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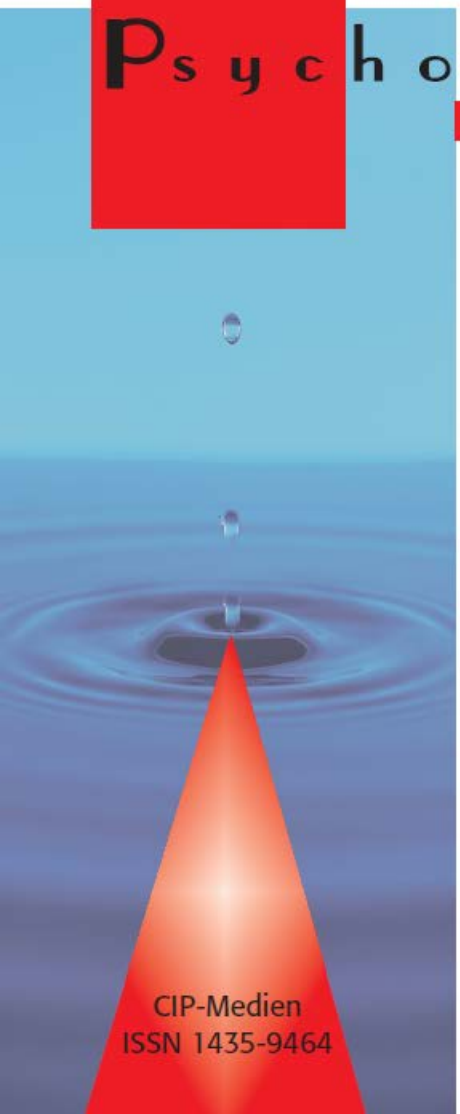

SPECIAL TOPIC

Alfried Längle

Existential Analysis

CLINICAL EXPERIENCE

CIP-Medien
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CONTENTS

Subjective Experience and Objective Empiricism

Europe's psychotherapy has rewarding developments to show for. Next to the empirical scientific studies of therapy research there is a great deal of experience, which is the creative hypothesis, generating material for temporal resulting research. When we assume a scientific psychotherapy, we naturally base it on the results of psychological and medical science and research. Whether it is psychology or psychotherapy, the creation of a hypothesis precedes each systematic empiricism. Stagnation will set in if these results are solely from previous empirical research.

Systematics are preceded by individual field observations, which are partially random. The empirical researcher starts to show interest when the conspicuously scanned phenomena reoccurs. The phenomenon leads to a hypothesis, which he or she then studies empirically. The empirically confirmed hypothesis leads to questions, which will help to better understand the phenomenon, resulting in further empirical research projects. Always remember however, that the source of such projects is creative input. Practicing psychotherapists repeatedly make these kinds of observations and therefore are able to report numerous phenomena.

With 30 years of practicing experience you probably cannot help but smile while reading that empirical research reports with a separation topic state new insights that agoraphobic and panic patients have relationship conflicts. Instead of belittling these young researchers, you should be happy about the fact that your subjective observations now are being objectified and can now be considered to be published in textbooks.

Even if the wheels of psychotherapy-research (partially due to lack of funds) are turning slowly, they do so with reassuring diligence.

Hence, we find experience and empiricism in this edition as well.

On one hand we have the study by Torsten Siol and colleagues on Posttraumatic Stress Syndroms in Train Drivers Following Serious Accidents and the study by Cornelia Albany and colleagues on Psychoanalytic Process using the Core Conflictual Relationship Theme (CCRT) according to the Ulm Process Model. On the other hand the theme magazine on further development of Viktor Frankls' approach to logotherapy for existential analysis is available.

We would be delighted if therapy researchers come across interesting hypotheses and practicing psychotherapists obtain confirmation and orientation after reading this magazine.

Serge Sulz

IMPRESSUM

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Editorial
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Posttraumatic Stress Symptoms in Train Drivers Following Serious Accidents: A Pilot Study

Abstract

Being involved in a fatal accident is a common event among train drivers that is likely to precipitate stress responses (1000 annual railway suicides in Germany). This paper presents data from a pilot study that retrospectively assessed the prevalence of severe accidents and consecutive posttraumatic symptoms in 429 train drivers using an accident questionnaire, the IES-R and SCL-90-R.

276 (64.3%) of the respondents had experienced at least one major railway accident, 50% of whom reported to have had stress symptoms of presumable clinical relevance in the first weeks following the accident. At an average of four years after the event, 8.2% still described actual symptoms to an extent complying with DSM-criteria of PTSD.

Key words: posttraumatic stress disorder, railway accidents, train driver

Introduction

Train drivers are at a considerably higher risk than the general population to be confronted with a potentially traumatic event: Taking into account about 1000 annual ‚railway suicides' in Germany, roughly 5% of all train drivers are involved in such incidents every year (Schmidtke, 1994). Moreover, a significant number of other serious accidents have to be added. There is a statistical risk for each driver to experience two suicides or other fatal situations during his occupational career. In contrast to other methods, railway suicides have a strong direct or indirect impact on other persons who inevitably are involved. Several authors have argued that people choosing this particularly brutal suicide method show an extremely high potential of aggression, sometimes maybe even wishing to be killed by another person (i.e. the train driver), or wanting to submit themselves passively to an overwhelming physical force (Menninger, 1938). This makes evident the potential negative impact on train drivers: Driving at high speed, they are neither able to stop the train in time nor to move aside to avoid the collision. Being in a situation beyond their control, they are regularly left in a state of helplessness. Moreover, the train driver – not rarely being on his own on the engine – not only has to report the accident, but also to secure the train or to dismount to give first aid to a surviving victim before any

assistance is available. Accordingly, several of the subjective risk factors for PTSD – as identified in clinical surveys (e.g. Green, 1994) – are inherent in railway accidents: unexpectedness of the event, small degree of control over the situation, (subjective) feeling of guilt and delayed appearance of external help. It seems quite obvious that most accidents meet the criterion of a traumatic event in the DSM-IV or ICD-10 system.

One aim of the present study was to assess the requirement of specific therapeutic support for this group. Additionally, different authors have suggested that railway accidents could serve as a model for studying the responses of healthy subjects to trauma (Malt et al., 1993; Vatshelle & Moen, 1997): Due to their high risk to be exposed to a traumatic event, there is a possibility to assess pre-traumatic conditions and relate them to the trauma responses. Differing from other areas, most accident situations are quite uniform (mostly suicides; the driver can neither anticipate nor prevent the accident) and the group of train drivers is rather homogenous regarding sociodemographic variables. These circumstances present an opportunity to examine the role of individual disposition with regard to the aetiology of posttraumatic syndromes.

Starting in the early '80s, in Scandinavian countries as well as in Great Britain psychological concepts were developed and implemented to minimise the negative effects of railway suicides on train drivers (Foss, 1994; Tang, 1994, Williams et al., 1994). Hitherto, a number of empirical studies have been published (Theorell et al., 1992, 1994; Farmer et al., 1992; Tranah & Farmer, 1994; Malt et al., 1993; Karlehagen et al., 1993; Myrtek et al., 1994; Vatshelle & Moen, 1997). But only one study focussing on psychophysiological reactions of subway drivers (Theorell et al., 1992, 1994) assessed the psychological and somatic state of health prior to the accident, however, less than half of the drivers had participated in this screening. Thus, inferences regarding the true effects of the traumatic incident as well as the evaluation of predisposing factors could not be made on a firm enough basis.

In an exploratory, retrospective project we tried to assess the frequency of posttraumatic stress reactions and the proportion of long-term disturbances in train drivers following fatal or nearly fatal on-the-track accidents. The results of the study presented in this paper, furthermore are serving as a baseline for a still ongoing prospective project designed to contribute to a more detailed description of objective and subjective variables, which increase the risk of suffering from PTSD after a traumatic event.

Method

Procedure

In co-operation with the occupational health service, the ombudspersons and the regional railway administration, a questionnaire was sent to all train drivers in active service in Cologne (August 1997), a total of 942 persons, who had been acquainted with the aims and procedures of the study. They were informed that the questionnaire should be a preparation for a

prospective research regarding post-traumatic distress of train drivers. Considering a relatively low response rate of 38.5% (n = 363) after 3 months, we decided to contact all subjects once again; with respect to the supposed scepticism of the train drivers regarding the confidentiality of the data, we included an answer-sheet with a different coding system. Thus, additional 66 questionnaires could be obtained, leading to an overall response rate of 45.5%. Statistical analysis was performed using SPSS 9.0; cases with incomplete data have been excluded.

Measures

Accident questionnaire: We developed this questionnaire basing on Myrtek's (1994) instrument asking for a detailed description of the accident, previous treatment and social support. Train drivers having experienced more than one serious accident were asked to focus on the subjectively most distressing event.

IES-R (Horowitz, 1979; Weiss & Marmar, 1996): The German version of the revised Impact of Event-Scale, authorised by M. Horowitz (Maercker & Schützwohl, 1998), was applied to assess the distress related to the accident. The Scale consists of 22 items with a four-point scoring range, comprehended to three sub-scales: *intrusion, avoidance* and *hyperarousal.* The drivers first were invited to report the current symptoms and then – to avoid possible triggering effects – asked to describe their distress in the first month after the event retrospectively.

SCL-90-R (DeRogatis, 1977; German version: Franke, 1995): This multi-dimensional instrument estimates the subjective impairment by psychological and somatic complaints. There are nine sub-scales (somatisation, obsessive-compulsive symptoms, social insecurity, depression, anxiety, aggression, phobic fear, paranoid thinking and psychoticism) and an assessment of the global psychological strain. The SCL-90-R is the most common questionnaire for these purposes with reference results for a broad spectrum of somatic and psychiatric disorders.

Participants

429 train drivers returned the questionnaire, 99.3% of whom were male. The mean age was 39.1 years (SD = 9.5 yr.); the respondents had a mean experience as train drivers of 15.7 years (SD = 8.9 yr.). 75.5% were married or with a constant partner, 17.5% single and 7% divorced. In order to investigate, whether our respondents form a representative group, we examined the sociodemographic data of all 1073 active train drivers in Cologne, who were on average about one year younger (mean = 38.2 yr.), but one year longer in service (mean = 17.0 yr.) than our sample at the time. Thus, we could calculate that the non-respondents were on average about two years younger and one year longer in service than the respondents. With the exception of a higher proportion of married participants among our correspondents, these differences regarding sociodemographic variables were not statistically significant.

Results

429 of the 942 questionnaires were returned, representing a response rate of 45.5%. 276 of

the 429 respondents (64.3%) confirmed to have experienced at least one major railway accident (range 1-11; 43.4% reported of one, 29.6% of two, 15.7% of three and 11.2% of four or more events). Suicide attempts (54.3%) were the most common experience, followed by non-suicide accidents (15.2%), collisions with other trains (9.4%), accidents at railroad crossings (7.4%) and derailments (3.9%). In 61.6% of the reported events at least one person was killed; 82.1% of these fatal accidents were suicides. The majority (55.3%) of the specified events had occurred within the last 4 years (median = 4 years).
Actual IES-R scores on all three subscales were lower than those computed for the recalled distress in the first four weeks after the accident (see Table 1).

Table 1: Mean Scores on the IES-R Subscales

	Actual IES-R scores (n = 232)		Recalled IES-R scores (n = 232)	
	Mean	SD	Mean	SD
Intrusion	8.3	7.6	14.2	9.5
Avoidance	10.2	10.1	13.0	10.9
Hyperarousal	7.7	7.7	11.4	9.4

Summarising the scores of the intrusion and the avoidance subscale, a general score was computed to estimate the clinical significance of the reported symptoms (Table 2).

Table 2: Percentage of Drivers at the Different Levels of Distress According to the IES-R (Intrusion and Avoidance Subscale only)

	Percentage with level of distress			
	no significant distress (0-8)	low distress (9-25)	medium distress (26-43)	high distress (> 43)
Actual (n = 232; mean = 18.5; sd = 16.3)	37.9%	31.0%	21.1%	9.9%
Recalled (n = 232; mean = 27.2, sd = 18.3)	22.8%	27.2%	29.7%	20.3%

With respect to the problematic simple addition of IES-subscale scores (see Zilberg et al., 1982), Maercker & Schützwohl (1998) proposed an estimation equation including the hyperarousal subscale (X = –.02* intrusion score + .07* avoidance score + .15* hyperarousal score – 4.36). They showed that in 82.8% the diagnosis of PTSD (if X > 0) could be assigned in

consistency with a structured diagnostic interview basing on DSM-III-R (sensitivity = .76, specificity = .88). According to this estimation equation, in our sample 8.2% of the train drivers having experienced a serious accident reported actual posttraumatic distress on the IES-R to an extent suggesting to comply with DSM-III-R criteria of PTSD; with respect to the retrospectively recalled distress in the first 4 weeks after the event 17.7% met these standards. Only 3.9% visited a psychiatrist or psychotherapist; mean sickness leave (self-reported) was 11.9 days (sd = 14.1). Asked about their sensations when passing the point of the accident, 30.3% reported to feel indifferent, 57.7% stated that the event was brought back to mind, 6.4% that they got quite nervous each time and 5.6% described additional somatic symptoms.

There were no statistically significant differences in the SCL-90-R scores (subscales and global indices) between train drivers, who had been confronted with a serious accident, and their colleagues without such an experience or the standard sample of the general population. Train drivers with a history of an accident were slightly older (40.2 vs. 37.0 yrs.; $p < .01$) and more experienced on the job (17.0 vs. 13.4 yrs.; $p < .001$). Drivers who reported an accident with casualties (n = 203) were longer on sick leave (13.9 vs. 3.9 days; $p < .001$), showed stronger reactions when passing the site of the accident (CC = .237; $p < .01$) and reported more distinct present symptoms of intrusion (mean = 9.2 vs. 5.5; $p < .01$) and avoidance (mean = 11.3 vs. 7.0; $p < .01$) than those, who specified accidents with only material damage (n = 52).

Discussion

We present the results of an exploratory, retrospective survey, focussing on the assessment of posttraumatic symptoms in train drivers. The response rate of 45.5% is not very high, and makes us cautious about the interpretation of our results. We cannot exclude a bias (under- or overestimation regarding the frequency of accidents) due to the low response rate, although a comparison of sociodemographic data showed, that our respondents were predominantly representative for all train drivers with reference to sex, age and experience in service. However, as Heberlein and Baumgartner have argued (1978), due to numerous factors affecting mailed questionnaires, already a response rate of 45-50% can be seen as a success. As the train drivers confirmed in the prospective phase of our study, the limited readiness to participate could be attributed to a restructuring of the railway company at the time, leading to massive insecurity regarding the future of their jobs, to hesitations regarding the confidentiality of the data and to a more general scepticism in respect of psychological and psychotherapeutic proposals.

Our findings endorse the results of other studies with respect to the extraordinary strain on employees in this occupation through on-the-track accidents (Farmer et al., 1992, Theorell et al., 1992, Malt et al., 1993, Vatshelle & Moen, 1997). Almost two thirds of the respondents had experienced at least one traumatic event meeting the DSM-IV-criteria (in 62% of the accidents at least one person was killed). Due to the limited response rate and the retrospective

nature of our data, the study does not allow for an exact estimation of posttraumatic symptoms in train drivers. Given these cautions, our findings suggest that in the first weeks after the traumatic event about 50% of train drivers show stress syndromes at a level of clinical relevance; more than 30% report medium or high distress several years after the accident. It can be assumed that only a minority of these train drivers present with a PTSD meeting DSM-criteria (17.7% adjacent to the accident and 8.2% at the time of the inquiry according to the IES estimation equation) and that subsyndromal affections prevail. Furthermore, it should be considered that our study included only train drivers in active service. Thus, we cannot exclude an underestimation of posttraumatic syndromes as train drivers unable to return to the train-service due to posttraumatic symptoms could not be taken into account.

The discrepancy between rather high levels of posttraumatic burden and a relatively low psychotherapeutic / psychiatric consultation rate (3.9%) seems to suggest that the support offered to traumatised train drivers has to be improved. Despite the limitations of our study, our findings provide the basis for further research. In a still ongoing prospective study we try to contribute to a more detailed description of objective, subjective, individual and psychosocial factors that influence the appearance and course of PTSD in train drivers and to develop adequate support and intervention strategies.

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Study of a Psychoanalytic Process using the Core Conflictual Relationship Theme (CCRT) Method according to the Ulm Process Model

Abstract

The study presents a description of the course of a psychoanalytic treatment with the CCRT method according to the "Ulm Process Model." Reformulated CCRT categories are used. The rich database at our disposal made it possible to analyze not only the absolute frequencies of CCRT components but the complex structure of the data as well. Besides a basic theme characterizing the therapy as a whole, there are typical categories for each phase of the therapy. These can be understood as interpersonal aspects of the focus of the particular phase. This may be considered a contribution to the "Ulm Process Model".
Key words: CCRT, psychoanalytic therapy, Ulm process model

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Introduction

The great volume of material that is brought to light in the course of a psychoanalytic treatment must be reduced to what is most significant. Events are not significant in themselves, however: significance is given to them. What an analyst considers significant in the analytic process depends on the criteria for meaningfulness he or she applies to the course of the psychoanalytic process. One idea of process will be more differentiated or more explicit than another, yet as a fundamental premise no treatment can be carried unless the therapist is in possession of conceptual models of courses of therapy which suggest ways of proceeding and criteria for evaluation.

A psychoanalytic treatment can be characterized in a great number of ways. Freud compared

the analytic process with a chess game and made analogies between the activities of the archeologist, the painter and the sculptor and those of the analyst. Freud's work, however, provides no definite conception of process beyond specifying a beginning, middle, and final phase (GLOVER, 1937). To this day the number of coherent models of the psychoanalytic process remains small (THOMÄ & KÄCHELE, 1996). In the Ulm Process Model (KÄCHELE, 1988; THOMÄ & KÄCHELE, 1985), psychoanalytic therapy is conceptualized as a continuing, temporally unlimited focal therapy with a changing, interactively developed focus. The sequence of foci is regarded as a result of an unconscious exchange between the needs of the patient and the resources of the analyst. The patient may make various "offers" within a certain period of time, but it is only the selecting activity of the analyst that can result in the forming of a focus. The mutual work of patient and analyst on one focus leads to further areas of concentration that would not have been possible without the preceding work. When the first focus has been worked through, access is gained to a second one; thorough exploration of the second focus may in turn make it possible to revisit the first focus in a qualitatively new way.

The thematic "offers" made by the patient may be understood in terms of what French calls "focal conflicts," which represent unconscious infantile conflict constellations (thematized by French as "nuclear conflicts"): in other words, they are the solutions generated under the pressure of the problem at hand. French, however, is left with an unresolved problem: "Still, searching for the patient's focal conflict is an intuitive art which cannot be completely reduced to rules." (FRENCH, 1958, p. 101)

The Core Conflictual Relationship Theme method developed by Lester Luborsky (LUBORSKY, 1977; LUBORSKY, ALBANI, & ECKERT, 1992; LUBORSKY & CRITS-CHRISTOPH, 1998) offers a way of making such focal and core conflicts operational. The aim of the present study is to investigate how effective the Core Conflictual Relationship Theme (CCRT) method is in depicting the therapeutic course of a psychoanalytic treatment according to the Ulm Process Model.

Current Status of Research and Aim of the Study

Although a considerable number and great variety of studies have been conducted with the CCRT method (for an overview, see LUBORSKY ET AL., 1999), to date there have been very few that follow courses of therapy with the CCRT method. The studies known to us are of short-term therapies (ALBANI, POKORNY, DAHLBENDER, & KÄCHELE, 1994; ANSTADT, MERTEN, ULLRICH, & KRAUSE, 1996; GRABHORN, OVERBECK, KERNHOF, JORDAN, & MUELLER, 1994; LUBORSKY, CRITS-CRISTOPH, FRIEDMAN, MARK, & SCHAFFLER, 1991). To our knowledge there have as yet been no investigations of long-term psychoanalytic therapies using the CCRT method. The aim of our exploratory study was to describe the course of the 517-hour psychoanalysis of the patient Amalia by the CCRT method. A guiding intention behind the study was to determine if and in what form the Ulm Process Model can be seen in a psychoanalytic treatment.

Clinical Description of the Patient Amalia

35 years old at the onset of therapy, Amalia was a teacher living on her own who came to treatment for increasing depressive complaints. She suffered from religious scruples with occasional obsessive/compulsive thoughts and impulses, although she had turned away from the church after a phase of strict religiosity. Respiratory complaints arose for periods of time.

In the order of siblings Amalia came between two brothers, to whom she felt and still feels inferior. Her father was absent for her entire childhood n initially due to the war, later for occupational reasons. Amalia took on the role of father and tried to be a replacement to her mother for her missing partner. At the age of three years Amalia contracted tuberculosis and was bedridden for six months. Then, because of her mother's dangerous case of tuberculosis, at the age of five Amalia was sent away (the first of the siblings to go) and lived with her aunt, where she remained for about ten years. She was dominated by the religious strictness and puritanical upbringing to which she was subjected by her aunt and grandmother. Since puberty, Amalia has suffered from an idiopathic hirsutism. The patient's entire development and social position were affected by the stigma of this virile syndrome, which could not be corrected and with which she tried in vain to come to terms. Among its effects were a disturbed sense of self-worth, deficient female identification and social insecurity, which made personal relationships difficult and rendered it impossible for Amalia to enter into any close sexual relationships. The hirsutism likely had a two-fold significance for Amalia: On the one hand it complicated her already problematic female identification. In Amalia's biography, femininity does not have a positive value. It is associated with illness (her mother's) and disadvantagement (in relation to her brothers). On the other hand, the hirsutism secondarily takes on a symptomatic quality as a manner of self-presentation: It becomes the patient's excuse for avoiding sexual relations.

In both clinical evaluation and psychological testing, the 517-hour-total psychoanalytic treatment has been judged a success; this is clear from all that has been written about it now (THOMÄ & KÄCHELE, 1997, p. 104 and KÄCHELE, 2000; KÄCHELE, SCHINKEL, SCHMIEDER, LEUTZINGER-BOHLEBER, & THOMÄ, 1999).

Empirical Studies on Changes in Amalia during the Course of Therapy

Detailed analyses of aspects of the course of therapy have been presented in a great number of studies. For example, NEUDERT ET AL. (1987a) used a category system of content analysis to study self-esteem in three areas: sexuality and female identity; achievement and success; aggressiveness and self-assertion. On the basis of a sample of 115 hours of analysis, an increase in positive feelings of self-worth and a decrease of negative feelings of self-worth were found in the course of the treatment.

In addition, our team examined the changes in the patient's suffering over the course of treat-

ment and determined a decrease in impaired functioning due to suffering as well as a decrease in helplessness towards the suffering (NEUDERT, HOHAGE, & GRÜNZIG, 1987b).
Comparison of the first and last eight hours on the variables of "emotional insight" (HOHAGE & KÜBLER, 1987) resulted in significantly higher values on the scales for "emotional accessibility" and "experiencing" at the end of the therapy.
A systematic observation of cognitive-affective aspects of the patient's dream life was analyzed by LEUZINGER-BOHLEBER (1989) on the comparison of the beginning and end of therapy, and by KÄCHELE ET AL. (1999) on the course of the therapy. A number of other studies on this psychoanalytical treatment can be accessed through the homepage of the Ulm research team (http://sip.medizin.uni-ulm.de/abteilung/buecher/Band_III/Cont.html). As part of the information available there, the systematic clinical description provides the transference configurations to which we refer in the course of the present study. These were determined by qualitative clinical means (KÄCHELE, SCHINKEL ET AL., 1999).

Table 1
Clinical Transference Configurations

Clinical Transference Configurations	Therapy phase	Session numbers
Analysis as confession	I	1-5
Analysis as a test	II	26-30
The bad mother	III	50-54
The offer of submission and secret defiance	VI	76-80
The search for norms of one's own	V	100-104
The disappointing father and helplessness of the daughter	VI	116-120
The distant, cold father and the incipient longing for identification	VII	151-155
Ambivalence in the father-relationship	VIII	176-180
The father as seducer or moral judge	IX	202-206
He loves me – he loves me not	X	226-230
Even father cannot make a son out of a girl	XI	251-255
The apron-strings feeling	XII	276-280
The poor maiden and the rich king	XIII	300-304
Fear of rejection	XIV	326-330
Helpless love for powerful father and jealousy of his wife	XV	351-355
Active separation and resisting abandonment	XVI	376-380
Discovery of her own critical powers, recognition of the analyst's deficiencies, new attempt at leave-taking	XVII	401-404, 406
The daughter held on the left hand – rivalry with the firstborn for the mother	XVIII	426-430

Clinical Transference Configurations	Therapy phase	Session numbers
Hatred for the bountifully giving analyst and growing out of this expectation	XIX	445-449
The art of love is to endure love and hate	XX	476-480
Mastering leave-taking: having worked through the oral-aggressive fantasy about the analyst	XXI	501-505
Farewell symphony: the return of many fears and discovery of many changes	XXII	513-17

It is not difficult to "invent" such descriptions, even as a non-specialist reading the transcribed sessions. Yet it is in fact a painstaking process: The texts are first read and reread with the utmost care by two medical students, who then prepare an extract which is in turn checked against the text for accuracy by two psychoanalysts. As a form of qualitative research, the resulting product is now finally gaining greater respect (FROMMER & RENNIE, 2001). From the beginning, the Core Conflictual Relationship method has occupied a middle position between qualitative evaluation and exact quantification. Let us now look at the first application of this method to a psychoanalytic therapy.

Method

CCRT Method

The CCRT method makes it possible to show internalized relationship patterns. It is based on an analysis of narrative episodes of the patient's relationship experiences. As these "relationship episodes" are the foundation of the method, the first step is to identify them. Three types of components are then determined: wishes, needs and intentions (W-component); reactions of the object (RO-component); and reactions of the subject (RS-component). Positive and negative reactions are categorized. Initially, formulation of the categories is kept as close to the text as possible ("tailor-made formulation"). Since the current American standard categories and clusters of the method have more than once been criticized (e.g. ALBANI ET AL., 1999), a reformulation of the category structures of the CCRT method was undertaken (for details see ALBANI ET AL., 2002). Unlike in the old system, a directional dimension was introduced into the wish component showing whether the activity comes from the object or the subject (WO – "What I wish the object to do for me" and WS – "What I wish to do for the object (or myself)"). This addition has proven relevant in initial studies.

In contrast to the old categories, the structure of the reformulated system has a consistent logic

to it (POKORNY, ALBANI, BLASER, GEYER, & KÄCHELE, submitted): All three dimensions are coded on the basis of the same predicate list, which is hierarchically structured. Reactions of the subject and object are analogous, and there is a complete analogy between wishes and reactions both of the object and of the subject (e.g. cluster A "Being attentive to someone": WO "The other should be attentive to me"; WS "I want to be attentive to the other"; RO "The other is attentive"; RS "I am attentive to the other"). In the resulting reformulation there is a predicate list of a total of 119 subcategories grouped into 30 categories, which in turn are grouped into 13 clusters. In the present study, the evaluation was done on the subcategory level, while the results were presented on the cluster level (for names of the clusters, cf. Table 2).
The Core Conflictual Relationship Theme (CCRT) is composed of the most frequent wish, the most frequent reaction of the object and the most frequent reaction of the subject.

Sample

The data were provided by the session transcripts of this completely taped psychoanalytic treatment, which are accessible in the Ulmer Textbank. A systematic time sampling was made of the transcripts by selecting blocks of 25 consecutive sessions with a 25-session interval between each block. In the present study we evaluated only the first and last time-blocks, here designated as therapy phases and numbered with Roman numerals. These were sessions 1-30 and 510-517. In addition, beginning with the 50th session blocks composed generally of five sessions were analyzed at 50-session intervals[1]. When a block was not found to contain at least ten relationship episodes, further sessions were added until a minimum of ten relationship episodes was reached. Our sample includes 11 of the 22 available blocks but has 92 sessions in it.
Evaluation of the sessions was carried out in random order by an experienced CCRT evaluator on the subcategory level. Subcategories were not assigned to the clusters until statistical evaluation was undertaken.

Statistical Analyses

Because of our rich database, it was possible to analyze not only the absolute frequencies but the complex structure of the data as well. On a two-dimensional contingency table, the variable "therapy phase" is set over against one of the CCRT variables (wish, reaction of the object and reaction of the subject). As the null hypothesis, the observed frequencies of the individu-

1 The sample description of the transcribed text of Amalia X (KÄCHELE, SCHINKEL ET AL., 1999) is based on 22 transcribed blocks of five sessions each, selected at 25-session intervals. The sessions analyzed here by the CCRT method were selected from half of the available sessions. For the sake of clarity and maintaining the connection to the other Ulm studies, we chose the numbering of 1-22 here as well. Thus the therapy phases examined here are the odd-numbered ones.

al dimensions are noted (e.g., wish clusters and therapy phases), and it is assumed that the two dimensions are independent, i.e. that the frequency distributions of the CCRT components are the same in all therapy phases. The alternative hypothesis, then, is that some categories occur more frequently in certain therapy phases than might be expected from the observed frequencies of the individual dimensions. This hypothesis of the homogeneity of the therapy phases is first globally tested by the generalized Fisher Test (Monte-Carlo method). In the following exploratory stage, using a one-tailed, classical Fisher test the CCRT categories are determined which occur more frequently than expected in a particular therapy phase. Thus both the absolute highest-frequency categories as well as the more-frequent-than-expected categories are presented. (For details of this process, see ALBANI ET AL., 1994; POKORNY ET AL., submitted).

Results

Reliability of the CCRT Evaluation

The CCRT evaluation was carried out by an experienced evaluator. In order to check for reliability and to avoid rater drift, during the evaluation process one session out of the 11 evaluated blocks was selected at random to be evaluated by a second evaluator. In this we followed the approach of LUBORSKY & DIGUER (1990). In the first step, agreement in the marking of the relationship episodes was checked, the criterion being an agreement within seven lines at the beginning and seven lines at the end of an episode. The percentage of agreement was 72% for the beginning of an episode and 69% for the end of an episode. In the relationship episodes whose marking was in agreement, agreement regarding the object of the episode reached 99%.

In the second step the relationship episodes were known, and agreement in the marking of the components was checked based on the criterion of seven words at the beginning and at the end of a component. The agreement at the beginning and the end of the component came to 76% for wishes, 96% and 95% for reactions of the object, and 94% and 96% for reactions of the subject. In the third step, the components were already given and the agreement regarding assignment to the standard categories and evaluation of the valence of the reactions was checked. Agreement regarding the valence of the reactions was a kappa coefficient of .78. For assignment to the standard categories (on the cluster level), the mean kappa coefficient was .68 (W .58, RO .60, RS .70).

Results of the CCRT Evaluation

In the 92 hours, altogether 579 relationship episodes were found, containing 806 wishes, 986 reactions of the object and 1103 reactions of the subject. The positivity index (number of positive reactions in relation to the sum of positive and negative reactions) came to 15.1% for reactions of the object and 23.9% for reactions of the subject.

Table 2 gives an overview of the frequency distribution of the categories on the cluster level.

Table 2
Frequency Distribution of CCRT Variables: Object-related Wishes (WO), Subject-related Wishes (WS), Reactions of the Object (RO) and Reactions of the Subject (RS) (Relative Frequencies in %, n = 579 Relationship Episodes)

Cluster		WO n=518	WS n=288	RO n=986	RS n=1103
A	Attending to	46.3	12.5	4.2	3.3
B	Supporting	26.6	4.9	5.1	2.4
C	Loving / Feeling well	14.3	19.8	4.4	6.0
D	Being self-determined	10.0	27.1	6.9	7.2
E	Being depressed	0	0	.3	6.4
F	Being dissatisfied / scared	0	0	1.7	24.2
G	Being determined by others	0	.3	5.3	15.3
H	Being angry / unlikable	0	0	4.7	15.5
I	Being unreliable	0	.3	19.3	.1
J	Rejecting	0	8.7	19.2	6.1
K	Subjugating	.2	6.2	13.6	1.4
L	Annoying / Attacking	0	2.8	7.3	1.4
M	Withdrawing	2.5	17.4	8.2	10.7

The Core Relationship Conflictual Theme (CCRT, most frequent categories of all) for the entire therapy is as follows:

WO: Others should be attentive to me (WO Cl A),
WS: I want to be self-determined (WS Cl D),
RO: Others are unreliable (RO Cl I),
RS: I am dissatified, scared (RS Cl F).

Table 3 presents the typical categories for each phase of therapy.

Table 3
Core Conflictual Relationship Theme (CCRT) in the Course of Therapy
(Absolute/Relative Frequencies in % in Relation to the Given Phase of Therapy)

Absolute highest-frequency categories	More-frequent-than-expected categories*
Therapy phase I, sessions 1-30, n = 30	
WO Cl A "Others should be attentive" (112/ 55)	**WO Cl A** "Others should be attentive" (112/ 55)
WS Cl D "I want to be self-determined" (42/37)	**WS Cl D** "I want to be self-determined" (42/ 37)
RO Cl J "Others reject me" (82/ 24)	**RO Cl J** "Others reject me" (82/ 24)
	RO Cl G "Others are weak" (24/ 7)
RS Cl F "I am dissatisfied, scared" (116/ 27)	**RS Cl F** "I am dissatisfied, scared"(116/ 27)
	RS Cl G "I am determined by others" (77/ 18)
	Negative RS 335/ 82
Therapy phase III, sessions 50-55, n = 5	
WO Cl A "Others should be attentive" (9/ 41)	
WS Cl M "I feel like withdrawing" (4/ 21)	
RO Cl J "Others reject me" (10/ 20)	**RO Cl F** "Others are dissatisfied, scared" (4/ 8)
RS Cl F "I am dissatisfied, scared" (11/ 26)	**RS Cl C** "I feel good" (7/ 16)
Therapy phase V, sessions 100-104, n = 5	
WO Cl B "Others should support me" (12/ 44)	**WO Cl B** "Others should support me" (12/ 44)
WS Cl C "I would like to love and feel good" (5/ 36)	**RO Cl M** "Others withdraw" (9/ 18)
RO Cl I "Others are unreliable" (12/ 23)	
RS Cl F "I am dissatisfied, scared" (25/ 42)	**RS Cl F** "I am dissatisfied, scared" (25/ 42)
Therapy phase VII, sessions 151-157, n = 7	
WO Cl A "Others should be attentive" (7/ 78)	
WS Cl J "I want to reject others" (3/ 43)	**WS Cl J** "I want to reject others" (3/ 43)
RO Cl I "Others are unreliable" (6/ 27)	
RS Cl F "I am dissatisfied, scared"(6/ 37)	
	Negative RO 22/ 100
Therapy phase IX, sessions 202-206, n = 5	
WO Cl A "Others should be attentive" (8/ 33)	**WO Cl D** "Others should be self-determined" (6/ 25)
WS Cl M "I feel like withdrawing" (4/ 31)	
RO Cl I "Others are unreliable" (11/ 26)	
RS Cl F "I am dissatisfied, scared" (11/ 22)	**RO Cl D** "Others are self-determined" (7/ 16)
Therapy phase XI, sessions 251-255, n = 5	
WO Cl A "Others should be attentive" (7/ 33)	
WS Cl A "I want to be attentive to others" (4/ 67)	**WS Cl A** "I want to be attentive to others"(4/ 67)
RO Cl I "Others are unreliable" (7/ 27)	
RS Cl F "I am dissatisfied, scared"(10/ 32)	

* Fisher Test, two-tailed, $p \leq .05$, W: n = 806, RO: n = 986, RS: n = 1103

Absolute highest-frequency categories	More-frequent-than-expected categories*
Therapy phase XIII, sessions 300-304, n = 5	
WO Cl A "Others should be attentive" (6/ 40)	
WS Cl M "I feel like withdrawing" (3/ 43)	
RO Cl J "Others reject me" (6/ 23)	
RS Cl F "I am dissatisfied, scared"(9/ 36)	
Therapy phase XV, sessions 351-355, n = 5	
WO Cl A "Others should be attentive" (19/ 54)	
WS Cl M "I feel like withdrawing" (5/ 36)	**WS Cl K** "I want to subjugate others" (3/ 21)
RO Cl I "Others are unreliable" (14/ 25)	
RS Cl H "I am angry, disagreeable" (17/ 28)	**RS Cl H** "I am angry, disagreeable" (17/ 28)
Therapy phase XVII, sessions 401-404, 406, n = 5	
WO Cl C "Others should love me" (7 30)	**WO Cl C** "Others should love me" (7/ 30)
WS Cl J "I want to reject others" (2/ 50)	
RO Cl J "Others reject me" (12/ 27)	
RS Cl G "I am determined by others"(9/ 25)	
Therapy phase XIX, sessions 445-449, n = 5	
WO Cl B "Others should support me" (17/ 33)	**WO Cl C** "Others should love me" (13/ 25)
WS Cl C "I would like to love and feel good" (11/ 37)	**WS Cl C** "I would like to love and feel good" (11/ 37)
RO Cl I "Others are unreliable" (25/ 23)	**RO Cl M** "Others withdraw" (18/ 17)
RS Cl F "I am dissatisfied, scared" (28/ 23)	**RS Cl M** "I withdraw" (25/ 20)
	Negative RS 42/ 91
Therapy phase XXI & XXII, sessions 501-517, n = 17	
WO Cl A "Others should be attentive" (40/ 45)	
WS Cl D "I want to be self-determined" (20/ 33)	**WS Cl L** "I want to annoy, attack others" (5/ 8)
RO Cl I "Others are unreliable" (46/ 21)	**RS Cl H** "I am angry, disagreeable" (45/ 19)
RS Cl H "I am angry, disagreeable" (45/ 19)	**RS Cl D** "I am self-determined" (37/ 16)
	RS Cl J "I reject others" (23/ 10)
	Positive RS 87/ 37

* Fisher Test, two-tailed, $p \leq .05$, W: n = 806, RO: n = 986, RS: n = 1103

As necessary background for the discussion to follow, it will be helpful to provide a detailed, systematic clinical description of the therapy and its thematic sections. The demand for such a presentation, far exceeding all customary requirements for case histories, was made by Kächele (1981) and could now be fulfilled by making the presentation available in all desired detail on the Internet (Ulmer Lehrbuch vol. 3, chap. 3.4.: http://sip.medizin.uni-ulm.de/abteilung/

buecher/Band_III/Cont.html). By taking up French's distinction between "nuclear conflicts" and "focal conflicts," we were able to determine that across all phases of the treatment one basic theme becomes clear in each of the most frequent categories of the CCRT procedure: Amalia's wish for attention (WO C1 A) and support (WO C1 B) from others; her experience of the others as rejecting (RO C1 J) and unreliable (RO C1 I); and her dissatisfaction and anxiety (RS C1 F). In each of the phases of therapy, the subject-related wishes are distinct.

The more-frequent-than-expected categories are characterized by the themes that distinguish the particular therapy phase from the other phases.

Initial therapy phase I (sessions 1-30) is characterized chiefly by Amalia's wish for kindly attention from others (WO C1 A). She speaks of her colleagues, by whom she feels "used" as a "dustbin" (RO C1 J) but with whom she cannot speak about her problems. Amalia envies her female colleagues for their relationships. She feels insecure in relation to her students (RS C1 G), thinking they regard her as an old maid (RO C1 J), and there are conflicts in which she does not feel properly supported by her director (RO C1 G). She describes her father as a sensitive, fearful and inaccessible person (RO C1 J, RO C1 G) and is disappointed at their distant and irritable relations (WO C1 A). A relationship episode with her father follows:

"P: … for example, when I come home, by car now, he won't even come out. I know from my colleagues that they have fathers much older, and they pick them up and carry their bags in and so on, and he doesn't even come. So when I get home, and maybe my mother opens the door, then I might go to the bathroom or something, or I'm taking off my coat and standing in the entryway, he doesn't come, he doesn't move. Or I go into the living room, and he'll be sitting in the other room, you see he somehow can't take a step towards a person …"[2]

In relation to her brothers she feels inferior and not taken seriously, either by them or by the family as a whole. She makes a theme of her dependence on the norms of the church, the opinions of others and on her mother, though her mother is the one she talks to. On the other hand, Amalia has the feeling she needs to be available for her mother and has feelings of guilt when she distances herself from her.

"P: … sometimes I really need my Sunday to just, well, and then there'll be something I have to do again, and then you see, my parents, they come around often, you know, my mother will call up and then she'll say, then, she'll just say: 'Come' and I've simply never managed yet to say, 'Please don't. I don't want you to.' or 'It won't work out' or …"

Her wish for change is expressed in her wish for autonomy (WS C1 D), which results from her experience of herself as dependent and weak, unable to set limits and dissatisfied. For this phase of the therapy, the high proportion of negative reactions on the part of the patient herself is particularly characteristic.

2 Transcript of the Ulmer Textbank.

In the ninth session, Amalia reports the first relationship episode with the analyst (out of a total of only four episodes in the initial phase):

"P: … (pause). You know, anyway today I was awfully, I am so dreadfully tired, I 've said that before and then today I really didn't have time to catch my breath from yesterday. The whole evening I was – well, I had a girl student visiting, who wanted something and so I didn't get to give it any thought, but just the same I started realizing some things yesterday and in that … Sure in a certain sense it was finished too, and what I'm left with as a question is always the same thing. Fine, I see it now, but what I am supposed to do and how is it supposed to go on and, and and what, I really didn't mean to say that, right.

T: With the students and the grading problem, you mean, if that is supposed to go on?

P: No, I mean here, how is this supposed to go on, when I lie here and tell you something and I try to understand it and you summarize it, then of course some things become clear, and nevertheless then I tell myself, what am I supposed to do with that, that's what was going through my head, and that's what I didn't want to say, because somehow it, because, I keep asking myself, if you recognize it, to what extent can you guide your actions by it.

T: how it will go on

P: and how it will go on, right, that was really the question. Somehow at the moment I experienced that as an insult to you, and therefore I couldn't say it."

