOR WHAT PURPOSE?**
6. Development from the affect level to the thinking level (self-efficacy): **TAKING OVER THE REINS**
7. Development from the thinking to the empathy level (empathy and compassion) **BEING COMPASSIONATE**

MST-A gives parental work a central role here: parents are supported in acting as "co-therapists" against the development and maintenance of symptoms and in becoming more self-"aware" parents. The goal is therefore to create conditions that make symptom coping and development possible. For this purpose, the young people are treated in a combination of individual and group settings, with the methods used addressing the symptom level, the emotion level, the cognition level and the behavioural level. Parents are involved through family meetings, parent discussions and specific parent training.

Case study: Sarah – presentation of the MST-A therapy that promotes mentalization based on a specific therapy case

To make the concept of mentalization-supporting therapy MST-A clearer, we can follow Sarah's treatment.

3.1 Information on Sarah's symptoms and life story

Sarah began her therapy at the Centre for Integrative Psychotherapy (CIP) at the age of seventeen and a half. She was referred to the youth outpatient clinic through a counselling centre for eating disorders and in the first contact, where she is present with her mother, she appears very friendly and rather reserved. Her mother dominates the conversation and appears perplexed and very worried when describing her daughter's problem. As the reason for coming she states that about a year ago Sarah started putting her finger in her mouth after eating and vomiting. Sarah herself associates fear of falling behind academically and recurring negative comments about her weight, especially from her brother, with triggers for the eating disorder. Vomiting would give her a "good feeling of control."

The patient lives with her mother (42 years old, administrative employee) and her stepfather (32 years old, mechanical engineering technician). Contact with the biological father is sporadic and is viewed more as a "fulfillment of duty". The brother, who is two years older, is training to be a fireman and is only at home at weekends. Her parents separated when Sarah

was 7 years old. Her mother remarried when Sarah was 14 years old. The patient's mother mentions night terrors from the age of 5 to 8 years, fear of beetles and spiders from an early age until today, and sleepwalking from the age of 5 to 16 as earlier psychic ailments. Sarah has a secondary school leaving certificate and is currently attending nursing school in her second year of training. In terms of learning behaviour, she is now motivated and eager in her training, but had massive problems in mathematics in the ninth class. In her final year, she worked her way up significantly through special achievements in all subjects. When it comes to social behaviour, Sarah is still very popular with adults today. She can express herself well verbally and appears very mature. She tends to have problems with girls of the same age- she is seen as precocious and arrogant and is quick to devalue others. She has always been rather tense and shy towards boys. She had her first period at the age of thirteen, to which Sarah would have reacted happily because she felt “grown up”. Her first sexual contacts were at the age of fourteen.

Her kindergarten time from the age of 3 was unproblematic. Sometimes she didn't like going to elementary school because she “wasn't as well received by the others as her best friend was”.

3.2 Diagnosis, behaviour analysis, therapy goal determination

Due to the symptoms recorded in the diagnostic phase (no food cravings or massive craving for food; but self-induced vomiting and fear of being “too fat”), Sarah was diagnosed with atypical bulimia nervosa (F50.3) and the secondary development of a moderate depressive disorder episode (F32.1).

The associated working model which analysed the conditions and was developed at the end of the diagnostic phase (based on Sulz, 2000, 2017a-d) can be presented as follows:

S: As her success at school increased there was more and more devaluation on the part of the rivalling brother with underlying strong idealisation by the mother (“Sarah is sensible and mature. She can do it”). The stepfather was emotionally absent and the father was over-demanding and emotionally abusive ("You have to take care of me because I'm unwell." "When I'm dead, you have to take care of my gravesite").

O: Sarah is cognitively very reflective and mature, has a great need for harmony while at the same time being unable to perceive her own boundaries (especially with her father and brother), she has very strong feelings of guilt when distancing herself or expressing criticism. She has a strong need for warmth and security and clearly fears loss of love or loss of control and has strong inhibitions regarding aggression. The anger impulse is separation anger. She has histrionic and self-insecure personality traits. She has above-average talent (IQ of 124).

R: The primary emotion is anger at the frustrating environment (especially family-related). The expectation is: “Then I will be left alone, no longer belong, or I will get hurt”. . Angry impulses are replaced by a depressive mood in combination with compensatory eating and vomiting.

