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SPECIAL TOPIC

GERNOT HAUKE
SERGE K. D. SULZ (EDIT.)

A 3RD WAVE THERAPY IN EUROPE: STRATEGIC BRIEF THERAPY

CLINICAL EXPERIENCE

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The corrective experience of values in psychotherapy: its relations with the change of defense mechanisms and symptom intensity in a course of short-term psychodynamic group psychotherapy

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EDITORIAL

Dear Readers,

You will probably miss the 2005 issue. The current 2006 issue was meant to be this 2005 issue. However, editorial work has been delayed to such an extent that we considered it more appropriate to actually title an issue, which will be published in August 2006, with the date of 2006. In accordance, subscribers will only have to pay a reduced price. The 2004 issue had not been published until spring 2005, which partly explains the current delay.

It becomes obvious that a practice-oriented journal of psychotherapy has to cope with two kinds of difficulties in Europe. On the one hand, it remains a fact that pioneering and innovative scientific studies still come from the US. Thus, a European journal aiming at reflecting the current status of international research in the field of psychotherapy will contain only a few European articles. This will be noticeable in our 2007 issue. Until then, we will have been able to access European editors and writers. With that issue we will give up our previous attitude, i.e. European authors writing for European readers, and will invite non-European writers as well. The second difficulty consists in the European readership. Readers are looking for publications about the particular therapy method in which they have been trained and with which they work predominantly. A reader who is not a behavioural therapist will not be interested in behavioural-therapeutic work. Someone who is not a psychoanalyst is not very likely to read a psychoanalytical article if that article is written in a language comprehensible to psychoanalysts only.
The present issue is dedicated – just like the preceding issues – to a therapy approach that has been developed in Europe: Strategic Brief Therapy. This approach is not an independent method of psychotherapy, but a particular conceptual procedure within the field of cognitive-behavioural psychotherapy, similar to Beck´s Cognitive Therapy, Young´s Scheme Therapy (Schematherapy), Haye´s ACT, Linehan´s DBT, McCoullough´s Cognitive Behavioural Analysis System of Psychotherapy (CBASP), Kohlenberg´s Functional Behaviour Therapy approach.

With the first publication in the year 1994, Strategic Brief Therapy has been established as an emotive-motivational version of the „vertical behavioural therapy" and as a counter-piece of „Plan Analysis" (Plananalyse) and of the later „Scheme Analysis" (Schemaanalyse) according to Grawe. In place of cognition, emotion was defined as a switch of behaviour, which naturally is initiated and modulated heavily by cognitions. Along with the „arbitrary" psyche, which is characterised by conscious experience and purposeful action, appears the „autonomous" psyche. The latter follows intentions - among conditioned reflexional and automised reaction processes – that are highly intelligent and purposive. On the basis of current knowledge, competence as well as needs and fears currently taking centre stage, they offer the best solution to the individual. The best solution may be the development of symptoms. It is this problem

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solving that is interesting for us as psychotherapists. If we add the trait of a person from the perspective of Piaget`s developmental theory we get one step closer to understanding. We can account for the system-perspective by including Watzlawik`s construction of reality as well as the principle of self-organisation (for example Haken and Schiepek). This approach is complemented and confirmed by Greenberg`s and Damasio`s emotion theories.

The neurobiology of motivational, emotive, cognitive and social self- and relationship regulation corresponds to the psychological statements in the theory of Strategic Brief Therapy. This approach may be called integrative. However, one might also take it as an example of the broadening of the cognitive-behavioural horizon in the past 15 years.

This issue gives a nearly complete overview. Three further articles (on couple, family and group therapy) would have gone beyond the scope of this issue. After making oneself familiar with the reading of the theoretical and conceptual basis, readers have the opportunity to learn more about the implementation in the treatment of anxieties, depressions and PTSD as well as psycho-oncological patients and in youth therapy.

We hope, these articles provide you with stimuli for your own therapeutic work.

Serge K. D. Sulz

IMPRESSUM

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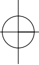

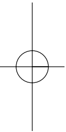

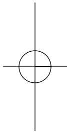

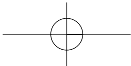

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The corrective experience of values in psychotherapy: its relations with the change of defense mechanisms and symptom intensity in a course of short-term psychodynamic group psychotherapy