This episode illustrates the description of the clinical transference configuration of these therapy phases: the analyst as father confessor and examiner, in front of whom Amalia is careful, reserved and uncertain but also beginning to come to terms with "authority." What is striking is that Amalia reports a great many relationship episodes in the initial sessions (on average 11 episodes per session), which makes sense from the clinical perspective: In the initial phase, the therapeutic relationship is being established and biographical material occupies a greater space.

In therapy phase III (sessions 50-55), Amalia describes episodes chiefly reflecting her wish to withdraw (WS C1 M), which she in fact succeeds in doing in relation to her mother and younger brother. The following episode with her mother gives a picture of the clinical description of this phase of the therapy as "the bad mother," but also shows that Amalia is exploring alternative types of behavior:

"P: No, otherwise on the weekend I actually have uh; well yes of course my mother called up again and wants, and would very much like me, uh, to come next weekend, or rather she would like to come, but I told her I wasn't sure yet what my plans were, and asked her to please wait, I mean, two or three weeks ago I would really have just, said, or let's say four weeks ago, uh please come and I have often said, yes please come, even when it wouldn't be convenient at all for me, and I just see that it, that it, uh would be perfectly ok alone,

that I, um, I really don't need to get so, so worked up all the time because now, now I'm sitting here all alone and so forth, and of course it would be nice, not to be sitting all alone that way all the time well it's not always but a great deal of the time for sure but, um, I could make a lot more of it, not that I didn't used to read before or didn't do this or that too, but I just feel better about it, um, I can honestly say."

Amalia is feeling better and experiencing moments of self-confirmation (she is driving alone again to take walks, painting again; RS C1 C), although there are confrontations with the parents of her students.

Her relationship to the analyst is also becoming a more frequent topic (in 17% of the episodes). She demands answers instead of silence from the professional authority (RO C1 J) and would like to give her own interpretations as well.

Therapie Phase V (sessions 100-104) is marked especially by Amalia's wish for support (WO C1 B). She feels that her director is judging her and discriminating against her because of her therapy (RO C1 J). She also is expressing her wish that the analyst give her clear answers and be open and honest with her. She experiences the analyst as the "most important person" (38% of all episodes deal with the analyst), but feels rejected by him. She is unsure who he is and what he thinks of her and complains of his changing the subject and of his keeping the rules secret (RO C1 M).

"P: You know, just this business with my boss, really went to show how difficult it is, uh, what with the self-assessment that you make of yourself, and the assessment others make of you, which you can always somehow sense or see, to hold the balance there, when the two of them clash. And that's where I feel you are someone I can assume, um, – right, I just feel – it's simply something like trust, and and nevertheless, after all that's why I went running to the C well, I didn't actually run to the bookstore, but I, I wanted to read it, because you see I keep wanting to know who you are, and uh, you, you can't help asking yourself the whole time, 'So who is this person that you are putting your trust in, and, and what kind of picture is he forming of you' – and, I mean, all those things that we've already spoken about,

T: um-hmm.

P: came back to me really powerfully – because – naturally I want to know: what kind of man is this, who has a profession like that, and a wife who also has a similar profession, uh, all that, that is somehow important. And then when you, if I can put it that way, to me it seems you change the subject, then I can't help asking myself: 'Why, why is he changing the subject – is he embarrassed – well, why is he embarrassed by that?' – or is it that he wants me to be independent, ok, right. it, of course it has to do with that. But, I just think it's kind of going down different tracks. I mean, if I trust a person, of course I am dependent in a way – thank God, I would say C and, and yet again at the same time I have to,

T: um-hmm.
P: I just need– at least here –to feel I have the right to sound you out, who you are and who I am – or rather I didn't put that quite right – who you are – it strikes me as very important, that, uh, why does he listen to me, right, it's another one of those questions. Why does he do that? What is interest in a person?
T: um-hmm.
P: What's behind it?"

According to the assessment by the CCRT method, the patient's "search for norms of her own," which was identified as a theme in the clinical description, appears to take place in two ways: on the one hand in coming to terms with her disappointed wishes for support, but also in her confrontation and identification with the analyst.
Amalia's wish to reject others herself (WS C1 J) becomes important only in **therapy phase VII** (sessions 151-157). Amalia is dissatisfied (RS C1 F) and is considering entering a convent. Alongside of her relationship to her father (who is the object of interaction in four of fourteen episodes of this phase), the focus of these sessions is the therapeutic relationship (the therapist is the object in six of the fourteen episodes of this phase). On the one hand she is afraid she is asking too much of the analyst; on the other hand she criticizes his interpretations and finds, for example, that does not laugh enough. During a visit by her parents she is disappointed that her younger brother is favored (WO C1 A), bringing back memories of her lifelong envy of her brother. In no other phase does Amalia portray the reactions of others so negatively as in this phase.

The wish that others should be self-directing (WO C1 D), characteristic of **therapy phase IX** (sessions 202-206), is aimed largely at her director, who lets himself be manipulated (RO C1 I) by a female colleague with whom Amalia is in rivalry and to whom she feels inferior (RO C1 D). From her analyst, Amalia wishes a direct answer to her concern that she might have caused herself damage in masturbation. She receives it (with some delay), in which process the therapist (by father transference) becomes a seducer and moral judge, as the clinical description emphasizes.

In therapy phase XI (sessions 251- 255), Amalia succeeds for the first time in initiating a date with a male colleague (WS C1 A). She wishes she were able to speak openly about sexuality with her mother (WO C1 A), recalling her cautious attempts to question her mother, and wonders about her mother's sex life. Amalia wants to understand what happens in analysis – she attends lectures by psychotherapists and reads publications by her analyst, but finds no answers, is unable to understand many things and feels inferior to the analyst (RS C1 F). The clinical description of therapy phase XI, "Even father cannot make a son out of a girl," strongly reflects the therapeutic conception of the analyst, who focused on the patient's penis envy. The

evaluation by the CCRT method, on the other hand, reveals above all Amalia's (new) openness ("I want to be attentive to others") in this therapy phase – both in the way she forms her relationships and in the way she confronts her own sexuality and femininity as she takes steps towards her mother.

During a three-week break in **therapy phase XIII** (sessions 300-304), Amalia decides to place a personal ad in a newspaper and receives several answers to which she in turn responds. She is afraid of how the analyst will react to this (WO C1 A), fearing his reproaches (RO C1 J):

"P: … In the weeks that you were away or unavailable, eh, I suddenly had the feeling I could "swim on my own" now. And then came my resolution that I will definitely not go on vacation with my parents this summer, that I'd do something on my own. I had answered this personal ad and made the decision to place one myself. And that was actually what I didn't want to tell you, because I was afraid you would interrogate me up and down and then you'd get angry and say, and then I was awfully afraid of what would come next and of course I've transferred that fear, but still it is sitting down there like an elemental force, that you will make an awful angry face and though you won't in fact forbid it, you'll say, 'So all has been for naught, you've understood nothing, and this treatment here just gets in the way of your doing what you want,' that was it I think."

The fact that her younger brother recognized her ad in the paper strengthens her wish to protect herself from her brothers' and parents' interference and judgments (WS C1 M), also intensifying her dissatisfaction and feelings of inferiority, as comes out clearly in the image of the "poor maiden" given in the clinical description.

In **therapy phase XV** (sessions 351-355), Amalia is disturbed (RS C1 H) by outward alterations (her analyst's department has moved, there is a new therapy room, noise from building site). She feels unprotected by the analyst (WO C1 A) and jealous of his own children (RS C1 H):

"P: … that you only moved up here to make it easier for you to take your children to school.
T: What do you mean easier?
P: Because I keep imagining your children will be going to school now in the, on Hochsträß and uh, and at first that made me, I mean, really furious."

She feels put under pressure both by her analyst and her father and thinks that there are expectations she has to fulfill. In her school, Amalia has confrontations with the janitor and her director (WS C1 K), in which she is able to adopt a more active posture and defend herself (RS C1 H). Her (unfulfilled) longing for her analyst's attention and her rage in its disappointment are also expressed in the clinical description: "helpless love for the powerful father and envy of his wife."

In **therapy phase XVII** (sessions 401-404), the analyst receives a bouquet of flowers which holds manifold symbolism. The bouquet was actually intended for a correspondent who had answered Amalia's next ad. At the same time it is an apology for the negative judgment of the analyst by Amalia's nephew, who knows the analyst from lectures and with whose criticisms of the analyst Amalia in part identifies (as also becomes clear in the clinical description). Amalia also identifies with her flowers, fearing that the analyst will not take good care of them (WO C1 C).

"P: I always really find it wonderful when someone knows how to take care of flowers. Most people take them and ram them in like a post in the earth, and let them sit in the vase till they hang their heads. No, you know, these ones especially began to droop last time, and I thought uh-oh,
T: I didn't understand, you were saying?
P: They were beginning to droop last time.
T: They,
P: They, the flowers began to droop.
T: the flowers right.
P: Right and so I thought, oh he's doing something wrong, that shouldn't be happening. And so naturally I was very glad today that you, that you did understand after all, how to give them the right amount of water and food."

Through her correspondence with various men, Amalia explores her relationship to men and recalls her brothers' air of superiority and the lack of validation she experienced through her father (RO C1 J):

"P: It was never a climate of affirmation, it was always, how it all comes back to me, oh God. It was always, if I wanted to be a girl, I was stopped, and if I wanted, I remember once, I put on ski pants and my father said then 'I don't happen to have three sons, I should like to request, not at the table, go get changed.' So I wanted to be a boy or to pretend it wasn't so important. It was always such an exclusive thing, the boys, I always had the feeling that my brothers, in spite of the connection I have to my younger brother, they did a better job of affirming each other and, and stayed together. Somehow behind my back they stuck together. After all they were the men and they were ok, and they were in the majority. Predestined from eternity to eternity. I don't know, it was just that way. A troublemaker and a liar, that's what I was, right and, ok yes. I have the feeling they were always watching to see what would come of it. They wanted to know just exactly what was different and what was going to come of it. And at the same time they always knew it in advance, what came of it. They just always knew everything better."

Therapy phase XIX (sessions 445-449) reflects Amalia's ambivalent experiences in her first relationship with a man. She wishes for a close, intense and also sexually satisfying relationship (WO C1 C, WS C1 C), but she is not sure of the affection of her partner (who still is attached to is ex-wife and also has other relationships) and is disappointed by his distance (RO C1 M, RO C1 I, RS C1 M).

"P: …and then he said, 'Listen, when it comes down to it, you know, our relationship doesn't justify such a thing, you basically have no right, uh, hmm, to keep me away from other relationships. It would be a different thing if we wanted to start a family and have children, then it is bad to go around with other women,' that's more or less what he said, and in retrospect it really shocked me terribly. And then when he called up on Monday, I had thought I wouldn't call again till Thursday, if he wants anything, let him do it, and then when he called on Monday, just as I had imagined,
T: first he wanted to put an end to it on Monday,
P: Monday was absolute rock bottom.
T: hmm
P: I thought, I really have to put an end to this. And on the telephone I was absolutely icy and didn't say an extra word but then of course he called again about the pills. So then we talked. And that's when he probably got the impression that I was, about putting an end to it, he probably sensed something, I don't know. I don't know. I never actually said 'I'm through.' And I never said 'Don't touch me again' or anything like that. Yes, indeed, we sure, oh we had such, talked so much on the telephone."

Insecurity, doubts about her physical attractiveness and guilt that she fails to live up to her mother's ideas of morality are the main traits of Amalia's feeling life, as becomes clear in high proportion of negative reactions in this phase. Here again, the clinical description and the CCRT evaluation contrast: While the clinical description chiefly emphasizes Amalia's ambivalent relationship to her analyst ("Hate directed at the bountifully giving analyst, and an incipient turning away from this expectation"), the CCRT focuses on her new relationship experiences outside of the therapeutic relationship.

In the **concluding phase XXI and XXII** (sessions 501-517) of her therapy, Amalia is chiefly occupied with coming to terms with the experiences of her last relationship and of a new one that is in the offing, though emotionally she still feels very strongly attached to her previous partner (WO C1 A). Set off by an invitation from her archenemy to a class gathering, intense feelings of hate awaken in Amalia, but she is able to come to terms with them (WS C1 L). In the professional sphere, despite a particular challenge from two teacher trainees whom she experiences as very pushy, she is able to assert her will (WS C1 D) and is proud of that (RS C1 D, RS C1 J, RS C1 H). The conclusion of the analysis and parting from the analyst are chief themes in this phase.

"T: …I mean, is there an idea, one that you have, as to what my way, my idea of coming to an end is?
P: That one's easy for me. Mine is quite bold. I just thought you would adapt yourself to me.
T: Um-hmm.
P: And it was just in these last sessions that I got that feeling. It was really a feeling that, yes of course, he'll do what I want. Whereas before, there was this kind of tugging, I felt like I was being tugged on a leash and I had the feeling, he doesn't understand a thing, he has some kind of peculiar idea of his own of how to finish. He won't tell it to me of course, so I don't know it. And it was like a real tugging. And now, for about three or four sessions I think, I haven't been counting, my mind is the way I was just telling you. It'll simply work that way. I'll be sitting in my tortoise shell, and the harvest will come in. Like I told you.
T: Um-hmm.
P: I'll just get up and go, and I liked that so much that I thought, there's nothing he'll be able to do but go along. That fact that it isn't quite his idea of things, and if he finds something more thematically, that is his problem. Because there will always be something to find …"

What is striking is the great number of positive reactions by Amalia in the concluding phase. The clinical description speaks of a "farewell symphony: the return of many fears and the discovery of many changes"; and this is powerfully evident in the CCRT evaluation of the concluding phase, which illustrates Amalia's newly acquired freedom of action.

Discussion

Within the framework of our study, it has become possible for the first time to examine a long-term psychoanalytic therapy with the CCRT method during its course. Thus, compared to previous studies of single cases using the CCRT method, it offers the most comprehensive sample to date.

The relatively great number of reactions of the subject compared with other CCRT studies may be due to the fact that this was a psychoanalytic therapy and the patient was particularly encouraged to reflect on her feelings and thoughts. The results of the evaluation by the CCRT method underscore the clinical assessment of the success of the therapy and support the results of previous studies done on this material. Though the negative reactions of the objects and of the patient still predominate in the final phase of the therapy, a significant increase in positive reactions of the patient becomes apparent. The patient also described the reactions of the objects as more positive at the end of the therapy, but these changes could not be statistically established. The component "subject-related wishes and reactions of the subject" reveals that in the course of the therapy, the patient was able to expand her freedom of action and acquire new competencies, and that her depressive symptoms decreased. The increase determined by NEUDERT ET AL. (1987a) in positive feelings of self-worth and the decrease in nega-

tive feelings of self-worth in the course of the therapy match the content changes of the subject's reactions in the present study. Moreover, the distinct increase in positive reactions of the patient herself further supports this finding. Starting in therapy phase VII Amalia is in a position to perceive and express aggressive wishes, and starting in therapy phase XV these gain relevance in action. Particularly when this is contrasted with the dominant feelings of dissatisfaction and fearfulness at the inception of the therapy, the change in Amalia becomes apparent.
Alongside of a basic theme manifested in each of the absolute highest-frequency categories ("nuclear conflict"), each of the therapy phases also showed typical categories which characterize thematic foci in the sense of French's "focal conflicts" and which can be operationalized by the CCRT method. Thus the CCRT method makes it possible to structure material by content.
Being confined to narrative material, the CCRT method manifests a limitation when compared with the clinical description, particularly in the initial phases: While the clinical description of the first two phases focuses on the meaning of the treatment ("Analysis as Confession," "Analysis as a Test"), the CCRT method can access such aspects only through relationship episodes with the analyst. Such episodes in particular, however, are rarely reported by Amalia at the beginning of the therapy.
In contrast to the clinical description, which uses metaphorical language to highlight a theme according to the subjective assessment of the judges, investigation of the therapy phases by the CCRT method makes possible a more differentiated (and less subjective) analysis of the themes, as is seen in therapy phase III. In the clinical description, the "bad mother" takes center stage, while in the CCRT evaluation other aspects emerge: "I feel good" (regarding the patient's newly gained/regained freedom of action). While the clinical description is limited to the transference configuration, the CCRT method makes it possible to access interpersonal aspects inside and outside of the therapeutic relationship.
Both the strengths as well as the limits of the CCRT method stem from its confinement to reports on relationship experiences by the patient herself. In other words, the investigation remains limited to those relationship experiences that the patient has perceived and verbalized. The method provides no way of including unconscious material (apart from the repetitive schemas that patients – often unconsciously – follow in describing the course of relationships) or of assessing defense mechanisms. Hence the evaluation remains very close to the clinical material, though it does reflect intrapsychic processes in the narratives of interactions.
Parallels between the patient's descriptions of her relationship with the therapist and others objects can be examined by means of the CCRT method. Thus the method makes it possible to capture structural aspects of the clinical transference concept. Nevertheless, the interactive transference currently in progress will not enter into the evaluation.
Although the method is called the "Core *Conflictual* Relationship Theme," Luborsky leaves the concept of conflict unclarified. Conflicts in the analytic sense between wish and defense, between different systems or levels or between drives (LAPLANCHE & PONTALIS, 1972) are not

captured by the method. The wish component makes it possible to describe conflicts between two wishes that occur simultaneously and are mutually exclusive. It might be most accurate to say that the CCRT captures the theme of the most frequent wish without immediately revealing the associated conflict itself. Therefore the CCRT should rather be understood as an indicator for capturing the patient's conflict. On the other hand, interpersonal conflicts are registered with great clarity and differentiation in the form of wish-reaction schemas. The ongoing interaction, however, is not captured; nor are the communicative and interactive functions of the narrative (QUASTHOFF, 1980) investigated within the therapeutic interaction.

With the CCRT method itself it is not possible to clarify how therapeutic changes have come about. In their studies, Crits-Christoph et al. (CRITS-CHRISTOPH, BARBER, & KURCIAS, 1993; CRITS-CHRISTOPH, COOPER, & LUBORSKY, 1998) showed a connection between the "accuracy" of the therapist's interpretations of the CCRT and the success of therapy.

It is now an uncontested fact that the quality of the therapeutic relationship is of critical importance for the success of therapy. On the whole, the relationship of the patient to her therapist seems to have been satisfying and positive for her – no other relationship is described with such a high rate of positive reactions of towards the object of interaction.

The present study shows that the CCRT method makes it possible to capture clinically relevant interpersonal aspects of the psychoanalytic process, from the patient's point of view, which support the Ulm Process Model. The analyst's contribution, however, is reflected only in the patient's narratives regarding her relationship to the therapist. Use of the CCRT method provides for structuring of clinical material, development of clinical hypotheses and checking on therapeutic focus during the course of therapy. The method is easily learned for clinical application and the time required in formulating the psychodynamic connections for clinical use is minimal, so that the method can accompany treatment throughout.

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EXISTENTIAL ANALYSIS

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General Introduction to Logotherapy and Existential Analysis

ABSTRACT

This article gives a general introduction to existential analysis and logotherapy. First, it outlines the origin and the beginnings of logotherapy and existential analysis under Viktor Frankl in the 1930s and it depicts its historical and philosophical background. Frankl's three-dimensional concept of humanity is explained including the emphasis he laid on the third or noetic dimension. This dimension concerns itself with human spirituality and the search for meaning. In this dimension logotherapy is situated.

The article then goes on to describe the modern development under the auspices of the GLE in Vienna. This comprises foremost Alfried Längle's elaboration of the four existential fundamental motivations as an anthropological framework for understanding behaviour and experience and for explaining psychopathology. The search for meaning, which was emphasized so strongly by Frankl is accounted for at the fourth level. Secondly, the development of Personal Existential Analysis by Alfried Längle produced a comprehensive psychotherapeutic procedure that is applicable for both short and long-term psychotherapeutic procedures.

Finally, this paper specifies the application and psychotherapeutic range of Personal Existential Analysis and notes organisational support structures and training opportunities.

Key words: Existential Analysis, Logotherapy, psychotherapy, existential fundamental motivations

1.) Introduction

The meaning of the terms "logotherapy" and "existential analysis" is not self-evident. Originally, logotherapy was intended by its founder, Viktor Frankl to complement existing forms of psychotherapy and deal with the quest for meaning (FRANKL 1986, 11f. Existential analysis was understood as an analytical procedure which enabled the patient to discover the concrete meaning of his or her personal existence (FRANKL 1985, 156f).

The term "existential analysis" brings to mind existential philosophy. This is not coincidental, since existential analysis is grounded in existentialism (FRANKL 1986, 17). In contrast to other psychotherapeutic approaches, existential analysis in its early stages was mainly founded on philosophical thinking. More recent developments have relied more heavily on psychiatric medicine, empirical data and practical experience.
Today, logotherapy represents the part of existential analysis which deals with the analysis, prevention and therapy of meaning-related problems and in particular with the loss of meaning. From a methodological perspective, logotherapy is considered an approach to counselling which deals with meaning-related concerns. A short definition might describe logotherapy as assistance in the quest for meaning.

The concept of existential analysis has been greatly enlarged since its beginnings and today designates a psychotherapeutic approach that comprises a theory as well as a practical application. Its aim is to empower people to live their lives with inner consent (LÄNGLE 1993, 1995, 1999). It may be described in short as an analysis of the conditions required for a fulfilled existence, the latter being a life in which the individual experiences fulfilment and meaning.

Existential analysis can furthermore be described as a phenomenological-personal psychotherapy which seeks to enable the person to experience life freely at the spiritual and emotional levels, to arrive at authentic decisions and to come to a responsible way of dealing with oneself and one's world (LÄNGLE 1993). This orientation reflects Frankl's position that human existence is characterised by freedom, the capacity for decision and responsibility. Furthermore, each of these three steps contains the most important asset of existential analysis, i.e. that of a person's own inner consent.

But existential analysis today is not only applied as a psychotherapeutic approach. Because of its anthropological breadth and relevance, it is also brought to use in education, in pastoral counselling, in the prevention of psychological diseases and in coaching.

2.) A Short Review of the Origin and Historical Background

When Viktor Frankl elaborated logotherapy and existential analysis in the 1930s and 1940s, he was reacting to what he perceived as deficits in depth psychologies. Frankl protested against what he thought of as psychologism and reductionism; he wanted psychotherapy to take into account the human spiritual dimension in theory and in practice (FRANKL, 1967, 31ff, 79f). He defined psychologism and reductionism as the attribution of all human behaviour exclusively to psychological or other deterministic causes. Frankl intended to add logotherapy to the psychotherapy of his time and not to question the importance of psychodynamics for the psychological development and preservation of life. Instead, he sought to overcome the reduction of the individual to psychodynamics by the inclusion of specifically human qualities, i.e. a person's capacity for freedom, responsibility and the search for meaning. Logotherapy was to complement the existing psychotherapies by introducing this dimension into the treatment, not only of patients with mental disorders but of all medical patients and of suffering people in general. (FRANKL 1986, XVIII) Furthermore, Frankl turned against what he called pathologism, which, in his view, reduced perfectly sane human behaviour, in particular the preoccupation with the question of meaning, to mere avoidance of pathological disorders (FRANKL 1985, 79f).

FRANKL (1984, 104) saw himself as the advocate of humane aspects of psychotherapy, and he saw the quest for meaning as the most profound, specific and primary human motivation. He saw this search not so much as a psychological than as a spiritual concern. He considered Freud's and Adler's theories and anthropologies as flat. To their two dimensions of body and psyche Frankl sought to add a third dimension which contained the human spiritual or noetic capacities (FRANKL 1985, 77ff).

Frankl's accentuation of the quest for meaning is due, at least in part, to the historical situation of his time. World War I, the German and Austrian defeat, the replacement of the monarchy by a republic and the Great Depression had shaken many secure beliefs and convictions. Numerous people had suffered enormous material, ideological and existential losses and had to redefine their own identities. In philosophy this had led to a concentration on the question of meaning and to the development of existential philosophy.

Apart from the political and economic situation in post-World-War-II Europe, Frankl attributed the widespread sense of meaninglessness to the Darwinist and naturalist concepts of humanity and to the prevailing utilitarian ideas. These had arisen as a consequence of the rapid development of technology and industrialisation. In opposition to this view, Frankl saw the person foremost as a being that is characterised by the qualities of freedom, responsibility, and spirituality (FRANKL 1985, XXIV) According to this view a person always decides what he/she is and what he/she is going to be. Thus the individual human being begins at the point where naturalism leaves off. It is especially in extreme situations that the true human nature with its capac-

ity for decision-making becomes manifest and contradicts determinism. Frankl developed this concept in the 1930s and impressively proved it through his own behaviour and experiences in German concentration camps in the 1940s, where he was able to survive with the help of his strong will and by clinging to his determination to see his wife again. He describes this in detail in his book "Experiences in a Concentration Camp", first published in Austria in 1946 (FRANKL 1984, 15-100).

3.) Frankl's Anthropology

As mentioned above, Frankl's anthropology added a third dimension to the two dimensions used by Freud and Adler. According to him, the three dimensions of human life are a person's body, psyche and mind or spirit (FRANKL 1985, 134ff. See also the footnote on pp. 65f, where Frankl comments on the inadequacy of either "mental" or "spiritual" as translations for the German word "geistig", which refers to the third, the distinctly human dimension, but without any religious connotations.)

The first dimension accounts for human needs, i.e. the bodily functions. Disease, hunger, thirst, cold, heat, sexual deprivation and all kinds of physical privation can impair one's life and vitality deeply and make all other emotions or problems seem unimportant in comparison.

The second dimension is that of the psyche, which, according to the old concept, included everything not physical, thus also everything metaphysical. But Frankl limited the content of the psychological dimension to the forces that express themselves in drives and emotions. These are not subject to free will, but follow their own rules and regularities. All information from the physical and from the spiritual dimensions about the world and about their own states enter the psychic dimension, where it is screened and evaluated according to its significance for survival. The psychodynamics process this information close to the physical dimension in the form of affects, moods and emotions and thus serve as a guardian for existence.

Frankl added a third dimension, which he termed "spiritual" in the beginning and later referred to as "noëtic". Greek "nous" signifies "spirit" or "mind" (FRANKL 1985, 79). Today the "personal" dimension is the preferred term. This dimension concerns itself with the processes commonly attributed to the conscience by deciding between true and false, valuable and worthless, free and not free, just and unjust, and responsible and irresponsible. In all of these questions our sensibility and conscience are called forth, and we reveal ourselves as the persons we are. This dimension touches the innermost core of the person, of the individual. This inner person is what makes us truly human and distinguishes us from animals.

Frankl's three dimensions are not clearly separated from each other but interact, since the person forms a unity. Deficiencies in the existential dimension may have somatic effects, e.g. muscular tension in the case of conflicts of conscience. The different dimensions may also find themselves in contradiction with each other and force the person to make a decision. Thus, the same thing can simultaneously procure pleasure and be experienced as wrong or inappropriate. But even if these dimensions influence one another, they do not merge. The physical and psychological co-relate strongly, and are both determined, which means that they follow certain rules and evade conscious control. This is why they are open to scientific analysis. In existential analysis the relationship is described as psycho-physical parallelism. For example, there is no anxiety originating in the psychic dimension without any physiological or somatic symptoms as a consequence.
In contrast, the third or personal dimension is free as far as its nature is concerned. For this reason, Frankl postulates a hiatus, a fundamental distance between the psychophysical parallelism and the third dimension. According to Frankl, the noetic dimension resonates with the whole person, and one is most authentic where the three dimensions intersect. Every person must continue on the lifelong task to balance and harmonise his/her diverging aspirations. It is in this struggle that Frankl saw the dominant role of the third dimension because of its meaning for the individual's relation to the outer world. At the same time he argued that, due to the cultural deficits of modern times, the struggle to harmonise diverging aspirations and values also presents the source of much suffering to the average individual and may lead to feelings of meaninglessness, of disorientation and lack of fulfilment.

It is characteristic of existential analysis to take the person as a whole into account. The person is seen as being intimately connected with his/her values. The experience of fulfilment is not necessarily generated by good physical health and drive satisfaction. Instead, human beings strive for more, sense the need to transcend themselves and to devote themselves to something bigger than their individual lives. This may include service to people or to self-defined aims, because it is only in doing so that one finds existential fulfilment. Frankl said: "I thereby understand the primordial anthropological fact that being human is being always directed at and pointing to something or someone other than oneself: to a challenge to meet or another human being to encounter, a cause to serve or a person to love. Only to the extent that someone is living out this self-transcendence of human existence, is he truly human or is he become his true self. He becomes so, not by concerning himself with his self's actualisation, but by forgetting himself and giving himself, overlooking himself and focusing outward." (FRANKL 1978, 35)

As far as motivation is concerned, one experiences needs on the physical level, the search for pleasure on the psychological level and meaning and values on the existential level. These are the dynamics or forces that move human beings. Logotherapy works in the third dimension as

an assistance and aid in the quest for meaning. Modern existential analysis adds the ability to engage life fully and to devote oneself to something transcendent as decisive criteria for fulfilled existence and as prerequisites for the quest for meaning. But existential analysis focuses also on the emotions and physical experiences, since the fulfilment of existence can only be achieved by a complete and interactive unity of all dimensions. Pathology is hence defined as a condition in which a person feels blocked or hindered in his/her attempts to live out one's values (LÄNGLE 1992a).

Frankl himself predominantly used the Socratic dialogue in order to help his patients find meaning in situations of conflict or suffering. (FRANKL 1985, 66) He was certainly extremely gifted in that respect, but this procedure is difficult to teach as a method. More recent developments in existential analysis have elaborated it as a theory and as a psychotherapeutic approach.

4.) Modern Development

Since the 1980s, the Gesellschaft für Logotherapie und Existenzanalyse (GLE) in Vienna and in particular Alfried Längle have conceptualised Frankl's anthropology more systematically and have rendered it more dynamic in order to transform it into a solid basis for psychotherapy. We refer to this new concept and theory of existential analysis as "general existential analysis."

Since 1986, Alfried Längle has been working to place Frankl's three-dimensional anthropology into an existential perspective. As a result of these developments, even more stress has been laid on the human capacity for decision-making and on the sense of duty, which accompanies the awareness of being human. Längle's elaboration is not only concerned with the nature of the three dimensions, their relation to each other and the differences in their functioning, but also with the tension they may create when in potential conflict with each other. In such cases the human capacity for decision-making capacity is challenged, and one is faced with possible failure and suffering. These questions create dynamics, and to exist means to respond to these questions and to find the right balance at each of these three levels. The tensions exist between:

- health vs. disease on the physical level,
- pleasure vs. aversion on the psychological level,
- fulfilment vs. void or faith vs. despair on the spiritual level.

An important factor for the further elaboration of existential analysis was the theoretical assertion that, personal fulfilment and meaningfulness are predicated upon additional, existential conditions. Fulfilment can only be achieved, if the underlying existential foundation is solid. Therefore, Alfried Längle developed a model between 1982 and 1992 describing the four fun-

damental conditions required for a successful and satisfying existence (LÄNGLE 1998, 1999). This model now forms, in addition to Frankl's three-dimensional concept of human nature, a part of the general existential analysis.

The requisites for a fulfilled existence are called the four existential fundamental motivations (LÄNGLE 1992b). All four are concerned with existential questions and are located in Frankl's noetic dimension. The quest for meaning is situated within the fourth motivation, but builds on three underlying, preceding, existential motivations. The preceding motivations concern our need for a sense of sufficient support and safety, the search for the value of life and the assertion of our individuality and autonomy. The four fundamental motivations form the cornerstones of human existence in its full sense and may be described in short as follows.

By the simple fact of being in the world one is confronted with the following questions:

1. Can I accept my place in this world and the conditions of life that I am subjected to? Do I experience protection and support in the world? Whatever the conditions may be, a decision is asked for, a decision to accept one's reality as it is. This acceptance, in turn, leads to a basic sense of ability.

2. Do I like the fact of my existence and do I sense that my life has sufficient quality? This requires feeling close to people, animals, things, and taking time for establishing and nurturing relationships. All of this is experienced, as well as decided upon. It takes the decision to devote time to whatever one feels is precious, to build relationships and to permit closeness. This leads to a sense of liking, to a consent to life.

3. Do I experience myself and my inner world as unique? Do I sense that I have the permission to be myself and to be authentic? These feelings arise from the experiences of having received attention, of having been justified in one's personhood and of having been respected. But one also has to experience these emotions towards oneself. This leads to a sense of one's own worth, of authorisation, of consent to one's own person.

4. Do I sense my own calling and purpose in the world as an orientation for the meaning of my life? Basically, human beings want to transcend themselves and want their lives to serve a purpose. An openness is required here and an active and decisive engagement in the pursuit of this calling. This leads to a consent to the challenges and opportunities encountered, which, in turn, provides a sense of existential meaning in one's life.

The first fundamental condition or motivation deals with the question whether one is able to be. This sounds easy, but, upon closer reflection, is not. This question concerns the environment, the space of one's life and the conditions in which one lives. In this context, acceptance

means to feel that one can survive and breathe under one's conditions. This does not mean that one has to agree with these conditions. It simply means that one is able to recognise these conditions as part of one's reality.

This consent forms the ontological basis of existence, the existential foundation. Support in the world is first of all experienced in one's own body. Everything that inspires confidence and supports a feeling of sufficient safety belongs to this level. It is considered an existential motivation since human beings strongly aspire to be part of the world, to have their place in order to be able to exist.

The second fundamental motivation deals with the question of whether we experience life as good and worthwhile. After all, being here requires life as a person, with its moods and feelings, with the extremes of suffering and joy, and, finally, with our dependence upon relationships. The decision required at this stage is to decide whether one says "yes" or "no" to one's life with its warmth, suffering and its relationships. The answer to this decision is called the fundamental value.

But one can only feel affection and warmth in relationships, if one has experienced these oneself earlier in life. We experience the value of our lives where we are in relationship. If our lives are deprived of interaction, we do not experience the fundamental value of life and tend to retreat inwardly and to suffer from the void and cold of an uninhabited life.

The third fundamental motivation deals with the questions of whether one can consent to the way one is, whether one can stand by oneself and one's actions and whether one is truly oneself. These questions concern one's world, one's personal identity. Everyone searches for recognition of one's individual way of experiencing, thinking, feeling and acting, as well as for the respect of one's dignity. We need recognition for the way in which we as individuals lead our lives: collective protection of the species alone is not sufficient. We need to find the sense of our own authenticity and to establish our psychological boundaries. We want to be ourselves and to appreciate ourselves for what we are. One's conscience plays an important role here, because self respect is predicated upon the ability to stand behind one's identity, what one does and what one has become. Here one feels one's value.

The fourth fundamental motivation differs from the preceding ones, because it is concerned with questions about the future, and these questions derive their importance from our awareness of our own finality. If our life ends, what purpose will it have served? This fundamental motivation deals with something that still lies in the future and waits to be realised. It is therefore always an open question and the answers may not always be fully realisable. But what is intended here, is a meaningful way of leading one's life, to become active and engaged and

to be committed to people, aims or values. In a sense, this is the comprehensive motivation and here one experiences fulfilment. This is where logotherapy works.

The existential fundamental motivations also provide an excellent framework for explaining psychopathological disorders. On the first level, where a sense of protection and support is required, we find anxiety disorders, phobias, obsessions and compulsions. All of these are the result of deficiencies as far as the conditions on this level are concerned. On the second level, where one's inner consent to life and its values is required, we find, in the case of absence, depression or forms of self-sacrifice in order to be loved by others. On the third level, psychological disorders can be found that arise from a lacking sense of personal authenticity and individuality. Hysteria, narcissism, borderline may emerge as a result of these deficiencies. Finally, on the fourth level, which deals with the conditions for fulfilled existence, addictions and dependencies will be the result, if one's life is not imbued with sufficient meaning.

The fundamental motivations are not presented in this sequence at random; on the contrary, they are based on each other. This is to say that, for example, the presence of the third motivation requires the fulfilment of the second. If one is, for example, overwhelmed by anxiety, one may not have the strength or the opportunity to truly experience one's values or to build relationships. One may, of course, also (ab)use relationships to compensate for one's anxiety. On the other hand, a person may be free of anxiety, but not responsive to values and may suffer from a lack of relationships and from depression. If this is the case, this person will also be unable to experience his or her own value, that is, the value of his or her own life, since this process generally emerges in dialogue and in encounter. The individual may consequently suffer from a lack of self-esteem and meaning. Furthermore, one can only experience one's life as meaningful, if one experiences oneself as authentic. In the sequence of fundamental motivations, the first and the second fundamental motivation ensure our existential and social survival, whereas the third and fourth lead to an authentic and fulfilled existence.

Clearly, the existential fundamental motivations offer a theoretical framework in which psychological problems can be well explained and easily understood. At the same time they facilitate the explanation of psychopathological phenomena. To put it differently, disturbances in the fundamental motivations may give rise to psychological disorders. This model may thus serve for diagnosis, but also for the development of therapeutic interventions, since it allows for the explanation of symptoms, an understanding of the patient's suffering and a comprehension of the causal deficiencies. Therefore this concept has proved an extremely helpful tool in psychotherapeutic practice.

5.) Phenomenology

This theoretical framework, however, does not exclude phenomenology, which plays an important role in the practical procedure in modern existential analysis. The reason for this is the notion that phenomena should primarily be grasped purely as they present themselves without any previous theory or understanding. For psychotherapeutic practice this is to be translated into an open, unprejudiced attitude on the part of the psychotherapist trying to make the patient visible from within himself. The patient's remarks are to be understood from within his or her own frame of reference. This demands of the psychotherapist to put aside his or her own judgement relating to a supposedly objective reality. Instead, a phenomenological reality is constituted from the subjective realities of the patient and the therapist, which form the basis for a possible reality they can reconstitute together. In this encounter, a great deal of psychological space is given to the patient and his or her story and the therapist does his or her best to bracket his or her clinical and general knowledge at this point. Of course, the therapist will later also draw on his or her theoretical knowledge and personal experience.

6.) Personal Existential Analysis

Recent developments of Existential Analysis have not restricted themselves to Frankl's anthropology, but have expanded to include the process of psychotherapy itself. At this point the quest for meaning is no longer seen as the core, but as the result of a process. Alfried Längle elaborated this process between 1988 and 1990 and called it personal existential analysis (PEA – see LÄNGLE, 1995, 2000). In a way, this constitutes a decisive turn towards stressing the personal element in therapy, because this method functions as a guideline on how to arrive at an autonomous, authentic, emotionally satisfying and responsible existence. PEA places one's subjective experience and emotions into the centre of the psychotherapeutic process. This subjective experience and the concomitant emotions are explored in relation to specific events, an opinion about them is established and a future course of action is decided upon. Meaning, in Frankl's sense of the word, is seen here as the result of a successful completion of this process. Only rarely is the quest for meaning used directly as a psychotherapeutic tool.

PEA is based on the concept of the person which assumes that the person makes real his or her existence in a dialogical exchange with the world. This comprehends three major steps, which mark the three basic abilities essential for personal encounter. These are openness, selectivity and interaction, which make the person accessible from the inside and the outside. At the same time, they always form a unity in the event of a dialogue.

PEA encompasses four phases. The first phase (PEA 0) consists in a description of the facts. This implies that the patient is required to establish a connection to the problem. On the part of the therapist this demands a cognitive attitude. The second phase (PEA 1) contains a phe-

nomenological analysis, in which the emotional content and the message of these facts are analysed. This requires empathy on the part of the therapist. The third phase (PEA 2) leads to an authentic restructuring process, which means that the newly identified impression is integrated into the patient's existing framework of values. This requires an inner decision on the part of the patient and a confronting and encountering attitude on the part of the therapist. The fourth and final step (PEA 3) comprises the self-actualisation of the patient, i.e. finding an adequate expression for his decision. The therapist has to be protective and encouraging in this phase. (LÄNGLE 1995b, 348-364)

7.) Application and Psychotherapeutic Range of Logotherapy and Existential Analysis

The four fundamental motivations offer the opportunity of arriving at suggestions for treatment that are oriented at the experience and behaviour rather than at the case history of the patient. This is important insofar as it allows the therapist to define therapeutic steps on the basis of the patient's personal way of processing experiences. Existential analysis considers any fixation of a certain type of existential attitude or behaviour as a disorder, because this hinders the open interaction with the world and oneself, i.e. the inner and outer dialogue. Corresponding to the four fundamental motivations such a diagnosis is given when inhibitions or obstructions hinder the person in his or her ability to perceive (I. FM), in his feelings (II. FM), in his decisions (III. FM) or in his conduct (IV. FM).

Existential analysis can therefore be applied as a preventive or therapeutic intervention, even before the disorder has reached a pathological degree. It is equally suited to treat all kinds of psychic disorders, sexual and family disorders, addiction and dependency, personality disorders and psychoses. But also in workplace coaching it has achieved good results.

Existential analysis is basically suited for the treatment of all psychological and psychosomatic disorders. Its effectiveness and efficiency for the whole range of these troubles had to be established before a specific board of the Austrian Ministry for Health, before existential analysis was officially approved as a psychotherapeutic approach in 1993.

A short-term application of existential analysis typically consists of fewer than 30 hours and is probably the most frequent form of therapy. Reasons for its relatively high frequency include patients' reservations about long-term therapy, loss of motivation after the suffering has diminished and financial reasons. The main objective of this intervention is for the patient to attain a precise grasp of the problem, an improved self-understanding, a change in perspective, an understanding of the disorder as well as the achievement of new attitudes, strategies and techniques. This happens within the framework of a relationship between therapist and client that

is marked by empathy and trust. Besides counselling various other specific techniques are used.

Personal existential analysis as a more deeper form of psychotherapy takes 50 hours or more, and in the case of serious personality disorders even years. The aim of this extended psychotherapy is a revision of fundamental existential attitudes and positions by systematically treating the recurrence of traumatic biographical material, identifying and correcting inadequate or erroneous decisions and working on continued conflicts and lack of psychological maturity.

Logotherapy emphasises the treatment of existential crises such as occur after experiences of loss through disease or death. Since logotherapy normally takes the form of counselling, usually less than ten hours will be needed. The task there consists primarily of a psycho-educational intervention which the client can apply to his or her life.