K: Fear of loss and the fear of being at the mercy of others are reduced and the feeling of control and warmth can be maintained.

The three specific therapy goals developed with Sarah against this background are:

1. To cope with the eating disorder

2. To feel more comfortable in relationships, i.e. that more comes back from the others and the patient does not constantly feel guilty ("What have I done wrong yet again?")

3. To change in dealing with feelings, i.e. not to be sad all the time without knowing why, but to recognise causes and learn to act more confidently

The therapy goals derived according to SAT/MST-A are:

1. Sarah should learn to establish a balanced eating pattern and avoid vomiting with appropriate reaction prevention measures

2. Sarah should learn to perceive and articulate better her needs and feelings

3. Sarah should learn to set boundaries -even with her fear of loss and her striving for harmony (especially with her father and brother)- to reduce the associated feelings of guilt or to deal with her anger constructively instead of showing depressive processing mechanisms and compensatory eating or vomiting

4. Sarah should learn to engage with peers and maintain their friendships instead of devaluing them in a fearful-avoidant way

5. Sarah should learn to increase her self-esteem

6. Sarah should learn to build up an affirming self-image (especially with regard to her own gender identity) and to reduce her fears towards the opposite sex, i.e., ultimately to partially revise her image of men.

3.3 Therapy course and parent work in individual mode

The time window of the therapy, which took place in individual mode, extended over approximately nine months and included the mother and stepfather. At Sarah's request, the now 48-year-old father (an electrical engineering technician), who does not live with Sarah, is not taking part in the therapy, which in this case is due to Sarah's limited ability, which is plausible, to differentiate herself from his heavy alcohol abuse and his boundary-overstepping behaviour.

In terms of the therapeutic process, after a general psychoeducational part on the topic of "eating disorders and the development of symptoms" for Sarah and her mother or stepfather, the structured eating behaviour that had already been initiated by the Counselling Centre for Eating Disorders was adopted in individual mode and methods were tested to stop self-induced vomiting (reaction prevention by means of jogging, listening to music, PMR). What was central to the emotional work here was that Sarah perceives her symptoms as a mouthpiece. For this purpose, the eating disorder was personified by Sarah writing the following letters to the eating disorder as an enemy/burden and as a friend:

Dear eating disorder, my enemy,

You! You, you are so, so stupid. Do you actually know what you're doing to me? Of course you're always there, but you take me over. You settled in with me without really asking. This is really the last straw. Without you, this "Help, I have eaten too much!" wouldn't even exist. You determine my - rubbish - your ideals. You see, I don't even know anymore whether it's mine or yours because you take over my entire self far too often. When fearful, you bring me down even more. You don't know anything about boys. You make me avoid them. Stop it! Let me be Sarah. You eat up all my courage and hope. Do you know something like happiness? That's what I

want. But you are selfish and only fake happiness. I don't want you anymore. Where do you actually live? In my head, in my stomach, in my heart or where?

I want you to leave. Become part of my past. I don't want the little, false moments of happiness anymore.

AND

Dear eating disorder, my dear friend,

You are always with me and never leave my side. You are unwavering. I don't have to make an effort to contact you. You are the way, the help when I have eaten too much. You create a way out of it. You impressed me. You are so simple. For you, one doesn´t need a strong will to lose weight. You take care of me and pay attention to what ideals I have. You give me refuge from my fears. You create ways out when I get hurt. You want me to get along with boys because you really do pursue the ideals. You're there when I'm feeling bad. You belong only to me, only to me...

Supported by the emotion tracking conversation (tracking down feelings), Sarah was increasingly able to sort through the perceived "emotional chaos" and also to allow feelings to arise without resorting to vomiting when frustrated.

The therapist's main attention was on Sarah's face and body. What emotion arises? What had she just said? "I see how angry it makes you when your brother makes a derogatory comment." And: "I see how sad you become when your mother leaves you alone with your painful feelings."

This was preceded by the reformulation of the prohibiting and commanding rule of survival into a new rule of life that gives permission:

Even if I less often hold back in a controlled manner and put up with a lot

and if I show my anger more often and defend myself effectively,

I maintain love and affection

and don't have to fear being alone.

Only this permission made the perception of anger and angry assertion possible - with the experience that the relationship did not get worse.