ABSTRACT

Corrective experience of values seems to be related with the phenomenon of the restoration of morale described by Frank as a result of unspecific psychotherapeutic factors.
The aim of the paper is evaluating the connection of a way of experiencing values with defence mechanisms – a construct specific to psychodynamic psychotherapy. In a studied group of 37 patients after a three-month-long psychodynamic group psychotherapy, statistically relevant transitions were noticeable: the increase in an ability to experience values on the Corrective Experiences of Values Scale ($\underline{p} < .001$) and in symptom improvement ($\underline{p} < .001$) on the S-II Symptoms Questionnaire.
The change in a way of experiencing values turned out to be connected with an increase of "mature" [$\underline{r}(37)=.55$] and decrease of "immature" defence mechanisms [$\underline{r}(37)= -.35$] (Polish version of the Defence Style Questionnaire) and, as it had been predicted with symptom improvement [$\underline{r}(37)= -.66$].
It is argued, that the phenomenon of the corrective experience of values may be a specific cause of some symptom relief during the course of illness, which is attributed to the impact of unspecific factors or a placebo effect.
Keywords: psychotherapeutic factors, experience of values, defense mechanisms

Introduction

The importance of values (i.e.the axiological dimension) in a psychotherapeutic setting is acknowledged by many authors (e.g., ORWID, 1996; BERGNER, 1998; FRANK, 1981; KOKOSZKA, 1991, 2000; HOLMS, 1996; com. ALEKSANDROWICZ, 1996). However, there is no comprehensive theory concerning changes in experiencing values from the view of psychotherapeutic factors.

Values are a central interest of existential psychotherapists. According to FRANKL (1971), a main reason of suffering is an inability to find a meaning and aim in life; and in result of that – a lack

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of ability to find one's unique identity. In his opinion "the drive to meaning" (*Der Wille zum Sinn*), in contrast to Freud's "drive to pleasure" and Adler's "drive to power" is a basic motive of human existence (CRUMBAUGH & MAHOLICK, 1981). This condition fosters a creation of neurotic symptoms resulting from noetic neurosis. According to currently developed existential psychothereapy, existential analysis is an explication of logotheory, which, in contrast to logotherapy, is a method of treating various mental disorders (LÄNGLE, 2003).

The outlines of the general concept of the meaning of experiencing values in pathological conditions as well as in psychotherapy were offered by an influential Polish psychiatrist Antoni Kępiński, who considered mental disorders to be a result of disruptions in the value order (JAKUBIK, 1981; KOKOSZKA & POPIEL, 2000; KOKOSZKA 2001). According to him, in each pathological condition there are some disturbances in experiencing of values, and due to this, experiencing values should be addressed in most cases of psychotherapy.

Kępiński's ideas, developed in the political isolation "behind the iron curtain", are related with FRANK'S (1981) views, who, having analysed studies concerning accessibility and reasons for which patients seek psychological help, ascertained that: "people seek therapy not only due to observable symptoms". What is common for the patients, besides the barrier of shame and feeling of guilt, applying for help, is, in his opinion, "demoralization" consequent of pertinacious not handling of internal stresses or caused by an external situation, which, according to the individual or close ones, should be handled (FRANK, 1974, 1981). As a result, a life territory of a demoralized person – full of anxiety, depression, disarray, dispiritedness, guilt and shame, narrows down to habitual actions.

More recently the similar topics were addressed by BERGNER (1998) who adducing to research and clinical observations, wrote about a neglected, yet often appearing phenomenon of "meaninglessness". In his opinion, it is too common, to be left only to specialists dealing with existential analysis. The difficulties are provoked not only by different terms used by patients: feeling of emptiness, uselessness, lack of motivation, lack of aim but also by different context of their occurrence. In the context of (1) existential neuroses a central reason of suffering is a lack of ability to find sufficient meaning of life, the so called noetic neuroses; in other circumstances it emerges from (2) a clinical syndrome – depression or PTSD, or (3) a difficult or traumatic situation, e.g. a loss of a loved one.

One can wonder whether a common motivation for patients seeking help can be described as a disruption in the value order, demoralization, meaninglessness or existential vacuum.

The described phenomena can be understood from a perspective of a science of values – axiology. An axiological dimension of man and psychotherapy is a subject of diagnosis and transition in Kokoszka's concept of corrective experience of values (CEV).

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The concept of corrective experience of values

Andrzej Kokoszka formulated the concept of corrective experience of values on the basis of the views of an outstanding Polish psychiatrist – Antoni Kępiński and a very influential philosopher Józef Tischner (KOKOSZKA, 2001).