8.) Forms of Organisation and Formation

The contemporary version of logotherapy and existential analysis was developed after the foundation of the Gesellschaft für Logotherapie und Existenzanalyse (GLE) in Vienna in 1982. The GLE has since edited a journal, called "Existenzanalyse". More recently, national societies were founded, in Switzerland in 1997, in Germany in 2001 and in other countries. The International Society for Logotherapy and Existential Analysis represents the international body which unites these national societies. Furthermore there is an international umbrella organisation for all societies of existential analytical psychotherapy worldwide: ISEAP – International Society for Existential Analytical Psychotherapy (http://www.existenzanalyse.org).

The national societies offer training courses for therapists and counsellors. Each formation starts with a two-year course in general existential analysis, which is then followed by the clinical training which takes six months for counselling and two years for therapists. Both phases of the training end with written examinations. After that therapists and counsellors continue to practice under supervision and finally complete a research paper. Throughout the training the candidate undergoes self-analysis, both in group and in individual sessions in order to enhance self-understanding prior to independent work with patients.

9.) Conclusion

In conclusion, the following points may serve as definitional highlights for logotherapy and existential analysis:

- The meaning of one's existence depends largely on the subject or individual. It consists of an existential meaning which remains elusive (subjective) and beyond grasp and may be

realised in concrete situations. Existential analysis provides aid to this process.
- Human existence is full with opportunities and potential meaning. This constitutes the ontological meaning, which lies beyond the domain of psychology or psychotherapy but belongs to that of philosophical debate and religious concepts.
- Human life has always been suspended in the space between existence as an open potential on the one hand and one's moral obligation within the context of one's life on the other. Decisions for one's future must reconcile these two factors. Life is never conclusive in and of itself, but always presents opportunities waiting to be realised.
- In each and every situation, trivial or difficult as it may seem, there is an opportunity or a task waiting to be realized.

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The Art of Involving the Person – Fundamental Existential Motivations as the Structure of the Motivational Process*

Abstract

From an existential point of view, motivation essentially involves the person (with his or her[1] specific ability to make decisions) in his or her world. Thus, motivation may thus be defined as a process in dialogical movement from the present, given reality towards the person's goals and intentions. From this perspective, motivation is an expression of the (mostly unconscious) human intention to be-come, to come into existence. This process unfolds according to the fundamental themes of existence. Thus, motivation is fundamentally related to the structure of existence, which in turn shapes the substance of the motivation. Operationally, motivation relates to the (spiritual or noetic) power of the person as described in the Personal Existential Analysis (PEA).

The intention of this paper is to show the relationship between the structure of existence and motivational processes. According to the "four cornerstones of existence" a person must first come to terms with his or her being in the world, then with his or her own life and finally with his or her identity. Subsequent to these tasks, the person is open for and prone to enter into relationships with a greater context (horizon), from which personal meaning is derived. This process has been documented throughout 20 years of phenomenological empirical research.

Moreover, these four fundamental aspects of existence form a matrix for the psychopathological understanding of psychological disorders and provide the background for clinical interventions. They represent the structural (or content-based) model of modern Existential Analytical Psychotherapy.

Key words: Motivation, Existential Psychology, Existential Analysis, Fundamental Existential Motivations

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[1] The male formulation in general topics is used in a generic sense for easier reading and equally embraces both genders

1. What Makes for Motivation?

Discussion about motivation is ubiquitous in social sciences, including psychology, psychotherapy, pedagogy, sociology, and politics, as well as in marketing and economics. It seems obvious that we need sufficient motivation for the achievement of our life tasks, for creativity, growth, social functioning and personal fulfillment. However, the substantial question inevitably arises as to the nature of motivation: Do we really need to *become motivated by extrinsic or outside sources* or are we inherently and *originally motivated* due to our nature? Is the essence of what we term the "motivational process" an act of *receiving* something? Or does the motivational process merely consist of shaping this primordial, omnipresent process? If the latter is true, then motivating someone would simply require one to provide a direction for that preestablished energy. This would imply that we do not help people to become motivated, but rather aid them in finding the most appropriate avenue to implement the existent motivational force in their lives. The motivational process would thus provide a theme, a direction for the intentionality, a reason for the decision, and would reveal the value of a particular action for one's life. In other words, motivating someone would involve helping them find possibilities, values, authenticity and meaning for what they do.

Alfred Adler or George Kelly (cf. BRUNNER ET AL. 1985, 290) took the position that human beings are originally motivated by their nature and required no external source of stimulation. This view was shared by Viktor Frankl, one of Adler's disciples or adherents of his school. This position was also taken by the "potentialists" of the humanistic psychology movement, such as CARL ROGERS (1961) who argued that if the circumstances are favorable for activity, humans develop all of their activities and potentials on their own.

2. Frankl's "Will to Meaning"

For Frankl, we are indeed motivated by *biological* and *social* drives, but primarily and most profoundly by our personal "will to meaning". This means that any person is fundamentally moved by a *spiritual* striving for a deeper *understanding* of one's experiences or activities. This motivational force is regarded to be a direct result of the essence of human "nature". The *spiritual striving* as well as the *will to meaning,* is observed and rooted in the spiritual (= noetic or personal) dimension of the person.

According to FRANKL'S theory of Logotherapy (1973, XVIII ff.; 1959, 672) this spiritual dimension is marked by the three basic human potentials[2]: "psychological spirituality"[3] freedom and

[2] Frankl calls them also "existentials" – referring to Heidegger's term "Existentialien".

[3] "Psychological spirituality" explains what is meant. It captures the meaning of the situation and activates the person's potential of being free. – Responsibility on the other hand is also related to freedom – it imposes itself only there where humans are free. – Seen from these practical aspects freedom reveals itself as the decisive factor of the spiritual dimension. – The importance of freedom explains why it is more often treated in philosophical and psychological theories than meaning and responsibility.

responsibility. The quest for meaning and the primary motivational process can therefore be understood as concomitant necessities inherent in this dimension. They basically consist of the challenge created by our freedom.

Freedom paradoxically brings along a compulsion of choice – being free means that we are forced to choose. A prerequisite for making any real choice is the understanding of both the content and the context in which the decision is to be made. The intentional goal of the will arises from this horizon, and if adopted by the individual, it turns out to be a value, probably the highest value, in the given situation. These are the constituent elements of *existential meaning:* The greatest (or highest or deepest) value in the given situation, which can be envisioned and understood by the individual to be within the reach of his or her abilities. Frankl's primary motivation thus turns out to be an immediate consequence of the realisation of the person's will, the human expression of freedom.

Frankl developed this logotherapeutic concept of motivation in an era that was dominated by determinism, reductionism, subjectivism and monadology, all of which he fervently combated. In spite of exposure to these ideas during his education, Frankl's personal and scientific accomplishments in Logotherapy are evidence that he was able to transcend these tendencies. He achieved this holism especially with respect to the concepts of meaning and of self-transcendence - both cornerstones of his anthropology. However, in the motivational angle of his theory, Frankl may have adopted some individualistic thinking by tracing back and reducing the concept of existential motivation to the concept of will. He even reinforced his motivational concept by naming it the "will" to meaning. Frankl himself explained the decision of calling it "will" to meaning by his intention to formulate a counterweight to Nietzsche's "will to power". In doing so, Frankl replaced the instrumental value of "power" with the more spiritual value of "meaning". Later on in chapter four we bring this critical remark to its conclusion by describing a concept, which we have formulated on an existential ground.

3. The Modern Quest for Meaning

In our times, arguments about freedom do not dominate the discussion of social problems, of psychopathologies and the scientific discourse. The neo-darwinian debate, that arose as a consequence of the genetic discoveries in the 60's and 70's and that led to the polarity of "freedom and necessity" and to the outburst of free will against repression in 1968, is no longer pertinent.

Nowadays different problems are predominant: Marital and family life has widely evolved into broadly accepted forms of being single; the communities, social experiments and sexual promiscuity of the 70's have been replaced with fantasy games in virtual worlds, TV-channel-hopping and internet surfing. Homosexuality has been widely accepted as a normal version of sexuality. The social cohesion in politics and economy has loosened and been replaced by a high degree of individualism, competition and rivalry, and a new feeling of freedom which uti-

lizes and challenges the resources of the individual to the utmost degree. This new feeling of freedom brings with it isolation not only for older generations, but also for entire cultures.
The *"schizophrenic" nature of our times* is that we have the best structures of communication in human history, that we travel internationally, more than any generation before us, but that in the end we are lonelier and more culturally isolated than ever before. The increase in contact between people of different cultures has led to a consumption of the pleasant aspects of cultures but not to a true dialogue. This lack of profound dialogue, and consequently of mutual understanding, provokes an anxiety of alienation and of loss of identity. This phenomenon can be observed, for example, in patterns tourism and immigration. The increase in speed has brought along a decrease in contact, the increase of information has led to a decrease in communication, and the increase of traffic has destroyed much of the personal encounter. The tragedy of September 11th is a prime example of the huge and frightening failure in communication and encounter between different cultures.

4. Existential Paradigm

Considering the unique problems of our day and age, it is imperative that we adapt our theories to the needs and sufferings of today. We have therefore further elaborated the motivational concept in Existential Analysis into an approach that is by no means less humanistic or personal. Our new concept follows a different paradigm. As a complement and counterweight to the individualistic paradigm of freedom and personal will, which laid groundwork for the development of this postmodern era, we now propose an **interpersonal paradigm.**
This is the direction we have adopted in modern Existential Analysis. We have enlarged our motivational concept by basing it on the most original activity of personhood: Our being essentially dialogical, prone to and directed towards exchange with others. Being oneself, finding oneself needs the field of tension of the "inter-", the "between", the "aida" as the Japanese say (KIMURA 1982; 1995, 103ff.). This spiritual need for communication and dialogue is also underlined by the numerous personality disorders related to the loss of self! – There is no "me" without a "you", as both Buber and Frankl explaining. Being oneself as a person means being in communication – being in a continuous intrapersonal and interpersonal exchange of contents and values. It means fine-tuning the outer with the inner reality and vice versa, coordinating oneself with the objective meaning of the situation. Motivation is understood as engaging in that continuous flow which is established by nature between the person and his world. They are inseparably connected and interrelated, in uninterrupted reciprocal action. Or as Heidegger has defined it: Being a person, "Dasein", means "being-in-the-world", means dealing with "otherness".

5. Existential Concept of Motivation

From an existential point of view, dialogue (or "communication" as Jaspers says) is an essential constituent in human psychology and in understanding the essence of human existence. If we take the capacity for *dialogue as a characteristic* of being a person (i.e. a being with mind and spirit and a potential for decision-making), then humans are always waiting for their completion by a "partner" in the broadest sense. As dialogical beings we expect and look for something or someone who "speaks" to us, calls us, needs us, talks to us, looks for us, challenges us. We get the necessary *provocation* through everything which confronts us, which challenges us, which engages us. At exactly that moment the object before us starts "speaking" to us. Being provoked means being called. This provocation is the *starting point for any motivation.*
In other words, seen from an existential point of view, ***motivation means involvement of the person,*** initiating the personal processes by provocation in some kind of vis-à-vis. Of course the best vis-à-vis is a partner speaking to us. This process-oriented capacity of the person is described in the theory of the method of "Personal Existential Analysis (PEA)" (Längle 1994c) which seeks to engage personal potential in a process of dealing with information and encounter.
This model, which is fundamental for any kind of involvement with the person, helps to distinguish **three steps** within the motivational process:

1. **Recognizing** something in its worth or value, in as far as it speaks to us. This is often a challenge demanding action on our part. What a situation 'pro-'vokes in us is indicative of or points to the situational meaning involved. To recognize this inner movement lays way to find personal meaning.
2. **Harmonizing.** Bringing the perceived value, challenge or meaning into accordance with our inner reality (i.e. examining the congruence with the rest of our values, with attitudes, abilities and capabilities and with our conscience etc.).
3. **Giving inner consent** to one's own **active** involvement. This consent and the act of harmonizing the new value with one's personal reality lead to the presence of the inner person in one's actions and to the integration of the new value and the person into a **wider context** (meaning).

Omitting the person in the motivational process, according to our opinion, misses the main thrust of human motivation. Instead it focuses on a sort of reflex or reaction, but no "action". Any act or deed is defined as a *decided* act and is therefore *voluntary* and free.

If we accept motivation as a *free* decision to act, then we must also take the concept of one's *will* into consideration. Frankl (1970, 37-44; 1987, 101-104) saw meaning as the motor in free will. An existential view of human will views it as the anthropological axis of existence. A *process-oriented description* of will, however, relies on the fundamentals of existence and therefore requires more than just meaning as the basis for constituting will. Free and realistic will is based on three more elements:

1. On the real ability and **capacity** of the subject;
2. On the **emotional** perception of the situational **value;**
3. On the inner **permission** for that act, emerging from an agreement with one's concepts of life and morality.

Before proceeding further, let us conclude this part of the exposition dealing with the structure of motivation by adding a reflection on the initial problem of the two basic concepts of motivation: Do people need to be motivated externally or can the motivation only be shaped, and channeled, because people are *intrinsically* motivated? Our theory is that this existential concept *bridges two seemingly opposing positions:*

a) Motivation emerges through the *interrelation* with the vis-à-vis. Being touched and provoked, as well as understanding the situation is akin to *being called* on by something or someone. This appeal activates the constitutional 'being-in-the-world' because of a recognition or understanding of what this particular situation is about. This process is the functional equivalent of the recognition of the situational or existential meaning. Furthermore, it implies that we *receive an impulse* from the recognition of the essential message from our vis-à-vis (outer world, but also body, feeling, thoughts).
b) The motivation is shaped and constituted via our *understanding* of the context and by our inner agreement.

Seen in that light, the notion of 'being-in-the-world' provides the ground, on which personal forces are activated. This happens by a perceptive encounter with some form of otherness or with oneself.

Let us now have a closer look at the four fundamental motivations for a fulfilled existence.

6. The four Fundamental Conditions for a Fulfilling Existence

In the first part we have elaborated a crucial point for motivation, which lies in attaining the *dialogical potential* of the subject. Its pro-*vocation* or elicitation can be regarded as the starting point for any motivation. The need and the ability for dialogue are seen as the dynamic essence of the person (with subsequent potentials like freedom and will). This dialogue (with the world and with oneself) is a prerequisite for developing motivation. We have pointed out that, for this reason, there is *no motivation without cognition, accordance, bringing into harmony, inner consent and meaning.* The concept of motivational freedom - defined as the movement of a person towards a free act within the world – must take the structure of will into account. The human will is fundamentally related to the structure of existence, which in turn substantially shapes motivation. This provocation into dialogue and the relation to the fundamental structure of existence is the *central hypothesis* of this paper.

A closer look reveals that this concept of motivation implies a dialogical *confrontation* with the given facts of our existence. All preconditions of existence can be summarized in four fundamental structures, the "cornerstones of existence":

- the *world* in its factuality and potentiality
- *life* with its network of relationships and its feelings
- *being oneself* as a unique, autonomous *person*
- the *wider context* in which to place oneself = *development* through one's activities, opening one's *future*

Existence in our understanding requires a continuous *confrontation* and a dialogical *exchange* with each of these four dimensions. It is on this basis that the subject forms his or her specific notions about reality. These four realities challenge the person to respond, they ask for his or her inner consent, activate his or her inner freedom. But they are not only challenging dimensions – they are also structures which, at the same time, allow one to entrust oneself to each of these given realities. Their facticity is the fundament of what we call existence. As such they fundamentally move our existence and can be called "fundamental existential motivations" (LÄNGLE 1992a, b; 1994a; 1997a, b; 1998c).

7. The World – Dealing with Conditions and Possibilities

The first condition arises from the simple fact that I am here at all, that I am in the world. But where to go from here? Can I cope with my being there? Do I understand it? I am there, and as an old German saying from the 12th century goes: "I don't know where I am from, I don't know where to, I wonder why I am so glad?" I am here, here I am – how is that even possible? Questioning this seemingly self-evident fact lead one into great depths, if one permits oneself this exploration. And if I really think about it, I realize that I cannot truly comprehend this fact. My existence appears like an island in an ocean of ignorance and connections that surpass me. The most adequate and traditional attitude towards the incomprehensible is one of astonishment. Basically, I can only be astonished that I am here at all.

But I *am* here, which sets before me *the fundamental question of existence: I am – but can I be?* To ask a more practical version of this question I need only apply it to my own situation. In that case, I may ask myself: Can I claim my place in this world under the conditions and with the possibilities I have? A positive answer to this question demands three things: *Protection, space and support.* Do I enjoy *protection*, acceptance, do I feel at home somewhere? Do I have enough *space* to be here? Where do I find *support* in my life? If these conditions of existence are not met, the result will be restlessness, insecurity and fear (cf. LÄNGLE 1996). But if I *do* have these three things, I will be able to trust in the world and have confidence in myself, maybe even faith in God. The sum of these experiences of trust is the fundamental trust, the trust in whatever I consider to be the last and final support in my life.

But, in order to be here, it is not enough to find protection, space and support – I also have to *take hold of* these conditions, to make a *decision* in their favor, to *accept* them. My *active* part in this fundamental condition of being here is to accept the positive and endure the negative. To *accept* means to be ready to occupy the space, to rely on the support and to trust the protection; in short 'to be there' and not to flee. To *endure* means to have the strength to persist in spite of whatever is difficult, menacing or unalterable, and to 'support' what cannot be changed. Life imposes certain conditions on me, and the world has its laws, which I can only accept. This idea is expressed in the word 'subject' in the sense of 'being subject to or dependent upon'. On the other hand, these conditions are reliable, solid and steady. To let them be, to accept them as given, is only possible if I, too, can be at the same time. Therefore, to accept means to let each other be, because there is still *enough space* for me, and the circumstances do not threaten me anymore. Human beings procure the space they need with their ability to tolerate and to accept conditions. If this is not the case, psychodynamic forces take over the guidance in the form of coping *reactions*, which aim secure life (LÄNGLE 1998a).

8. Life – Dealing with Relationships and Emotions

Once one has space in the world, one can fill it with life. Simply being there is not enough. We want our existence to be *good*, since it is more than a mere fact. It has a 'pathic dimension', which means that it does not simply happen, but that we experience and suffer or enjoy it. Being alive means to cry and to laugh, to experience joy and suffering, to go through pleasant and unpleasant things, to be lucky or unlucky and to experience worth and worthlessness. We experience happiness to the same extent and depth that we experience suffering. The amplitude of emotionality is equal in both directions, whether this suits us or not.

Therefore I am confronted with the *fundamental question of life:* I am alive – but do I *like* this fact? Is it good to be here? It is not only strain and suffering that can take away the joy of life. It may also be the superficiality of daily life and the self neglect of one's lifestyle that make life stale. In order to seize life, to love it, I need three things: *Relationship, time and closeness.* To verify the presence of life in one's own situation we may ask ourselves the following questions: Do I have *relationships*, in which I experience closeness, in which I invest time and which give me a sense of community? – What do I take *time* for? Do I take time for valuable things, which are worth my time? To take time for something means to give away a part of one's life while spending it with someone or something. Do I feel close and maintain *closeness* to things, plants, animals and people? Do I permit myself to come close to another person? If relationships, closeness and time are lacking, *longing* will arise, then *coldness* and finally depression. But if these three conditions are fulfilled, I can experience myself as being in *harmony with the world and with myself*, and I can sense the depth of life. These experiences form the fundamental value, the most profound *feeling for the inherent value* of life. Our experience of any

and all values are shaped by this fundamental value, it colors the emotions and affects and represents our yardstick for anything we might feel to be of worth. Our theory of emotion and theory of values relate to this fundamental aspect of our existence.
Still, it is not sufficient to experience relationships, time and closeness. My own consent, my active participation is called for. I *seize* life (*carpe diem*), engage in it, when I *turn toward* other people, toward things, animals, intellectual work or to myself, when I move towards it, get close, get in touch or pull it towards me. If I turn toward a loss, *grief* arises. This 'turning to' will make life reverberate within me. If life is to make me move freely, my consent to being touched (to my feelings) is a prerequisite.

9. Being a Person – Dealing with Uniqueness and Conscience

As pleasant as this emotional movement may be, it is still not sufficient for a fulfilling existence. In spite of my being related to life and to people, I am aware of my being separate, different. There is a singularity that makes me an 'I' and distinguishes me from everybody else. I realize that I am on my own, that I have to master my existence myself and that, basically, I am alone and maybe even lonely. But in addition to my solitude, there is *so much more* that is equally singular. The *diversity, beauty and uniqueness* in all of this make me feel respect for it.

In the midst of this world, I discover myself unmistakably, I am *with* myself and I am given *to* myself. This places before me the *fundamental question of being a person:* I am myself – *may* I be like this? Do I feel free to be *like that*? Do I have the *right* to be what I am and to behave as I do? This is the domain of identity, of knowing oneself and of ethics. In order to succeed, it is necessary to have experienced three things: *Attention, justice and appreciation.* Again one can verify the presence of this third cornerstone of existence in one's life by asking: Who sees me? Who considers my uniqueness and respects my *boundaries*? Do people do me *justice*? For what am I *appreciated* – for what can I appreciate myself? If these experiences are missing, *loneliness* will be the result, *hysteria* (histrionic disorders) as well as a need to hide behind *shame*. If, on the other hand, I experience these qualities, I will find myself, find my authenticity, my relief and my self-respect. The sum of these experiences builds *one's worth,* the most profound worth of what identifies my own self at its core: My self-esteem.

In order to be able to be oneself, it is not sufficient to simply experience attention, justice and appreciation. I also have to say "yes to myself". This requires my active participation: To *look* at other people, to encounter them and, at the same time, to delineate myself and to stand by my own, and to refuse whatever does not correspond to myself. *Encounter* and *regret* are the two means by which we can live our authenticity without ending up in solitude. Encounter represents the necessary bridge to the other, causes me find his or her essence as well as my own 'I in the you'. Thus, I participate in my self-appreciation, attain my self-acceptance.

10. Meaning – Dealing with Becoming, Future and Commitment

If I can be there, love life and find myself therein, the conditions are fulfilled for the fourth fundamental condition of existence: The recognition of what my life is all about. It does not suffice to simply be there and to have found oneself. In a sense, we have to transcend ourselves, if we want to find fulfillment in life and to be fertile. Without this self-transcendence, moving beyond ourselves toward something greater, we are condemned to a life of loneliness and triviality.

The transience of life confronts us with *the question of meaning of our existence:* I am here – *but for what purpose?* To experience this sense of direction in life, three things are necessary: *A field of activity, a structural context and a value to be realized in the future.* To become pragmatic, we may ask ourselves the following questions: Is there a *place* where I feel *needed*, where I can be productive? Do I see and experience myself in a *larger context* that provides structure and orientation to my life? Where I want to be integrated? Is there anything that *should still be realized* or accomplished in my life?

If I cannot answer these questions in the affirmative, the result will be a feeling of *emptiness*, *frustration, even despair* and may frequently result in *addiction* or *suicidal* tendencies. If, on the contrary, these conditions are met, I will be capable of *dedication* and *action* and, finally, of my own form of *religious belief.* The sum of these experiences adds up to the meaning of life and leads to a sense of fulfillment.

It does not suffice to have a field of activity, to have one's place within a context and to know of values to be realized in the future. Instead, a *phenomenological attitude* is needed to which we referred at the beginning. This attitude of openness represents the *existential access* to meaning in life: the ability to deal with the questions put before me in each situation (Frankl 1973, XV, 62). How am I challenged by this moment, and how should I respond? The meaningful thing is not only what ***I*** can expect from life, but, in accordance with the dialogical structure of existence, it is equally important what *life wants from me.* And what the moment expects *from me*, and what *I* could and should do *now* for others as well as for myself. My *active* part in this attitude of openness is to bring myself into *agreement* with the situation, to examine whether what I am doing is really a good thing for others, for myself, for the future, for my environment. If I act accordingly, my existence will be fulfilling.

Viktor Frankl (1987, 315) once defined meaning as "a possibility against the background of reality". In another context (Frankl 1985, 57), he referred to the potentialities underlying the meaning: "The potentialities of life are not indifferent possibilities; they must be seen in the light of meaning and values. At any given time only one of the possible choices of the individual fulfills the necessity of his life task."

This notion of valuable possibilities, endorsed by the theory of the fundamental existential motivations, defines meaning even more concretely as the *most valuable, realistic* possibility of the given situation, for which I feel I should decide myself. *Existential meaning* is therefore what is

possible *here and now,* on the basis of facts and reality, what is possible *for me,* may it be what I need now, or what is the most pressing, valuable or interesting alternative now. To define and redefine this continually is an extremely complex task, which requires an internal "organ of perception" or ability capable of reducing this complexity to livable proportions: Our sensitivity as well as our moral conscience.
Apart from this existential meaning we may also consider an *ontological meaning.* This is the overall meaning in which I find myself and which does not depend on me. It is the philosophical and religious meaning, the meaning the creator of the world must have had in mind. I can perceive it in presentiments and in faith (cf. LÄNGLE 1994b for the differentiation between the two forms of meaning).

There is a *story* that Frankl used to tell and that illustrates in a simple way the importance of the ontological meaning for understanding life (cf. LÄNGLE 2002, 60ff). With this story I intend to *end* my presentation.

It was at the time when the cathedral at Chartres was being built. A traveler came along the way and saw a man sitting at the roadside, cutting a stone. The traveler asked him astonished what he was doing there. "Don't you see? I am cutting stones!" Nonplussed the traveler continued on his way. Around the next bend, he saw another man, also cutting stones. Again he stopped and asked the same question. "I am cutting corner-stones," was the reply. Shaking his head, our man traveled on. After a while he met a third man who was sitting in the dust and cutting stones, just as the others had been. Resolutely he walked up to him and asked: "Are you also cutting corner-stones?" – The man looked up at him, wiped the sweat from his brow and said: "I am working at a cathedral."

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The Method of "Personal Existential Analysis"

"All our presentations wait
to be supplemented, built on,
and thereby rectified"
S. FREUD
(quoted by Frankl 1983, 202)

ABSTRACT

Existential analysis (V. Frankl) as a clarification of possibilities for an existence that is appropriate to human dignity, gives a general anthropological frame for psychotherapeutic forms of intervention. In theory and practice the further development of the existential-analytical concept of person pointed to three basic faculties of personhood: They form the framework for a methodically structured procedure of existential analysis termed "personal existential analysis" (PEA). PEA begins with personal conditions for existence, where personhood is unable to break through to a meaningful existence due to an obstruction of just those basic faculties. In addition to that, personal existential analysis offers a theoretical structure for the application of different psychotherapeutic forms of intervention and techniques.

Key words: Existential psychotherapy, existential analysis, method, person

1. Introduction

The introduction of the concept of "personal existential analysis" is intended to be programmatic. Besides the "general" and "special" existential analysis – "special" pertaining to an anthropology or an anthropological and existential interpretation of certain clinical pictures in FRANKL´S (1982a, 39, 162) concept – a new term has been coined. It stands for the application of existential analysis to the individual in therapeutic practice and in a person-oriented pedagogy of dialogue.

In another sense, "personal existential analysis" is programmatic in that it contains in itself a practical *method* for its application.

The method, based on Frankl's existential analysis, was born out of introspective experience, theoretical reflection and phenomenological analysis. Drawing from Frankl's anthropology, a specific method was the developed which could be described in a methodical manner. It is applied to the individual and the motivating circumstances of his or her life. "Person" and "existence" are the central terms. The work focuses on the person as the center of existence.

"Personal existential analysis" (PEA) is mainly concerned with locating personhood in its authenticity and assisting its breakthrough in the context of its existence. The aim is openness to (SCHELER 1980, 381, 392 ff; SCHELER 1991, 38 f), and a personal exchange with, the world. Prior to all existence we find the personal challenge in a given situation. Life becomes "existence" only by personal responses to the challenge and the offer of a situation (FRANKL 1982a, 71 ff; LÄNGLE 1987, 64 f; LÄNGLE 1988, 40 ff). Therefore PEA is genuine existential analysis in the tradition of Frankl, to which it adds a form and a practical method of application. Hence existential analysis is also applicable when existence is not proceeding smoothly and unhindered.

The term "analysis" is of course not completely correct in this case, even as a "rare" case of analysis (FRANKL 1984, 170). The procedure is just as much synthetic (Asogioli calls it "psychosynthesis") but it is essentially not that either, because the noetic is at the same time clearly defined *and* correlated, elementary *and* complete, hidden *and* visible.

Hence, PEA is an attempt to develop a viable practice of the anthropological theory of Frankl's existential analysis. This in turn lends empirical validation and control of the usefulness of the theory.

From the perspective of theory of science, PEA, as a method of psychotherapy, has the express purpose of introducing the noetic to therapy – a dimension easily neglected and underrated in its importance in general psychotherapy.

For the existential analyst, PEA has yet another purpose: The practical procedure demanded by theory should be made transparent by a sequence of steps. Such a methodical structure does not deny the intution of the therapist and pedagogue. Certain rules and formal guidelines, however, relieve the pure intuition and improvisation demanded by Frankl's logotherapy. Methodical structure adds to the practical application of existential analysis and makes it more teachable, while improving its efficiency. I hope further for important results through the use of the Existence Scale (LÄNGLE ET AL. 2000). Finally, this methodical structure might shed some light on when and where certain techniques should be applied in theory.

2. How was the Method Developed?

The development of the method in the last five years[1] was determined by two factors: Theoretical reflection on the concept of person and daily confrontation with people suffering

[1] First published in 1993.

from personal and existential deficits. Theoretically, I was guided by sifting, selecting and recombining the theory of person. For this I am very grateful for the talks with Dr. Rolf Kühn, who provided valuable insights. Furthermore, I was also guided by my patients. Describing and working on their different states of suffering, on their deficiencies and inhibitions, their assistance, hard work and my own putting-up with many a failure and well-intended but sometimes ineffective experiments, finally lead to the result now open to discussion. Without the sensitive, anticipating search of my patients for personal wholeness, this way could not have been found. I am gratefully obliged to them. Before this method began to take shape, I was much too quick with suggestions offered by the theory. This essentially counselling style of intervention, however, offered little help for some of my patient´s more difficult disturbances and more basic traumas. It tended to hamper the initiative to the patient´s own development.

I thus had little success with such disturbances and the whole issue of meaning was soon exhausted. Thanks to existential analysis, I knew what life should be, and it wasn´t hard to see what existential mistakes the patients were making. What I did not know, was how, by means of existential analysis/logotherapy, I could guide them in a development that would cause neurotic patterns to dissolve by themselves. Other methods and techniques suggested themselves. – But did a consistently applied existential analysis not have the potential to produce its own tailormade practice? If not, the theory would be an end in and of itself, and irrelevant for psychotherapy.

The following presentation of the method should begin with an outline of the theoretical background, followed by a description of the individual methodic steps.

3. Abstract of the Theory of Person

PEA goes back to Frankl´s existential analytic concept of person and existence (Frankl 1982b; 1984), according to which person can be seen as the noetic power opening to (Frankl 1984, 121) , but also *differentiating* from (Frankl 1982b, 115) the world, thus enabling the unmistakable unity and wholeness of "I" and "you" significant to personhood. From the outset, this polarity between openness and limitation forms the basis for intimacy and expression in a person. Differentiation enables that which is modestly hidden from public view as constituent of personhood. To adequately express one's own personhood, through action, language and the giving-of-oneself, forms the basis of, and gives special value to human encounter. Thus seperated, to be oneself, and open, to transcend oneself, personhood is *fundamentally enabled for dialogue.*

This faculty for dialogue could be called the basic characteristic of personhood, presenting the starting point for further reflections. Thus language becomes a uniquely human trait. Human beings are surrounded by language in the same way as by the air that they breathe (Buber 1973, 41). Language is naturally also expressed in a glance, the tone of voice, mimicry, gesture, posture and by action.

PEA defines personhood as *that which speaks in me.* Speaking to myself, I create the inner world of *self-distancing*. Speaking to another produces the outer world of *self-transcending* ("Co-world").
Owing to its dialogical nature, personhood is always in a process of *exchange with the world and in mutual exchange with itself and the world.* In this way one[2] fundamentally realizes one's "being a person", by bringing oneself into a relationship with oneself and the world, which in turn complements or completes "the other in oneself" (to become whole = to be healed). Therefore, personhood is always being in relation (to have relationship), brought about by the special way of encounter (LÄNGLE 1986, 55 ff). Encounter is no immovable or fixed relation but always in motion, a coming-out-of-oneself, with oneself; it is being drawn and taken out of oneself by the other into the "in-between" of communication. Encounter is dynamic, active and inter-active. In personal terms one might say that exchange through encounter allows my own to be touched by the other, and adds my own to the other.

PEA wants to create relationship through encounter: Relationship in the general sense that includes encounter with things, experiences, with earlier experiences, and with oneself. Thus, it is the *general goal of PEA*, to lead people to encounter what concerns them: self and the other. Human beings should be able to enter into dialogue with themselves and their world (LÄNGLE 1988, 10).

This description contains the traits of personhood emphasized by FRANKL (1959, 672-696): To be with sombody or something, to be free, and to be responsible. Like light through a prism, freedom unfolds its inherent variety of colours through dialogue. It is revealed by what is uniquely my own, and – in as far as it is authentic – which I have been responsible for from the beginning. Besides, freedom is reflected in the unexpected, *surprising turn*, that every dialogue is essentially open for (BUBER 1973), in the same way as it is open to the *new*, the unknown, the unsuspected.

3.1 How the Person can be Reached through Dialogue

Dialogue, in the general sense mentioned above, is essential for the actualisation of personhood. Every dialogue, however, requires *three constituent elements.* They appear to be fundamental to a methodic conversation within PEA, providing it with a structure:

1. Dialogue has an addressee – it wants to *address.*
2. This addressee should *understand* what is said.
3. Finally, dialogue requires a *response.*

[2] To be understood as a generic form.

To be receptive, to understand and to answer, are three activities fundamental to personhood from the practical viewpoint of dialogue.

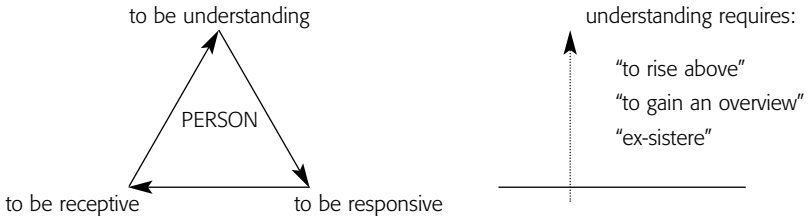

Figure 1: How personhood reveals itself and can be found in an encounter

Let us connect what has been said, to experience.

1. What do I experience when I am adressed? – By being spoken to, I realize that now I am no longer able to escape the world unnoticed. I myself have been unmistakably addressed, sensing that nobody can substitute for this "I" and its effect. I have been unavoidably called into existence. This is all about me! I immediately become relevant and involved as person. Directly addressing you in my talk, for instance, will cause an immediate and intense personal awareness of yourself. It would perhaps even make you blush, although the question is completely harmless, because now it is up to you, to the position you take, and the saving of your face (as "surface" of personhood). Much can depend on that, like your position and respect in a group. Without being exposed to physical danger, this experience of being and feeling addressed may cause fear (in this case, perhaps, fear of embarassment). By being spoken to, however, I also experience the other side of being a person: The freedom of openness, of being tangible and alive, of the security and value of the relationship. To be receptive opens a world to me – my world.

2. What does *understanding* have to do with my person? – To be understood by another person, is one of the most healing and pleasant human experiences. One feels accepted as a person. Somebody else notices what moves me.
   Only understanding leads to real encounter with the other person. Where I am able to understand another person, I will feel closeness to him or her. Whatever seperates, disappears; exchange begins to flow.
   We often do not quite understand ourselves. That is when understanding is especially important: the understanding of the patient by the therapist. Facilitated by the therapist's understanding, the patient can start to understand him or herself.

3. "I feel spoken to" – "I feel understood" – a third statement could be: "I feel responded to". Instead of meeting a wall of silence, I have received an answer. The other has revealed him or herself to me.
   In contrast, how intense is my experience of loneliness, when my whispering, speaking, shouting, crying, and my retreating into silence does not meet an answer! How lonesome I feel even when the other understands, but refuses to answer, as so often happens in the breaking up of relationships. The answer does not have to be by speaking; a gesture can say more than words. Sometimes simply suffering with another person in "meaningful" silence can be more important than any words.

As we think about answering, this would be the place to especially consider the child, lest we leave it without an answer too often. How should it know itself and realise its personhood, without a response? Only by encountering a person can it be lifted into the personal space where it can become a person. And to what extent am I as an adult a person, if I am not responded to?

3.2 The Dealing of Person with Itself

Personhood is to be met "from outside" in the encounter. The one who encounters is confronted with personhood, wherever he/she experiences human beings as receptive, understanding and responsive.

To encounter does not mean to lay hold of person, but simply touching on some form of its effect. Personhood is revealed to the one who encounters, while at the same time it remains hidden behind the limitations of unconditional subjectivity. (See above: The dialectic of essential openness and delimitation of personhood. This could be figuratively compared to the physiological structure of the eye, where the aperture – or pupil – is delineated by the iris. Only this structure enables sight, by guarding the innermost with the necessary boundary of its aperture.)

The question is whether a person can experience him/herself. Here we agree with Scheler, who maintained that persons can never be the object of their own inspection (SCHELER 1980, 386 ff; also FRANKL 1959, 676; FRANKL 1984, 85; WICKI 1991). The person cannot observe him/herself from a distance. But he/she can experience him/herself in an act (SCHELER 1980). Extrapolating from Scheler´s view (or perhaps simply specifying it), three parts can be detected in the performance of an act, desribing it´s emergence, maturation and execution.

Incidentally, the three basic "external" activities of the person correspond to *three subjective modes of experience.* Being receptive is subjectively experienced as *being impressionable.* In an impression, which is always emotional, the person is seized by the logos of the opposite person. The mere impression, however, does not determine the exact proportions of external reality and internal attitude in the sensation. To be impressionable and to be adressed, could be termed *primary personal event* (analogous to Freud´s primary processes). These immediate spontaneous sensations represent the raw material available for further personal-noetic

processing, with the potential to cause significant affective resonance. Earlier, I already introduced them as "primary or original emotionality", to be recovered as a first step in therapy.

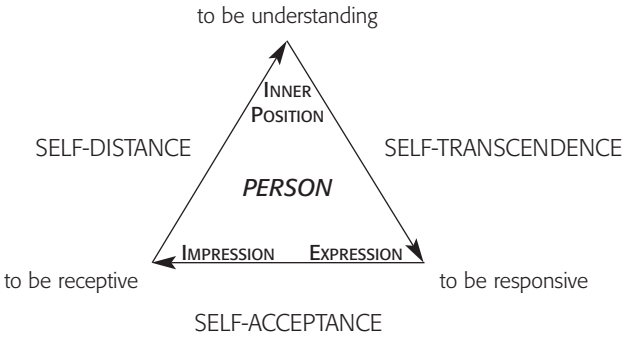

Figure 2: The subjective side in the experience of a personal event

Before the person can respond, the most personal and intimate task is required:Taking an *inner position.* Here the noetic unconscious (Frankl) flows together with the conscious (judgment) and the entire condition of body, soul and spirit. By taking this inner position, personhood unfolds out of its own center (conscience) by means of its world – and thereby creating its own world, with itself as the center. By taking this inner position, personhood enters the space opened before by the impression. With this position, the person realizes his/her essence: To be free from of the depths of final unconsciousness, which it can never fathom by itself. By taking an inner position, human beings are ahead of themselves. Yet they remain a secret, ultimately unconscious of themselves, as long as they live. This unconsciousness, however, does not keep one from taking an inner position (e.g. spontaneously or emotionally or somatically). On the contrary: Without this inner position, the person could not defend him/herself against parts of his/her consciousness (rules, norms, habits, etc.). Without an inner position, he/she would lose him/herself. What happens in this inner positioning? The primary sensation is related to everything, that is valuable to the person, everything he/she feels attached to, because it makes up his/her life. The person adds his/her own, with his/her value judgments to that spontaneous first impression. Therefore this step could be termed *"secondary or integrated emotionality"* (LÄNGLE 1989). Some distance is added to the always unilateral, primary sensation. By gaining an overview, it can now be related to the entirety of pertinent values. This relativizes primary sensations while assigning them their position in life´s biographical setup. This happens mainly by means of sensing: Actively following inner tracks (as opposed to the more passive event of being impressed, which leads to the sensation). Thinking and consciousness can assist, as well as hamper this process.

As soon as such an original emotionality is integrated, the power of the impulse becomes willpower – a will which is rooted in feeling; not rationally deduced, although it is rationally understandable.

In the dialogical event, taking an inner position is essential. Contrary to an echo-like semblance of conversation (echolaly) or the meaningless façade of a salesperson, dialogue lives from independent partners, each taking their own inner position. Inner positioning means creating connections between one's own and the other. That is why inner positioning corresponds to understanding (see fig. 2), which is also essentially concerned with making connections. It is not possible to understand without inner positioning.

The person who has found his/her inner position, will not remain hidden. He/she is ready to act. He/She is urged to express him/herself by responding to and acting in the world. Addressed by the factual, he/she has personally transformed the impression while opening it to his/her own understanding. Now he/she wants to express what is being said inside. He/she wants to penetrate back into the factual world by acting, in order to realize the "possible" world. This is how the person realizes him/herself. He/she realizes His/her possibilities in the world, and thereby realizes him/herself as possibility. This, in the end, makes him/her a personality.

4. The Area of Indication for "Personal Existential Analysis"

PEA is a profound therapeutic procedure which tries to mobilize personhood out of the depth of its feeling and the center of its sensing.

Indications are:

1) Disorders of *personality development.* Especially in the case of internal or external *speechlessness*, or a missing *sense of values,* caused by rejected or unprocessed impression. This includes the entire picture of noogenic neurosis and existential vacuum.
2) In the case of *missing or incomplete inner positioning.* Here patients feel a lack of inner freedom or complain about insecurities, fears, the inability to decide or assert oneself, insecurity of, or alienation from self (being unable to do what they want, or unable to understand what they do).
3) The third area of indication is a disturbed *responsive behaviour* in the relationship with others. Patients feel misunderstood; relationships tend to be fragile and full of conflict. Patients are unable to respond to the demands of the situation, to the demands and signals of a partner or they fail to give the proper response.