At this point, therapeutic non-verbal material was also used, with the help of which Sarah learned to differentiate and grasp the feelings that were avoided with the eating disorder. Sarah painted a picture in which the "mouth of the eating disorder" eats up feelings such as love, sadness, hope and longing. With the help of the drawing, Sarah recognizes and feels the importance of perceiving, articulating and enduring feelings. In the process, she develops new, comforting thoughts to counteract the old thoughts that promote the eating disorder and depression. During the course of this, it was possible to reduce the depressive processing mechanisms in individual mode by working on the patient's feelings and relationship issues. The vomiting no longer occurred for a certain time and only appeared again briefly in group mode against the background of an acute crisis. In her individual work, Sarah also began to increasingly deal with her father's frustrating behaviour, to define her boundaries and to evade his influence by reflecting on the frustrating situations or using corresponding imagination exercises. In relation to her brother, she was able to express needs better and also to set boundaries with the help of role plays. Sarah made the leap towards partnership and

relationships. Before the parent training, Sarah described her relationship with her mother and stepfather as rather difficult because neither of them understood her.

The ideal parent exercise was very helpful here. Sarah accepted the invitation to imagine having the parents she needed: “My ideal mother would have been sensitive and able to accept and support me even when I was sad and angry. She would have stood by me reliably, given me warmth and security, and would have supported myself-determination and independence. My ideal father would not have stopped loving my mother and both would have stayed together. He would have had strength and would never have abused her emotionally.”

These parents were brought into the therapy room in the imagination. They were seated on empty chairs to the left and to the right, holding each other`s hands. The therapist lends them her voice and lets them say literally, for example: “When you are sad, I am completely with you.” and “It is good if you show me how annoying that is for you.” Other statements that Sarah wants to hear from them are expressed, the physical togetherness and looking after each other are further developed so that Sarah can completely immerse herself in this wish-fulfilling imagination and staging and enjoy it. She is then invited to recall this scene often and to enjoy the remembering.

The new rule of life allows anger to be felt and expressed. It was possible to let Sarah experience this directly by playing a dialogue with the negative aspect of the biological father. She imagined him facing her. He won't say anything, he will just accept her annoyance and anger. She looks him in the eyes with an angry and determined expression and tells him how bad his behaviour was for her, how angry it makes her and that she won`t put up with it anymore. She underlines each sentence by hitting a cushion with her fist, as if she were angrily hitting the table. She knows that this exercise is not a blueprint for real encounters with her father, but only serves to clarify her inner feelings. In order to deal with him in real life, role-plays with socially competent behaviour are planned.

As far as the parallel parenting work in individual mode was concerned, the mother initially appeared to be avoiding problems and invalidating the daughter's emotional crises or being barely able to endure them. The principle was “Everything is fine”, “It will be okay” and “Close your eyes and get on with it”. In a similar way, the stepfather trivialised Sarah's psychological problems and here her mother`s and the stepfather`s helplessness towards Sarah was very noticeable. The stepfather did not want to question his “safe and secure home that was shielded from the outside world” at any cost, which is why the attachment figure conversations with both parents were primarily about intensified psychoeducation, de-trivialisation, and raising sensitisation to Sarah's needs.

3.4 Course of therapy in combined individual and group mode

What represented a central theme for Sarah in continuing content in the group mode was, on the one hand, the fear of loss that she felt, especially in the partnership she was living in at the time. On the other hand, it was clearly also how to deal with frustrations of the central needs for warmth and understanding. The challenge in the group was to endure disharmony or discord and also to be defensive, which Sarah managed better and better. Sarah learned to express criticism in the group and to be defensive against the verbal overstepping of boundaries by a young person with social behaviour disorders. At the end of the group phase, Sarah articulated clear gains from the group processes.

3.5 Course of parent training

As far as parent training is concerned, the patient's mother can be described as defensive at the beginning. In the course of the process, however, she was able to recognise her position in the family with the self-awareness parts “My Rule of Survival” and “Frequent/Strong, Feared and Rejected Feelings”, where she “covers up” problems, brushes them away and hardly allows them. Especially in her relationship with Sarah, the mother was able to develop alternative reactions when Sarah was feeling bad. Instead of “It’ll be okay” and “It’s not that bad”, the mother increasingly accepted her daughter’s search for help and took on a supportive, more understanding role. Especially when it came to desperation or sadness, the mother - as she herself recognised - used to ward off her daughter out of helplessness in dealing with it. It was now possible to allow comforting physical contact more easily. The mother is currently trying to get a feeling for how much support Sarah needs and where she has to refrain from providing it in the service of individuation. What is particularly healing for the mother-daughter relationship is that conflicts can now be allowed. Both sides perceive this as a cleansing thunderstorm which eases their burden - anger is allowed and does not destroy the relationship.