Antoni Kępiński, who wrote his 9 books during the incurable disease and died in 1972 before their publications, had significant impact on Polish culture at the time of a political isolation of Eastern European countries. In Poland, he is considered to be a founder of an axiological psychiatry and the one who recognized psychiatric disturbances as a result of disruption of the order of values (the axiological order) (see JAKUBIK, 1981; KOKOSZKA, 2001). He considered transitions in the manners of experiencing oneself, others and the surrounding world, as changes possible to achieve during psychotherapy. According to Kokoszka's analyses they may occur in a relationship with another individual (KOKOSZKA, 1997). On one hand, the therapist helps the patient recognize, understand and work through experiencing oneself, others and the surrounding world through pathological schemas formed in the past which the patient unconsciously displays in the presence of the therapist in a transference process. On the other hand, by upholding a proper attitude a therapist helps the patient to open up to the experiencing of values that confer the meaning to life, which are immanent in every individual and become inaccessible only as a result of disturbances in functioning. This is done through riddance of difficult or unbearable emotions tied with certain memories, conflicts, etc. and through experiencing values which enable to find the meaning of life.

As the result, the therapist should:

- from one side, remain relatively neutral and not burden the patient with personal issues,
- from the other side, be aware of the lack of knowledge on the topic of human nature and of the limitations of the used method, as well as continue being open to novelty in the contact with every patient, even if it should mean the necessity of questioning the hitherto, profound, personal beliefs.

This type of demeanour – parallel to the attitude expected of the patient, "allows the other individual to be", enables "the encounter with another person", fosters the building of bonds.

In other words, the therapist should be a good craftsman with a skilful ability to use psychotherapy, a researcher open to recognizing new information and ready to verify own views and outlooks and, most of all, a person sensitive to the other individual's, the patient's experiences.

Helpful in the understanding of experiences connected with regaining the sense of personal meaning in one's life and satisfaction from accomplishing values, are TISCHNER'S (1977, 1982) phenomenological analyses. Tischner depicts two kinds of experiencing values: the agatological experience allows one to discover what is good and what is bad, whereas the axiological experience is a projecting experience, which assumes hope, a feeling of strength and the existence of a "sense of reality" that uncovers which values may be accomplished. It stems from the experience expressed by the word: "if you want to, you can". According to Tischner, a spe-

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cial contact with another individual, which according to the philosophy of the dialogue is called the "encounter phenomenon", is the source of axiological experience. TISCHNER (1982) claims that crucial experience of this phenomenon is best expressed by the statement: "I know that you understand me, therefore we are".

Kokoszka's concept refers to Frank's views concerning "demoralization" (KOKOSZKA, 1999). The condition of "demoralization" is characterized by "the feelings of helplessness, social isolation, despair, deterioration of self-esteem and of rejection by others because of failure to meet their expectations".

In Frank's opinion the chief problem of all patients who come to psychotherapy is demoralization and the effectiveness of all psychotherapeutic schools lies in their ability to restore patients' morale through the so called "specific" therapeutic agents.

Corrective experience of values is defined as a "justification for a given manner of behaviour, reflection and feeling that enables the implementation of a prior unrealisable values". Corrective axiological experience can be understood as a special case of the corrective experience of values that allows for the attainment of a sense of personal meaning to the realization of defined values and for regaining the sense of life by supplementing the therapeutic effect of insight into the symptom mechanisms and corrective emotional experience.

Concept of the corrective experience of values was confirmed by results of numerous studies. They concerned, what TISCHNER described (1982) as the core of experiencing values, the words: "if you want to, you can…", which bring to life the feeling of mutiny and strength (KOKOSZKA, 1996, 1999). This moment is realized by the patients. Asked about the most meaningful experience in the course of disease and therapeutic meetings that had most influences on improvement of the frame of mind, the patients adduce the moment of being ready to undertake action in the direction of executing aims. Their utterances concerning change concentrate on important values, contact with another person and changing the meaning of symptoms (KOKOSZKA & CURYŁO, 1999). The questionnaire was sent to 56 persons who underwent three months of intensive psychodynamic group psychotherapy at the daily unit. The main question in the questionnaire was: "During the course of the disease, did you observe such a stage in which symptoms did not disappear, but their meaning for you changed; as a result of which the symptoms had become less burdensome? If such a situation did occur, please write about these changes and the situation in which they occurred". 20 (36 %) subjects replied; 11 women and 9 men of age ranged 21-51.

The descriptions of experiences supporting the concept of the corrective axiological experience were delivered by most of the subjects (12/14) who reached symptom relief after treatment and by no one from the group of 6 persons who reported a lack of improvement after the treatment.