A *contraindication* would be a serious depression, due to the lack of energy necessary to take an inner position, and because the unilaterally negative mood generally distorts impressions. Whatever causes massive fears is a relative contraindication. Here the personality needs enforcement first, lest unnecessary resistances be provoked. Experiences with psychosis, schizophrenia, paranoia and organic psychosyndromes are not present.

5. "PEA" as a Method

The model of personal dialogue forms the methodical sequence of "PEA", leading to four steps:

1. The description of relevant facts (entering a relation).
2. The awareness to initial impressions and sensations among the facts (self-acceptance).
3. The achievement of an understanding (by the therapist and the patient) resulting in the patient taking an inner position (self-distancing).
4. The attainment of an adequate response (self-transcendence).

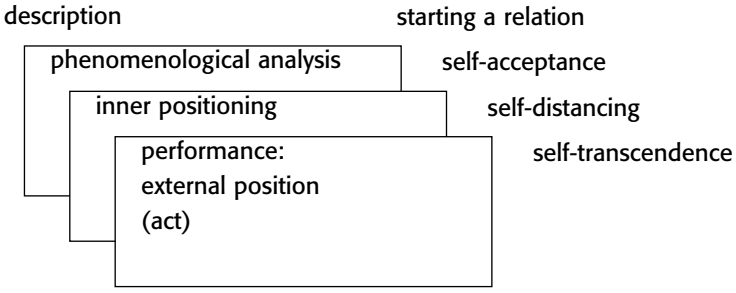

Figure 3: The methodical steps of "PEA" and their anthropological implications

This procedure leads to existential meaning, which makes "the best" out of given circumstances and is realized in response to given facts. Hence, the four steps of existential discovery of meaning will also be found in this method, as described elsewhere (LÄNGLE 1988, 42 ff):
1. by recognition, 2. by finding the intrinsic values, 3. by choosing and deciding, and 4. by the effect of acting.

5.1 Description

- *Goal:* Matter-of factness. Reality (truth) is always the basis for existential-analytical dialogue
- *Anthropological implications:* Starting a relation by talking about facts
- *Technical steps:* Reports, descriptions, narratives, statements
- Visualizing concrete situations ("scenarios")
- *Methodic suggestions:* Emphatic questioning, clarifying of contradictions
- *Level of motivation:* Searching for lebensraum ("will to be")
- *Assortment of typical questions:* What happened? What is now? Who?-What?-Where?-Why?-How?-When? For how long? How often? What is it about (issue)? What do you want to say?
- *Further methods:* Diary, hypnotherapy, etc.

The descriptive phase is meant to gather information for the following psychotherapy. A report of the situation or the problem is necessary. Generally it includes the description of the circumstance and the anamnesis. Attention should be paid that impressions, opinions, wishes and explanations are not dominating. The patient should be rooted in the irrefutable facts. This necessary precision mostly requires a careful and empathically directed conversation. The patient's suffering naturally tends to distort his/her vision, causing him/her to overlook important facts while tending to justify him/herself. The following two practical examples show that this phase can often be very subtle. The therapist should keep in mind that verbalizing or describing (not reflecting on) circumstances always means admitting the event to oneself. Besides, this describing creates closeness to what has been told, so that emotional involvement is to be expected. This is precisely what is essential for the therapeutic process.

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As an example, I remember the talks with a young man, whose self-destructive, suicidal tendencies to a large extent had resulted from the severe harshness he and his father had been brought up with. The patient loves, respects and fears his father. It took a long time until he could talk about the circumstances of his upbringing. He could neither describe nor talk about that time, sticking to general statements: "I really had a strict upbringing. – My father was a strict man.- You can't talk with him …" It took him several weeks of gaining confidence to say, what he had really done (mostly confidence in himself, to be able to bear the pain). It was quite understandable, that he could not speak sooner and describe what had happened, to himself and to me. Already at the age of 18 he had been kicked out of the family home by his father. He lived in shelters, shaken and abandoned. But even before then, his father had treated him with the same severity. To talk about such life-threatening experiences is only possible where there is enough support. How much courage and confidence it needs to talk about deeply engrained and terrible experiences. This can be demonstrated by another example. I was speaking with a young woman who kept people at a distance by a sickly-sweet affectation. In spite of many helpful relationships, she was very lonely and secretly unhappy. She had not always been like that. It began soon after she turned 14. And that is precisely where she began to falter – when she was about to talk about her pastor. He seduced her, and did so several times in the following years, always under religious pretexts. As she noticed that she was not losing my respect, she could talk about it surprisingly quickly. She herself felt hardly anything during her report. She had succeeded in the description, but the entire emotional weight and meaning for her life had not yet entered the picture.

5.2. The Phenomenological Analysis

- *Goal:* Grasping the essential in an impression
- *Anthropological implications:* Self-acceptance by accepting the spontaneous (including unwanted) sensation.
- *Technical steps:* Phenomenological view, letting the observed object take effect. Recovering of the initial emotionality (the spontaneous sensations), discovering values by being open to be touched.
- *Methodical suggestions:* Abandoning all explanations and interpretations as information that is not original.
- *Level of motivation:* Searching for the value of life. Fundamental value.
- *Assortment of typical questions: basic question: "How" is that for you?*
  * How does it feel? (looking for the spontaneous feeling) How are you dealing with it? – What do you like about it? – What bothers you?
  * How does it affect you? (looking for the intentional object) How do you experience it? – What does it say to you? – What is his/her message to you?
- Further methods e.g. painting or music therapy; elements of Gestalt therapy, elements of psychoanalysis, etc.

Facts form the framework for life´s events. While not decisive they are requirements and conditions for actual life. The essential part of facts for human beings is their effect on the person. In other words: Their meaning for the one concerned is essential. In order to break through to the essence, facts must be left behind, and seen through to their depths. Such a phenomenological analysis gives further depth to the therapeutic intervention. Without being receptive to the experience, without giving room to what has been felt, and (perhaps unconsciously) sensed, and (emotionally) accepting it (letting it be), or without perhaps becoming consciously aware of it, human beings cannot take up their lives and live. One remains a stranger in one's own house, directed by circumstances and mixed up in a net of emotions. One has to guard oneself against them in order to function in society – functioning, in order to survive. Such "guarded" persons with their lack of emotion seem stiff and uptight. They are exposed to the fear of their own inner abyss (fear of life).

The search for and acceptance of immediate sensations can cause significant tension. It may reveal a discrepancy between reality and desire. It may serve as a dynamic motivator or result in fear and defensiveness. Defensiveness is demonstrated by a lack of emotion, while looking at the facts, and by not being able to remember earlier sensations. Fear is an indication to proceed at a slower pace, enabling the patient to carefully raise his visor (or perhaps an intermittent therapy of fear is necessary). In both cases, the therapist needs to carefully accompany and support the patient. Furthermore, it may be helpful to proceed by alternating between the

level of impression and the level of inner positioning (next step of the PEA).
In many cases, following the traces of an effect may lead directly to the biography the person has grown out of, constituting its personality (FRANKL 1984, 204). This background often illuminates why a situation could cause an initially incomprehensible effect.

5.3 Inner Positioning

- *Goal:* To relate the new to the prevailing
- *Anthropological implications:* Self-distancing (Frankl), personification
- *Technical steps:* Understanding and taking up a position (judging); integrating emotionality into the entirety of one's values (conscience).
- *Methodical suggestions:* Method of dialogue; double positioning (of the patient toward the content and of the therapist toward the patient's behaviour); method of direct speech, explanation, confrontation, interpretation.
- *Level of motivation:* Searching for the right to live (justified existence)
- *Assortment of typical questions: basic question: "What do you make of it"?*
  * Do you understand it? What did he want with it? – What was it good for?
  * How do you judge it? What do you say about it? – Do you think he/she has done the right thing? – What do you personally – deep down ("secretly") – really think of it? – Do you think it was right?
  * What does it mean to you? What have you lost by it? – How important is it for your life today (… was it … then)?
- *Further methods:* Rogerian psychotherapy etc.

Being touched emotionally creates great proximity to what is recognized. Therefore it influences, and has power over the person. Consequently, the person is called to free him/herself from the spell of being affected, in order to regain power over him/herself. The person gains sovereignty by taking up a position (as described above), for which judgments ("own opinions") are important. Judgments set limits. They grant the person superiority. Judgment sets the person free again. The person thereby re-creates him/herself and sets him/herself free from the precariousness of the impression. What is at hand, becomes available for use. Taking up a position means disassociation from the object and acceptance of existing facts. The sensation ("emotionality of the aspect" by being affected) is integrated into the entire system of existing personal values, and is no more the only decisive factor. Creating these personal (and also factual) connections leads to understanding what has been experienced. Emotion is integrated by association with other points of contact of the person ("conscience" as agent of "overall value judgments"). The taking up of directed occasional viewpoints by the therapist (possibly including "explanations") may help the patient to find his/her own position.

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I would like to pass on a few statements from therapy with a 30-year-old man, from the phase of taking up positions for the first time.

Psychopathologically, the patient is a socially-inhibited personality living in a symbiotic relationship with his wife. She suffers from a severe hysterical neurosis. It is a dangerous, but not infrequent combination. The following incident may serve to demonstrate how destructive such relationships can be.

Because of a suicidal attempt (ca. 50 sleeping pills), the patient was in intensive care for several days and consequently hospitalized in a psychiatric clinic for protection and therapy. Two days after his release he went on a little outing, faithfully following an advice of his doctor. He wanted to preserve the distance he had gained during hospitalization. His wife, however, was determined to accompany him with their six-month-old baby.

So they set out for the Semmering, some 80 km from Vienna. During their walk, the wife became angry because she had expected the afternoon to be different. She began to attack her husband heavily, telling him he was not a real man, without an ounce of self-esteem. He should ask his therapist, how long it would take until he could live without her so that she could get a divorce. His silence only served to aggravate her even more, sending her into a rage: She accused him of being mentally disturbed, like his friend X, leaving her as the only normal person. Her attacks finally culminated in her insistence, that should he ever try to commit suicide again, he ought to at least do it right.

So far the incredible scene. It is hard enough to believe, that a woman with three small children could insult her husband so bitterly immediately after his release from psychiatric care. But what did he do? – He kept silent to the end. He did not have the courage to say anything. He listened to her. He began to believe her. He was deeply affected. When she finally left him alone on his walk and disappeared into a café, he realized, how the cliffs of the Semmering began to draw him like magnets. He was overcome by an almost intolerable desire, to jump off a cliff and put an end to his misery. In order to escape this, and in his desperation, he called his mother in Vienna from a telephone booth. He told her, he was on an outing at the Semmering, along with his wife and the baby, and asked her how she was and what she was doing. No word of what had happened, not the tiniest hint of his suicidal tendencies, lest "she be worried"!

The next day he showed up for his appointment for the first time after his release from the hospital (he had been with me twice before hospitalization). After his report I asked him what position he took: "What do you say about your wife´s behaviour?" – "That´s the way she is. – She has always been that way. – It´s hard for her, being with the children all the time. – She had different expectations, before we drove up the Semmering."

These were his answers. Are these answers really inner positions? They are, of course, judgments and opinions, but not about the situation and not on the basis of the feelings he expe-

rienced. That is why they fall short existentially. – These oppinions are general statements. He does not take up a stance toward the concrete effect, which the behaviour of his wife has on *him* now. The fear of losing his wife (something she has seen through for the longest time) is like a wall in front of the concrete position, which is in this case, certainly loaded with conflict. He remains alone behind this wall, without a relationship to her. In this case, it is more a stance toward his fear than toward his wife. In this way he can keep his fear at bay for a short time, but not his wife. He remains at her mercy.

The following section of a conversation impressively demonstrates how much the patient was both missing a personal focus in himself, and independence in the relationship to his wife. It was impossible for him to be open to what the situation would show him. His defenselessness becomes apparent. The lack of personal position leaves only dependence.

After the patient had talked about his deathwish for a while, he came back to the behaviour of his wife, which apparently still concerned him. But there was not a trace of surprise, rage, anger or critique. To give him an idea of possibly taking up a position, I again asked him:

Th.: "What do you say about it? What do you say about what your wife said and did?"
P.: "I don´t understand. I don´t even understand your question!?"
Th.: "Is it good or bad, right or wrong in your opinion? Do I like, what she says and does?"
P.: "That means I would have to have a point of view! – It all depends on the point of view! I can´t just have a purely subjective point of view!"
Th.: "You should try just that: Find your own purely subjective point of view!"
P.: "But then....then I would end up having to decide if I should leave her...(patient becomes restless, scared)....I never thought about that, not once. (...) If my children would be taken from me, murder would be on my mind....That leaves me with only one alternative (sic!): to kill myself or her (his wife). But that would be no solution, because I can´t live without her anyway. The thought is unrealistic, because, because -."
Th.: "I believe you...To think about it does not mean, you have to seperate... You could find out, just for yourself, what was going on there. That would hardly mean you´d have to do something right away...".

After nine months of working on understanding and taking a position, he was independent enough to tell his wife, during a quarrel, for the first time: "If it goes on like this, I will soon get a divorce!" He had slowly become capable of personal responsive behaviour. – In our context, this leads us to the last step of the method.

5.4 The Responding Performance (Act)

- *Goal:* Self-actualization as preparation to carry out existence
- *Anthropological implications:* Self-transcendence (Frankl), expression as holistic involvement of the person, integrated existence, future orientation, meaning
- *Technical steps:* Plan of action
- *Methodical suggestions:* Playing through scenarios
- *Level of motivation:* meaning in life: "Will to act" – "will to find meaning"(Frankl)
- *Assortment of typical questions: basic question: "What do you want to do?"*
  * What would you like to do most of all in this case? What can you do/tell him/her? Who do you do it for?
  * How do you want to do that? What means are available to you? – Are they adequate? – Can you take the responsibility for what you intend to do? – What will it lead to? What is he/she going to say?
  * What will you tell him/her? Could you tell me the way you would tell him/her (directly)? What will happen because of it?
- *Further techniques:* Behavioural therapy, psychodrama, systemic methods, strategic methods, concentrative movement therapy etc.

The preparation to practical action is an essential part of therapy. To leave the patient alone with it is often asking too much. To know *what* should be done does not yet mean to know *how*. By what means, in which way, and when should what be done? What can the patient trust him/herself with – what changes can he/she expect from his/her environment? How should a day be started and structured? What could help him with that? The accompaniment by the therapist will often remain necessary for a long time for such practical, behavioural or systemic/strategic reflections and attempts. Some patients are quick and sure in their orientation, but somewhat weak, clumsy, helpless and lacking imagination in carrying out their intentions. Finally, the therapist should demonstrate solidarity where the patient occasionally is frustrated by his/her environment, or falls back into old behavioural patterns, and not leave him/her alone.

The time between therapy sessions is of great value to expand, and let the patient experience, the autonomy aimed at in therapy. I frequently end a session by leaving the patient with an immediate, concrete task, to bring him/her to an openness for a still missing meaning and for life in the future. Existential-analytic therapy is not only understanding, feeling, recognizing and taking up a position, but also practicing, experimenting and acting. A therapy often begins with tasks involving the patient with himself: memories, feelings, standpoints, a new structure for the day or for recreation and sport activities. Later they shift to the external world: Encountering certain people, conversations with parents, siblings, friends and partners. It may be about deal-

ing with a child differently, or consulting with the boss. In other cases it might be a matter of changing a working style or an attempt to deal with oneself differently (e.g. solitude).

6. Conclusion

PEA is an attempt to exploit the cornerstones of personal self-actualization in therapy. Should the method actually contain essential ways of approaching and dealing with the person, it would naturally lend a general structure to psychotherapy which, to a large extent, would be independent of orientations of specific schools of thought. This makes good sense because every psychotherapy wants to reach and mobilize the center and essence of human beings. This is where different schools meet, however different their approaches might be. (In a similar way the basic variables of Rogerian psychotherapeutic conversation were used by many schools of therapy.)

This possible asset of PEA, to lend a general methodic framework to personal psychotherapy, could be interpreted as a weakness for existential analysis itself, because PEA lacks the orientation of a specific school. Or is existential analysis so fundamental in its concept, that it should be placed prior to the splitting up of psychotherapy into different points of emphasis?

Many questions as to application and indication remain open. For instance, it is not yet completely clear whether the method can be used in the same way with different diagnoses, or whether specifications dependent upon the diagnosis are necessary. So far, experience has shown that patients with fear need more time and attention for the description (first step of PEA), which they have a harder time attending to, because of their fearful tendency to avoidance. Involvement with the irreproachable facts of life makes the missing support tangible for them. On the other hand, depressive patients have a negatively distorted impression of their reality and need correction on a second level, the level of being affected. Hysterical patients lack personal positioning ("escapism") and are in need of the therapist's resistance, in order to penetrate to their own, real feelings and positions.

With them, the therapist will have to stress the third step of PEA, enabling "personal" positions related to values, instead of frequent and hollow pre-judices. For patients with personality disorders, the emphasis should perhaps be put on the integral level of taking position and on their disturbed existential mode of behaviour. In this way, different points of emphasis begin to emerge for application, although they would still need verification and further experience. In any case, the task of PEA lies at the forefront of personal existence and in the preparation of geniune existentiality. Existential-analytic psychotherapy wants to enable people to find personal expression in, and have a personal effect on, their worlds. They should be partners in taking up a position in the system of their relationships. The power of person is designed for an existential field of tension. For the person, this is the world, for which he/she is responsible. Where this interaction is successful, the patient experiences that which brings healing. Indeed, this meaningful effect in the world could be his/her destiny.

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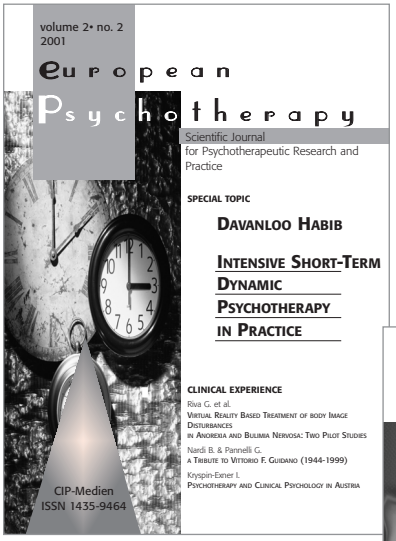

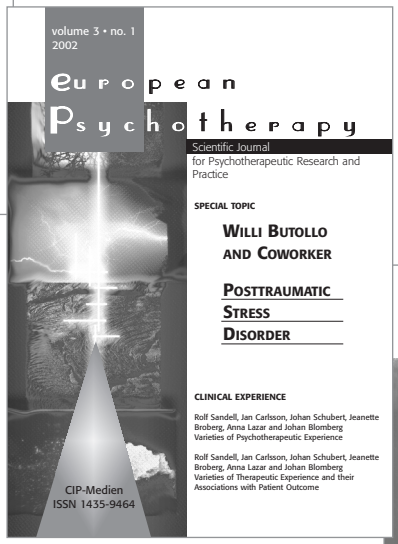

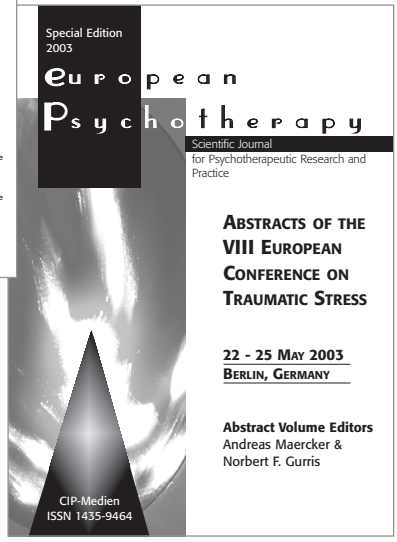

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Levels of Operation for the Application of Existential-Analytical Methods

Abstract

On the basis of the fundamental human (spiritual) abilities for self-distancing and self-transcendence Viktor Frankl developed two methods: Paradoxical intention and Dereflexion. The further development and the differentiation of the existential-analytical concept of person and existence by Alfried Längle has enlarged the anthropological basis of interventions and their methodological descriptions.

A survey of the current state of logotherapeutic and existential-analytical methods is given, and their specific indication and functioning are discussed with reference to Personal Existential Analysis (PEA), the process model of Existential Analysis. On the one hand this allows the assignment of methods based on their mode of action on specific human resources (or fundamental abilities), on the other hand it describes three operating levels where specific methods either address, support or actualise certain aspects of the person. This procedure includes a map of anthropological and methodological assignments of the different methods.

Key words: Existential Analysis, methodology, methods, process assignment

Introduction

This paper surveys the methods of Logotherapy (LT) and Existential Analysis (EA) as they are actually used in psychotherapeutic practice, and are taught as part of the curriculum and training program for psychotherapy and counselling of the International Society for Logotherapy and Existential Analysis (GLE-International) [today]. This has to be emphasized because there are great differences in applying and teaching methods between different logotherapeutic societies.

The intention of this paper is not just to enumerate a list of methods but to try to explain why they work. This will be done in the first part of the paper by linking the interventions to the anthropological concept of Existential Analysis, and in the second part to the layer or the depth of disorder where the methods target, respectively to their operating level.

It is my aim to make the structure of existential-analytical methods transparent in respect to these two apparently essential aspects.

1. The First Aspect of Methodological Structures: Anthropological Basis for Existential-Analytical Methods

To begin, it may be useful to reflect on the themes and the mode of operation of Logotherapy and existential-analytical therapy. A. Längle's paper on the "Existential Fundamental Motivations" in this issue surveys the structural model of Existential Analysis (A. LÄNGLE 2003). The author describes the goal of modern existential-analytical therapy as achieving the ability to live with inner consent, which means to find within oneself a "yes" to one's way of acting. One might describe this inner consent as the means to act and deal with one's situations in a way that leads to self-affirmation and to assuming responsibility for one's actions. Existential freedom means to be able to live with affirmation, with consent.

The access to the free will of the person proves to be the basis of a mature, meaningful life, a life characterized by self-and other-affirmation and responsibility. As a consequence, all methods of LT and EA share the common goal of achieving this personal, existential freedom.

Thus far I have described the general direction of interventions. In order to develop a more detailed structure of methods we have to take a more internal look at the structure of existential analytical anthropology.

1.1. Anthropology of Classical Logotherapy (V.E. Frankl)

Which steps and personal processes enable us to live with existential freedom?

Classical Existential Analysis, which is based on the anthropology formulated by V. E. Frankl (see e.g. FRANKL 1985, in German e.g. FRANKL 1959, 1986, 1991), postulates two basic abilities of the noetic person: *Self-detachment and Self–transcendence,* which are *basic conditions for existential being.* Frankl describes these conditions as a specific way of being in the existential, *noetic dimension,* in which he contrasts with the psychic and somatic (or biological) dimensions.

SELF-DETACHMENT emphasizes the ability of the noetic person to oppose his or her psychological and biological mechanisms or, as Frankl says:

"Man is free to rise above the plane of somatic and psychic determinants of his existence. By the same token a new dimension is opened. Man enters the dimension of the noetic, in counter distinction to the somatic and psychic phenomena. He becomes capable of taking a stand not only toward the world but also toward himself." (FRANKL 1985, 19)

Since being a person means to be able to distance oneself from the life's conditions and from oneself by mobilizing one's will to freedom, the following question necessarily arises: "Towards what shall the will be directed?"

The answer lies in the concept of **SELF-TRANSCENDENCE.**
I would like to give a description in Viktor Frankl's own words, since they represent his Logotherapy in a nutshell.
"It is a tenet of Logotherapy that self-transcendence is the essence of existence. This tenet means that existence is authentic only to the extent to which it points to something that is not itself. […]
Man, I should say, realizes and actualizes values. He finds himself only to the extent to which he loses himself in the first place, be it for the sake of something or somebody, for the sake of a cause or a fellowman, or 'for God's sake'. Man's struggle for his self and his identity is doomed to failure unless it is enacted as dedication and devotion to something beyond his self, to something above his self." (FRANKL 1985, 87)
Frankl stresses that human beings are not prisoners of their feelings or their environments, but that they can transcend their egocentrism and view their situation from a different perspective. Human beings are free to choose and decide where to turn, and to be dedicate to something or someone beyond themselves. But in Frankl`s view only the process of leaving oneself behind, of neglecting oneself leads to existential being, to personal fulfilment.
In elaborating his concept of psycho-noetic antagonism, Frankl stresses that one has to leave behind the psycho-somatic dimension and conditions and transcend these restraints. Frankl`s formulations concerning his anthropology lead to an ambiguous one-sidedness, which may also have implications for the person's relation to him-or herself. This topic, for example, concerns self-experience in the psychotherapeutic training program. (cf. S. LÄNGLE 2001, 20f, A. LÄNGLE 1996c)

1.2. Anthropology of the Personal Existential Analysis (A. Längle)

Frankl has seen a psycho-noetic antagonism as a starting point in every psychotherapy (FRANKL 1959, 686). But in modern Existential Analysis this paradigm has changed substantially.
The one-sided openness of the person to the world is supplemented by the "personal turn" which is, as the name says, a turn to the conditions of the person as well as a "turn to emotionality" (cf. A. LÄNGLE 1999a, b).
Here we have a great change in comparison to Frankl's original Logotherapy. In addition to seriously considering reflection, reason and conscience, Personal Existential Analysis (PEA) gives equal attention to human impulsivity, instinctiveness and corporeality. These aspects are discussed in greater detail in the publication on the PEA of A. Längle in this volume (see also A. LÄNGLE 1993).

In our context it is of substantial importance to note that the PEA model does not view the noetic and psycho-physical dimensions as inevitably and a priori antagonistic. The noetic does not have primacy over or supersede the psychological and physical dimensions. On the contrary; in first instance they are one.

The person bears the innate capacity of being impressed, being acted upon, through sensations, feelings, impulses, and spontaneous reactions show a unity of the noetic with the psychological and somatic dimension. The same applies to the active expressions of the person. Here, too, the noetic exists in harmony with psychological and physical forces, as well as the de facto conditions of the world.

Only when human beings make a conscious decision do they step out of this psychophysical unity. Taking a stand relates to a spirituality (which, in this context, is not understood in the religious sense) that is beyond the situational restrictions.

This signifies, in respect to personal resources, that, in addition to SD and ST, human beings have the ability to overcome antagonism, and it is this ability that guards and protects human identity: This ability points towards self acceptance.

This **Self-Acceptance** comes from an openness towards oneself, which likewise means, to accept an exterior reality as well as what occurs in my inner awareness, what is going on in myself, what is set in motion in myself, and to dedicate oneself to both with equal seriousness. As a consequence, human beings remain in continual dialog with the external world as well as with the internal world.

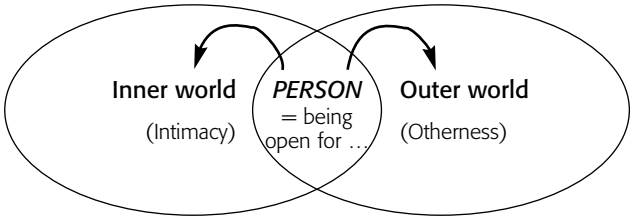

Figure 1: The double way of openness of the person as a result of the double reference

Taking a position opens up the possibility of a dialogue, which now turns in two directions and, as a consequence of the person's wholeness, this dialogue has a process-oriented interchange between inside and outside.

In sum, we find in the current version of EA a third personal resource in addition to the human capacity for self-detachment and self-transcendence outlined by traditional LT, the ability of self-acceptance (SA).

These are the three pillars that make a continuous dialog of the person possible. Standing in this dialog refers to the "I-THOU" relationship, described by M. Buber (1973), as the basis of vital, existential encounter and relationship. This existential way of living is always an actualisation of one's personal freedom by remaining open to the situation and by giving one's own answers. This actualisation is the aim of every existential therapy and counselling.

Actualizing personal freedom, as the general aim of any existential analytical intervention, focuses on SD, ST and SA in particular as the human resources which lead to this personal freedom. In these three personal abilities we find a *first structural aspect of EA methods.* The methods differ depending on whether they aim at SD, ST or SA; for instance, it is well known that Paradoxical Intention aims at SD and Dereflexion at ST.
This leads to the second part of the paper.

2. The Second Structural Aspect of the Methods of EA and LT: Mode of Operation

Today we have a considerably enriched repertoire of methods to pursue the above mentioned aims. Most of them were developed by A. Längle in the eighties and early nineties and published in German. We will survey these methods in respect to the two structural aspects, the anthropological as well as the methodological.
A closer look at the methods reveals three different layers or levels differentiated by their manner of working.

2.1 First Layer: Resource-oriented

On the first level we find the classical methods as they were developed by V. Frankl: **Paradoxical Intention, Dereflection** and **Modification of Attitude** (e.g. FRANKL 1970, 100ff and FRANKL 1985, 140ff). Here we follow the classical trace of intervention as initiated by V. Frankl: It directly draws upon personal resources. Implicitly these interventions are based on the presumption of sufficient access to personal abilities. The counsellor or therapist leads the patient in an internal and external dialogue based upon the assumption that the patient will find answers and thereby immediately experience his or her own competence or ability for him/herself. The patient spontaneously finds his or her way, which means he or she becomes conscious of previously forgotten experiences and becomes open to novel ones as well. These experiences make the patient aware of his or her own integrity and authenticity.
Distinct from psychotherapy, which guides a longer process of development, these methods work where experiences are accessible spontaneously, or at least relatively spontaneously, with the help of a supportive, but stimulating counsellor. The result may be a changed perspective or a fresh look at an old experience, which means an opening and widening of the impression received. Existential-analytic therapists may apply Paradoxical Intention, Dereflexion or the Modification of Attitude if the patient's sense of personal competence has remained intact, but is not freely accessible because of the hindering experiences of problems. In order to make personal resources accessible the patient needs an impulse through an empathic, therapeutic relationship. In such cases the patient may be unable to dialogue and reflect in respect to specific topics, but the general ability or competence remains intact.

The resource-provoking methods have one basic notion in common: They break through a secondary cycle of instability and produce an attitude of expectancy or a *phenomenological openness* in the face of threatening situations.

Frankl has demonstrated how such circle mechanisms form the basis of a self-preserving process that leads increasingly into an attitude of avoidance. (cf. FRANKL 1985, 143ff; FRANKL 1970, 102ff)

More specifically, they symptom, as the starting point of the vicious circle, has a destabilizing effect on the patient. This experience of insecurity or anxiety leads to increased attention and expectancy, which, in turn, reinforces the symptom.

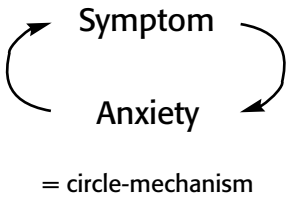

Figure 2: The anxiety circle

In such a *vicious circle of destabilisation* anxiety about a certain situation becomes fixed, but can be ameliorated by experiencing the described personal resources:

- *Anticipatory anxiety* refers to the experience of an existential threat in certain situations (like blushing in public). Here SD can help to realize that one continues to exist in spite of this anxiety. The appropriate method is *Paradoxical Intention.*
- *Compulsion to self-observation or Hyperreflection* arises from the fear over losing control. Patients with this compulsion are prone to hyperintention regarding security and control with a guaranteed outcome. ST leads to a new openness to become involved with new experiences, as applied in *Dereflection.*
- *Fixed attitudes* often reveal a fear of change towards that which is perceived as life-threatening. SA leads to a more open view of life; one can dare to go forward with one-self, and to let life come as it may, even if it is not within one's control. This requires a *Modification of Attitude.*

All these methods activate the patient's ability to face his or her own insecurity, and challenge him or her to move beyond the role as a victim in relation to his or her anticipatory anxiety or fixations.

Let me give a classical example as V. Frankl described it in his literature:

"A young physician came to our clinic because of a severe hydrophobia. He had been troubled by disturbances of the autonomic nervous system for a long time. One day he happened

to meet his chief on the street, and as the young extended his hand in greeting, he noticed that he was perspiring more than usual. The next time he was in a similar situation he expected to perspire again, and his anticipatory anxiety precipitated excessive sweating. It was a vicious circle; hyperhydrosis provoked hydrophobia and hydrophobia, in turn, produced hyperhydrosis. We advised our patient, in the event that his anticipatory anxiety should recur, to resolve deliberately to show the people whom he confronted at the time just how much he could really sweat. A week later he returned to report that whenever he met anyone who triggered his anticipatory anxiety, he said to himself, 'I only sweated out a litre before, but now I am going to pour out at least ten litres!' What was the result of this paradoxical resolution? After suffering from his phobia for four years, he was quickly able, after only one session, to free himself of it for good by this new procedure." (FRANKL 1985, 143)

The methods outlined above do not address the contextual causes of the problems and negate thus the background of the problems. Instead they directly provoke fundamental personal abilities which lead to a stabilisation; they provide a grounding or support and lead once again to a free internal and external dialogue.

The task of the first, resource-oriented layer is the restitution of support, protection and space. The patient's insecurity is challenged by the experience of his or her factual being. This procedure suspends the escalation of insecurity via the vicious circles.

In an existential-analytical understanding, the activation of SD, ST and SA are prerequisites for any ability to deal with reality. This potential corresponds to the content of the first fundamental motivation (cf. A. LÄNGLE 2003). The experience of being grounded in an existential sense is induced by the experience of the patient's ability to be in spite of deficiencies, as outlined in the methods presented above.

Personal ressources / Mode of operation	SD	ST	SA
First layer Resource-oriented	PI	DR	MA
…			
…			

Figure 3: The methods of the first level in their relation to existential analytical anthropology

2.2 Second Layer: Problem-oriented

The methods of the second layer differ from the resource-methods in the sense that they pay more respect and attention to the patient's *experience of problems or trauma.*

A deepening and supporting procedure reveals adoptions of opinions and previous judgements, including wishful thinking, avoiding attitudes, and helplessness or powerlessness on behalf of the patient. Through elevating the patient's emotional state, activating an attitude, a point of view, or clarifying where to go, the patient is required to first reflect and then draw upon his or her personal resources or abilities. This is done in a supportive and dialogical manner that elicits and reinforces untapped resources.
More precisely, we find in the second level methods that the patient enters into a *relationship with himself and with his or her environment* by dealing with the problem. Step by step the methods lead to an increase in interpersonal and intrapersonal contact. Thus, these methods lead to a closeness with oneself and others, and may even result in feelings of profound gratitude. This can bring about an orientation towards one's experiences of self-worth, replacing the previous orientation towards expectations, wishes, conceptions, or projections.
In the existential analytical understanding this process corresponds to the level of development in the second fundamental motivation. (cf. A. LÄNGLE 2003)

Devotion to something or someone beyond oneself leads to an experience of relationship and closeness to others, but more importantly to oneself, which in turn allows for intimate dealing with one's own emotions and may induce a re-affirmation of one's life. The attachment to one's own life is strengthened. Finally, the affirmation and enjoyment of life provides the basis for every experience of worth (intrinsic value), it opens the patient up even to a sensation of values, which means, the whole person is touched by such an experience of values.
An example may clarify the psychotherapeutic work on the second level further.
During the medical treatment at a hospital after a suicide attempt the patient was offered the opportunity for psychotherapy. During the initial meeting the 25-year-old woman spoke about the reasons behind her act of desperation. She had been addicted to drugs since she age14, and had gone to therapy for the first time at age16. Unfortunately, she relapsed due to the relationship with her chemically-dependent boyfriend. She considered herself a failure. For the last two years she had increasingly contemplated suicide, but had not spoken to anybody about it. Now she was glad that her attempt had failed, and felt as if a thousand angels had taken care of her when she jumped down from a bridge onto an underground train.
Throughout the last years, her life was dominated by drugs, although she recalled a successful period of two years after first going to see a therapist, during which she had been clean.
She was happy to have the chance to live again, but at the same time felt afraid to fail again. She doubted if she could manage to abstain from drugs on her own, but this would be the only way of life she desired to live, that would be worth living for her.

Although it was an ideal starting point for therapy, her situation also had several limitations. Due to several severely fractured bones, she was to be admitted to a local hospital and was expected to remain there for several weeks, following which she was to be transferred to a rehabilitation and drug treatment centre. This limited the number of our sessions prior to admission to ten. What could and what should be done in this time? No doubt, priority should be given to the stabilising and supporting her will to live.

She could not see a way to turn her wishes into reality, which she subjectively experienced as a lack of willpower. As a result, she viewed herself as a weak person, as a victim of her circumstances and infirmities. She doubted that she could reach her goal. She suffered from low self-esteem, was afraid how things would go on with her boyfriend, but hoped that her mother would help her. Moreover, she felt guilty for what she had done, and this in turn further reduced her self-esteem.

In existential analysis the aim of the psychotherapeutic intervention is to re-establish the autonomy of the person by facing the intended project head on.

In the case of this young woman we thus employed the "Method of Will-Strengthening" (WSM) (A. LÄNGLE 2000b), which applies the following steps:

The first step consists in describing her intensions and the positive consequences expected from psychotherapy. Her intention to live without drugs was very clear at that moment. She wanted to start a new life. She wanted to lead a normal life, to be capable to endure struggles and difficulties that life brought her way. A life with drugs was too exhausting for her.

The second aspect of the WSM is the elaboration of negative consequences, the articulation of the opposite of her desires. What would she lose by living without drugs? What would she have to give up? Using drugs has been her proven way of dealing with problems. She would have to find and learn ways to endure emotionally-difficult situations. "I used the drugs to close myself off." What will happen to her when she cannot close herself off anymore?

In this second step we had to look thoroughly at her ability to seek immediate relief in drug use and thus avoiding her problems and suffering. Does she have and will she be able to find sufficient courage? In whom and what can she trust? By abandoning her lifestyle of drugs, she also stood to lose her well-known milieu, the environment which supported her habit. It is the task of this second step to make the patient aware of all the obstacles, of all the reasons which work against her intentions. We have to take them as serious as the anticipated positive outcomes. These questions caused her quite a lot of anxiety, because the thin veneer of her well-known lifestyle covered a vacuum; a drug-free life was novel to her and very little grounded this new way of existence. This step concerned not only a question of handling the handicaps. It was a weighty step to encounter herself, to develop an awareness not only for the positive but also for the negative feelings, to come closer to herself. It was arduous to endure the frustrating feelings, to feel how alone she was. But to have survived at least thus far gave her a strong hold and basis for life. The experience of being able to communicate her feelings and to be serious with herself furthered her growing sense of confidence and courage. Her original

orientation toward something outside herself was directed back to herself: "What does my intended goal have to do with myself?" The development of the will was a step-by-step decision to live her life on her own terms. To feel this strong will means to be ready to dedicate one's life to the intended goal. The aspired idea of a drug-free life was no more just a common goal, the obvious thing; it was her own personal decision for her life, with her own reasons for it.
In this case, the patient managed to take this step of questioning, of casting doubts. It was important not to cling to illusions about the future or the past. The more we could concretise her hopes and fears the more she could experience the relief of truly being able to remain in her new life.
Now she was ready for the third step - the intensification of the positive. In existential analysis this intensification entails a 'getting closer' to one's own feelings, which are elicited by the intended goal. This, in turn, leads to an internalisation of this goal.
Once again she was reassured of her desire to quit a lifestyle of drugs through the process of exploring what implications this decision had for her entire life. In this final step she managed to recall her previous situation: For her the will to live without drugs was originally a decision for or against life. But now she felt much closer to herself, had become more acquainted with herself. And this provided her with a strong starting point for the long, hard way ahead. She had reduced her fear of failure and had experienced that being alone was not so terrible; she could trust herself.
Eventually this trust translated into her fundamental ability to transcend herself, to be able to dedicate her life to something or somebody, and with that decision make her life truly worth living. To the degree that she is able to tap into her personal ability to transcend herself, she is likely to rediscover the strength of her will.

This process of the second layer, the exploration of the problem, requires a certain level of ego strength. If the patient cannot overcome such a challenge - like the questioning of her goals – we would have to go a step deeper to develop her personal autonomy and resources as it is commonly accomplished in PEA.

These first two levels are the genuine domain of short-term therapy, which ranges between counselling on one side and the therapeutic process-oriented proceeding on the other side. (cf. S. LÄNGLE 1996)
It is interesting to note that, in this group, we also have three methods, each belonging to one of the fundamental personal abilities SD, ST and SA.

- **Personal Position Finding – PP** (A. LÄNGLE 1994a) is a three step method to discover one's personal position or attitude towards a given situation. It introduces a more profound process of SD and ridding oneself of restrictions and constrictions, which come from a missing assess-

ment (or position) and an entanglement in a given situation. Problems in relationships are often indicative of such an entanglement structure of getting mixed up or being involved in a way where one doesn't know how to go on. In these cases this method is indicated.

- **Will–Strengthening Method - WSM** (A. LÄNGLE 2000b) is a step-by-step method that works on the will to meaning. The evolution of will happens in the two-fold inner and outer dialogue, which clarifies and invigorates the process of realizing one's goals and in turn strengthens ST. The indications of this method are, on one hand, various types of addiction, and on the other, the frustration of or inability to complete a given task, such as one's studies or work.
- **Search for Existential Meaning - SEM** (A. Längle 1988, for an example also Drexler 2000): This method goes back to the ability to accept oneself which constitutes the foundation on which the person is able to perceive (become aware) and answer the question of meaning. The four steps of SEM relate to the four fundamental motivations of existential analysis. The intended range of application for this method includes situations and states where meaning is lost or where the search for meaning is failing. This often happens after a significant loss or a transition.

Now we can extend our scheme:

Personal ressources / Mode of operation	SD	ST	SA
First layer Resource-oriented	PI	DR	MA
Second layer Problem-oriented	PP	WSM	SEM
…			

Figure 4: The relation in two levels between ea methods and anthropology

2.3 Third Level: The Process of Developing a Personal Dialogue – Person-oriented

With increasing personal support the patient's access to his or her personal resources changes from

1) *activation* by a direct appeal to untapped potential at the first level to

2) a step-by-step *uncovering* and training at the second level towards
3) a *process of development* of yet unrealised potentials in the third level.

