Emotion Tracking - Healing and Growth of the Wounded Soul

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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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