Corrective experience of values is a justification for a given manner of behaviour, reflection and feeling. It results in regaining the ability to execute aims and in improvement of social functioning, despite the remaining symptoms. Corrective axiological experience, a variant of the cor-

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rective experience of values, is an experience of the meaning of achieving certain values, which results in finding the meaning of life. Being responsible for undertaking action in the direction of executing aims, corrective experience of values is dealt with as a hypothetical third therapeutic factor, besides the intellectual insight and a corrective emotional experience. This kind of understanding is common with a popular view that mental activity requires to comply cognitive, emotional and behavioural factors. These three aspects are represented by the three abovementioned therapeutic factors.

On the basis of the described concept of corrective experience of values, a tool for measuring changes in functioning, directed at the aspect of executing aims (despite the remaining symptoms) was founded. The diagnosis expanse is experiencing values – i.e. the ability to experience them, not the values themselves. Hitherto studies (KOKOSZKA, OHL ET AL., 2003), upon which the Corrective Experience of Values Scale proved to be a sensitive tool for measuring the transitions in the course of therapy ($t = -7.59$; $p < .001$), confirmed that results scored on the Scale moderately correlate with diagnostic improvement ($r(60) = .39$).

According to Frank, restoration of morale is a result of non-specific factors, irrespective of the kind of therapy. In the opinion of the Scale's author regaining the ability to execute aims is due to corrective experience of values.

It is worth stressing that all of the conducted studies were performed in the conditions of psychodynamic group psychotherapy. An important theoretical construct in the psychodynamic approach are the defence mechanisms (KOKOSZKA, ROMAN, BRYŁA & GRABOWSKI, 2003). The classical term: defence mechanisms, was introduced by Anna Freud "to replace the Freudian «ego defence»". Defence mechanisms are "the ways and means by which the ego wards off unpleasure and anxiety and exercises control over impulsive behaviour, affects and instinctive urges" (FREUD, A., 1965).

There are few reports about alteration of defence mechanisms in the course of therapy (KOKOSZKA, ROMAN, ET AL., 2003). The measuring tool: The Defence Style Questionnaire (D.S.Q.40) was created on the basis of a definition by the American Psychiatric Association, which defines defence mechanisms as "patterns of feelings, thoughts, or behaviours that are relatively involuntary and arise in response to perceptions of psychic danger" (ANDREWS, SINGH & BOND, 1993; BOGUTYN, KOKOSZKA, PALCZYŃSKI & HOLAS, 1999). Research show that three defence style clusters constituted with the use of factor analysis: (1) mature, (2) neurotic, (3) immature, differentiate the patients' group from the healthy population. Polish studies conducted with the use of the described Scale (KOKOSZKA, ROMAN ET AL., 2003) showed that in a course of short-term therapy only the scope of "mature" defence mechanisms stated relevant change.

Therefore, it seems interesting to enquire whether there is a connection between the way of experiencing values and the symptom intensity as well as defence mechanisms – a construct characteristic of psychodynamic psychotherapy.

Method

Participants. The group consisted of 37 patients (67.6% females and 32.4% males) aged 20 – 47 (M = 28.34; SD = 7.60), with a diagnosis of neurotic disorders (39.5%), personality disorders (23.7%), mood disorders (7.9%) and behavioural syndrome (2.6%). Patients were recruited from different groups of three-month-long psychodynamic psychotherapy (two 90-minute sessions each day), in the daily unit setting. 39.5% of participants were also treated pharmacologically.

Procedure and Questionnaires. The study was conducted in a correlation model (with repeated measurement) in the procedure of t-test and Pearson Correlation Coefficient of the SPSS. The tools used to evaluate the patients' functioning before, during and after psychotherapy, were the following self-rating questionnaires:

Corrective Experience of Values Scale (CEV) (Kokoszka, Ohl et al., 2003) measures the ability to experience values, yet not the values themselves or their hierarchical order. The evaluation is conducted on twenty two five-notch scales (Likert's), where a participant marks a present state. The general score is estimated on the basis of the sum of points scored on each of the scales. The results span form 22 to 110 points. The higher the score, the higher the ability to experience values. A factor analysis led to development of seven factors inclusive 67.8% of variations. The factors are: (1) meaning, fulfilment and hope (2) wisdom, (3) eagerness and optimism, (4) pleasure, (5) strength and responsibility, (6) sufferance meaning and freedom and (7) satisfaction from responsibility. Reliability (alpha Cronbach) of the scale is 0.87. The scale's validity, circumscribed through its correlation with Crumbaugh and Maholick's PIL Scale, amounted to r(38)= .726.