As the therapist encounters patients with less ego-strength, such as is common in personality disorders or PTSD, he or she moves the psychotherapy from resource activation methods to a personal, process-orientation.

Personal Existential Analysis – PEA (A. LÄNGLE 1993; 1999a; 2000a; engl. 1995) is the intra/interpersonal, dialogue-predicated process through which the person constitutes him-or herself in the decisive step of taking a position vis-à-vis a given situation. In PEA, which is considered the core of existential analysis, the person is regarded primarily as process, that is, as a developing rather than a fixed entity. Personal potentials are realised or actualised as the person engages in a dialogical exchange with the world in these three steps.

Being impressed, taking a position and finding an expression mark three fundamental abilities of the person. They create an intrapersonal encounter, which is an intimate access to what we find in ourselves, and they lead to interpersonal encounter. The latter renders possible an access to the other and to their response to one's existence.

The dialogical process in the personal impression, position-taking and expression always constitute a unity. They show, respectively, the person's capacity for openness, selectivity and interactivity.

The realisation of experiential values, such as creative values and attitude values as described by V. Frankl (for example FRANKL 1970, 70; 1985, 29), can be viewed as the process of living out these capacities of the person.

The theory of PEA offers an understanding of human development that results in a personal and existential way of living. This means that we can develop tools to aide this development in the therapeutic process. Wherever this development is interrupted, impeded or disturbed, therapy may revitalize this growth process and lead to the confidence and ability to successfully manage one's life.

How can therapy provide guidance in this process?

In Existential Analysis the guidance comes from two sides:

1) The structural model as derived from the fundamental motivations
2) The process model based on PEA

The therapeutic method of PEA takes place in three steps and is preceded by an introduction.

It can be described as follows:

PEA 0: The preparation or introduction gives space to a contextual description of the facts and problems. Additionally it serves to establish the therapeutic relationship between patient and therapist. The task of this stage is a cognitive attention of the therapist.

PEA 0 can be seen as a first actualisation of SA.

PEA 1: This is the stage of a *phenomenological analysis* with the task of eliciting the patient's primary emotions. That is the first 'emotional answer' to the situation. Whatever the situation means to the person is its phenomenological content. At this point the therapeutic attitude is determined by empathy.
The further elaboration of primary emotions activates SD, in which the person gains more distance vis-à-vis his or her initial impression.

PEA 2: This is the stage of an *authentic restructuring*. Here the impression is integrated into existing value structures, a process which aims for the patient to understand, decide and arrive at a resolution to his or her problem. The aim is the development of an internal attitude that leads to *integrated emotions.* The original primary emotion may have changed in content, but has essentially evolved from a psychodynamic or unconscious reaction into a conscious attitude. The therapeutic task here is confronting and encountering.
In this second step the greatest separation from psychophysical conditions is accomplished as well as the greatest activation of the noetic (personal, existential) dimension and its capacity to develop, empower a personal attitude.
At this point of culmination of existential freedom the person can leave behind psychodynamic or unconscious limitations and start his or her "future". This means that he or she is able to decide what is essential for his/her life and future. This opens the way for ST.

PEA 3: This stage deals with the self-actualisation of the patient. We want to arrive at an *adequate expression* of the patient's active response, which translates into an external attitude. This response is a prerequisite in order to live decisively in a self-transcendent and yet self-accepting manner. The therapeutic task here includes support and encouragement.

PEA is a kind of being-on-the-way, a type of development and living, step by step. The actualisation of personal existence is characterized by a wholeness, where SD, ST and SA now are inseparable domains in the accomplishment.

Existential-analytical therapy always includes work on the whole process. Well-known therapeutic procedures, such as biographical work (cf. Kolbe 1994; A. Längle 1994b; Tutsch, Luss 2000), imagination exercises (cf. Popa 2001) or the shifting of perspective (cf. Kolbe 2000) represent different approaches to this process and employ the different existential resources SA, ST or SD as the starting point.

Now we have a complete scheme and can arrive at a comprehensive understanding.

Personal ressources / Mode of operation	SD	ST	SA
First layer Resource-oriented	PI	DR	MA
Second layer Problem-oriented	PP	WSM	SEM
Third layer Person-oriented	←	PEA	→

Figure 5: The complete methodological scheme of EA

3. Summary

We now find three levels of methods:

- *Resource*-oriented in breaking through a vicious circle → provoking;
- *Problem*-oriented in supporting step-by-step access to one's own emotions and feelings → training;
- *Person*-oriented in the process of increasing the personal ability to sustain intrapersonal and interpersonal dialogue → development.

In each of these layers the three fundamental personal abilities are addressed:

- SD as a release from being closely bound up with oneself, one's psychodynamics and the world;
- ST as intentionality towards the world, to other, and as a dialog to the external environment;
- SA as a dialogue with the internal world, as truly and deeply accepting oneself.

The above mentioned methods provide the therapist with a variety of interventions, which enable him/her to engage the patient. The interventions are designed to help the patient find him/herself existentially; they seek to empower the patient to find his/her voice and give description and expression to new and better ways of being. In addition to the methods introduced in this paper, EA provides the therapist with other interventions which target specific diagnoses, including fear, obsessive-compulsive disorders, depression disorders, personality disorders like narcissism, histrionic disorders etc.

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Of the Phenomenology and Therapy of Narcissistic Personality Disturbance

Abstract

In the first part of the article the appearance, form of manifestation, the typical phenomena of the narcissistic dynamics, as well as aetiopathogenetic influences on narcissistic personality development are described according examples taken from therapeutic practice. The therapeutic steps, specific to the disturbance, and the phases of an existential-analytical therapy will be introduced in the second chapter.

Key words: narcissism, phenomenology, therapeutic steps

At first glance

Mr A comes to therapy concerned about problems with his hysterical girlfriend – he wishes to marry her, but she rejects him again and again, excludes him from her life, withdraws, which clearly correlates with her hysterical structure. He offers her practically everything she could wish for, but she doesn't appreciate it. He is a surgeon, at this time under pressure because he has twice applied for a position as chief surgeon but has been rejected – "well, it is all to do with those who are jealous and who love intrigue" – the best thing would be for him to retain his equanimity. Nevertheless, he sometimes feels real hate for these idiots.

He casually asks me to speak to him on his left side, he is almost deaf in his right ear, my voice is somewhat low. He is also massively short-sighted in his left eye, which I understand to be the real reason for his coming to me. With sensitivity and care I ask how his disabilities affect his performance when operating? "No problem," he said without the least sign of annoyance. He instead speaks of his beautiful villa, which he has purchased especially for his family to be, and of his professional engagement – "the colleagues are incapable" – of his mother – "no problem in keeping her in her place" – he is, after all, her absolute treasure, which is understandable because she has nothing else in life – could that be a problem for him? "No, no, it's of no importance!"

Unfortunately something happened to him that is not correct – he hit his girlfriend, it was just "a slip of the hand" – well, that certainly gave him a fright, but she was so hysterical, the way

in which she is difficult, anyway, to bring to reason when she is excited. Naturally, it must not happen again. "That should be brought under control in a couple of hours? What do you think?" Actually, it is his girlfriend who should come to therapy, but it is not a problem, I'll take care of it.
"If you need the time urgently for someone else, you can cancel my appointment at any time," he said jovially as he left.
The essence of a narcissistic disturbance is already clear in this short sequence: The lack of an inner feeling for problems, and a feeling for external disturbances; emphasis of his own competence and magnitude, inappropriateness in the structuring of the relationship.

Mr B, on the other hand, comes because his secretary was of the opinion that he should do something and had recommended me. My question of why he should do something remained unanswered, as well as the question of what *his* opinion was. But let us give it a try with therapy, he said. With a great deal of effort, and almost relieved, I found several symptoms such as a slight fear of flying, although this" certainly has to do with his unstable balance organ, and therefore not really a matter for our therapy," – arachnophobia – certainly pronounced – "but who cares, one doesn't actually live in the wilderness." He finally confided in me, and said that he was in a bad way overall "always, but then, what is good about this world and life in general? – yes, he feels rather depressive." Actually, he didn't want to change himself, he just wanted to be left in peace, alone in his glamorous hotel hall with many anonymous people, or sit on the deck of an ocean liner and simply sail away – unfortunately he has never managed to become rich enough to be able to afford that lifestyle permanently.
What did he want from me?
"Nothing specific", perhaps an attempt to change his depressive mood, although he did not believe that there was anything to be done about it – it had always been that way. Perhaps just to have someone who takes an interest in him, without wanting anything from him, he would like that very much. I told him that it was naturally a matter of whether he could use, or put into practice anything from our sessions. I understood his request in such a way that we should first search together for any questions and themes. "Yes, good. At a fixed hour each week, always at the same time, there would then still be time for the newspaper and a breakfast at a café." – Does he like doing that? – No it's boring. – then why does he go? – "It is perhaps a little less boring than most other things."
Only later did he reveal why he had really come – despite his increasing self-control and his distanced attitude to what happened around him, he burst into rage at the slightest triviality, which he found dreadfully embarrassing – such a thing should not occur." Control and sovereignty were of the utmost importance – having no contacts was preferable to losing one's sovereignty and *be* embarrassed.
Mr B did not want anything specific from me, only "take an interest in me, ask." – He didn't let me participate long in what became visible to him. –

In this example further typical narcissistic phenomena are seen: The puzzling and meaningful narcissistic *inaccessibility* and the vagueness of the experience of the Self and the world, which leaves the narcissist and his/her concerns in a pre-personal mode according to mood.

Behind the illusion – need and fear

Behind their pushiness, respectively, impenetrable superficiality, narcissists generally appear endearingly childish, naive and in need, curiously, even, in need of protection and more or less clearly dependent on the reactions of others.

Thus Mr A, for example, waits after almost every sentence for some sign of my recognition and confirmation of his hypotheses. He is not really interested in complementary, additional or differentiated comments from me, he passes over them or disparages them. He needs *recognition* in order to feel a sense of wellbeing. He is unable to directly formulate his own needs or wishes, for example, he calls me outside of our appointment times – "he has come out of the OR earlier, have I got time and would I care to undertake a little therapy?" His tone is by no means suggestive, more of astonishing casualness, and when one listens more intently, there is the attempt to hide his need for help and the fear of his wish being refused. "No, not possible? Never mind, it's nothing urgent, I happened to be passing your way. Perhaps just a short question, since I've got you on the phone … my girlfriend fired me, so to speak, yesterday …"

It is different again with Mr B. His needy side remains hidden: He comes late, as usual, and I use the time to collect the mail, which is the reason why I do not open the door immediately when he rings. I see him through the glass pane of the front door. He cannot see that I am on my way to open the door to him. Fear, even panic, is written in his face. He breaks down completely, seems beside himself and repeatedly rings the doorbell, more and more hectically. I open the door and he is frightened, pulls himself together and says in his usual distanced manner, with a glance at the mail: "Excessive amount of mail for a practice – an important woman!" It is apparently a satisfaction and a pleasure to have "such an important" therapist, and he is fully restored. Need, fear and supposed weaknesses are not only hidden from others, but also from himself, or are not admitted, so that the relationship to himself in this respect does not appear to exist.

"Apparent" or "hidden" narcissistic forms of manifestation

Two differing forms of manifestation are seen in these two examples. Mr A is "apparently" narcissistic. He is of the "loud", rather exhibitionistic type, self-promoting in his showing off and demands recognition. Everything that clouds his grandiosity is only touched upon in passing – he does not appear to be aware of it as a problem, and it is certainly of no interest to him.

Mr B, on the other hand, is one of the quiet, rather autistic types. His grandiosity requires no

words – or still has no words. His life and pole of perfection is less certain, he can only maintain his perfection through distance and a lack of contact. At the slightest upheaval of this harmony, self-doubt and feelings of inferiority arise, so that the quiet type only finds stability in a symbiotic, untouchable state. Perfectionism blossoms without relationship and is uncontrolled in fantasy, or exists in the grandiose control, cultivation and perfection of the irremovable lack into the making of a special type "extremely strange old coot – bit of a rarity" – "do you have many more fools like me in therapy?"

With Mr A we also find borderline and histrionic elements, while Mr B displays more schizoid tendencies. Because some of the main things noticeable about the narcissists – lack of relationships, lack of openness and sensitivity to other people, are seen in antisocial tendencies, we also find these in both forms of manifestation.

On closer observation

It is noticeable in conversation that the world is only seen and felt in *relation to the Self.* Only one's *own* contributions to interaction are spoken of, those of others remain vague and appear unimportant. Despite all the grandiosity and behaviour meant to impress, *boredom and emptiness* easily arise, and the conversation is kept preferably to all that brings applause and success. Even with high intelligence, a propensity *to platitudes* is noticeable. A *dialogue* does not generally take place; if all that is meaningful has been reported, the conversation often ends with the remark, what a "nice talk" that was. *Childish charm* compensates only for the time being for the lack of *humour* (humour as the reverse side of superiority, and as a capacity for self-irony, is not the strength of narcissists). Misanthropically derogatory – "only the dumb are happy" – or an apparently marvellous mood oppresses the *atmosphere* and is unable to banish the omnipresent emptiness.

"As for the other one …"

Narcissists have a *lack of sense of appropriate proportion* in social situations, through which *embarrassing* or *suggestive* situations often arise. Mr F, for example, observes without inhibition the way in which I am dressed. He notices that I wear socks and not tights under my jeans, and that without the slightest feeling of inappropriateness and a lack of distance of his words. In answer to my question of why it was of interest to him, he then said, again rather inappropriately: "Well, my wife thinks that socks are dreadful. – I will tell her not to worry." This insensitive and over-familiar approach, combined with an expressed enhancement of the importance of the therapist, as well as the lack of a personal opinion, has an effect on him that is a mixture of annoyance concerning his suggestiveness and his feeling of importance.
The narcissistic relationship mode can be closely followed in body language: Standing on one's

toes, jostling, achieving personal space without consideration, as if the other were not even there, interspersed with gallant attention.
The other person is used predominantly as "food for the cause" (KERNBERG 1988, page 154): Avid, even greedily, the reflected and confirming surroundings are incorporated, and what is opposing, critical and separating is destroyed, respectively dropped. Idealisation for the cause of participation in the grandiose, and denial of the difference of the other person, possibly following initial pleasure, very quickly communicates to the other person the feeling of only being used as an object of maintaining the Self.
The lack of relationships, obsession with recognition and inner emptiness make understandable the promiscuous leanings of the narcissistic. They desire diversity and great number, and a high threshold of attraction.

Living in the infinite now

Although the narcissistic greed is so very much attuned to receptivity, satisfaction through attention, success and applause quickly disappears – whatever is kept pales quickly and falls into emptiness, his inner life does not accumulate rewarding experiences. Experiences leave hardly a trace – a life in the *infinite now.* "That grandiose Self remains alone in a strange, timeless world of repeated cycles of wishes, occasional idealisation, greedy incorporation and the disappearance of reinforcement due to destruction, disappointment and debasement…the passing of time and aging embodies an outward situation, which in a consternating way overwhelms him "without preparation for the changes taking place in time (KERNBERG 1988, page 156).
The narcissist lives from hand to mouth. As for recognition, he seeks the vampire-like guarantee of perfection extracted in such a situation and not the reality, so that this, too, is not able to sediment into the past and into history. Which makes understandable the idea of "nothing" remains.

Pseudo-youthfulness

This lack of history and inner emptiness often reflects in the characteristic, lasting youthfulness of narcissistic patients – as if time has left them untouched. Accordingly, for example, age differences are ignored and one's own physical aging goes unnoticed: The Self image remains immaculate and perfect.
Mr D, for example, finds it preposterous that a woman "who looks like that" could think that he was interested in her. Mr D, by the way, is in no way blessed with a particularly attractive body himself, which lends his disconcerting remark a touch of embarrassment.
According to my cautious hypothesis, this lack of a past is also manifested as "neuronal" in "excessive forgetfulness and often leads to a more rapid "advance" in dementia in old age.

Loneliness and pseudo-independence

The lack of a past and the exclusive relationship to a grandiose image of his own self manifests itself as an experience of *loneliness, emptiness and pseudo-independence.* Being alone gives rise to boredom and hunger for resonance from others, because the narcissist lacks wholeness. Despite all this, he feels independent and lives with the feeling of not really needing anybody, and that the world will know the loss "when he does not shine in it." Here, too, he can only experience his lack when projected outwardly.

Thus Mr A, for example, was apparently in a wretched state when his partner left him. Asked about his feelings, his whining changed into a completely cool façade and he said: "Oh, you know, to be honest I'm not sorry, but she was so beautiful and everyone was envious of me. I know, I'm not a good person, when I say that," he adds not without pride.

All that is bad comes from outside … the others are to blame

Appropriate to the maintenance of the purity of the narcissistic self-image, unpleasant feelings and anything unachieved are, if at all, seen as the fault of others. If a personal failure is beyond ignoring, the anger turns into self-destructiveness (e.g. hitting one's head with a fist, crushing accusations and self- derogation, childishness, angry foot stamping, tipping into the grandiose incompetence, "incapable of doing anything", are some examples)

No performance without applause

The sphere of action/performance is also subject to the narcissistic regime: Interest in the matter is certainly of secondary rank. What is important is how expertise and abilities are *perceived.* The narcissist is thus only capable when applause from those around him is in the offing. Otherwise the hindrance to performance dominates as well as a lack of joy and interest.

It is not rare, respectively, according to talent, that we find an overestimation of one's own capabilities and competences. Tremendous performances, which have little of the character of reality, are reported, the obvious is over-dimensionally emphasised, etc.

Morals without ethos

What is also noticeable is the discrepancy between the idealisation of sublime systems of value and honourable principles, and a marked antisocial tendency. The narcissist has his *own morals* – full of ideals and principles, yet still without personal ethos. The clinging to primitive ideals constructs a code of honour that atrophies into false morals.

Grandiosity and worthlessness

In her fantasy, Mrs E has the notion of being the best of all diploma students and of having her knowledge emphasised and of being so noticeable to the examiner that he would offer her a job and that she would become one of his closest colleagues. Her efforts were "only" sufficient to achieve a good degree, without her work being given a special grade. Although she knew that she had written the last part of her work without care, she remained attached to her dream and was so disappointed with the result that she was unable to celebrate gaining her degree, or feel any joy, release or satisfaction, and had the feeling of never wishing to look at her degree paper again. "If I had my way I would apply again." – If the grand fantasy is not achieved, all else is of no value.

Hate and envy

The narcissistic insult changes quickly into hate, whereby the destruction felt within is directed outwards. Anyone who is different quickly becomes an enemy. Feelings of envy against all those enjoying more recognition, attention or success are witness to the great threat to one's feeling of self-esteem: If the narcissist is not the best, he or she is nothing.

All and nothing

Although the lack of relationship to an undifferentiated experience of the world implies the loss of the world's values and of the interest in something other than personal brilliance, the narcissist can only remain within the shell of platitudes and generalisations. This is also shown in generalising concepts ("all, never, nothing, one …") and in the experience of inner emptiness and worthlessness.

Maintaining the "narcissistic equilibrium"

The "technique" for maintaining the narcissistic equilibrium is the *intolerance to difference* to the inside and the outside – manifest as

1) Obsession with absolute harmony
2) Hunger for recognition
3) Living in a world of distance.

The *"narcissist warning system",* functioning whenever the feeling of self-esteem is endangered, also belongs to: *Hypochondrias* (as an excessive physical attention to disturbance of the body), *sensitivity to criticism,* the selective interaction directed to *recognition,* and the *hatred* of all that is disturbing, and the *depression* that encases all that hurts in a lack of sensitivity.
The *fragility* of these efforts is evident. The frame breaks easily, becomes perforated and the

lack of perfection breaks through. An inner lack of feeling and emptiness, crisscrossed with nagging self-doubt at every uncertainty leads to renewed hectic and an excited search for equilibrium and satisfaction. In this way life remains blank, the ego remains retarded and cannot experience anything in life. The grandiose part of the personality becomes evermore embroiled through the machinations for the maintenance of its divinity. *Statements and values* as "bridgeheads" of existence are lacking. There is no "you" and no personal development.
– How does this come about?

Considerations of aetiopathogenetics

The creation of the narcissistic self, with its pole of grandiosity, which is threatened by the opponent pole of triviality, together with the – in my opinion not to be neglected *constitutional* conditions – often show three typical basic constellations in the physical genesis, which each exist in a violent or "gentle suffocation" of the self and which are not in accord with perfection. These are dissociated and threaten – addressed by criticism from the outside – the self-esteem.

1. Disparaging, derogatory, mocking *judgments,* often coupled with *comparisons,* in which another person is idealised as an example, are made; with simultaneous emphasis of what acknowledgment is worthy of in other persons;
2. uncertainty through *uncritical idealisation* and denial of all weaknesses;
3. *withdrawal from the sufferings of the world,* in symbiosis and harmony with the generally depressive, unhappy mother, who creates a better world through her child and is not aware of the problems and conflicts of the child, and, finally, allows them to arise.

Mocking, glorification and possessive indulgence lead to the development of a fragile feeling of self-esteem and to a greatly polarised and dislodged self-image.
The development of one's self allows for only the perfect; the stigma, the common and the suffering remain lost. In this way a rigid, but partial identity is created, which is sensitive to minimal uncertainty. With increasing age, loss of vitality and reduced social possibilities, it becomes more difficult to maintain the façade and the shell. The split attacks the self-esteem under the cover of the criticism of others and leads to increasingly pronounced and more helpless compensatory efforts, which in old age often lead to deep depression, bitterness or also to a socially desolate state.

Essential features of the therapy

1. "Basso continuo" of the therapy: Seriousness and high regard as a basic attitude in the therapy

The attitude of the therapist corresponds to the fundamental existential needs (as described by LÄNGLE 1992) for protection, space, support; relationship, time, closeness (empathy); re-

spect, justification and respect, as well as the openness for "that what arrives" from the inner and outer worlds of the clients. According to current necessity and the state of development of the patient, one or the other is to be pushed to the fore

Moreover, we are able to note a "Basso continuo" with every given state: In the case of narcissistic disturbance, it is the finding of oneself and self-esteem promoting seriousness, high regard and respect, as well as the attentiveness to apparently unimportant things and the quiet minor tones. At the beginning, these are to be given a slight narcissistic coating, so that the one concerned has even the slightest chance of mustering a preparedness for confrontation and dialogue: Respect requires a nuance of deep respect, high regard a touch of admiration, confrontation a dignified note, and the average given its appropriate weight.

This attitude in confrontation is the frame and the prerequisite for the assumption of a narcissist's relationship to himself and the consequent post-maturation of the self. This, again, is the prerequisite for anchoring the person within the depths of his self.

2. "Nobody there" – how do we wish to get moving?

To be able to come to a movement towards change, the therapy should be resource-orientated in the first phase for promoting the growth and expansion of the self, without attacking the defensive structures (KOHUT 1976), and certainly not work against it.

The first phase of the therapy with narcissistic patients comprises, in my opinion, three basic movements:

a) *search* for the *person* through the platitudes and generalisations and thus make a *confrontation* possible;
b) *assume defensive* (covering) *structures,* endure and relieve the actual situations;
c) *strengthen compensatory structures* (expand and promote abilities).

ad a) search

The search phase is, above all, a challenge where the narcissist seeks only an atmospheric recognition and addition to his self, an echo without words. It is difficult here to even come to a theme or into conversation. Due to the inner emptiness, the tangible contents vanish.

An example: The hours during the first year of therapy with Mr B always followed the same pattern. Mr B comes just on time, or late, and with half-closed eyes offers his hand in a distanced greeting, moves somewhat like a sleepwalker to the couch, makes himself comfortable and closes his eyes completely: That is all.

I attempt in various different ways to make contact with him.
I ask him, for example, whether there is something he wishes today:

Mr B: Nothing, there is nothing, well nothing much…nothing special …

Or I wait – Mr B then sits up after a while and with the words:
Well, ask me, it is all about me …

Th.: Is there something about which I should ask you?
Mr B: Well, something, you're the therapist.
Th.: Could you perhaps look back on what you did this week, and how it was for you? We can then find out what is occupying your mind or what was important.

There would be no point in challenging Mr B further to look for a theme himself, what would be important to him, what moves him, or what occupies his mind. He finds nothing that meets his idea of a problem, and for that reason nothing comes forth from him. What he seeks is an atmosphere and a relief of mood, he feels good when he was in the company of someone with whom he feels well – only if this narcissistic harmony is created can anything arise, something of his life and experience from the examination of his everyday life.

The aim of the first phase is to bring the patient to a relationship with what is there, and thus take a small step beyond the manufacturing of the narcissistic ubiquitous feeling of wellbeing (BALINT 1981). Working on a problem or a deepened confrontation with him is not yet to be expected.

There is hardly any continuity in the work in this initial period. Mr B can never remember the theme of the previous occasion and the possible realization that he has won from it. He retains nothing – everything lives in an echo of the presence of the other person. It is also important to explore further here.

Thus Mr B often asks:

"What did we talk about last time? I don't remember. Tell me, you certainly know! – Didn't you make a note of it…?"

Th.: We will try to pick up the thread together and get back on track. Do you remember anything, perhaps a feeling, a situation, a key word …?

If Mr B is actively occupied with anything at all in this initial period, then it is with my presence, mostly with my outward appearance; for example, whether he should apply therapy to me today because I look so pale, or whether my lipstick is suitable, etc. I attempt to search with patience for what leads him to such ideas and whether and for which reason it is important to him. I have the impression that Mr B is not aware of his impertinence. Confrontation with the "unsuitable" would be too early, Mr B would withdraw into his narcissistic solemnity and stamp it as "unimportant" or simply and uprightly learn to let it be.

ad b) assuming defensive (covering) structures

Mr C comes to therapy in an existential situation in which his narcissistic experience of self is tipped to the negative pole – in the grandiose catastrophe. He feels "deeply depressive, completely incapable of getting on with anything – it is all over, my eyes have been opened, I have kidded myself throughout my life, the only thing left is to kill myself."

Every attempt at considering whether this objective, according to his view, however, a completely muddled situation, is not so bad and is to be unravelled is rejected by Mr C with a mild,

yet definite gesture. His dear friends have also said the same thing to him, it is very endearing and delightful but the scope of the whole was covered by it. Naturally, nobody can really assess it, how could they? Thank God that Mr B also has patience with me. Mr C speaks softly, full of import, and I remark that it is difficult to ask about facts pertaining to his situation in life. Mr C now needs the narcissistic protection of the grandiose catastrophe, otherwise the sadness and the fear concerning his "misguided" life would catch up with him too much. I confirm for him that, fully remaining in a narcissistic mode, this is really a very difficult phase in his life and not easy to change, that it is even a great human effort to endure it.
Mr C only begins to move when I do not attempt to prove that his grandiose wretchedness is, from a realistic point of view, to be changed, but by first taking his grandiose wretchedness seriously and finding notable the performance that he shows in bearing and enduring it. Only through this initial narcissistic reassurance is it possible to come to the point in a confrontation.

ad c) strengthening compensatory structures (abilities)
Mr A at last moves in with his girlfriend, and continuously weakens her opposing arguments by accounting for them with her histrionic, vague attitude and her incapacity for decision.

Mr A: It is not normal, *she* should come to therapy. I'm banging my head against a wall. It is really impossible …

Th.: Perhaps it is important not to always bang your head against a wall and sometimes give up and admit to being powerless, to lend an ear to these arguments and fears, to listen to your girlfriend and to question yourself more closely? Perhaps you will then come to understand more exactly what makes your girlfriend afraid, and then know better what you can contribute to solving the problem.

The therapy in the initial phase takes place under the motto "sailing with the narcissistic wind" – which means to expand competences through the assumption of the narcissistic grandiosity and through the assumption of the narcissistic ambition. That makes new experiences possible in dealing with oneself and with others, which is then felt as an advantage and an easing in relationships. At the same time, the narcissistic self must never, or only very well-meaningly, almost in passing, be questioned. Otherwise the fear of invalidity/triviality and shame will take the upper hand and the narcissistic defence mechanism will be strengthened.

3. Post-maturation beyond childish interest

Through these three points of access there will be, initially through repetition over a period of time, a structural growth (LÄNGLE 2002), and thus more openness and interest in the confrontation with oneself and with others. It is important that the grandiose self continues to remain "untouched" because the correlated threat only weakens the ego structure, and streng-

thens the narcissistic regulation. The therapy would then come to a stop through resistance and the strengthening of the tendency to recognise oneself narcissistically.
It is now a matter of directing the perspective towards the child in a narcissist. His inexperienced, fearful, often failing, damaged and insulted sides are to come into contact with the world and should be made visible. The most important thing is that he feels that his childish parts of personality are not – as he shows them – less appreciated as a lack, but are approached in an objective and natural way.
If in the previous phase of the narcissistic mode there is a motor for new experiences, at this moment it is rather the "the inquisitiveness of the child."

4. "Crisis": From self-glorification to self-criticism

The relationship with oneself and with others, also brings the *neglected and unsuccessful experiences* into view. This leads to a critical phase in the therapy. The inner and outer emptiness in which he lives have become clear. The grandiosity "has received a hard knock" and the loneliness with which the narcissistic self-image is accompanied, is to be felt. The shock concerning whatever has been neglected or forfeited, the indebtedness, strengthen the depression and can even lead to suicide.
The danger of this crisis lies in the flight back into the narcissistic grandiose self and to notice that the narcissistic façade is no longer to be manufactured to perfection. The opportunity lies in finding oneself through assuming and enduring the depression. That requires the mourning of the loss and the enduring of the correlated pain.

An example:
Mr B: I feel worse and worse, but you must know what you are doing …
Th.: What is worse?
Mr B: That I come to know myself more and more, and this is not a pleasure. It attacks my feeling of self-esteem and takes away my drive when I can no longer kid myself. My entire, carefully constructed sovereign roles fall, I am no longer a funny old coot, but…a nonentity of a person, insignificant, unimportant, unattractive, I don't like myself, nothing that is special, no humour – just average …
Th.: A nonentity – is that what you really see in yourself, or is that just a derogatory judgement of yourself because you do not fulfill your own idea of what you should be?
Mr B: Yes, naturally, in some areas I am very good, professionally for example,
but I am also like many others.
Th. When you see it that way, which feelings do you have inside you?
Mr B: Sadness, despair, also resignation. I have lost a feeling of security in my life, a feeling that teased me into believing, at least from time to time, that I am a special sort of person, who masters and controls everything…now nothing is left to me.

Th.: … of these personalities –
Mr B: Now only I remain – and I don't like myself.
Th. What do you feel when you speak about yourself in that way?
Mr B: Hmnn – two feelings, on the one hand I would like lay it on a bit thick, disparage myself, throw away, destroy myself … on the other hand I am shocked by it.
Th: – and in this shocked state – what arises within you? What do you feel there for yourself?
Mr B: (…) almost as if I had to protect myself, a little affection. But then there comes immediately this arrogant, disparaging voice in me, which puts me down: "Look at yourself, you are a ludicrous figure!"
Th.: What do you feel when this voice speaks in this way?
Mr B: It insults me, it hurts …

The opportunity of this crisis lies in whether it is possible to "come to oneself on the other side of the relationship" – from the aspect of the disparagement of the weaknesses, the mediocrity, etc., or the excessiveness of sympathetic affection.

5. Farewell to narcissism

Only when it is possible to develop sympathy for oneself, can the grandiosity be progressively bid farewell.

Mr B has come closer to himself and can feel the pain when he so mercilessly errs and suppresses so much. The "reflex" to save himself into grandiosity has turned into a longing for it. His authenticity, achieved in stages, still carries too little weight, due to a lack of history to be a sufficient counterbalance to wishful fantasy. Thus, in this phase the grandiose self is to be subjected to a critical view and to "scratch" in the soil of the relationship established to himself, as well as making subject to experience the lack of freedom connected to the maintenance of the grandiose self. Thus, we can strengthen the farewell to the grandiose self and also the relationship to it from the aspect of the narcissistic regulation.

James Bond was a help in the therapy of Mr B.

Mr B spoke again about films – he knew a lot about them. He casually mentioned: I like James Bond films – fantastic!
Th.: What is it that you like about them?
Mr B: He is simply so shamelessly terrific.
Th.: What is terrific?
Mr B: He can handle everything, every woman is at his beck and call, he does everything with ease and with great superiority, has absolute control over everything.

Th.: Someone who is absolutely perfect…
Mr B: Super, unreachable, nobody has the chance to be a danger to him or get close to him …
Th.: Could also be boring. One only has some profile when there are bumpy spots?
Mr B: Hmnn, interesting interjection. But to be quite honest, I would love to be like James Bond.
Th.: What would then be better?
Mr B: I would not always need to be afraid of whether I can do something or not. The worst part is: I want to, but can't and I lose my sovereignty …
Th.: In which situation do you need James Bond's support?

At this point it is a matter of raising the longing for superiority and being special in concrete situations of his everyday life and to see where he can support himself and improve somewhat, respectively, to permit the mourning and the pain that is connected to his feeling of being "average."
From this initial thematic situation there are two directions for proceeding further: The assumption of a relationship to his (supposed) weaknesses and the pain connected to them – to take a look at himself and assume the rejected and dissociated elements; to be aware of the "critical" enlightenment from the "aspect of costs", the price of the desires, vulnerability, being beyond illness and terrific.
In this way Mr B slowly comes closer to the lack of relationships and security, which lie in this ideal, and can therefore increasingly distance himself from this ideal.
A further step along the road is the removal of what these desires mean to him: Relationship, nearness and respect.
It is now possible and is also time to turn to the causes of his self-seclusion, and to unearth the pain from the depths of his life's history. It is a matter of mourning: The insults to his way of being, the otherworldliness of his parents' home, the unhappy mother, the many relatives that died in a concentration camp, and all that which was once not a problem, which were "simply like that" and what he had earlier not experienced as a problem. This despair and this pain can now be allowed to arise and to thus integrate into the suffering part of his self.

The prognosis – realistically observed

KERNBERG (1988) writes that narcissistic people have no admission of the necessity for change, if they are not forced to confront it through the pressure of symptoms or their surroundings. Thus they often find themselves in old age standing before the ruins of their lives. When the power of glory recedes, when nobody will hear their stories anymore, and when they are professionally no longer important, they remain in their pseudo-world, complain of the badness and ungratefulness of the world, and cannot admit that they have contributed something to it or have done something wrong.

Therapeutically the prognosis is all the better the more the narcissistic grandiose self is subject to fluctuation and the more effective interest there is. Prognosis is poor where the projection and accusations are perfect, respectively, dominate. Kernberg indicates that the therapy of narcissistic personality disorder only has effect after there have been a series of experiences of suffering. But there should also not be too many, because the bitterness will again cause the patient to close up. He sees the most favourable time for change as being the end of the forties and beginning of the fifties, because it is there that narcissistic satisfaction (through beauty, success, etc.) decreases, which forces one to self-awareness (compare KERNBERG 1988).

Seen from everyday life in a practice, it is already a success, if the authentic person develops next to the narcissistic configuration, and can be critically aware and thus weakened. Even this step generally requires several years in the therapy of narcissistic personality disturbance.

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Existential Analytical Aspects of Mental Health

Abstract

The recently developed 'Existence Scale' (ES) comprises four dimensions: self-distance, self-transcendence, freedom, and responsibility and intends to measure the individual capacity to utilize noetic resources and to address and fulfill meaning in life in the sense of Frankl. This investigation deals with the relationship between these measurements and those of other personality dimensions, particularly mental health, as assessed by the Trier Personality Inventory (TPI) and whether this relationship is stable considering age and gender.

211 persons from 18 to 70 years old (mean age 38±7 years) participated in the study (92 male, 119 female; 144 below and 67 above age 40). Participants answered the ES and the TPI comprising the following sub-scales: Behavior control, mental health, meaningfulness (vs. depression), self-obliviousness (vs. self-centeredness), freedom from distress (vs. nervousness), expansiveness, autonomy, self-esteem, and capacity to love. Relationship between the four ES sub-scales and the 9 TPI sub-scales was assessed by canonical correlations.

Results indicate two independent correlation structures between ES and TPI. While all strata showed this two-factor solution, the details of the relationship varied across groups. The first canonical root, accounting for approx. 60% of common variance, shows a relationship between the existential abilities, 'freedom' and 'responsibility', and self-transcendence on one side and 'mental health' on the other (together with additional factors that varied across age and gender groups). The second root, reflecting a common variance of about 15 to 17%, relates 'self-distance' and in most cases also 'self-transcendence', i.e. personal resources, to low values of 'behavior control'.

These results can be seen as an indication that besides the interpretation of the magnitude of the scores reached in the sub-scales of the ES, special consideration should be given to an imbalance between existential and personal factors.

Key words: personality measurement, mental health, behavior control

1. Introduction

The view of PETERS (1984) that mental health should be defined as a specific form of person-environment fit, focusing on the social and cultural aspects of the environment, is opposed by concepts which emphasize the personal-existential aspects (BECKER, 1992). Mental health, in this view, should not be reduced to the ability to cope with demands from the environment. It should be considered that human beings aim at goals, which they themselves define. Living in harmony with oneself, might be as or even more important as adaptation to the (social) environment.

From an existential-analytical viewpoint mental health is defined as the ability of a person to act in such a way that the behavior – during the act and retrospectively – is sensed as proper and right by her-/himself (LÄNGLE, 1992). Human beings unfold their self most significantly not by adaptation but by taking a standpoint in relation to themselves (LÄNGLE, 1988). Only if a person's appraisal includes the recognition of values in a spontaneous and responsible way, can existential fulfillment be reached (ORGLER, 1991). While, according to FRANKL (1983), to some degree even neurotics are able to make their life meaningful, existential fulfillment relies on noetic resources.

A recently developed questionnaire (LÄNGLE & ORGLER, 1991; LÄNGLE, ORGLER & KUNDI, 2000; see also pp. 135-151 in this journal) focuses, from an existential--analytical viewpoint, on the ability to take a standpoint towards one's own behavior. This 'Existence Scale' (ES) comprises four dimensions: Self-distance, self-transcendence, freedom, and responsibility.

The present investigation deals with the relationship between the personal and existential resources as measured by the Existence Scale and personality dimensions, especially mental health, covered by the Trier Personality Inventory (TPI). Furthermore, it addresses the question whether this relationship depends on age or sex.

2. Materials and Methods

211 persons from 18 to 70 years old (mean age 38±7 years) participated in the study (92 male, 119 female). In the sample persons with higher education (64%) were overrepresented, and, consequently, lower occupational categories were underrepresented.

In addition to questions covering sociographic characteristics, the Existence Scale and the Trier Personality Inventory (BECKER, 1989) were answered by the subjects.

The TPI has 9 sub-scales: Behavior control, mental health, meaningfulness (vs. depression), self-obliviousness (vs. self-centeredness), freedom from distress (vs. nervousness), expansiveness, autonomy, self-esteem, and capacity to love.

The 9 sub-scales of the TPI and the 4 sub-scales of the ES were transformed to T-values and subjected to a canonical correlation analysis for the total sample and stratified for age and sex. Only canonical roots that reach the level of significance, set to 5%, were considered.

3. Results

Fig. 1 shows the results of the canonical correlation analysis for the total sample. The first two roots were statistically significant. The first root is mainly characterized by the relation between responsibility, freedom, and self-transcendence at one side and mental health and – to a lesser degree – meaningfulness, expansiveness, freedom from distress, and autonomy on the other side. Independent from this most prominent relationship, a second structure was extracted, showing a relation between self-distance and self-transcendence together with low values for freedom and responsibility on the one side and low values of behavior control and high values for capacity to love on the other side.

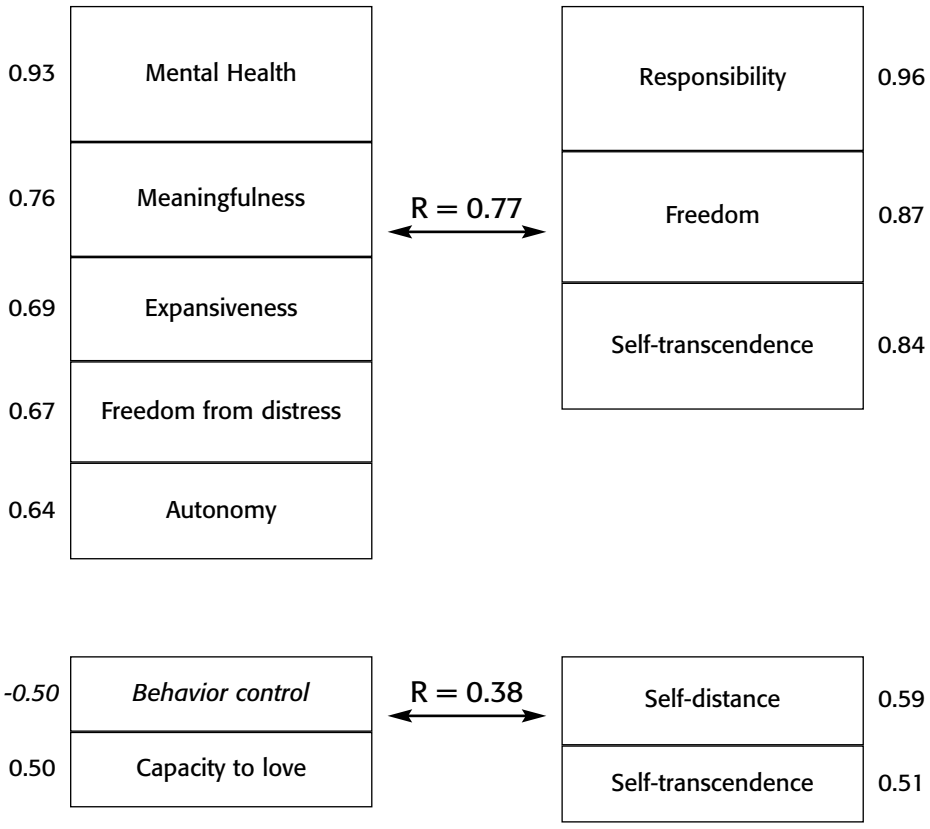

Fig. 1: Results of canonical correlation analysis for the total sample. Size of the cells is proportional to the magnitude of the canonical coefficients (shown to the right or left of the variables). Variables with negative coefficients are shown in italics.