In the case of the stepfather it was possible to achieve a somewhat more hesitant development. For a long time he stuck to trivialities even in training. It almost seemed as if he was competing with Sarah for her mother and therefore wouldn't allow any change. It is only in the last third of the training, when the relationship between mother and daughter improves significantly, that the stepfather first articulates the feeling of feeling excluded and he is only just beginning to reflect on his options for shaping relationships alternatively. He currently wants to try to give Sarah more understanding.

4 Final assessment of mentalization-supporting therapy for adolescents

Based on the previous results on the evaluation of strategic adolescent therapy (Richter-Benedikt, 2016; Sedlacek, 2015, Peukert 2020) and on the evaluation of mentalization-supporting therapy (Sulz, Richter-Benedikt & Sichort-Hebing 2012, Sulz 2022b,c, Theßen, Sulz, Wedlich et al. 2024, Sulz, Brejcha et al. 2023, Theßen, Sulz, Birzer et al. 2024, Theßen, Sulz, Patsiaoura & Feder 2024) it can be said that, in addition to symptom therapy, working on the central relationships or the associated needs, fears and anger impulses appears to be important and supports health and mentalization. Over the course of the therapy, the young people learn to differentiate feelings, sense and regulate needs, and largely show an improvement in their psychological well-being. In our opinion, the combined individual-group concept and the very intensive parent work have proven to be particularly effective. Changes within families and among individual parents and young people are particularly evident in the areas of “dealing with one's own boundaries” and “dealing with frustrating situations”. Some of the young people have emotionally unstable characteristics that can be addressed well with the intensive emotion regulation component. Self-injurious or self-damaging behaviour can definitely be reduced and, in many cases, eliminated completely. The youth groups are a big challenge for the patients. However, the young people can use the group’s feedback and our observations after the group frame to learn to cope with things among themselves and with each other. According to the patients, the group was often experienced as supportive. The group can offer relief, especially when it comes to shame about one's own symptoms. In the

spirit of peer dynamics during adolescence, young people also learn to get into contact more with their peers and to deal with difficult situations amongst each other.

Another argument in favour of the strategic adolescent therapy and mentalization-supporting therapy approach (MST-A) is that the adolescents and their parents can be involved in the long term and that we have relatively few discontinuations of therapy. The joint parent-child discussions that follow the groups also suggest a learning effect. The feedback from many parents is positive, although there are clear teething problems at the beginning of the parent training (talking about your own issues in front of others, etc.). After the parent training, the parents report being less helpless and more empathetic when dealing with the children and being able to reflect better on psychological processes in themselves and others. The parent group also seems important, especially when dealing with feelings of guilt towards one's own child. By dividing the parents into different groups, it was also possible to address and deal with couple conflicts and lack of parental alliances. Some parent groups continue to run privately and after the training several parents decided to undergo couples counselling or their own individual therapy.

It is conceptually problematic if the young people do not want their parents to be present during the therapy or if both parents refuse to cooperate. In such cases, we try to get the young person and/or parents to cooperate or motivate them, but we do not continue the therapy if there are no changes. This may sound radical to some, but it is related to our understanding of disorder and recovery. It also becomes difficult if the parents themselves have severe psychological disorders and we cannot convince them to start their own therapy. For some parents, it takes a lot of persuasion and also pressure at the beginning of the training (see comments like “But my child is in therapy, not me”). There are parents who “cannot take part in parent training because of other important appointments”. In such cases, the lessons are made up individually. In this context, it appears to be central to the implementation of the SAT/SJT that the parent training takes place in the second phase of the therapy and is preceded by joint preparatory work or collaboration in individual mode. In other cases, the parents may be overwhelmed by the group situation and the large amount of personal experience. The training situation can be a great support, but in individual cases it can also be a very frightening situation for the parents. Due to their comprehensive approach strategic adolescent therapy and mentalization-supporting therapy are certainly reaching their limits with regard to the implementation of hourly allotments which have been approved by health insurance companies, but so far they have proven that they are largely efficient and can be executed well in practice.

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