The Symptoms Check List (S-II) (Aleksandrowicz, 2000) measures the intensity of neurotic symptoms. The questionnaire consists of 85 questions which are evaluated on a four-notch scale (Likert's) where a participant marks if and to what extent, symptoms and ailments within the previous week were severe for the individual. The general score is estimated on the basis of the sum of points scored on each of the scales. The range of scores is from 0 to 595. The higher the score, the higher the symptom intensity. Values over 165 point to a neurotic disorder. Ten symptom subscales isolated on the basis of factor analysis (preliminary studies) inform of a kind of dominating symptoms. The scales are: (1) anxiety and nervous tension, (2) dissociation symptoms, (3) hypochondriac symptoms, (4) somatic dysfunctions, (5) neurasthenia, (6) dystymia, (7) sleeping disorders, (8) sexual dysfunctions, (9) thinking disorders and (10) relationship dysfunctions. Reliability of the questionnaire is .79 – .90 of alpha Cronbach.

Polish version of the Defence Style Questionnaire (D.S.Q.40) (Andrews, Singh & Bond, 1993), (Bogutyn, Kokoszka, Palczyński & Holas, 1999) which derives its universum from the American Psychiatric Association's classification included in the DSM – IIIR (Andrews et al., 1993), measures the scope of using defence mechanisms. The evaluation is done on forty nine scales (Likert's) where a participant marks a degree of conformation with respective state-

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ments. The scales evaluate twenty defence mechanisms, two statements were assigned to each of them. Possible span of scores for each mechanism is from 2 to 18 points. Furthermore, factor analysis of the original version appointed (in respect of criterion) three clusters of mechanisms – defence styles. The (1) “mature” defence style cluster consists of: sublimation, humour, anticipation, suppression. The (2) “neurotic” defence style cluster is made of: undoing, pseudo-altruism, idealization, reaction formation. The (3) “immature” defence style cluster consists of: projection, passive aggression, acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, somatization. The general score for every style is estimated from the sum of points scored on all the representing mechanisms. The higher the score, the bigger the range of using particular defence mechanisms. Reliability (alpha Cronbach) of the Polish version of D.S.Q.40 was much lower in the case of “mature” style (.39/ .68) and slightly lower in the case of “immature” (.73/ .83) and “neurotic” (.56/ .58) styles.

Coefficients. Measurement of variable coefficients was conducted before psychotherapy and three months later – directly after its completion. The coefficient of change for each of the variables was estimated on the basis of the difference of measurements before and after therapy. Results scored on CEV are an indicator of an ability to experience values, the ones gained on Symptoms Check List S-II indicate symptom intensity, whereas the particular scales (styles) of the Polish version of D.S.Q.40 rate a scope of using defence mechanisms.

Data Analysis

Chosen transitions (Tables 1-3)

T-test for dependent samples was used for testing of the relevancy hypotheses. Measurement of transitions was conducted with the results of the CEV, S-II and D.S.Q.40 tests, filled out by patients before therapy and after its three-month-long course.

Transition in the way of experiencing values (CEV) in the course of psychotherapy (Table 1). The mean result on the CEV was: before therapy: $\underline{M}$= 65.84 ($\underline{SD}$= 17.59) and $\underline{M}$= 79.81 ($\underline{SD}$= 15.09) after its completion, [$\underline{t}(37)$= -4.08; $\underline{p}$< .001].

Table 1: The change (t-test) of mean results of the corrective experience of values (CEV).

	M before therapy	SD before therapy	M after therapy	SD after therapy	T	DF	P
CEV	65.84	17.59	79.81	15.09	-4.08	36	.001

Caption: M- mean, SD- standard deviation, T- t-test results, DF-degrees of freedom, P- probability level

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Symptom modification (S-II) in the course of psychotherapy (Table 2). The mean result on the S-II was: before therapy: M= 265.37 (SD= 131.06) and M= 183.87 (SD= 119.28) after its completion, [t(37)= 4.41; p< .001].

Table 2: The change (t-test) of mean results of the symptom intensity (S-II).

	M before therapy	SD before therapy	M after therapy	SD after therapy	T	DF	P
S-II	265.37	131.06	183.87	119.28	4.41	36	.001

Caption: M- mean, SD- standard deviation, T- t-test results, DF-degrees of freedom, P- probability level

Alteration of defence mechanisms (D.S.Q.40) in the course of psychotherapy (Table 3). The mean result on the D.S.Q.40 for the "mature" style cluster was: before therapy: M= 35.42 (SD= 9.53) and M= 37.03 (SD= 10.98) after its completion, [t(37)= -.84; p< .41]. For the cluster of "neurotic" defence mechanisms it was: before therapy: M= 34.12 (SD= 10.21) and M= 33.03 (SD= 10.15) after its completion, [t(37)= .68; p< .50]. For the cluster of "immature" defence mechanisms the values were: before therapy: M= 103.64 (SD= 28.13) and M= 98.00 (SD= 25.41) after its completion, [t(37)= 1.78; p< .08]. For the mechanism of "passive aggression" the scores were before therapy: M= 8.15 (SD= 4.16) and M= 6.36 (SD= 3.76) after its completion, [t(37)= 2.61; p< .010].