Whether or not the relationship extracted is stable across sociographic strata, is analyzed by separate canonical correlations for sex- and age-groups (below and above 40 years).

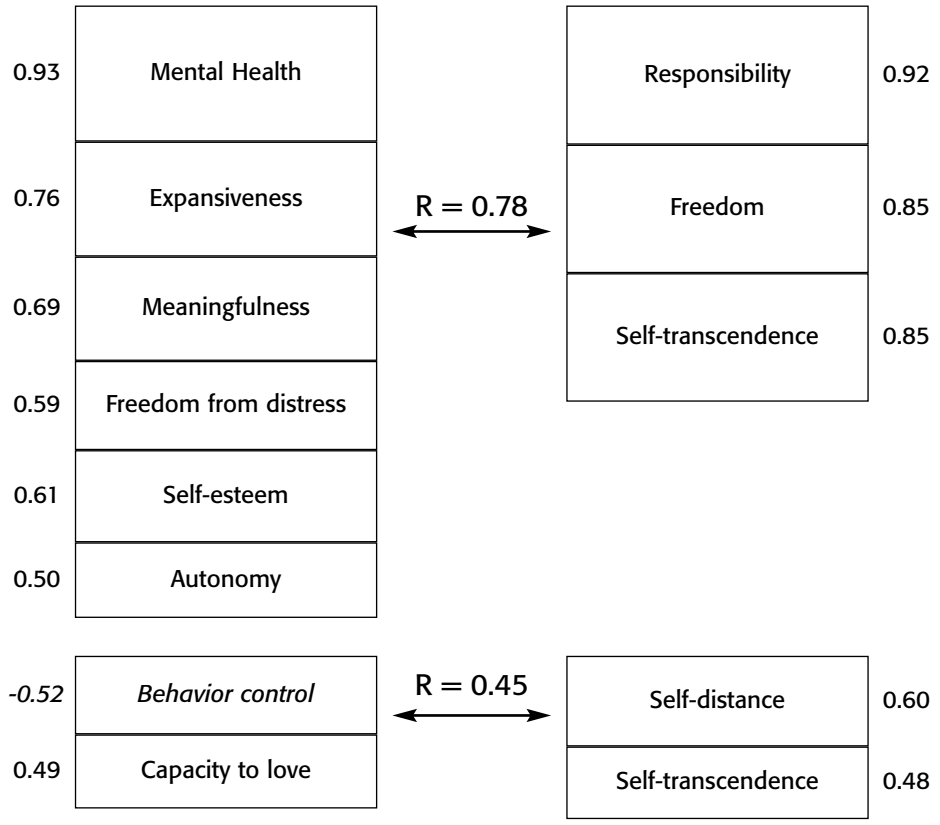

Fig. 2: Results of canonical correlation analysis for male subjects. Size of the cells is proportional to the magnitude of the canonical coefficients (shown to the right or left of the variables). Variables with negative coefficients are shown in italics.

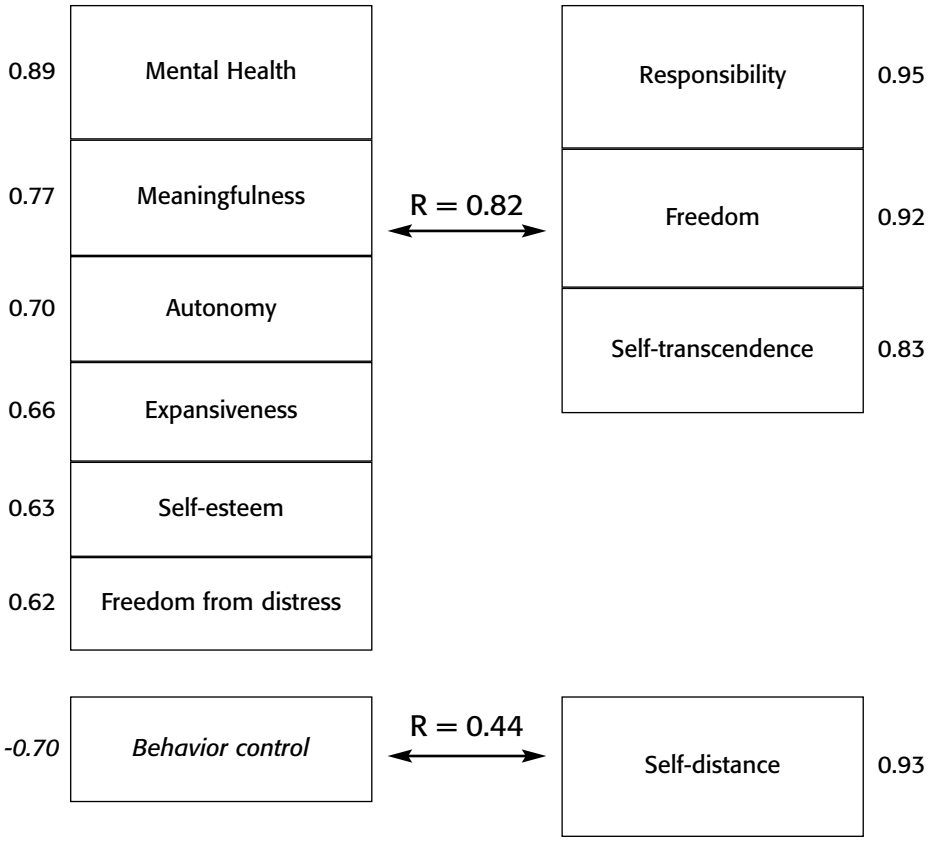

Fig. 3: Results of canonical correlation analysis for female subjects. Size of the cells is proportional to the magnitude of the canonical coefficients (shown to the right or left of the variables). Variables with negative coefficients are shown in italics.

Fig. 2 and 3 show the results for male and female subjects respectively. For both groups two canonical roots were statistically significant. Although the fundamental properties of the relationship shown above were also found in the sex-groups, several differences should be noted: The first canonical root for females is almost identical to that shown above, only 'autonomy' had a distinctly higher weight as was the case for 'self-esteem', in males 'expansiveness' and 'meaningfulness' changed places, with 'expansiveness' showing a higher weight. For the second root the canonical weights in males are almost identical to those shown for the overall sample, while in females the second root is characterized by a relationship between 'self-distance' and low values of 'behavior control'.

The analyses within age groups are summarized in fig. 4 and 5. For the lower age group the TPI sub-scales that are related to the ES sub-scales 'responsibility', 'freedom' and 'self-transcendence' are, in decreasing order of magnitude of their weight: 'Mental health', 'meaningfulness', 'expansiveness', 'freedom from distress', 'autonomy', and 'self esteem'. In the older age group 'autonomy' and 'self esteem' have relatively higher and 'expansiveness' and 'freedom from distress' relatively lower weights (note that, while the canonical correlation remains almost constant, the older age group shows less differences between the canonical weights for the different sub-scales). The second root is almost identical in both age groups, except for 'self-transcendence' showing a canonical weight below 0.4 in the older age group and a lower weight for 'behavior control' in the younger age group.

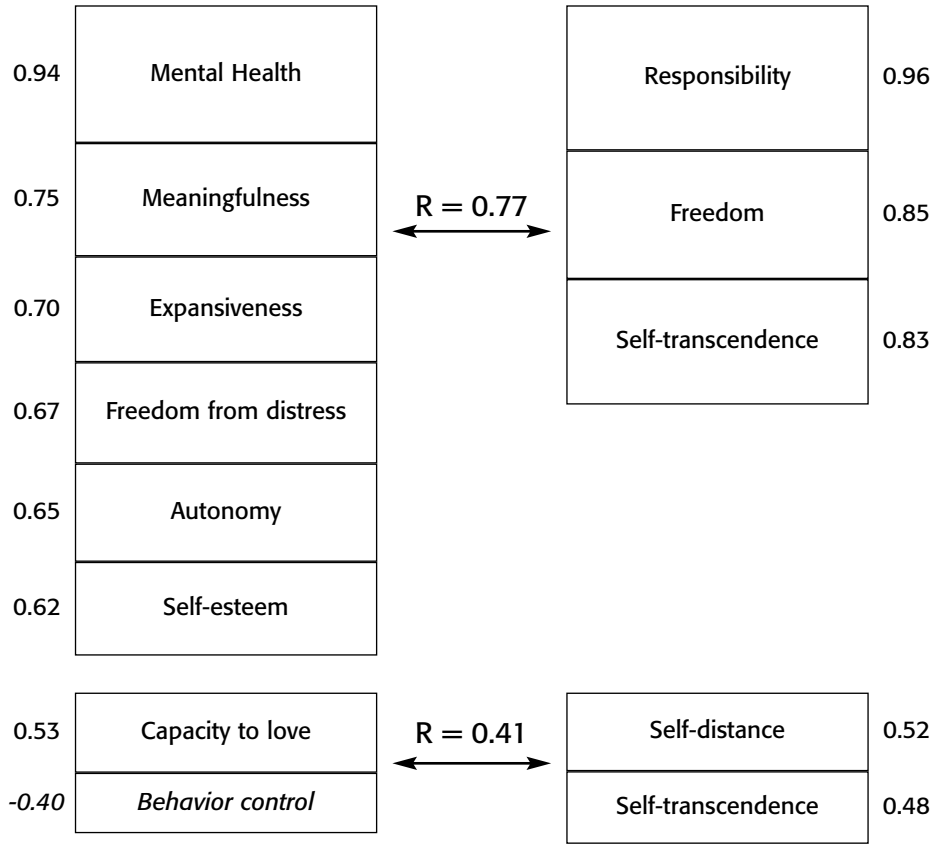

Fig. 4: Results of canonical correlation analysis for subjects below age 40. Size of the cells is proportional to the magnitude of the canonical coefficients (shown to the right or left of the variables). Variables with negative coefficients are shown in italics.

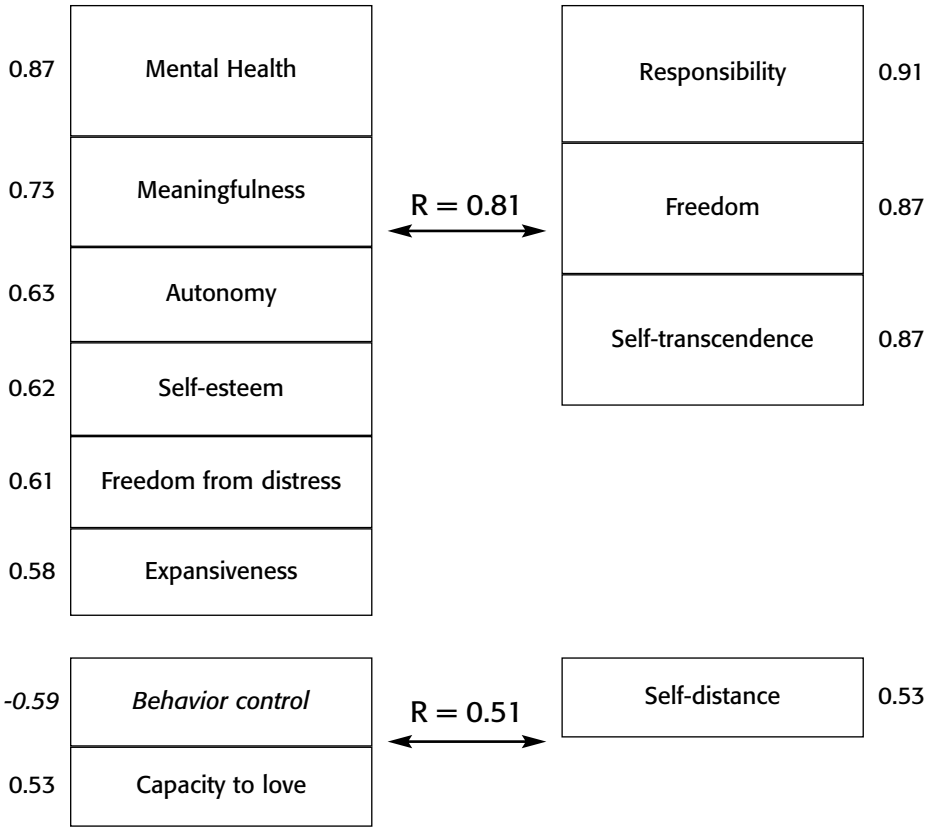

Fig. 5: Results of canonical correlation analysis for subjects above age 40. Size of the cells is proportional to the magnitude of the canonical coefficients (shown to the right or left of the variables). Variables with negative coefficients are shown in italics.

4. Discussion

WURST and MASLO (1996) reported on the correlation between mental health, measured by the TPI, and sub-scales of the ES. These results are complemented by the present investigation. The most prominent relation between these scales – accounting for about 60% of the common variance – is the one between self-transcendence, freedom and responsibility on the one side and mental health (together with TPI sub-scales varying in importance within different groups) on the other. Apparently, the capacity to utilize noetic resources has a strong relation to mental health as measured by the TPI. Within this relationship, existential capacities are

more important than personal ones, however, both aspects seem to be necessary to constitute mental health. Conversely, dispensation of personal and existential aspects letting oneself be driven by the forces of the factual world (FRANKL, 1959) might be the essential step in the development of neurotic disorders.

Independent from this relationship a second canonical root was found in all subgroups, responsible for about 15 to 17% of common variance. While differing in detail, one common feature of this second relationship was the opposite weight for personal factors (self-distance and self-transcendence) in their relation to 'behavior control' and the positive one to 'capacity to love'. Furthermore, low personal in the presence of high existential capacities are related to low capacity to love, low values in meaningfulness, but high self-esteem and self-centeredness. From an existence-analytical viewpoint this relationship might be interpreted as reflecting the sheer but free acceptance of responsibilities without personal involvement which is related to a loss of fulfillment of meaning (with respect to social aspects indicated by high self-centeredness). There is an apparent relationship to the burn-out syndrome, where deficits in the ability to take a critical standpoint towards oneself lead to an 'existential vacuum' and to a loss of meaning in life. On the other hand, high personal and at the same time low existential abilities are related to a loss of behavior control. This indicates that the inability to establish the recognized goals and to take over responsibility is accompanied by a general disability to adjust to demands, internal or external ones. The picture of a gentle person lacking ability and thirst for action arises. The second canonical root generally reflects the imbalance between personal and existential capacities.

The two relationships extracted are not mutually exclusive; rather they reflect two components simultaneously present within each person in varying degrees. A person might gain confidence and stability out of its controlled and reserved behavioral style. However, if habits and rules loose their sense, i.e. their existential meaning, a reasonable self-reflection should lead to a change in life style. If aims and purposes are determined by others or by circumstances the risk of burn-out increases. LÄNGLE (2002) points out that being occupied with obligations most of the time leads to an increased risk of burn-out. An equilibrium between a deliberately chosen functionality and the ability and readiness to react flexibly to the demands of life by taking a personal standpoint towards oneself seems to be a firm basis for mental health and well-being.

Although the basic properties of the relationship between TPI and ES are preserved across strata, some differences should be addressed. Males showed smaller correlations of 'meaningfulness' and 'autonomy' and higher correlation of 'expansiveness' to the ES sub-scales compared to females. Efficiency and dominance seem to be more important for existential fulfillment in males. The second canonical root reveals another less apparent difference: In males high existential and low personal capacity is related to fewer concerns about the future and high satisfaction in life. In females, however, the opposite is observed, great concerns about the future and poor satisfaction in life. Apparently the 'existential vacuum' characterized by taking over

responsibilities and choosing the necessary and determined steps without recognizing or even bothering about their meaning and without taking a critical standpoint towards oneself is a male feature indicating their greater dependence from external rewards and appreciation with respect to satisfaction in life.

The analysis revealed a common variance of TPI and ES of about 75%. Although both instruments share the same theoretical background they address personal and existential aspects from different angles. The ES focuses on the ability to utilize and recognize personal and existential factors in life, while the TPI is more concerned with the consequences and effects of these factors. The study of the relationship between these instruments may uncover fundamental properties of the relationship between noetic resources and mental health. While the most apparent and strongest relationship, and an almost trivial one as it is, was found between all ES sub-scales except self-distance and mental health, another independent relationship was found, that especially comes to bearing if an imbalance between personal and existential abilities occurs, that tends to be inhomogeneous across strata and that may further be investigated in subjects with different neurotic disorders.

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The "Para-Existential" Personality Disorder

ABSTRACT

The development of the concept of the existential fundamental motivations in modern existential analysis opened a specific approach to psychodynamics and thus to the understanding of personality disorders. As a consequence of this theoretical development a specific type of personality disorder can be discerned and distinguished from the related disorder, such as narcissistic personality disorder. A description of the psychopathology and psychopathogenesis of this disorder, which I propose to be named "para-existential personality disorder", is provided.

Key words: Personality disorder, Existential Analysis, existence, life-goal, existential motivation

Existential analysis elaborates its own instrument for approaching psychodynamics by means of the personal existential fundamental motivations. With the help of this instrument I shall attempt, in this article, to describe a particular form of personality disorder as well as its psychopathogenesis. This personality disorder is seen as a *disorder of the self* with a thematic involvement of the fourth personal existential fundamental motivation and I have called it the "para-existential" personality disorder.

1. Concerning the Concept of Personality Disorder

Before describing a new form of personality disorder, which, according to the theory of existential analysis, represents a particular disorder, I believe it advisable to make a short incursion into the history of the concept of personality disorder.

The personality disorder issue has constituted a constant preoccupation of psychiatry, psychopathology and psychotherapy from the very beginning of the nineteenth century. In 1801 the French psychiatrist Pinel spoke about abnormal personalities and described what he then coined as "manie sans délire", and in 1835 J.C. Prichard, giving a larger meaning to the concept, spoke about "moral insanity", a concept that until quite recently has maintained acceptance. After KOCH (1891) had introduced the term of "psychopathic inferiority", Kraepelin, over-

coming his initial hesitations with respect to the approach and labelling of this category of subjects, spoke about "psychopathic personality" and described seven types of such personalities. He was concerned only with those personalities causing suffering and inconvenience to the people around them. A significant step towards the contemporary understanding of this nosological category was achieved by Kurt Schneider who, after remarking in his psychopathology that what we call abnormal personalities represents a deviation from the norm, stated that: "What is crucial is the statistically-oriented and not the value-oriented criterion" (KURT SCHNEIDER 1962, 17). "Among the abnormal personalities, we coin down as psychopathic personalities those personalities which suffer from their own abnormality or which cause sufferance to the society by their abnormality." (ibid.)

Thus, it was for the first time that both sides of the suffering provoked by abnormality were emphasized, that is: The subject's own suffering, on the one hand, and the suffering he or she inflicts on the people around him or her (the society), on the other hand. Thus, Schneider introduced the social dimension into diagnosis; although, as the author himself remarked, the criteria for judging the latter part of the definition remained extremely vague.

Unfortunately, the confusion around the term of psychopathic personality, even with this extended definition proposed by Kurt Schneider, has not come to an end; moreover, it seems that nowadays it is preferable to speak of "personality disorders", a term adopted by the two current classification systems, namely ICD 10 and DSM IV. In spite of the fact that the classification criteria have remained unaltered, two main means of classification have prevailed. On the one hand, there is a purely descriptive method and on the other hand, there is another method which, besides the descriptive elements, also has "etiologic" references, in the sense of a connection with (hypothetic) causes.

Over time one can note repeated attempts at defining the etiology and the pathogenesis of these disorders. The scholars emphasize in various manners two basic elements: That which is innate, inherited on the one hand, and that which is achieved by ontogenesis (by learning, experiencing or by noesis), on the other hand.

Viktor Frankl, the father of logotherapy and of existential analysis emphasized in his "dimensional ontology", but also on other occasions, the presence and the blending of these elements in the personality genesis. The biological type and the psychological character are things which the person "has". Human beings "have" these things but they "are" persons (FRANKL, 1970, 151). "And my being a person means freedom – the freedom of *becoming* personality" (ibd.). This is the ground on which Frankl defined the person as "that which is free in man" (FRANKL 1990, 226). This perspective on the person was further developed by Alfried Längle who emphasized the fundamentally dialogical character of the person when he stated the following: "The personal existential analysis (PEA) defines the person as *that which speaks within me.* By speaking with myself, I am able to achieve the inner world of *self-distancing.* By speaking with the others, the outer world of *self-transcendence* is created." (LÄNGLE 1993,137)

Frankl viewed the personality as a result of development, while its shaping takes place through the person: "Man is a person and becomes a personality" (FRANKL 1970, 151). This is how the structuring of personality takes place, by the permanent dialogue that the person has with him or herself and with the outer world.

Recent developments in existential analysis and logotherapy emphasize, (ESPINOSA 1998, 8), the personality as a structure of psychodynamics, and thus anchored in the psychological dimension. On these grounds the personality acquires a circumscribed readiness for spontaneous emotionality, affective responsiveness and implicit impulsivity and action, all of which are manifest in noesis and in behaviour (see LÄNGLE 1998a). Underlying this readiness, there is the interaction of the subject with his or her own world. In an individually varying proportion we find, intermingled within the personality, both innate behavioural and noetic elements and acquisitions of the person along with his or her ontogenesis.

The theory of the personal existential fundamental motivations, elaborated by Alfried Längle in 1993 approaches the person's deepest motivational structure. It describes, besides **the will to meaning,** which Frankl believed to be the human motivational force, three more fundamental motivations preceding it, namely:

1. **the foundation of being** (*Dasein-Können* – the fundamental question of existence),
2. **the fundamental value** (*Wertsein-Mögen* – the fundamental question of life),
3. **the self-esteem** (*Selbstsein-Dürfen* – the fundamental question of the person).

All these together represent a complex motivational system underlying and being responsible for the structuring of the personality (see also in this volume pp 11-36: G. v. Kirchbach: General Introduction to Logotherapy and Existential Analysis and A. Längle: The Art of Involving the Person).

By elaborating these new theoretical perspectives, it has become possible for existential analysis to approach psychodynamics with its own theoretical instrument. According to the fulfilment or non-fulfilment of these fundamental conditions of existence, as well as their being experienced or not and to the way in which they are responded to during life and implicitly, during development, the personality will be structured harmoniously or not. The differences between the personality types are generated by the characteristic manner of one's subjective handling of life conditions.. From this perspective existential analysis divides the personality types and the personality disorders into four big groups. In doing so, it starts from the four fundamental conditions of existence which are dynamically expressed as fundamental motivations. The anxious personality disorder (avoidant, anankast and schizoid) corresponds to the first fundamental motivation, the depressive personality disorder corresponds to the second motivation, the sociopathic personality disorder (histrionic, narcissistic, borderline, paranoid) would correspond to the third and the dependent type personality disorder corresponds to the forth motivation which supposes the will to meaning (see LÄNGLE 1998a, 16-27).

In the following, I shall try to insist on this last type of personality disorder, while attempting to provide a more nuanced and subtle analysis of the psycho- and noodynamics underlying it.

2. The Para-existential Personality Disorder

The personal existential motivations defined by Alfried Längle actually correspond to the fundamental attitudes towards existence. These attitudes are developed on the grounds of the experience that human beings, as psychological beings, achieve by the dialogic confrontation with the world. The blockage or the troubling of such experiences leads to psychic disorders, including personality disorders. The effect in this case is represented by the occurrence of rigidities (fixations) on the level of psychodynamics.

The disorders belonging to the fourth fundamental motivation (the will to meaning) lead to changes in the discovery of and approach to meaning. Thus, the openness towards the future and one's own becoming are also affected. The central factor here is represented by the absence of the existential turn. The personality thus structured is incapable of discovering existential meaning. The paradigm according to which such a person acts is that of *giving* meaning (Sinn-*gebung*) and not of the *discovery* of meaning (Sinn-*findung*). Because these people do not have access to the fundamental existential attitude, but rather "pass by the existence" to a certain extent, we have opted, in the description of this disorder, for the term "para-existential" (in Greek "para-" means "by"). Frankl underlines this fact when he states: "The meaning must be discovered; it cannot be elaborated. What can be elaborated is either a subjective meaning, a common sensation of meaning or – lack of meaning (…) …however, there appears the danger of living outside or by the real meaning, away from the real tasks from the outer world. (FRANKL 1991, 15).

When speaking about meaning, we make a clear distinction between the existential and the ontological meaning, the latter transcending the area of study of existential analysis as a psychotherapeutic method (LÄNGLE 1994, 15-20).

The openness to the world, to which M. Scheler refers is not present in the people we have in view. There is no real openness or what FRANKL calls "self-transcendence" (1982, 160), a dialogic relationship with the world (LÄNGLE 1988b, 10), but only the substitute (German – Ersatz) of these phenomena. The dialogue does not take place with *the world* but with *the subject's projection on the world.* From this world the subject selects only those elements of reality which confirm or support his or her projective construct, which support, certify and validate *the pattern* to which he or she adheres.

A dependent type of personality thus arises. But the addiction follows, first and foremost, a certain pattern. The pattern-like aspect of life results from a lack of openness and dialogue with the world and thus corresponds to the projection of one's self-desires. The person has developed this pattern at some point in his or her life (for instance: "I want to be a musician like Elvis Presley"). This pattern was not adjusted by reality afterwards, but kept in private as a life-attitude. This is how a certain immaturity persists. We can also speak of blockage or lingering, respectively a fixation in a certain phase of the personality development and individuation.

In practice, we can sometimes notice "a real addiction" to a certain person but, in my opinion, this is nothing but an "embodiment", a fetish of the pattern that the subject has in mind. For

instance: in Nicolae Ceausescu there was a real addiction to his wife, in Napoleon to his mother and in Lenin to his "life companion". These women embodied force for those men. However, as life patterns, Ceausescu chose Adolf Hitler and Stalin and Napoleon chose Charlemagne. Future research in this direction will most certainly lead to interesting results.

3. The Blockage of Meaning

But why do people presenting such a personality disorder which I would like to call **para-existential**, lack the capacity to discover true existential meaning? What exactly prevents this from happening?

According to the contemporary theory of existential analysis, the individual becomes truly free to discover the existential meaning of the situation in which he or she finds him or herself only when the four fundamental motivations are fulfilled. This is the necessary and obligatory premise for achieving the process of discovering meaning. On the other hand, a series of other conditions must be met; the following quotation represents a summary of Alfried Längle's description of these conditions:

"For the discovery of existential meaning a special attitude is necessary towards oneself and the world. This supposes a certain degree of self-distancing so that the world with its intrinsic value may be perceived (openness towards the world). The meaning is in the world, so the world is the only place where it can be discovered and not in our own fantasies or lusts, as Frankl says (FRANKL 1982, 57). On the contrary, the discovery of meaning presupposes first and foremost the agreement with the situation and not the pursuit of one's own ideas and desires. The existential meaning thus represents living openly towards the world, instead of the pursuit of self-accomplishment." (LÄNGLE, 1997, 21)

These conditions cannot be met by the individual suffering from a para-existential personality disorder. The person cannot detach him or herself from his/her own projections and all his/her doings are driven by a desire of unscrupulous self-accomplishment, according to his/her "pattern". He/she has difficulty both in the dialogic relation with his/her inner world, with him or herself (self-distancing) and with the outer world (self-transcendence). Because he/she is not open, he/she cannot be touched or moved by the values in the world.

The current existential analysis defines the existential meaning as "the most *valuable* possibility of the situation" (LÄNGLE 1994, 17). This means that the discovery of meaning is mediated by values and that the values precede the meaning. "From this perspective, values are primordial, while meaning is secondary, respectively that goodness which is produced through the experience of values."(ibd.)

In the process of experiencing values there are two ways of access to the values: One starts from the subject's own perspective or plan and the other from the appeal of the situation itself. This is only natural because human beings are fundamentally dialogical by nature.

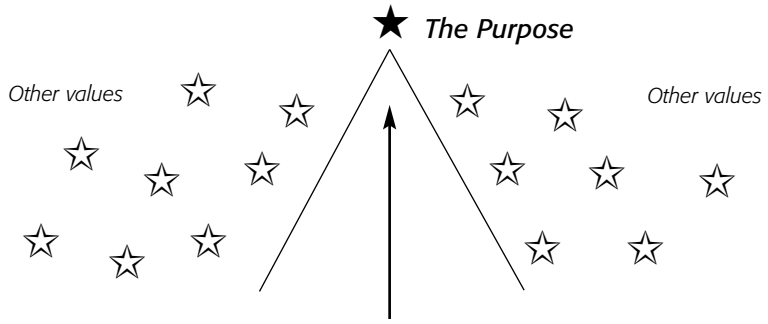

Fig. 1: The para-existential personality disorder is completely oriented towards its own project so that all the other values that might come in its way are set aside. In other fields in life, which have no relevance for the purpose, life can carry on freely.

In the first case we are in the field of satisfying needs, of achieving a settled purpose and we speak here of *attributing* value (Wert-*gebung*), which is done by the subject. In the second case, we can speak of a fulfilment, of *discovery* of value (Wert-*findung*) – here the agent is the object at hand. In the first case, value results from usefulness and we can speak of *utilitary* value, while in the second case value results from the nature of the object, and we can speak of *intrinsic* value (*Eigen*-wert).

Normally, these two ways blend and intermingle in a unitary and harmonious whole. But if the *purpose* is achieved only through the utilitarian value, the *meaning,* on the other hand, can be discovered only through the intrinsic value.

The frequent confusion between meaning and purpose, present in every-day speech should consequently not come as a surprise even though the difference is clearly represented in the sensitive and profound noesis of each and every one of us.

One can, for instance, feel a great satisfaction upon achieving the settled purpose, but fulfilment occurs only when one experiences the respective thing as full of meaning. If this does not happen, one will soon suffer from a vacant feeling again, imperiously demanding to be filled up, that vacuum which FRANKL called "existential vacuum" (for instance: 1987, 18 and the following, 31, 42, 202, 291, 298, 315).

Human beings can project and aim to achieve the settled purposes but, at the same time, they discover the authentic, the essence, in one word, the meaning in the world, leading towards the fulfilment of their own existence.

The occurrence of a disequilibrium between these two approaches, of unilateral and lasting fixations, can cause particular behavioural patterns consecutive to the psychodynamic modifications that correspond to the fourth fundamental motivation. In this case we are faced with what psychopathology labels a personality disorder.

With the para-existential personality disorder the predominance of *attributing value* (Wert-*gebung*) can be noticed, as opposed to the *discovery* of values (Wert-*findung*). In other words, the meaning is mistaken for the purpose. The main problem is determined on *the emotional level,* by that inner response (impression) to what comes from the world and impresses and touches me, suggesting that something good might result from it. We could say that they are not "blind to values", but suffering from "daltonism" to values. Consequently, the feeling of boredom, of an all-encompassing vacuum will be intensely felt and will lead to *a continuous struggle to achieve more and different immediate or future settled purposes,* hoping to fill up this vacuum. This explains the expansive character of these personalities. The final purpose is that of achieving that "pattern of being in the world", interiorly conceived of as providing security. This is how we can understand why people who are perceived by their entourage as very successful come to complain of the meaningless of their own existence.

The feeling of vacuum and boredom will lead to a scepticism toward meaning, which in turn will also lead to a real anxiety when confronted with meaninglessness. The consequence on the psychological level will be a neurotic fixation experienced as an existential vacuum (FRANKL).

4. The Coping Reactions

On the psychodynamic level, the inability to fulfil the fourth fundamental condition of existence on the basis of a disturbed third fundamental motivation, will lead to a series of rigid undifferentiated reactions, which will be always the same, whatever the exterior circumstances.

Individuals suffering from such a personality disorder are expansive and self-centred. If considered superficially, they can be easily labelled as narcissistic and histrionic. There are, on the other hand, a series of particularities specific only of this category. For instance, according to the ICD 10, they lack four of the six diagnostic criteria for the histrionic personality (self – dramatization, suggestibility, exaggerated expression of emotion and the effort to be in the centre of attention) and, according to DSM-IV, they lack at least five of the nine diagnostic criteria for the narcissistic personality (preoccupied with fantasies of unlimited success, unreasonable expectations of especially favourable treatment, requires excessive admiration, lacks empathy, is often envious of others). On one occasion, even Kretschmer spoke about the *expansive dependent,* whom he defined as different from the histrionic.
These expansive and dynamic personalities will impress their entourage by *the tenacity* with which they pursue their immediate purposes, but also by *the ease* with which they give them up, once the fact that they might fail becomes obvious. This apparent inconsistency and *provisional attitude* toward life represents the basic movement. This is a first coping reaction and an attempt to avoid a potential danger. But this should not mislead us because a more care-

ful and longer-lasting analysis will show the existence of a crucial factor, of an *"ultimate purpose"* which will never be given up. This *ultimate purpose aims to achieve the pattern* with which it has identified itself. For instance, if the pattern to be achieved is that of the "scientist", any opportunity will be used in order to achieve that position, regardless of the subject-matter involved (Geology or Hermeneutics, Medicine or Astrophysics).

The position to achieve is decisive, and this kind of person will display crucial "excitement" in all of these fields; his/her abilities in this field are irrelevant, as long as he/she can achieve the "scientist" image. Another dynamic tendency – the paradoxical movement (LÄNGLE 1998a, 23; 1998b, 8) is the *idealization.* Because of the tenacity in professing their ideas or beliefs, these personalities seem idealistic or fanatic.

When threat becomes imminent a specific form of aggressiveness appears: *The stubbornness and the obstinacy* bordering on the irrational.

People with such a disorder first appear pleasant and communicative, driven by generous ideas, socially oriented and well adapted, even succeeding in winning over several followers, whom they will consequently keep under their influence by domination and even blackmail. These connections are selected according their utility. It is "implied" or taken for granted that they disserve "everything", not necessarily for themselves (they have no problem with the validation of their self-esteem), but rather for what they "stand for".

As long as one shares their ideas and confirms their position, things go well but, upon the slightest doubt, dissymmetric reaction of opposition with confusing aggressiveness will ensue. This way of reacting induces "preventive" and "avoidant" behaviour in their entourage. This will only convince the subject even more of the "righteousness" of his/her beliefs, of the "power" that he/she has. Everybody plays by this person's rules so that "everything goes well", in order to avoid conflicts. But this avoidant behaviour, of the entourage at a certain distance creates an empty space that must be filled by retaining control and influcene over the remaining followers, "by all means".

5. The History of a Para-existential Life

Olga is well-known in her town as an influential person in the intellectual and academic world. When one first meets her, she gives the impression of being a nice and pleasant person, well-meaning and agreeable in conversation. But this opinion is not shared by her colleagues from work where, although she does not have a leading position, she succeeds in almost always imposing her point of view and her own desires. If one opposes to her or contradicts her, one will be confronted on the spot with an extremely violent and aggressive reaction. She won't have any arguments contrary to her opinions and she reacts with stubbornness.

In childhood, she was the "apple of the eye" of the family. Her mother, a strong and authoritarian personality, had a special position in the town's social life. Her father, a peaceful and submissive man, would do anything to fulfil his "little daughter's" desires and wishes. He made a

good impression at the side of his wife but had no rights in decision-making. He was "the husband of his wife".
Upon high school graduation, the question of university studies was naturally put forward, but anyone ever considered Olga's real abilities. This is one of the defining attitudes for her life; for her fixations and traumas respectively.
They selected a college, which would guarantee a privileged social position, at the same time instilling in her the idea that she should climb as high as possible on the social ladder, to a top which her mother herself had not been able to reach. Endowed with a good intelligence and social abilities, being supported at the same time by the solid relational system of her parents, she manages to graduate, even though she had never manifested any real attraction towards this profession.
The same pattern was used in choosing her field of activity. She opted for a field that she had thought shameful a few years before, because she considered it unscientific and not rewarding from the financial point of view. She chose a field which offered her the advantage of guaranteeing an important job in her home town. As soon as she made this decision, she proved to be extremely "passionate and engaged" in this new field of activity. In every area concerning her career she seemed to be extremely available and generous, even in matters that did not interest her. Within a few years she succeeded in imposing herself, she took a doctorate and began a rapid university career; all these things were due to the fact that a "free corridor" had appeared, through which she could achieve her settled purpose. The professional aspect being now solved, the next point on the agenda was taken into consideration.

At 47, she thought that the time had come for her to have her own home. She bought and arranged a house, obviously with her parent's help, even though she went on living with them afterwards, remaining "the priceless daughter" of mummy and daddy. Even now, something is missing from the nice picture – a husband. She chose, according to her criteria, the "right" man for this role (good-looking, university educated, with good connections and money, but obedient like her father) and decided to get married, but not right away. First, she became engaged, strictly observing all the phases of the ritual (tradition must be respected), only to get married a few months later. The wedding was very spectacular. Only important persons were invited, because, through their social position or fortune, they might be useful for the future of "the young couple".
Now everything is right for her, she awaits the rewarding moment of the university career, but it is hard to say whether she has at least one true friend besides her parents, having, on the other hand, a lot of "adherents". There are a lot of people around her but she is essentially alone. A vacuum is growing around her, although one might first be fooled by the crowd. Olga has no problems regarding the value of herself. She does not need to "reflect herself" in the eyes of the others in order to confirm it. On the contrary, she is convinced of it. Her own value represents a certainty and she struggles for her project and purpose, using all the means at

hand. These will be employed as stereotypes, according to the rigid formalism of her personality.

Even if histrionic and/or narcissistic elements appear, this "constructed" life of Olga's, marked by the ambition to achieve the settled purpose, is fundamentally different from these adjacent psychopathological frames.

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Burnout – Existential Meaning and Possibilities of Prevention

Abstract

Burnout can be understood as the symptom of a non-existential attitude adopted by a person towards his or her life and existence. The misrepresentation of existential reality is of such a degree that it manifests itself in symptoms of vital deficiency on the somatic and psychological level and can be understood as an internal protection against further harm. Prevention of burnout can be derived from this existential understanding. It has similarities to the prevention of addiction and extends from behavioural programs to the development of personality and to the central topic: analysis of existential attitudes.
This paper deals with existential attitudes in relation to experience and practice.

Key words: Burnout, Existential Analysis, Existential Meaning, Existential Vacuum

1. The Evolution of the Concept and the Definition of Burnout

Burnout can be described as a specific set of psychological symptoms that arise in the context of work. The symptoms of burnout were first identified and described by Freudenberger in 1974. In his study, Freudenberger observed a series of characteristic symptoms such as exhaustion, irritability and cynicism occurring in people who had volunteered to work for aid organisations. These volunteers had worked with great dedication and enthusiasm for several months prior to the onset of these symptoms. From his observations, Freudenberger described these people as "burned out" in contrast to their initial "glowing enthusiasm" (cf. FREUDENBERGER ET AL. 1992; SCHAAB ET AL. 1993, 45; KARAZMAN 1994).

MASLACH provides an important description of burnout (1982, 3):
Burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind.
Other authors, however, do not agree that burnout is restricted to professions of social work. PINES and AARONSON (1988) for example, regard burnout as a symptom of extreme exhaustion and that this can be seen in any professional or non-professional (housework, for example) work.

The primary causes of burnout, according to MASLACH and JACKSON (1981 – cited after BROSCH 1994, 156f.), are emotional exhaustion, "depersonalisation" and a diminishment of productivity (see table 1).

1. emotional exhaustion:
chronic fatigue (even at the thought of work), sleep disturbance, sleep disorders, diffused physical symptoms, being prone to illness;
2. depersonalisation - dehumanisation
negative, cynical attitudes towards colleagues, negative feelings towards the people who seek aid, feelings of guilt, retreat, avoiding behaviour and reduction of work, automatic and routine-like "functioning";
3. reduced efficiency and discontent with achievement
subjective feelings of failure and impotency, lack of recognition, pre-dominant feelings of insufficiency and permanent overcharge.

Tab. 1: The main symptoms of burnout after Maslach & Jackson (1981)

SONNECK (1994) adds a further list of symptoms to Maslach and Jackson's model of burnout. Sonneck introduces the term "vital instability" to describe symptoms of: depression, dysphoria, excitability, inhibition, anxiety, restlessness, despair and irritability. "In a certain way", these symptoms are Sonneck suggests, "a development towards a presuicidal state" (ibid. 27).
Burnout is a specific health risk, particularly among medical doctors. When the symptoms of burnout are combined with depression, drug dependency and/or despair, it can lead to suicide, a rate which is about 50 percent higher among Austrian male doctors and about 250 percent higher among Austrian female doctors than the average population. Similar results were also found in BÄMAYR & FEUERLEIN (1984). It should be mentioned, however, that suicide rates in general are much higher among men than among women.
KARAZMAN (1994) found that the amount of hours a doctor worked per week had a direct effect on emotional exhaustion. How efficient a person was, however, did not appear to be significantly affected by the number of working hours. Similarly, there was no significant relation between the symptoms of depersonalisation and the total amount of working hours.

Rough estimates, with the help of the MBI (Maslach Burnout Inventory) in the U.S., have shown prevalent rates of burnout anywhere from 10 to 25 percent in the social professions (SCHAAB ET AL. 1993, 47).

The developmental stages of burnout are handled in different ways. FREUDENBERGER, for example, distinguished between two stages initially, one with and one without sensations (cf. BURISCH 1989, 19). In 1992, he expanded his description to include 12 stages. These stages

begin with a compulsion to prove oneself, continue with a reinforced effort accompanied by a neglect of one's own needs, a reinterpretation of values, negation of the resulting problems and lead finally to retreat, depersonalisation, an inner void and total exhaustion (FREUDENBERGER 1992, 122-156). MASLACH, by contrast, divides the phases of burnout into four parts (cf. also KARAZMAN 1994, BURISCH 1989, 19):

1. Idealism and overtaxing
2. Emotional and physical exhaustion
3. Dehumanisation as an antidote
4. Terminal phase: loathing syndrome (loathing of oneself, of others, finally a loathing of everything) and breakdown (professional resignation, illness).

SCHAAB ET AL. (1993, 46) provides an etiological description of burnout utilizing three complementary models:

The *individual*-psychological explanations underline the discrepancy between the exaggerated expectations in regard to work and everyday reality.

The *social*-psychological explanations see the taxations of social interplay as the main reason (e.g. Maslach).

The *organisational*-psychological explanations suggest that the main reason for burnout lies within the structures of an organisation (e.g. Cherniss 1980: not enough autonomy, role conflicts, little support and feedback from management, excessively high expectations in regard to the co-workers, etc.).

What follows is an attempt to describe burnout from the perspective of Existential Analysis. Existential Analysis is an individual-psychological model of interpretation. From this perspective, we will consider the dynamics of burnout. We will also describe the process wherein a person adopts a particular "existential attitude", an attitude that may lead to the symptoms and experience of burnout. Finally, a few considerations about the prevention of burnout will be made.

2. The Description of Burnout from an Existential-Analytical Point of View

We understand burnout as an *enduring state of exhaustion due to work*. This is the leading symptom and the general characteristic of burnout from which all the other symptoms can be derived. A state of exhaustion affects the general well-being of a person first. Burnout then influences subjective experience, which in turn affects a person's decisions, attitudes and actions. This type of exhaustion encompasses the three dimensions of human existence that FRANKL (1959) described in his anthropology:

Somatic dimension: physical *weakness,* functional disorders (e.g. loss of sleep) and even susceptibility to illnesses;

Psychological dimension: listlessness, cheerlessness, emotional exhaustion, irritability;
Noetic dimension: retreat from demands and relationships, disparaging attitudes towards oneself and "the world".

If the symptoms of burnout continue, it can lead to the formation of a "lens" that colours all further experience. A person's experience of themselves and the world is seen through this "lens" and is further characterized by a feeling of *emptiness* due to a persistent lack of somatic-psychologicalal energy. This is accompanied by an increasing loss of orientation. As a consequence, feelings of emptiness will be accompanied by an overall feeling of meaninglessness that will expand into other aspects of life (from work to leisure and into the private sphere) and will finally consume a person's life in its totality.

3. Burnout as a Special Form of Existential Vacuum

Frankl defined the term *existential vacuum* as a loss of interest (which could lead to boredom) and a lack of initiative (which could lead to apathy). As a consequence, such a loss of interest and initiative lead to a profound feeling of meaninglessness (FRANKL 1983, 10, 140 ff.). The predominant symptoms of burnout are similar to the two main symptoms of Frankl's "existential vacuum": feelings of emptiness and meaninglessness. Thus burnout could be understood within the framework of Logotherapy. It could be seen as a special form of the "existential vacuum" which also includes physical symptoms such as exhaustion. Although apathy and boredom are included in Frankl's definition of the existential vacuum, neither of these are primary symptoms of burnout but can occur as a consequence of other recurring symptoms.

These theoretical reflections on burnout are empirically backed by Karazman's study (1994) on 271 female and male doctors in Austria. The study showed that doctors with a sense of meaning in their private and professional lives exhibited only minor to medium susceptibility to burnout. But doctors who exhibited the manifestations of an existential vacuum, as described in the Maslach Inventory, displayed a high incidence of burnout with efficiency being only moderately affected. The existential vacuum goes hand in hand with a high degree of depersonalisation (distance towards patients) and a high degree of emotional exhaustion. These two symptoms in particular were found to remain high even when the subject's personal life was considered meaningful in contrast to their professional life.

What is the reason behind this exhaustion? What factors contribute to this exhaustion? Why are some people susceptible to burnout while others who work as much seem conversely to suffer from burnout? From a Logotherapeutic perspective, burnout can be explained as a *deficit in existential meaning.* Existential meaning is characterised by a sense of inner fulfilment. This experience will persist even in the face of fatigue and exhaustion if the relation to oneself, the experience of doing one's activities voluntarily and the sense of their value remain emotional-

ly present (FRANKL 1984, 28; LÄNGLE 1994). In contrast, a person whose life is dominated by a narcissistic pursuit of career or social acceptance is a life that lacks fulfilment and emotional reward (which contribute to existential meaning). A narcissistic pursuit demands energy and engenders stress. Instead of joy in one's achievements only pride will be felt. Pride is neither nourishing nor does it warm the soul. Even recreation and relaxation cannot fill the void of inner meaning and experience. These activities only replace the physical and psychologicalal energy that is being lost or diminished. They do not replace the personal (subjective) and spiritual meaning inherent in these activities.

EXISTENTIAL MEANING		SEMBLANCE OF MEANING → BURNOUT
❍ ⟵ ⟶ ❍		
FULFILLMENT		**EMPTINESS**
Activities and experiences are lived as **values**		Feeling **compelled** to action, disregard of experience values.
Life is	creative	exhausting
	dedication	sacrifice
	designing (creating)	designed (being created by others)
	eventful	uneventful
	personal	factual
	free	forced
	responsible	obliged
fulfillment in spite of fatigue		emptiness in spite of relaxation

Tab. 2: Confrontation of existential meaning and seeming meaning with their respective psychological effects.

From a Logotherapeutic perspective, a person experiencing burnout lacks an existential meaning **towards the activities he or she is engaged in.** This means that personal fulfilment is not achieved. Thus, burnout can be described as a disorder of well-being, caused by a *deficit of fulfilment.* A sense of fulfilment is the result of a life dominated by the experience and realisation of personal values ("personal values" being understood as subjectively meaningful and attractive in contrast to more objective values such as cultural or social, for example).

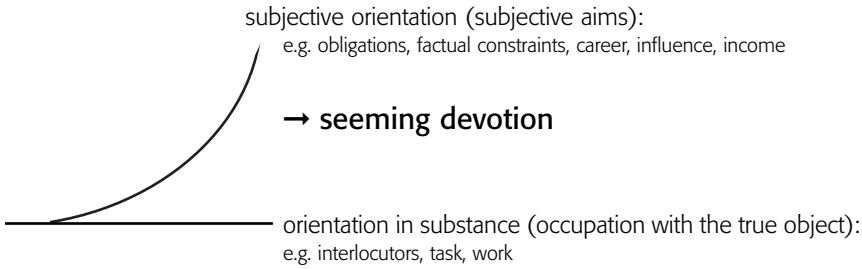
To put it differently: *true fulfilment in work is the best protection against burnout.* If a person works with pleasure and interest on a project and experiences his or her life as meaningful and fulfilling, he or she is not in danger of sliding into burnout. These feelings or experiences must,

however, be differentiated from feelings of enthusiasm, of unfounded idealism, idealization and the hope (if not expectation) for happiness and success, for example.

4. Motivational Theoretical Analysis

If we look further into the question of how such a massive and persistent deficit in fulfilment can come about, we find a motivational theoretical divergence between subjective intention and objective occupation.

The deficit in fulfilment is caused by a difference between
- subjective orientation (subjective aims) and
- orientation in substance (functionalism – actual occupation with a certain task)



Tab. 3: The motivational theoretical analysis leads to a divergence between the subjective motive of action and the objective task.

The orientation of people on the verge of burnout is not directed to the service of a project or a cause, but to *subjective* aims, such as career, influence, income, recognition, social acceptance, obligations or objective constraints (many of which one would like to be rid of). Even seemingly "selfless" motives, such as religious or humanitarian volunteering "for a good cause", can result in a relational discrepancy with the project itself. A person who approaches a task with an orientation such as this is not motivated by the substance or value of the work, but by some external consideration. Therefore, providing aid or the specific work is not undertaken "because of this particular human being" or "because of this concrete task", the people or the tasks are basically interchangeable. The true aim becomes the activity in and of itself and not the inherent value of the project. In these cases, a person's dedication to the project is not genuine.

Thesis 1: Burnout is the result not of a motivation in substance, but only in *form* (= foreign to the project and lastly egoistical motives) and therefore leads to a mere semblance of dedication.

In addition, a person may feel less attracted rather than compelled to undertake a specific activity or project in which case the value of the experience is lost.

To be so strongly motivated "away from" values that are inherent in activities or projects, suggests that there could be an underlying deficit that is psychologically rooted. A formal analysis of motivations leads us to the second thesis:

Thesis 2: Dynamics of the genesis of burnout:
actions are mostly undertaken because of
- **subjective needs**

and only secondarily because of
- **objective need**

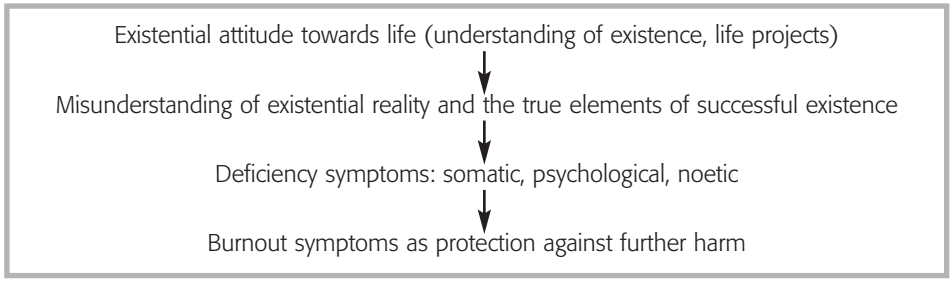
These subjective needs, in relation to burnout, can in fact be invisible for a long time, such as the idealistic aid worker that Maslach describes who devotes himself or herself to a project with great conviction and dedication. If a doctor develops symptoms of burnout during a flu epidemic, this need not be related to an initial state of neediness on his or her part, but rather to the limitless demands of the emergency. If the doctor dedicates himself or herself to the project with inner consent and conviction, he or she will be exhausted, but they will not show other typical symptoms of burnout such as cynicism, feelings of guilt, emptiness and suffering. Characteristically, burnout is not seen very often in times of calamity rather, it appears during daily work.

In general, for burnout to arise there must be an initial neediness, a non-existential attitude that is psychologically rooted which can lead to illness. There are also cases in which idealistic attitudes do not arise out of subjective deficits, but are adopted from others or derived from particular convictions, ideologies or religious beliefs. In either case, if a person is not able to compensate internally for the emotional loss generated by his or her efforts, the psychological manifestations are the same. This raises the question once again as to whether there may be in general psychological disorders or levels of internal neediness that reside underneath the symptoms of burnout.

5. Etiology from an Existential Perspective

Formally, the genesis of burnout was often explained by excessive stress or overwork. As a consequence, burnout was characterized by emotional exhaustion, it rendered relationships banal and functional, it was seen as causing a loss of self-confidence and productivity (KARAZMAN 1994). From an Existential Analytic perspective, we want to identify the specific *attitudes towards life* at the root of behaviour and motivation. We are interested in the degree to which

a person suffering from burnout is aware or unaware of these foundational attitudes. Whether a person is aware or unaware, these attitudes reflect a subjective understanding of what is thought, perceived and felt to be necessary and "what really counts in life". The symptoms of burnout do not happen accidentally but flow from a personal and subjective understanding of one's existence and what guides one's actions. The existential attitude adopted in cases of burnout "misinterprets" the requirements and elements for successful human existence. This misinterpretation stems from a deficit in the somatic, psychological and noetic levels. Burnout in its final stage - diminished activity - can therefore be understood as an internal response in order to protect against further damage to the self. Existential Analysis views this final stage as a possible motivation, one that leads a person to reconsider their "attitude(s)" toward life.



Tab. 4: The etiology of burnout from an existential--analytical point of view has its origin in a non-existential attitude (and idea of life "foreign to existence") and thus leads to exhaustion.

Let us re-examine the individual steps. A person experiences burnout when he or she is directed solely by a personal aim or motivation that is not linked to the task itself. In other words, the activity becomes merely a means to an end. Further, the attitude adopted toward the activity is prevalent prior to the onset of symptoms of burnout. Burnout starts with the person's experience of alienation towards his or her work long before the symptoms appear. The work loses its unique worth and instead becomes merely of value for its use or usefulness (for example, its use as a stepping stone to get from one job to another). The person is oriented toward an aim or goal and not toward the unique value and meaning of the work. The first step reveals a person's predominant attitude towards life. In this case, a person feels he or she needs a specific aim in order to have a valuable and worthwhile life. Paradoxically, such an attitude will inadvertently miss what is valuable and worthwhile. It will misconstrue the realities of the world and the requirements for a fulfilling existence. Such an attitude will not lead to a meaningful experience but only to the achievement of aims. These aims remain lifeless because they lack an inner consent or relation. Life then loses its capacity for quality. This can be expressed by the following two images: If the tasks and topics serve merely for one's own aims, they are merely used as fuel – and life turns cold in their ashes, or "First the object is burned up and then oneself."

A misconception or misunderstanding in one's perception of the existential reality results in a disregard for:

- *the intrinsic worth* of other people, objects and tasks, which leads to a trivialisation of one's relations with the world; and
- *a disregard for the value of one's own life,* a person's body, emotions, needs and a sense of what is right are ignored and this leads to a loss of relation with oneself. As a consequence, a person will feel at odds, lifeless and discordant (cor = heart - one's heart is not in it).

A life that exhibits a disregard for the intrinsic value of others and of one's own life will produce *stress*. If we describe stress as an experience, we suggest that stress originates from a reduced contact with values; what a person is engaged in is not experienced as valuable or worthwhile. From an Existential Analytic perspective, stress can be described as a "lack of inner consent" with relation to the specific activity. The deepest root of stress from our perspective is doing something without truly wanting to or engaging in an activity without one's heart in it ("dis-cordant" life).

What follows is a summary of the problem of burnout from Existential Analytic, Logotherapeutic and Motivational-Theoretical perspectives. The experience of emptiness, a lack of fulfilment, psychological neediness and a reduced quality of life, all have the same origin. These experiences arise because a person lacks an *inner consent.*

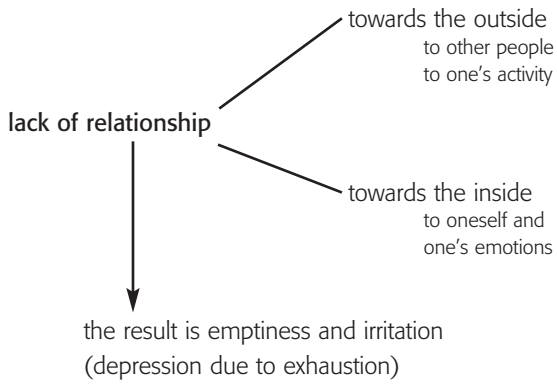
Thesis 3: Burnout and stress originate in a life where the inner consent is missing from the contents of one's activity.

If a person pursues an activity or a profession over a prolonged period of time and uses his time without having an inner relationship to it, without seeing the intrinsic value of this task, without being able to consent to its content and without being able to really dedicate himself or herself to it, an inner emptiness will arise. This inner emptiness is a kind of *"pre-depression"* as there is no dialogical exchange, in which one gives, and also receives.

An attitude that is orientated toward aims rather than values, subordinates all activities under this orientation. This leads to a distancing between a person and his or her job. A person will not enter fully into relationships and will prohibit any openness by withholding his or her inner consent. This attitude and response to life leads to an emotional disengagement in which work becomes void of life. Work becomes a mere substitute for a lack of closeness and affect. Essentially the person becomes lifeless and empty. This *lack of relationship* contributes the most damage to a person and his or her life. Further, this damage is not without consequences.

As with many disorders, the lack of relationship that we have described here (corresponding to the 2nd existential fundamental motivation) tends to culminate with some form of depression. Burnout is a form of depression (depression due to exhaustion according to Kielholz – cf. Pöldinger 1994) that is brought about not by trauma or biological deviation, but by a loss of life values, of which nourishing commitment and devotedness to the object is key.

Thesis 4: Behind burnout there are two distinct "attitudes"



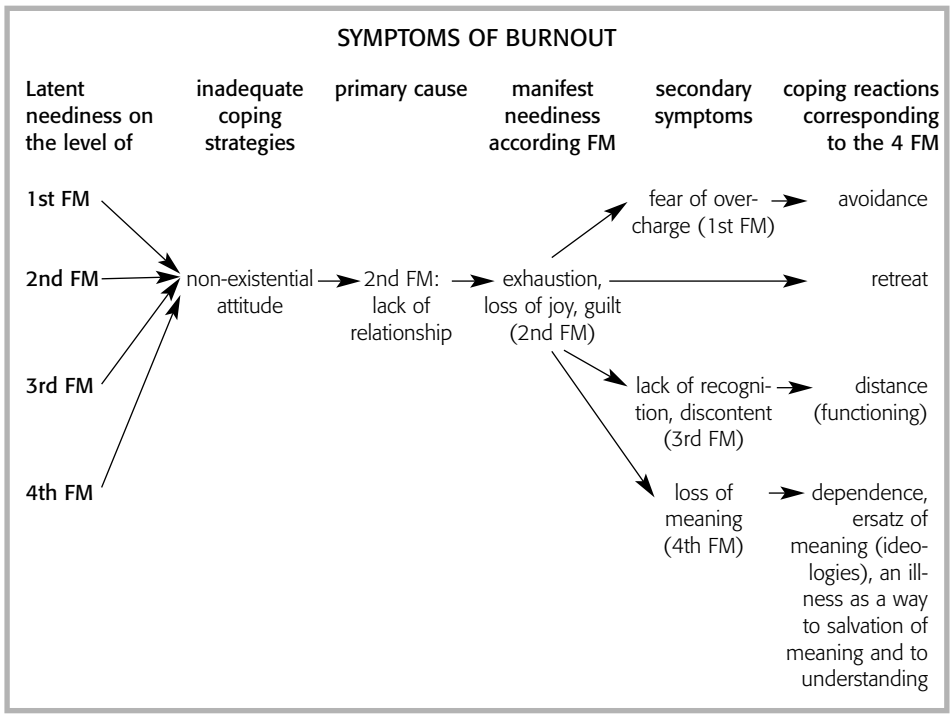
Burnout is therefore the result of several steps, the origin of which resides in a non-existential attitude towards life. By a non-existential attitude we mean a life that is merely oriented towards the aims or goals of life, that life is seen merely as a means to an end rather than an orientation towards the conditions of existence. Burnout from our perspective, begins with the symptoms of the existential vacuum, is compounded by external influences and/or subjective neediness and leads to a utilitarian attitude towards life. The result is what we term a lack of inner consent. This lack of inner consent in turn leads to a lack of relationship (towards others and toward oneself) and to a disorder on the level of the second existential fundamental motivation as set out in Existential Analysis. At its foundation, burnout is viewed from our perspective as a deficiency in the personal-existential fundamental motivations. In the next section, we will elaborate on this point.

6. The Origin of the Neediness and the Frustration of Personal-Existential Fundamental Motivations

A deficiency in *personal-existential fundamental motivations* makes inner consent impossible and gives rise to a psychological neediness. A life that is lived with great effort, but which lack relationships, leads to an inability to fully experience values and contributes to an increase in

emptiness and discontent (psychological frustration). This in turn will cause characteristic behaviours of aversion as a protective reaction (psychological coping-reaction). Burnout, therefore, can be linked with psychological neediness.

In conclusion, we will illustrate how existential life is impeded by burnout.



Tab. 5: Analysis of the non-existential attitude leading to burnout. On the basis of latent and misunderstood needs attitudes towards life will be developed that do not fully correspond to the existential reality of man and lead primarily into a poverty in relationships, if it comes to a burnout. The consequence will be a manifest state of deficiency on the level of the 2nd fundamental motivation with the other fundamental motivations also touched upon (maybe in resonance with the original deficits?).
A non-existential attitude can also be directly derived from the personal dimension, e.g. from religious convictions (see the final remark in chapter 4).

According to existential analysis inner consent can only be given if the conditions for a full existence are met. A life without inner consent leads to psychological stress and disorders. In relatively sane people who have sufficient psychological perseverance and who are inspired on the personal level by an ideal or an aim in life, can however, lead a life that is poor in rela-

tionships which can create symptoms of burnout. An identical situation need not necessarily end in burnout, but may also result in a fixation of coping reactions (automatic strategies of handling difficult situations) that result in a *neurotic depression.* Finally, stress in work can also lead to *psychoses.*

Deficits can appear on the level of the *first fundamental motivation,* which deals with a person's need for security, protection, space and acceptance in the world. A life that lacks the experience of support leads to feelings of insecurity and danger. Such people are prone to rigidly ordered activities to which they stick because they provide support. These people will do everything in order to keep this "safe living space".

The *second fundamental motivation* deals with relationships and the value of life, with care and closeness, which give rise to emotional warmth. Disorders on this level, such as blocked emotions, fear of relationships or emotional stress lead to basic feelings of obligation toward others rather than relational openness. Such people are inclined toward the helping professions to compensate for their feelings of guilt, worthlessness and lack of relations. However, such people often do not escape their depressive feelings. Characteristically, these people live as if in a prison of their own neediness, which makes them sacrifice themselves for others. They struggle in order not to burden others; they put their own demands last and strive to be a "good" person.

The *third fundamental motivation* deals with the need for recognition, recognition of one's own individuality, of one's own worth and the justification of one's existence before oneself and before others. A person wants to be appreciated by others and wants to be able to appreciate himself or herself. Disorders on this level make a person prone to seek flattery and praise and to equate one's intrinsic value with a career or money. The neediness on this level points to a lack of self-worth and drives a person to become dependent on external recognition, validation and respect from others.

Finally, the *fourth fundamental motivation* deals with the meaning of existence. In this larger context, a person can come to understand themselves and his or her life. The three preceding fundamental motivations are prerequisites for this motivation. A person who does not have this existential motivation experiences only partial meaning, experiences mere semblances of meaning (fashions, socially approved aims, ideological explanations, for example) in contrast to a meaning that holds personal value, a meaning that is richer, more well grounded and rewarding.

7. Therapy and Prevention

Therapy and prevention of burnout, aim, of course, first at situational relief. Strategies that are considered are related to the person, the organisation and the institution (SONNECK 1994, 27).

They include above all behavioural steps such as: the reduction of time pressure, delegation and division of responsibility, definition of realistic aims, discussion of normative opinions, dysfunctional beliefs and patterns of thinking and strategies for the improvement of work efficiency. Supervision and work on team conflicts have priority here (ibid.). Finally, treating a lack of autonomy and conflicts with authority are mentioned (SONNECK 1995, 9).

The *existential-analytical* treatment of burnout will initially proceed in the same way, but it will then treat burnout within the paradigm of the four fundamental motivations. Thus the attention is shifted from outer or external conditions to the attitude and meanings a person subjectively holds and expresses towards life. Discovering and elaborating on one's authentic existential attitudes in therapy represents a positive gain to be had from the experience of burnout.

In terms of prevention, ROTHBUCHER (1996) recommends the *existential meditation* as LÄNGLE (1988, 110-119) has described in the chapter entitled, "Anleitungen zu existenzanalytischen Fragen" and BÖSCHEMEYER (1988, 140-145) in the chapter, "Anstösse zum sokratischen Dialog". The existential situation can be examined by this means with possible pathologies and inconsistent areas detected early on.

The importance of relaxation techniques and recreation as a prophylactic is undisputed. In addition, Existential Analysis works specifically on *existential attitudes and situational decisions.* Only then will relaxation and recreation have a lasting effect. In prevention of burnout, Existential Analysis also goes into the development of personality. A few characteristic questions for prevention and treatment of burnout are compiled in table 6.

Prevention of burnout by questioning oneself:
- ➢ *Why* am I doing this?
- ➢ Do I *like* doing this? Do I experience that this is good and that therefore I like doing this? Do I get something out of this activity right now?
- ➢ Do I *want to live* for this – will I want to *have lived* for this?

Tab. 6: A few essential existential-analytical questions for the prevention of burnout.

Rothbucher and other authors precede their arguments by a poem by Eugen Roth, which runs about as follows:

A PERSON SAYS – AND PROUD IS HE:
I LIVE FOR MY DUTIES!
BUT SOON ENOUGH – AND LESS HAPPY,
HE DROWNS IN HIS DUTIES.

The danger of burnout because of mere obligations can be prevented. A rule of thumb could be:

Thesis 5: If someone spends more than **half of his time**
with things he/she does not like,
in which his/her heart is not in it and
that do not give him/her joy – sooner or later
he/she will be susceptible to **burnout.**

Burnout is a fashionable term that describes a frequent phenomenon of our times. Our times can be characterized as hectic, demanding and achievement oriented. But our present day is also marked by a lack of relationship and a lack of commitment in the service of achievement. Burnout can therefore be understood as the bill that we are presented with for a life that is alienated and remote from our existential reality and that is determined by the demanding character and the spirit of consumption that marks our present times.

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Translated by Godela von Kirchbach. English language consultation by Britt-Mary Sykes, University of Ottawa.

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The Relationship between Existential Fulfillment and Burnout

An empirical study from an existential-analytical perspective (N = 105)

Aim:

The aim of the project is to point out the relationship between the lack of existential fulfillment and various aspects of burnout, psychosomatic disorders and characteristics of personality.

Background:

Although "a negative attitude towards life", "hopelessness", "feelings of meaninglessness", "suicidal intentions" and "existential desperation" are part of the closer definition of terminal Burnout-Syndrome, attention is seldom paid to an explanatory connection between burnout and existential aspects. This attempt was made by LÄNGLE (1997), who explains the origin of burnout in light of an existential-analytical point of view in several stages: the basic condition of its origin is a non-existential attitude towards life, stemming from a deficit in personal-existential fundamental motivations. A person in this position longs for a fulfilled life but has no orientation in the most basic existential premises. Because of an illusionary sense of purpose and sham interpersonal skills based on motives outside of oneself, a subjective neediness emerges which results further in a reductionistic, merely task-oriented life philosophy. This attitude lacks the deep-rooted affirmation that guides a person to do and to be. It is this missing connection which brings about emptiness, apathy and desperation, described for instance by FREUDENBERGER (1982) as the last stage of the burnout cycle. The work presented here will point out the relationship between existential fulfillment and burnout based upon existential-analytic views and provides empirical evidence by means of a random sample among teachers in Salzburg, Austria.

Method:

Existential fulfillment was measured with the Existence-Scale (Längle, Orgler & Kundi, 2000), the dimensions of Burnout with the Burnout Inventory (GAMSJÄGER, 1994), an extended version of the MBI by MASLACH and JACKSON (1986), the personality constructs of *neuroticism* and

extroversion using the EPI by EYSENCK (1968), *psychosomatic disorders* with the BEB by KASIELKE ET AL. (1974). The extent of existential fulfillment was correlated with the values for the factors of *burnout* and the complete burnout testing score as well as with the scores for psychosomatic disorders and the extent of *neuroticism* or *extroversion*. The calculations were completed using SPSS 10.0.

Results:

There is a significant negative correlation between the scores of the Existence-Scale and those from the Burnout Inventory in all sub-factor points and in the overall test for the relationship between *existential fulfillment* and the wide range of *burnout* aspects among the test subjects. This signifies a statistically reliable relationship between the degree of burnout and the extent of missing *existential fulfillment.* High correlation was found in regards to *emotional exhaustion* and all of the Existence-Scale values.

Table 1: Existence-Scale

BI	EE	RPL	DP	BI
SD	-.50**	-.32**	-.25**	-.47**
ST	-.56**	-.51**	-.38**	-.61**
P	-.60**	-.49**	-.37**	-.62**
F	-.58**	-.56**	-.39**	-.64**
V	-.64**	-.52**	-.36**	-.65**
E	-.65**	-.56**	-.39**	-.68**
ES	-.69**	-.57**	-.41**	-.70**

Significance levels: * = $p < .05$; ** = $p < .01$

Correlations between the values represented in the Existence-Scale (SD = Self-Distancing, ST = Self-Transcendence, P = Person, F = Freedom, V = Responsibility, E = Existence, ES = Overall Score of the Existence-Scale) and the Burnout Dimensions (EE = Emotional Exhaustion, RPL = Reduced desire for personal investment, DP = Depersonalisation) of the Burnout-Inventory (BI).

Connections between the values of the Existence-Scale and the result of the test to define disorders point to the high correlation of personal, existential and overall test results from the Existence-Scale with physical-functional and psychic disorders.

Table 2: Existence-Scale

BEB	KFB	PB	BEB
SD	-.32**	-.47**	-.43**
ST	-.42**	.-47**	-.47**
P	-.45**	-.56**	-.54**
F	-.44**	-.48**	-.49**
V	-.54**	-.54**	-.59**
E	-.53**	-.54**	-.58**
ES	-.54**	-.55**	-.63**

Significance levels: * = $p < .05$; ** = $p < .01$

Correlations between the values represented by the Existence-Scale (ES) and the results of the KFB (physical-functional disorders), PB (psychic disorders) as well as the overall test result of the disorders definition test (BEB).

The scores of the Existential-Scale and the results of the EPI in regards to the personality trait *neuroticism* show highly significant negative correlation. No significant correlation could be proven for *existential fulfillment* and *extroversion,* with the exception of the sub-factor value freedom.

Table 3: Existence-Scale

BI	NEURO	EXTRA	
SD	-.48**	.16	
ST	-.56**	.17	
P	-.63**	.18	
F	-.64**	.23*	
V	-.77**	.12	
E	-.75**	.18	
ES	-.74**	.20	

Significance levels: * = $p < .05$; ** = $p < .01$

Correlations between the values represented by the Existence-Scale and the Neuroticism-Scale (NEURO) und Extro-version (EXTRA) from the EPI.

Conclusion:

The test results listed here demonstrate a statistically reliable connection between burnout and a lack of existential fulfillment. The close relationship between neuroticism and burnout verify the test results of PINES, ARONSON & KAFRY (1981) among others. Maslach emphasizes that persons with negative self-perception will experience potential burnout conditions differently and handle them less successfully.

The fact that burnout processes coincide with manifold psychosomatic reactions confirms the integral body-soul-mind nature of humans. The list of disorders shows an apparent resemblance to neurasthenia as described in ICD-10. This study also confirms that burnout is an exhaustion syndrome with emotional depletion, bodily weakness, mental vacuity and lack of orientation.

The evident connection between lack of existential fulfilllment and burnout should be stressed once again in conclusion. One out of five of the tested teachers suffered from a lack of existential motivation; one out of three was found to have a more or less serious burnout syndrome with marked psychic problems and a series of diverse disorders. These male and female teachers need assistance, which can be offered preventatively to some extent through innovative teachers´ training, but more essentially, must be reinforced by professional supervision of the occupational activity. In the case of very stressed instructors, organisational and institutional strategies are necessary which primarily relieve the immediate situation. Strategies must be developed to reduce time pressure, promote delegation and the division of responsibility, and define realistic goals.

The existential-analytical treatment of burnout then will consist of a deepening process of shifting the attention away from the outer situation to the attitudes towards life and structures of motivation that define the subjective view of life. The emergence of an authentic, existential attitude thus contributes toward the decisive changes in the personality that can be gained as a result of having gone through burnout.

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Attitudes towards Suicide, Existential Motivation and Self Reported Suicidal Phenomena

Comparisons between Physicians, Teachers, Trainees in Psychiatric Nursing, Politicians and Inpatients of a Crisis Intervention Center (N = 237)

Aim:

The aim of the project is to reveal the differences between physicians, teachers, trainees in psychiatric nursing, politicians and patients of the crisis intervention center in light of the attitudes regarding suicide and the extent of existential motivation, as well as establishing the personal connection to experiences with individual suicidal tendencies. The results are intended to receive consideration in suicide prevention work in Salzburg (Austria).

Background:

Reports concerning the relationship between attitudes towards suicide and the personal connection with an individual suicidal tendency are very complex with partially contradictory results. It is clear however, that human beings will be influenced in their suicidal tendency by specific attitudes toward suicide and related standards of life.

In cooperation with SUPPORT, an organization for the prevention of suicide within the Assembly of European Regions (AER), attitudes towards suicide, the extent of existential motivation and experiences with individual suicidal tendency were researched among various professions as well as a random sample with patients.

The choice of people groups had the following reasons: politicians are significant in the support of suicide prevention within the political health systems; teachers play an important part in the transfer of information and the creation of a sense of awareness for psychic problems, medical doctors and nursing students are directly confronted with the treatment of patients. Finally, patients represent the perspective of those directly affected by the problem.

Method:

Attitudes towards suicide and experiences with individual suicidal tendencies were measured with the ATTS (Attitudes towards Suicide, SALANDER-RENBERG & JACOBSSON, 1998) and the extent of existential motivation, using the TEM (Test for Existential Motivation LÄNGLE & ECKHARDT, 2000). N = 237: Physicians (n = 53), teachers (n = 50), nursing students (n = 42), politicians (n = 49), patients (n = 43).

For the comparison between all five groups regarding the attitudes towards suicide and the experiences of suicidal tendency, the nonparametric Mann-Whitney-U Test was utilized. The significance level was adapted to achieve a familywise type I error of 5% for each question. (Bonferroni-correction).
Content-related connections between individual items were processed using a linear discriminant analysis and the particular discriminant function scores were tested in pairs (Spjotvoll and Stoline Test).

The extent of existential motivation was determined by adding the point values for each item and correlated with the attitudes to suicide and the experiences with suicidal tendencies. The calculations and graphics were completed using STATISTICA 5.5.

Results:

Physicians differ significantly from all other groups in the discriminant function scores (DF) of **Suicide as a right** (DF = 5 items; e.g. *A person suffering from a severe, incurable disease who wishes to die should get assistance.*). Doctors reject the right to suicide strongest (Fig.1a). **Prejudice** (DF = 4 items; e.g. *People who threaten to commit suicide, rarely do so.*) is held significantly less by doctors and teachers then by the other groups (Fig.1b).

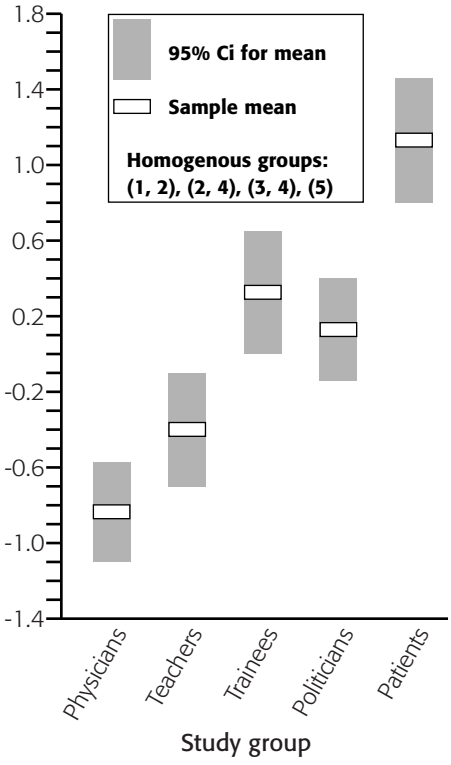

Fig. 1a: Suicide as a right

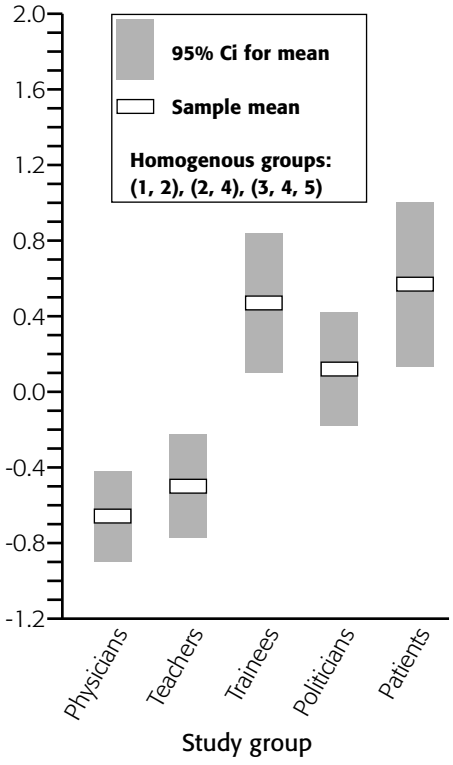

Fig. 1b: Prejudice

Preventability (DF = 5 items; e.g. *It is always possible to help a person who has suicidal thoughts.*) is seen significantly more optimistically by patients and politicians than by members of the other groups (Fig.2a). Physicians differ concerning **Tabooing** (DF = 3 items; e.g. *Suicide is a subject that one should rather not talk about.*). Of all the groups, doctors attach taboos to the subject least (Fig.2b).

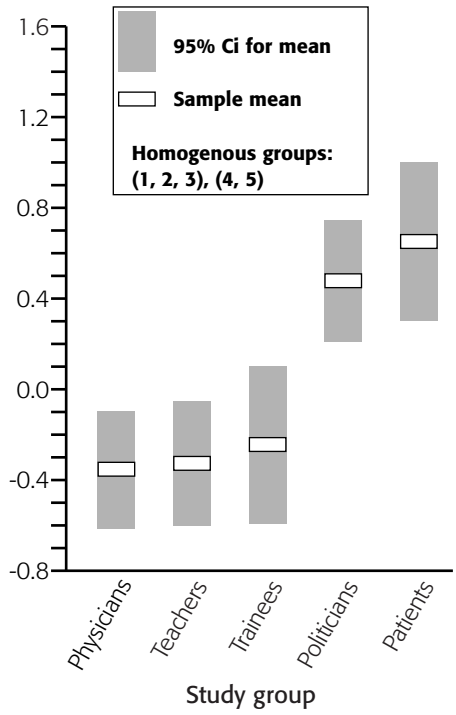

Fig. 2a: Preventability

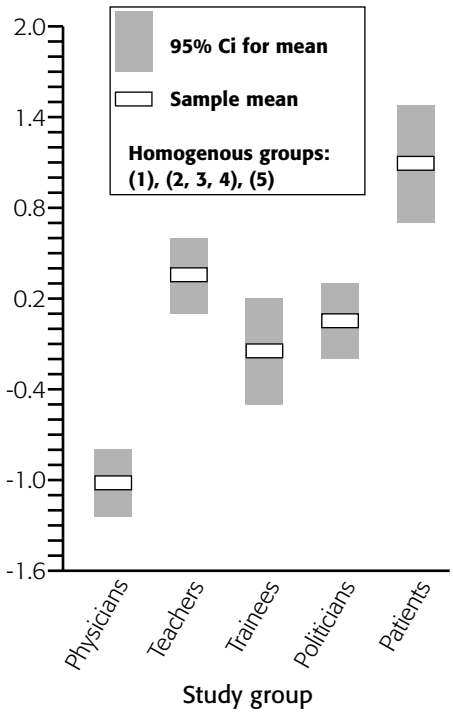

Fig. 2b: Tabooing

Patients check **Suicidal feelings and thoughts** ("Suicidality") in the context of last year significantly more often (DF = 4 items: *questions about lack of self-worth, wishes oneself dead, suicide ideation and suicide plans in the last year*). Nursing students report suicidal tendencies considerably more often compared to politicians (Fig.3a).

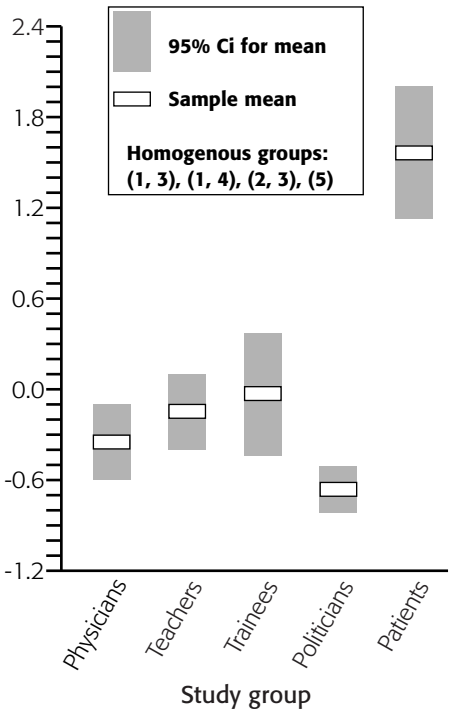

Fig. 3a: Suicidality (last year)

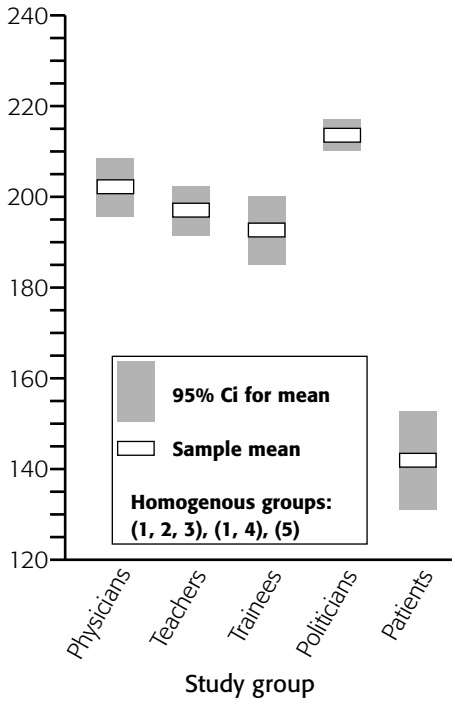

Fig. 3b: Existential motivation

The extent of existential motivation (EM) was significantly lower for the patients than for the other groups (Fig.3b). Physicians and politicians show the highest values in existential motivation.

Existential motivation shows a medium strong pertinence to both suicidal tendencies in earlier life ($r = 0.45^{**}$) as well as suicidal tendencies during the last year ($r = 0.67^{**}$).

Conclusion:

The doctors who were polled for the most part rejected the right to suicide, stating their unanimous opposition in the current debate in Central Europe on legalizing assisted suicide. Since doctors and teachers have fewer prejudices regarding suicide phenomena and more information about suicide problems, it would be expected that these professions could be more strongly motivated in preventing suicide. In addition, the patients apparently trust the helping professional greatly, should they assume in the first place that a person in a suicidal crisis can be helped at all. This confidence is strong among politicians too: an important fact in the sup-

port of suicide prevention on the part of the political health system. Suicidal phenomena like the feeling of worthlessness, wishes oneself dead and suicidal ideation are to be found in all professions, thus confirming the findings that they also exist among the general public (e.g. PAYKEL ET AL., 1974).

Suicide attempts last year, to the contrary, were found almost entirely among patients. If one takes the suicide attempt to be the strongest factor in predicting a later suicide (e.g. VAN HEERINGEN, HAWTON & WILLIAMS, 2000), then the importance of an adequate stationary treatment facility like the stationary crisis intervention in Salzburg becomes clear. The low level of existential motivation among patients confirms the premises of FRANKL (1967) that positive attitudes in life present an effective suicide prevention. High values in the level of existential motivation, which arise from affirmation of the world, of life, identity and meaning, infer less affirmation of potential suicidal behaviour and a better way of dealing with life's problems (e.g. LÄNGLE, 2001).