Table 3: The change (t-test) of mean results of defence mechanisms (Polish version of the Defence Style Questionnaire - D.S.Q.40) in the course of therapy.

	M before therapy	SD before therapy	M after therapy	SD after therapy	T	DF	P
MATURE	35.42	9.53	37.03	10.98	-.84	36	.41
Sublimation	8.57	4.26	9.24	3.75	-.77	36	.45
Humour	9.15	4.72	10.54	4.09	-1.69	36	.10
Anticipation	10.70	4.16	9.64	3.23	1.63	36	.11
Suppression	7.00	3.75	7.61	3.80	-.73	36	.47
NEUROTIC	34.12	10.21	33.03	10.15	.68	36	.50
Undoing	9.97	3.62	9.81	3.77	.19	36	.85
Pseudo-altruism	9.88	4.14	9.51	3.43	.73	36	.47
Idealization	7.09	4.99	5.70	4.00	1.56	36	.12
Reaction formation	7.18	3.57	8.00	3.73	-1.13	36	.26

Table 3: The change (t-test) of mean results of defence mechanisms (Polish version of the Defence Style Questionnaire - D.S.Q.40) in the course of therapy.

	M before therapy	SD before therapy	M after therapy	SD after therapy	T	DF	P
IMMATURE	103.64	28.13	98.00	25.41	1.78	36	.08
Projection	8.51	4.48	6.91	3.92	1.85	36	.07
Passive aggression	8.15	4.16	6.36	3.76	2.61	36	.01
Acting out	11.70	4.84	10.73	5.15	1.60	36	.12
Isolation	8.97	5.33	7.67	4.56	1.32	36	.19
Devaluation	7.70	3.41	7.54	3.49	.22	36	.83
Autistic fantasy	11.30	5.59	10.27	5.01	1.07	36	.29
Denial	4.97	3.04	5.30	2.84	-.51	36	.61
Displacement	8.73	3.88	8.24	4.07	.66	36	.51
Dissociation	5.76	3.87	6.06	3.10	-.57	36	.57
Splitting	7.06	3.69	6.76	4.28	.49	36	.63
Rationalization	10.09	3.79	11.21	3.92	-1.54	36	.13
Somatization	10.70	4.12	10.94	3.83	-.44	36	.66

Caption: M- mean, SD- standard deviation, T- t-test results, DF-degrees of freedom, P- probability level

Chosen correlations (Picture 1)

For testing of the dependency hypotheses, the Pearson correlation coefficient was used. Coefficient of change for each of the variables was estimated on the basis of differences in measurements before and after therapy.

Correlations between corrective experience of values (CEV) and symptom intensity (S-II) (Table 4). The studied group showed a negative correlation between the general results on the CEV and S-II as well before [$r(37)= -.66$; $p< .001$] as after therapy [$r(37)= -.58$; $p< .001$]. Coefficients of change also correlated negatively [$r(37)= -.66$; $p< .001$].

Table 4: Correlations (Pearson r) between corrective experience of values (CEV) and symptom intensity (S-II).

	CEV		
	r before therapy	r after therapy	r of changes
S-II	-.66***	-.58***	-.66***

Caption: r- Pearson correlation coefficient, P- probability level, * $p< .05$, ** $p< .01$, *** $p< .001$

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Correlations between corrective experience of values (CEV) and defence mechanisms (D.S.Q.40) (Table 5). The studied group showed a moderate, positive correlation between the general results on the CEV and D.S.Q.40 (in the "mature" defence style cluster) before [$r(37)= .50$; $p< .01$] and after therapy [$r(37)= .37$; $p< .05$] and a relatively strong correlation of changes coefficients [$r(37)= .55$; $p< .001$]. Coefficient of change of the "sublimation" mechanism moderately, positively correlated with the CEV coefficient of change [$r(37)= .37$; $p< .05$], "humour" showed a moderately positive correlation with CEV before [$r(37)= .39$; $p< .05$] and after therapy [$r(37)= .35$; $p< .05$] as well as in its course [$r(37)= .44$; $p< .01$]. "Suppression" showed a moderate correlation with CEV before therapy [$r(37)= .45$; $p< .01$].

Table 5: Correlations between corrective experience of values (CEV) and defence mechanisms (D.S.Q.40).

	CEV		
	r before therapy	r after therapy	r of changes
MATURE	.50**	.37*	.55***
Sublimation	.14	.33	.37*
Humour	.39*	.35*	.44**
Anticipation	.17	.24	.16
Suppression	.45**	.15	.35*
NEUROTIC	-.04	-.14	.10
Undoing	.17	-.03	.18
Pseudo-altruism	.06	.04	.10
Idealization	-.22	-.17	-.10
Reaction formation	-.05	-.21	.07
IMMATURE	-.41*	-.35*	-.35*
Projection	-.36*	-.60***	-.44*
Passive aggression	.01	-.29	.05
Acting out	-.25	-.11	-.47**
Isolation	-.35*	-.14	-.28
Devaluation	-.02	-.23	-.15
Autistic fantasy	-.69***	-.45**	-.36*
Denial	-.01	.15	.09
Displacement	-.37*	-.44*	-.30
Dissociation	-.03	.20	.26
Splitting	-.32	-.01	.06
Rationalization	.40*	.06	.45**
Somatization	-.46**	-.11	-.21

Caption: r- Pearson correlation coefficient, P- probability level, * $p< .05$, ** $p< .01$, *** $p< .001$

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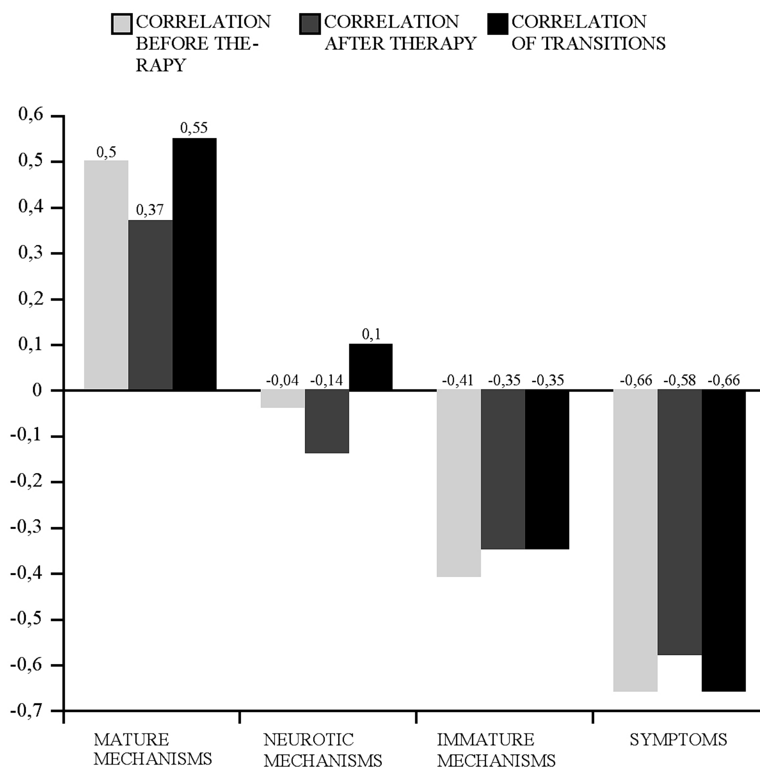
A relevant correlation was not observed between corrective experience of values and the whole "neurotic" defence style cluster as well as particular "neurotic" mechanisms (table 5).
There was a moderate correlation of "immature" mechanisms before [$r(37) = -.41$; $p < .05$] and after therapy [$r(37) = -.35$; $p < .05$] as well as in its course [$r(37) = -.35$; $p < .05$]. "Projection" showed a moderate correlation with CEV before [$r(37) = -.36$; $p < .05$] and a strong one after

	Correlation before therapy	Correlation after therapy	Correlation of transitions
Mature mechanisms	0,5	0,37	0,55
Neurotic mechanisms	-0,04	-0,14	0,1
Immature mechanisms	-0,41	-0,35	-0,35
Symptoms	-0,66	-0,58	-0,66



Picture 1: The relations of the scores in Corrective Experience of Values (CEV) before, after therapy and relations of the transitions in the CEV scores during therapy with: Defence Mechanisms (DSQ-40) and Symptoms Intensity (S-II)

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therapy [$r(37) = -.60$; $p < .001$] as well as moderate connections with the change in CEV in the course of psychotherapy [$r(37) = -.44$; $p < .01$]. Alteration of the "acting out" mechanism moderately correlated with the change of CEV [$r(37) = -.47$; $p < .01$]. "Isolation" correlated with CEV moderately before therapy [$r(37) = -.35$; $p < .05$]. "Autistic fantasy" correlated with CEV strongly before therapy [$r(37) = -.69$; $p < .001$], moderately after its completion [$r(37) = -.45$; $p < .01$] and with the change within its course [$r(37) = -.36$; $p < .05$]. "Somatization" showed a moderate correlation before therapy [$r(37) = -.46$; $p < .01$], whereas "rationalization" moderately and positively correlated with CEV before therapy [$r(37) = .40$; $p < .05$] and its change moderately and positively correlated with the change on CEV in the course of therapy [$r(37) = .45$; $p < .01$].