These results are to be considered relevant not only for a resource-oriented therapy but also for the general sense of awareness and the transfer of information about the problem issues surrounding suicide.

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The Existence Scale
A new approach to assess the ability to find personal meaning in life and to reach existential fulfilment

ABSTRACT

The Existence Scale (ES) is a new self-rating test assessing the degree of personal fulfilment in one's existence. The test is based on FRANKL'S anthropological theory and on a four-level process model of a person's search for meaning in life (LÄNGLE). The test consists of 46 items and determines the degree of existential fulfilment on four scales – 'realistic perception', 'free emotionality', 'decision-making ability' and 'responsibility'. The test has been applied in a number of validity studies investigating more than 1000 persons. External validity was assessed by the application of two self-rating scales and three tests, the Purpose-in-life-Test (PIL), a Depression-Scale (ZERSSEN) and the EPI (EYSENCK).

1. Introduction

Viktor Frankl founded logotherapy ("logos" Greek: originally 'word' later 'rational principle', 'meaning') in the thirties in response to the, in his view, incompleteness of psychoanalysis. By doing so he created a counterbalance to the impulse-oriented concept of humanity prevailing in psychoanalytical schools of that time. Frankl stressed the free and responsible (i.e. "spiritual" or "noetic") dimension of human beings, which makes them "persons". A "person" is, according to his view, essentially more than a mere „psychic apparatus" (Freud). As "persons" human beings are able to supersede the psychological level thanks to the capability of what Frankl calls "self-transcendence". As a consequence persons are receptive not only to instinctual cues, but are also sensitive to values in the world and to potential meanings underlying their decisions and actions. As such people do not primarily pursue lust (Freud) or power (Adler), but according to FRANKL (1982, 1984, 1985, 1987) the deepest human motivation is the *search for meaning*. If people do not act along the lines of their noetic (spiritual) sensitivity but follow primarily their drives (lust, search of power) they become existentially frustrated. This leads to the symptoms of the *existential vacuum* (FRANKL 1985c): lack of motivation and

a sense of emptiness and meaninglessness. The existential vacuum has a general impact on the development of all neuroses. Inasmuch as human beings are "persons", they are mainly concerned with "noetic" endeavours like the search for meaning in life, justice, freedom, responsibility, values or truth (FRANKL 1985a, 1985b).
Frankl called the existential fundamentals of logotherapy "Existential Analysis", whereas those concerning meaning he called "Logotheory" (FRANKL 1985, 37).
Frankl published his most important articles and books only after the Second World War following his liberation from the "Nazi" concentration camps. Quite a number of his publications were translated into English (FRANKL 1963, 1977, 1978, 1985a-c, 1986, 1988). The relevance of Frankl's concept for psychotherapy has been empirically investigated after World War II in many studies (for an overview see ASCHER ET AL. 1985a,b; BECKER 1985, 1986; CRUMBAUGH 1968; CRUMBAUGH & MAHOLICK 1972; FRANKL 1983, pp.15f.; KOCOUREK ET AL. 1959; LÄNGLE ET AL. 2000; LUKAS 1971; WURST ET AL. 1996.

2. Objective

The Existence Scale (ES) is a questionnaire based on Frankl`s theory and on a specific method derived from it. As an instrument specifically designed to evaluate noetic dimensions it is based on an exploration of the personal and existential realities of human beings. This of course is an infinite area but has to be operationalized by a finite number of items, which is accomplished by resorting to four basic elements of existence: Perception, recognition of values, competence for decision-making (freedom), and responsibility. The ES measures these personal abilities, which can be called "personal competencies for existence", by a standardized self-rating procedure. It is a test assessing the competence of an individual to cope in a meaningful way with oneself and one's world.
The questionnaire, which closely resembles typical personality tests, is designed for scientific use and for assistance in therapeutic practice. There is a wide field of application in scientific investigations within psychology, sociology, psychotherapy, management or pedagogy. Application in these instances is guided by the interest in the role of the mentioned central human coping-competencies, which in most investigations is merely part of the error variance. The ES can also be used to further explore existential-analytical theory (especially its concept of humanity, its theory of existence and nosology). Furthermore, it can be utilized in studies comparing different therapeutic methods.
Another field of application of the ES is screening in sociological and group-psychological research, prophylactic work (particularly in pedagogy and psychology) and existential-analytical diagnosis for psychotherapeutic practice. The ES can be employed to evaluate whether the individual has realized the personal-existential dimension and to what extent it has been incorporated into his or her personality development.
In particular there are three important issues:

- Is the ES suitable to differentiate between psychically ill and healthy people, and between different types of psychic disturbances? From a theoretical point of view blocked personal-existential competencies favour the development of psychic illnesses and disturbances. On the other hand, it has to be noted that physical illnesses and handicaps do not preclude the development of personal-existential abilities.
- Are there specific differences between different psychic disturbances in the profile of the subtests? If so, do they describe the type or the degree of these psychic disturbances?
- Do the results give guidance to the therapeutic process in the sense that they indicate 'causes' of the disturbances? (Or do the results refer to an unspecific, generally personal level with no direct link to the specific psychic [mental] disturbance?)

Results concerning the first question are available, sufficient research concerning the remaining two questions are still lacking.

3. The Construction of the Questionnaire

From the vast amount of possible statements about the view one person may have on existential aspects of his or her life, items were drawn by a theory guided rather than mere psychometric procedure. In this theory, the structure of the human being is described by a three-dimensional concept according to the traditional distinction of mind/spirit (Geist), psyche (Seele) and body. But the decisive difference of Frankl's theory to these older concepts is the notion of a dynamic interaction of the three dimensions. According to this, the spiritual dimension is taking position towards the psyche and the body. This makes human beings free to decide over themselves and to deal with their world.

In this concept human beings are fundamentally seen as a confluence of the somatic, psychic and noetic (spiritual) dimension, each of which differs in nature, regularity and function from each other. None of the dimensions is reducible to the others. The dimensions describe different modes of being despite their inseparable unity: The somatic dimension represents human life in the physical reality; the psychic dimension comprises the impulse-oriented, reactive mode of being; and the noetic (spiritual) or rather "personal-existential" dimension describes the spiritual world of meaning, freedom and responsibility. This third dimension enables a creative exchange with the physical reality (Umwelt), with the social world (Mitwelt) and also with the world within ourselves (Innenwelt). A person acts freely, authentically and responsibly when he/she is in accordance with his/her own sense impressions, emotion and thinking. It is the noetic dimension, which enables us to look at ourselves as an object of evaluation (abstract from our somatic and psychic conditions, so to speak) and to reach beyond ourselves, to devote ourselves to tasks worth living for and essential to life. FRANKL (1984, 148f.) calls these distinctively human abilities "self-distance" and "self-transcendence".

The practical application of this existential-analytical concept of humanity led to questions about the preconditions allowing this existential competencies to be realized and come into existence. How do human beings reach an authentic fulfilment of their lives? LÄNGLE (1988, 42ff.) proposed a *system of four consecutive steps,* that lead to the realization of the existential potentiality which is subjectively felt as a "meaningful life". Being of pure formal nature, they have no specific contents like interests, sexuality, believe, love, ambition etc.

The **first step** in the search of meaning consists of the *perception* of the world's objects as they are (not in 'essence' but in a communicable sense). For this initial interaction with the world it is important to gather relevant information and to get acquainted with the conditions and circumstances of the situation. A meaningful life always deals with the facts and realistic chances (possibilities) beyond the margins of unchangeable truths. Distortion of reality or the inability to accept it could be an obstruction to reach the other steps.
In the **second step** the subject gets to understand the qualitative relationship between the objects and between the objects and him/herself. A hierarchy of the more valuable goals (contents, possibilities) is developed. This is based on the recognition of one's emotional and evaluative reaction to perceived and imagined objects.
The decision between different options occurs in the **third step.** The individual has to eliminate some possibilities in favour of others. He/she has to be aware of the choice and the consequences. There might be circumstances when the individual is forced to some action or the other, but he/she can still be aware of his/her own choice.
But still the decision is not enough, the subject has to act, to commit him/herself to the chosen option. In an essential decision this may mean the devotion of one's life to the chosen goal.
Hence the **fourth step** consists of carrying out the plans and decisions, which completes the existential act.
The construction of the ES is based on these steps: The ability to perform the first one is termed, according to Frankl's analytical system, 'self-distance', for the second step the term 'self-transcendence' is used, because in an essential meaning of evaluation, it ultimately reaches beyond the self, the third step is termed 'freedom', and the fourth 'responsibility'.

The first two steps are very close to the "ego". They depend mainly on the development of the personality and are combined to form the **P-factor**. The decision for something and its realization represent the classical existential field, hence the last two steps are combined in the **E-factor**.

We are not aware of any test that intends to measures human personal-existential dynamics. The ES is meant to investigate the person's competence for existence (the degree of "existential" self-realization) and the latent construct of basic attitudes to life.

Construction of the ES started from a systematic compilation of statements related to the four steps of the theory sketched out above. In this process 159 statements describing the common way individuals deal with themselves and their world were formulated. The separation of dimensions and the primary selection of items was not based on factor-analysis because basically the dimensions are viewed as interrelated. Instead the selection was aimed at optimising internal consistency of the scales. Furthermore, the difficulty and variability of items was introduced as a selection criterion. Finally 46 items were obtained that had sufficient item-total correlation, acceptable difficulty and variability.

The sub-scale "self-distance" (SD) includes 8 items, the sub-scale "self-transcendence" (ST) 14 items. The sum of the scores of these sub-scales forms the P-factor. The third sub-scale "freedom" (F) includes 11 items, the forth "responsibility" (R) 13 items. Their sum is termed E-factor ("existentiality"). There is no alternate form, but the test can be repeated within a short time because there seems to be almost no learning effect. The test can be administered individually or in groups. The inventory is self-explanatory. It usually takes between seven and twelve minutes to complete, however, in some cases it has taken significantly longer. The items should be answered spontaneously, without too much reflection, to avoid thinking about social desirable answers. Response to the items is done in a six-point Likert-type scale, which enables a graded response between "true" and "not true" with respect to the statement of the item. If the analysis of the test is not computerized it can be scored using a transparent scoring aid and an analysis-form.

To investigate external validity several studies were conducted applying in addition to the ES one or more of the tests and questionnaires presented below.

Two logotherapeutic tests were employed in this comparison: The "Purpose-in-Life-Test" ("PIL") by CRUMBAUGH and MAHOLIC (1969) which investigates the "existential vacuum" (FRANKL 1983, 10f.), and the "Logo-Test" by LUKAS (1986) which deals with the accomplishment of meaning and with existential frustration (FRANKL 1983, 11, 49). Both tests measure the "status" of existential condition by self-assessment.
Two global self-assessments, specifically "satisfaction with living-circumstances and with fate" and "satisfaction with one's own effort to shape life", were used to validate the ES. In addition items of the *Schedule of Recent Experience* (SRE) served as external criteria. The SRE is an instrument of Life-Event-Research.
The well-known *EPI* developed by EYSENCK & EYSENCK (1964a,b; EGGERT 1974) measuring two major dimensions of personality, neuroticism and extraversion, was used to investigate the theoretical independence of ES from the trait 'extraversion' and the expected relationship to neuroticism. The *Depression-Scale* by ZERSSEN (1976) form D-A was also included.

4. Test-theoretical Investigation and Standardization of the ES

The ES was tested in a sample of 1028 Austrian adults aged 18 to 69 years. Clinical contrast groups consisted of depressive in-patients from two psychiatric hospitals in Vienna and untreated (mainly depressive) psychiatric patients.

Table 1

		sample from general population (N=1028)
self-distance (SD)	(8 Items)	.70
self-transcendence (ST)	(14 Items)	.84
freedom (F)	(11 Items)	.82
responsibility /R)	(13 Items)	.83
P-Factor	(22 Items)	.87
E-Factor	(24 Items)	.90
Total score	(46 Items)	.93

Table 1: Cronbach Alpha coefficient for the subscales and for the total score as well as for the P- and E-factor in the sample from the general population

Internal consistency (Cronbach Alpha coefficient) is satisfactory for the different sub-scales and the total score (Table 1).

Comparison of the scores reached in the general population and the two contrast groups revealed distinct differences. A relatively high score of self-distance (SD) in the untreated group is consistent with the assumption that in order to manage the mental stress without treatment the maintenance of some ability of self-distance is necessary. The low freedom (F) score in the in-patients group may reflect the relatively high degree of restriction due to the disease and to hospitalisation (see Table 2).

Table 2

	sample from general population N = 840	untreated depressive persons N = 188	clinical group (in-patients) N = 60
Total score	222,23	178,25	173,09
E-factor	112,11	87,71	85,03
P-factor	110,11	90,53	87,77
SD	36,48	30,07	27,80
ST	73,62	60,45	60,06
F	52,74	40,89	38,41
R	59,39	46,82	45,40

Table 2: Mean-values of total-test scores, E-factor and P-factor values, as well as of the sub-scales SD, ST, F and R for the sample from the general population (N=840), for the untreated depressive group (N=188), and for the clinical (mainly depressive) in-patients group (N=60)

The results of the ES are independent of gender. This is an interesting result. It means that personal-existential abilities as assessed by the ES have no gender-preference. A slight age-dependence was found: Subjects under 20 years and above 50 years show slightly lower test-results than middle-aged individuals. Dependence on educational level is most distinct, the test results increase with educational level.

Based on the sample from the general population a standardization with respect to age and education was performed. Percentiles and T-values were tabulated that can be used to assess a person's position with respect to the reference population.

The final version of the ES was checked for homogeneity in the sense of Rasch, by application of model tests with respect to several meaningful stratification criteria. It was shown that item parameters were invariant with respect to these stratification criteria. Hence it was concluded that the items form unidimensional scales and that the sum of item scores can be seen as a sufficient statistic for the person parameter.
Furthermore, the final version was subjected to oblique factor-analysis. It was shown that, except for two items, the original four-scale structure was maintained in this analysis.

5. Results of the Validity-studies

External validity was analysed by correlational studies with respect to the scales and tests mentioned above.
Subjects were asked to specify their satisfaction with living-circumstances and fate (V1), as well as their satisfaction with the shaping of their lives (V2). Correlations between these scores and the P-factor, E-factor and total score of the ES were moderate but significant at the .01 level. This implies that people who are satisfied with their living-circumstances or with themselves to a high degree also show higher scores in the ES.

Table 3

	P-factor	E-factor	total score
V1	.35	.37	.39
V2	.32	.45	.42

Table 3: Pearson correlation coefficients between P- and E-factor and the total score of the ES and satisfaction with living-conditions (V1) and with one's ability to shape life (V2)

After elimination of participants (less than 1%) who had an increased lie-score in the EPI (correlations of r = -.03 to r = .16 were found between the lie-score and the sub-tests of the ES), correlations were calculated between the test results.

Table 4

	P-factor	E-factor	ES-total	Depr.	PIL	Neurot.	Extrav.
P-factor	1.00	0.56	0.75	-0.41	0.46	-0.34	0.06
E-factor	0.56	1.00	0.83	-0.43	0.45	-0.43	0.08
ES-total score	0.75	0.83	1.00	-0.46	0.49	-0.42	0.08
Depression	-0.41	-0.43	-0.46	1.00	-0.41	0.49	-0.14
PIL	0.46	0.45	0.49	-0.41	1.00	-0.32	0.14
Neuroticism	-0.34	-0.43	-0.42	0.49	-0.32	1.00	-0.02
Extraversion	0.06	0.08	0.08	-0.14	-0.14	-0.02	1.00

Table 4: Pearson correlation between P-, and E-factor and ES total score, Zerssen depression scale, Purpose-in-Life-Test (PIL), and the two factors from EPI (neuroticism, extraversion)

As can be seen in table 4, the scores of the ES show moderate negative correlation to the depression-scale and the neuroticism score, and the PIL score did show a common variance of about 25% with the ES total score. Extraversion did not correlate with any other score.

A factor analysis of the ES scores together with the other test results shown in Table 4 was done to assess the ES in the greater context of these psychometric procedures. The varimax rotated factor matrix is shown in Table 5.
The sub-scales of the ES have high factor loadings mainly on the first factor, self-transcendence loads also highly on the second factor that is characterized by the PIL and depression scores. Neuroticism and especially extraversion form the last two factors respectively.

Table 5

	Factor 1	Factor 2	Factor 3	Factor 4
PIL	.38847	.79625	-.14279	.11812
Depression	-.23396	-.79387	.39530	-.07578
Extraversion	.02879	.10395	-.01657	.99014
Neuroticism	-.24894	-.26035	.88822	-.00581
SD	.82184	.27458	-.09219	-.05435
ST	.68119	.61571	-.07419	.05566
F	.75679	.34676	-.34921	.14575
R	.74137	.18915	-.48586	.04390

Table 5: Rotated factor matrix of the principal component analysis including the sub-scales SD, ST, F, and R of the ES, Zerssen's depression scale, Purpose-in-Life-Test (PIL), and neuroticism and extraversion scores from EPI

6. Interpretation of the Results

Overall ratings of satisfaction with their fate and external living-circumstances show only moderate correlations with the P- or E-factor scores of subjects. Although living-conditions are material for the shaping of life, they do not guarantee existential fulfilment nor need a subject have high noetic abilities to be lucky enough to live in comfortable conditions. On the other hand, subjects who achieved high scores in the ES, tended to be more satisfied with their own efforts to shape life and more so than with the external living-circumstances. However, the differences in these relationships were small and also for satisfaction with one's own achievements can be viewed as rather loosely related to noetic abilities.

A moderately high negative correlation of the ES with depression ($r = -.46$) and neuroticism ($r = -.42$) could be interpreted as an indication of the importance of the personal-existential dimension with respect to psychic health. A similar but slightly looser relationship was found concerning the development of an existential vacuum, which is measured by the PIL: PIL-depression: $r = -.41$, PIL-neuroticism: $r = -.32$.

Extraversion (Eysenck 1967) was independent from all other personality factors, not only those that have previously shown to be unrelated (neuroticism and depression) but also from fulfilment through meaning (measured by Crumbaugh & Maholick's PIL) and subjective fulfilment in one's own existence (measured by ES).
Regarding the ES, independence from extraversion shows that the realization of the noetic dimension does not depend on such characteristics as being comfortable in the company of others. Existential fulfilment does not require extraversion.

The basic concept that the ES measures a dimension independent of other factors is at least partially confirmed by the fact that factor analysis revealed one factor that is almost exclusively defined by the four sub-scales of the ES, and that these scales have only moderate or small coefficients on those factors that are determined by the other tests.

Also the PIL forms a more or less independent factor, that nonetheless includes depression (loading of .80). This factor can be interpreted as the realization of meaning, the main criterion for mental health (Becker 1985) and freedom from depression. It might be concluded that the depressive suffers from the feeling of meaninglessness, and those that have a feeling of meaninglessness tend to become depressive. It is interesting to note that the sub-scale ST (self-transcendence) of the ES has also comparably high loading of .62 on this factor. It seems that the development of depression is connected with a loss of free emotion and a reduction of the feeling of one's own value. These aspects, however, are substantial elements in fulfilling meaning according to the theory (Längle 1988). The ES is correlated with the PIL through the ability to utilize free emotion. As mentioned above, the existential fulfilment (ES) does not sim-

ply measure one's own feeling of meaning. The ES is related to the application of personal abilities in dealing with oneself and with the world (inner and outer behaviour). For that task not only the self-transcendence, but also self-distance (SD), which shows high loading only in the first factor, play an important role. Without self-distance self-transcendence is too closely connected with the dimension of depression, so that fulfilment through meaning is to be almost equated with freedom of depression. DYCK (1986) obtained similar results for the PIL. The PIL has only a weak correlation with the sub-scale self-distance. This can provide an explanation for Dyck's results as outlined above.

The sub-scale freedom contributes weakly, but more than the other scales, to the factor that is mainly determined by neuroticism. This supports FRANKL'S statement (1987, p.98) that people with neurotic symptoms lack freedom and responsibility. It seems that neuroticism affects more the ability to deal with the world and less the personal characteristics of self-distance and self-transcendence. The neurotic struggles more with the handling of "his/her world" than with him/herself.

We obtained a distinct answer to the initial question whether healthy and psychically ill people differ in utilizing their personal-existential competencies. Psychological health does not only depend on aspects like tension, mood, defence mechanisms, but is significantly influenced by personal-existential forces. The ES differentiates very well between healthy and ill, and it does it incremental to the discrimination provided by the neuroticism scale.

Future research should address the issue whether the pattern of the sub-scores provide characteristics useful for differential diagnoses. The ES measures the personal-existential dimension that represents the capacity of subjects to deal with oneself and one's world, i.e. also with the disturbances. The personal-existential dimension - where the performance takes place - is thus on another level as the psychic dimension which generates the symptoms. It is true that the ES does not directly refer to the state of health or suffering. From this it may be concluded that no specific profiles that characterize a psychic disorder can be expected from the ES. On the other hand, one can assume that syndromes like anxiety disorders, are persistent due to enduring personal deficits which are specific for a disorder. Therefore, the patient with anxiety could have developed this handicap as a result of deficits in the first level of the meaning finding process, i.e. in perception and self-distance. An investigation including sub-scales of psychic health supports this hypothesis (WURST & MASLO 1996).

It should be mentioned that there are some cases that obviously cannot be assessed by a standard testing procedure. Subjects with strong hysteric characteristics tend to have extremely high scores on all sub-scales. Such attempts of deception could possibly be singled out by lie-questions. Extreme test-results should be handled with caution and a verification through an inter-

view should be obtained. Generally it is recommended that the results of the ES be discussed with the participants at which time they are asked whether they can accept the score with its current interpretation. The test describes personal abilities that should not fall victim to a test-routine that would offend the dignity and individuality of people by putting a theoretical framework on them and their own experiences, attitudes and thoughts. It is to be hoped that the results of this test might supply solid material for a frank and personal dialogue and thus facilitate the commitment to life.

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Appendix:

Alfried Längle, Christine Orgler, Michael Kundi

Existence Scale

Date: . . . . . .

Name or **Sign:** . . . . . .

Age: . . . . . .

Occupation: . . . . . .

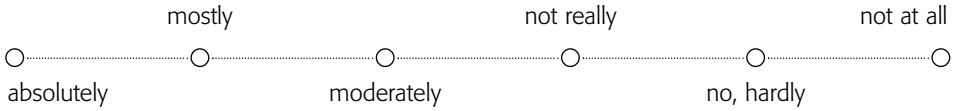
SD	ST	P-scale
☐	☐	☐
F	**R**	**E-scale**
☐	☐	☐

Total score: ☐

Total number of **Therapy-Hours:** . . . . . **Since last testing:** . . . . . .

Diagnosis: . . . . . .

Please mark the circle on the scale which is closed to how you generally feel, apart from occasional, brief fluctuations:

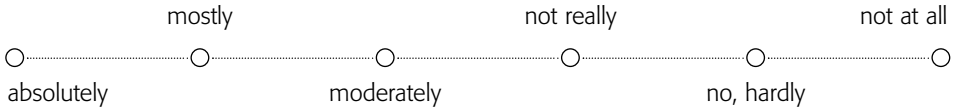


	To what extent does this statement apply to me?	
	absolutely	**not at all**
1) I often leave things unfinished because they take too much effort.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
2) *I feel personally addressed by my tasks.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
3) Things are only meaningful to me as far as they *meet my own desires.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
4) *There isn't anything good in my life.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
5) I prefer minding my own business (my own *worries, wishes, fears and dreams*).	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
6) *I am usually absent minded.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
7) I often do not feel satisfied, even after having accomplished a lot, because there would have been more important things to do.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
8) I am always ruled by other people's *expectations*.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
9) I try to put off unpleasant decisions without *thinking too much about them*.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
10) I am easily distracted, even when I do things I *enjoy*.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
11) There is nothing in my life I am really committed to.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
12) *I often do not understand why it is me who has to do something.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
13) *The way I live now is good for nothing.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
14) I have a hard time realizing what relevance things have for my life.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	
15) I have good ways of dealing with myself.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○	

Please mark the circle on the scale which is closed to how you generally feel, apart from occasional, brief fluctuations:

	To what extent does this statement apply to me?	
	absolutely	**not at all**
16) I don't take enough time for the things which *are important.*	○ --- ○ --- ○ --- ○ --- ○ --- ○	
17) I never know right away what to do in a situation.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
18) I do a lot because I *have* to, not because I *want* to.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
19) I am easily confused when problems arise.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
20) I rarely prioritize what I have to do.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
21) I am always eager to see what the day will bring.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
22) I rarely think about consequences before I act.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
23) I can't rely on my feelings when I have to make *a decision.*	○ --- ○ --- ○ --- ○ --- ○ --- ○	
24) I have a hard time starting something (even if I really care) because I don't know its outcome.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
25) I never quite know my exact duties.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
26) I feel inwardly free.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
27) Life has betrayed me because it has not fulfilled my wishes.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
28) I am relieved when I have no choice in a matter.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
29) There are situations in which I feel totally *helpless*.	○ --- ○ --- ○ --- ○ --- ○ --- ○	
30) I do a lot of things without really knowing enough about them.	○ --- ○ --- ○ --- ○ --- ○ --- ○	

Please mark the circle on the scale which is closed to how you generally feel, apart from occasional, brief fluctuations:

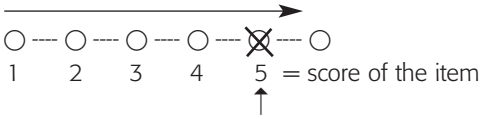


	To what extent does this statement apply to me?
	absolutely **not at all**
31) I usually don't know what is important in a given situation.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
32) The fulfillment of one's own wishes has priority.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
33) It is difficult to imagine myself in someone else's shoes.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
34) *It would be better if I didn't exist.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
35) Ultimately I can't relate to many things I have to deal with.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
36) I like to form my own opinions.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
37) I feel torn because I do so many things at the same time.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
38) Even when I am doing important things, I lack *the stamina to finish them.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
39) I do a lot that I really don't want to do.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
40) I'm only interested in a situation that meets my wishes.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
41) When I am ill, I don't know what to do with my time.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
42) I often don't realize that in every situation I have several choices of action.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
43) *I find the world I live in boring.*	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
44) There are so many things I have to do, that I rarely consider what I want to do.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
45) I cannot enjoy life's goodness, because there is always another side.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○
46) I feel dependent.	○ ---- ○ ---- ○ ---- ○ ---- ○ ---- ○

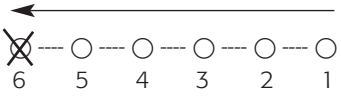
EXISTENCE SCALE (ES) – Evaluation sheet

The following schema offers an evaluation of the test without tools.
The score of each item results by counting the number of cercles from *left to right*

until the marked circle:



Attention! The marked * questions are inverse – the counting goes from *right to left*



P-value:

SD	
Question No.	value
3	
5	
19	
32	
40	
42	
43	
44	
Total RV	

+

ST	
Question No.	value
*2	
4	
11	
12	
13	
14	
*21	
27	
33	
34	
35	
*36	
41	
45	
Total RV	

= **P-value:**

RW
PR
T-Value

E-value:

F	
Question No.	value
9	
10	
*15	
17	
18	
23	
24	
*26	
28	
31	
46	
Total RV	

R	
Question No.	value
1	
6	
7	
8	
16	
20	
22	
25	
29	
30	
37	
38	
39	
Total RV	

E-value:

RW
PR
T-Value

Total score:

RW
PR
T-Value

Existential perspective:

Christopher Wurm

Is "Addiction" a Helpful Concept? An Existential View.

ABSTRACT

Ideas about addiction have evolved, and today behaviours such as excessive gambling and sex are called addictions. Medication and psychotherapy are offered, but many people avoid treatment. The dominant "bio-psycho-social model", despite being holistic, does not address freedom, motivation or spirituality, and some common terms and ways of working offend or alienate drug-takers, indirectly perpetuating their problems. Here CHRISTOPHER WURM argues for a reconsideration of the concept of "addiction".

Key-words: addiction, existential approach, motivation, treatment

In considering the helpfulness of the concept "addiction" the real question is: Is the concept of "addiction" helpful to the individual concerned? The notion of "Harm Reduction" is important here, for some people with a pattern of drug use do not see themselves as "sick" or "at-risk". Hence our ways of offering help may have dramatic consequences if we stick to rigid definitions of what needs to be done based solely on moral judgements.

Recent debates about needle exchange programs are a case in point. While Australia has lower levels of HIV among injecting drug users than countries like the USA, the initial introduction of needle exchange programs in Australia was met with much resistance. The argument was that enabling a young person to avoid infection with a potentially lethal virus was "sending the wrong message." This rationale is still used to oppose proposals to research the potential of providing medically prescribed heroin.

If our terms don't fit the perceptions of clients and the broader community, valuable advice may miss its target or be dismissed. People may see themselves as social drinkers or recreational drug-takers, and assume that a brochure about "Alcohol Abuse" or "Heroin Addiction" is not for them. People are not keen to accept treatment if they don't feel they have a disease. Offering advice and assistance with other problems – for example, budgeting assistance for those in debt, free vaccine against Hepatitis B, and thiamine tablets to prevent brain damage in a person at risk due to drinking – should not be either-or options.

Could appropriate psychotherapy be offered that allows clients to clarify their concerns and

deal with their issues, without being conditional on their acceptance of a particular "authoritative" explanatory model? Certainly where the use of drugs is illegal, the fact that potential clients are already breaking the law gives a clue as to their regard for authority figures. It can be hard to maintain dialogue with someone who is convinced there's nothing wrong with what they are doing. If we are to be useful we need to give information without setting the scene for an argument that invites clients to state more and more firmly their reasons for continuing to do what they are doing. In fact, people are often ambivalent about drug use, and giving them an opportunity to tell us about their mixed feelings while offering some practical assistance, can do wonders for rapport.

In many doctors' waiting rooms, community health centres, and government agencies such as student services and the like, there are pamphlets with titles like Alcohol Abuse. These pamphlets are intended to provide useful information and advice, but how many of the people for whom the pamphlets are intended would see such titles and identify them as relevant to themselves? Therapists see many people whose lives have been made difficult by the impact of alcohol, but few, if any, ever describe their situations in terms of "abusing alcohol." Many might meet the criteria for various definitions of "alcoholism", but only a minority willingly use this term to describe their lives.

A name or label that people do not relate to can serve as a barrier to their access to useful input. It is reasonable to use clearly defined, objective terms, but which words are these? The term "alcoholism" originated in 1849 with Magnus Huss, but has since been through many usages. It is now more widely perceived as an insult than as a neutral, scientific term, and for over twenty years the World Health Organisation has recommended against its use in favour of more clearly operational, less pejorative terms.

Perhaps the term "addiction" also deserves scrutiny. Might it serve as a self-fulfilling prophecy? Could it deflect attention from the way in which the person has continued to make choices that fit with their ongoing drug use/gambling/compulsive sexual activity/chocolate eating? Could it be a comfortable excuse? Humorous expressions such as "television addict," and "sex addict," suggest that the concept has broad applicability, at least in the popular mind, but does "addiction" really offer us a clear and worthwhile explanation?

Similarly the term "problem gambling" refers to the situation in which a person's gambling activity gives rise to harm to the individual player, and/ or his or her family, and may extend into the community. But "harm" is essentially a value judgement made by individuals, families, and the community. What is judged to be harmful for an individual depends on social norms and varies according to gender and to the lifecycle of the individual. Where the individuals and families involved live in a society with diverse cultural values and expectations it is more difficult for researchers and service providers to discern the nature and extent of "harm" (Amies, 1999).

Another equally problematic definition comes from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) which describes problem

gambling as *"a progressive disorder in which an individual has a psychologically uncontrollable preoccupation and urge to gamble. This results in excessive gambling which compromises, disrupts or destroys the gambler's personal life, family relationships or vocational pursuits. The problems in turn lead to intensification of the gambling behaviour. The cardinal features are emotional dependence on gambling, loss of control and interference with normal functioning"* (AMERICAN PSYCHIATRIC ASSOCIATION, 1989). However it has been pointed out that governments may also display these features, as they rely increasingly on revenue from poker machines and licensed premises (XENOPHON, 2000).

Explanatory models

POLS and HENRY-EDWARDS (1988) describe five common models of problem drug use:

- *The Moral Model,* which characterised the thinking of the early Temperance movements and also, to a lesser extent, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)
- *The Disease Concept,* a medical model which was originated by Jellinek, and became a mainstay of Alcoholics Anonymous and Narcotics Anonymous, later leading to clinical diagnoses such as "Alcohol Dependence Syndrome". Jellinek actually described a variety of patterns of drinking which he referred to as beta alcoholism, gamma alcoholism, epsilon alcoholism and so forth
- *The Social Learning Model,* currently favoured by the World Health Organisation. It also lies at the centre of the Bio-psycho-social approach to treatment
- *The Population Consumption Model,* which originated with the Ledermann hypothesis and fits with Public Health strategies to deal with problems at the community or national level
- *The Existential Model;* this approach draws upon the work of Dame Mary Warnock, Viktor Frankl, Leslie Drew, Herbert Fingarette, William Black and Emmy van Deurzen

Recently such models have been heavily criticised. Drew, who had played a part in the WHO development of the "Social Learning Model", later argued from an existential perspective that *"those of us who have contributed to the literature about models of drug dependence have indulged in irrelevances. We have pursued an abstract scientific course rather than responding to existential needs. We have produced a psycho-bio-social model of drug dependence that excludes the essence of human existence – options, freedom to choose, and the centrality of human values"* (DREW, 1990).

One can see the relevance of such criticism by considering some of the most common assumptions in the field of addiction treatment. For example, take the belief that some drug users undergoing treatment need time out to sort out their lives, especially when there is likely to be a physiological withdrawal process. Is it consistent to remind an "addict" that they are (relatively) free to choose other ways of life, and then write them a certificate for Social Security declaring that they are unable to work for the next eight weeks due to a "medical condition"?

Questioning assumptions

Preconceived ideas have been very influential, and probably unhelpful, in both research and practice. Maggie Brady has written about the terms used by Anglo-Australian academics when writing about Aboriginal people who have stopped drinking without formal treatment. She points to the use of jargon such as "spontaneous remission", and objects strongly to the suggestion that such a profound change is "spontaneous remission". It may look spontaneous because it has happened without the kind of intervention that mainstream theories predict will be needed, and it is referred to as a "remission" because the previous pattern of alcohol use was viewed by the researchers as a disease. However such thinking may be tactless at best, showing that such writers simply haven't listened to what people were saying. Brady writes that *"several [aborigines] thanked me for listening to them, saying that no-one had ever taken any interest in their success or given them encouragement"* (BRADY, 1993). If a concept like "addiction" leads to professionals only accepting people for treatment who agree to do things their way, then those who might be willing – and able – to make changes on their own terms may be ignored, or even actively discouraged (BRADY, 1993).

Media reports also influence public policy and how the public perceives social and health issues. Is drug use a social, criminal, or health issue? That depends on which drug you consider. Some of the earliest laws on drug use in Australia related to opium, but they only restricted the smoking of opium (as was seen to be the pattern among the Chinese), while allowing the use of opium tincture, as used by Anglo-Australians (ELLIOTT & CHAPMAN, 2000). As Miller has noted: *"For whatever reasons, popular thinking in the addictions field, particularly in the United States, has tended to be dichotomous. Alcoholism is like pregnancy – either you have it or you don't, and there's nothing in between. [The assumption is that] there is only one really successful road to recovery (which just coincidentally happens to be the method we offer in our program), and all other approaches are misguided"* (MILLER, 1996).

Existentialism and Addiction

Existentialism shares its historical origins with Phenomenology. Although few psychotherapists have any formal training in philosophy, Beumont has written about the importance of phenomenology in the development of psychiatry in Australia and New Zealand (BEUMONT, 1992). The Greek derivation of the word "phenomenology" reminds us that our experiences only relate to the external appearance, rather than any ability to know about things as they really are. Existential therapist Ernesto Spinelli emphasises the benefits in clinical practice of listening and exploring with an open mind (SPINELLI 1989), and any therapist who begins by using a term such as "addiction" may have already started to define and anticipate what the client is going through. The phenomenological strategy of "epoché" aims to avoid this pitfall. "Epoché" refers to the therapist putting his or her personal and theoretical assumptions and biases in brackets,

in order to approach the client's experience with an open mind. Hence an existential orientation to therapy should limit the risk of jumping to conclusions.(WURM, 1997a)

Existential approaches to drug problems are now appearing. The useful observations of William Black show the potential for applying existential thinking, particularly Frankl's work in the area of alcohol dependence and related problems, to the field of addiction (WURM, 1997b). Drew uses similar sources in developing his concept of alcohol dependence as *"a way of life leading to predicaments", adding that "the simple fact that a person keeps on repeating the same hurtful behaviour does not mean that they have lost the power of choice, whether or not the behaviour involves the use of drugs"* (DREW 1986). Currently there is a television advertising campaign that asks *Drinking – where are your choices taking you?* The ad raises the possibility that a decision to drink alcohol may lead to a situation that the individual regrets; it shows other choices while leaving the individual to decide.

Such approaches take into account the role of choice in the way people use alcohol, despite the social, psychological and physiological aspects such as withdrawal symptoms that may make it hard to choose differently. Of course, sometimes the behaviour pattern becomes so entrenched that it is hard for the individual to see that there are conscious decisions involved (WURM, 1997b), but describing the problem as "addiction" may make it even harder to see the role of decision-making (WURM, 1997c).

A recent pilot study explored the underlying bases of excessive gambling and drinking, with surprising results. Using a new measure of "attachment", as well as a test of dependence modified for gambling, the authors compared 16 adults reporting problems related to gambling with 16 adults who sought treatment for drinking problems. They compared aspects of the two groups' behaviours that were not directly based on the biological elements of the "bio-psycho-social model" (tolerance and withdrawal, collectively referred to as neuro-adaptation). There were strong similarities between the groups. Psychological withdrawal symptoms were more common in the problem drinking group than in the problem gambling group, but both groups showed psychological symptoms such as irritability, tension, and poor concentration when they broke their usual behaviour pattern. Qualitative analysis of detailed interviews supported the view that both types of behaviour may be mediated by factors that relate to attachment. The authors concluded that *"gambling may be just as addictive as alcohol, in the sense that people whose gambling has been causing them problems describe an attachment to gambling quite as strong as the attachment to alcohol described by people whose drinking has been causing them problems"* (ORFORD ET AL., 1996, 54).

Rather than talking of "attachment" we could use terms which highlight the process of choice – prioritising, preferring, or valuing. To speak of an act as addictive implies that there is no choice. Reminding clients that they are making choices enables them to review how their choices fit with their personal values and their plans for the future. Telling them they are addicted often seems to take away any sense that they might be able to make a difference.

Treatment, choice and responsibility

MILLER (1983) has developed a treatment approach known as "Motivational Interviewing," which combines existential concepts with cognitive behaviour therapy. The result is a treatment modality that de-emphasises labelling, avoids self-fulfilling prophecies, emphasises the client's own personal responsibility for his or her behaviour, and engages in a "Socratic" style of questioning. Miller writes:

[The] assignment of freedom of choice to the client (which of course the client has whether or not we assign it) leads to a more existential approach to counselling… [in which] the person must accept that he bears the primary responsibility for change in his situation. Although other people can assist the person in many ways, and even though the options open to a person may be limited by various unchangeable realities, each person continually makes choices between options. (MILLER, 1983)

Adding to this, Drew has argued that:

Persons with addictive behaviour have, by definition, given up the responsibility of making difficult choices. They tend to feel more externally determined than other people. They will need help to develop a strong sense of autonomy. They should not be allowed to excuse their behaviour because they "have an illness", or are underprivileged, or anything else. (DREW, 1986)

Of course, there have been huge advances in other areas of health through biomedical research. Some people hope for similar breakthroughs in dealing with the harm associated with alcohol and other drugs. Until recently there was only Disulfiram (Antabuse) available as a specific pharmacological treatment for alcohol dependence, but now Naltrexone and Acamprosate have both been approved for this purpose. Unlike Disulfiram, which acts by blocking the metabolism of alcohol so that a person who drinks while on it becomes physically ill from a build-up of acetaldehyde, Naltrexone and Acamprosate are said to reduce "craving" for alcohol. Bupropion is now available along with Nicotine Replacement Therapy for tobacco smokers, and Methadone and Buprenorphine are now available for people dependent on heroin. Those affected by marijuana or amphetamines and other stimulants have no pharmacological substitutes or deterrents available, but that doesn't mean they can't alter their behaviour.

However, this pharmacological focus still has to be connected to good communication skills and rapport on the part of the treating practitioner, in order to influence the motivation of the client. A doctor who knows that a certain medication may be valuable cannot bring about a cure until they gain the trust of their patient, who remains, as always, free to accept or decline such medication. Hence, even from within the parameters of pharmacological treatments of drug dependence, there is scope to consider goals, freedom, and responsibility, and not to suggest that craving or withdrawals turn an individual into an automaton.

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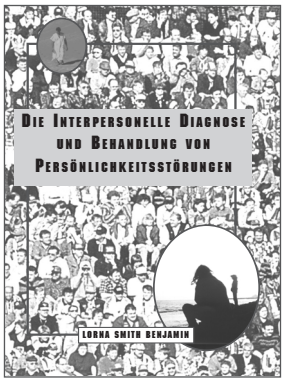

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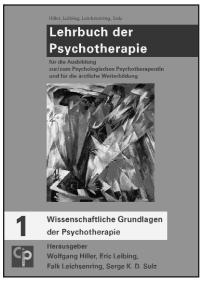

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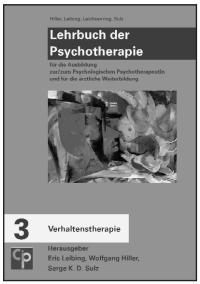

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