Discussion

In the course of a three-month-long psychodynamic group psychotherapy, there appears to be an increase in the ability to experience values, which is responsible for regaining the ability to execute aims, "morale", described by FRANK (1974) and Kępiński "heroic proportion" (KOKOSZKA, 1999).

This important transition, which is realized and expected by patients, leads to improvement of fettle and social functioning. Also observable is the expected symptom improvement (KOKOSZKA, OHL ET AL., 2003). What is interesting though is that alteration of defence mechanisms, characteristic of psychodynamic psychotherapy, was not relevant for any of the mechanism cluster, although the direction of change was consistent with research of ANDREWS ET AL. (1993), in the light of which, the therapy increases the range of "mature" and decreases the range on "immature" and "neurotic" defence mechanisms. To an extent this is also incompatible with the results of Polish authors (KOKOSZKA, ROMAN ET AL., 2003; TRZOS, CURYLO & KOKOSZKA, 1998), whose studies prove that a short-term psychodynamic group psychotherapy causes a relevant increase in the scope of using "mature" and decrease in using "immature" defence mechanisms. Defence styles as well as particular mechanisms changed, yet in a very limited range. The lack of relevant change of "neurotic" defence mechanisms is explained by the authors (KOKOSZKA, ROMAN ET AL., 2003) as a result of specific problem-oriented therapy and working with the most dysfunctional mechanisms as well as its short-term form. In accordance with HERSOUG'S suggestion (2002) changes in the area of used defence mechanisms demand a long-term therapy. Therefore, it can be presumed that a short-term, problem-oriented therapy does not lead to such a distinct intrapersonal transition. KOKOSZKA'S ET AL. (2003) and ANDREWS'S ET AL. (1993) studies are two of few concerning alteration of defence mechanisms in the course of psychotherapy. This field calls for further analyses.

A hypothesis concerning connections between a way of experiencing values and symptom intensity was confirmed. A high number of symptoms before and after therapy was accompanied by a low ability to experience values. Obtained correlations were a lot stronger from the ones from previous studies (KOKOSZKA, OHL ET AL., 2003). It may be a result of different

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research surroundings: KOKOSZKA (2003) participants were patients undergoing a six-month-long therapy, some of them while being hospitalised. Besides that, the general number of symptoms and the ability to experience values was a lot lower before starting psychotherapy. Conducted analyses allow to think that defence mechanisms, although to a lower extent than symptoms, differentiate the group of patients in the aspect of experiencing values: the bigger the range of "mature" defence mechanisms and smaller of the "neurotic" and "immature" ones, the higher the ability to experience values.

Let's pay attention to the fact that after therapy, the connection between the way of experiencing values with symptom intensity and the range of using defence mechanisms, is weaker. After having participated in psychotherapy, a lower concentration on the symptoms is observable in the patients' utterances. It can be assumed that recovering is more likely to differentiate the group of patients (different aims, expectations, reactions to interventions) than the reason that induces them to begin psychotherapy. Yalom points out that lowering the number of neurotic symptoms is not the only aim of psychotherapy. In his opinion, within therapy, patients may change hierarchies of values, make important decisions, find meaning in new experiences, therefore, important transitions can not be caught by using equivalent criteria of change for all patients. Finally, regaining the ability to experience values, as a result of corrective experience of values – turned out to be relevantly connected with symptom improvement and also with defence mechanisms – a construct characteristic of psychodynamic therapy. It is connected with an increase of "mature" and decrease of "immature" defence mechanisms.

Conclusions:

1. In psychodynamic psychotherapy there appears a significant transition in the way of experiencing values (in an axiological dimension) which results in regaining the ability to execute aims.
2. Transitions in therapy's axiological dimension appear relatively fast and are easy to pick out in a short-term therapy.
3. The ability to experience values is relevantly related to mental disorders and their therapy.
4. Studies show that transitions in the described dimension are connected with the intrapersonal characteristic of psychodynamic psychotherapy – defence mechanisms (COM. FRANK, 1974, 1981). Taking into consideration the multi dimensionality of the transition, it is probable that they are a result of different therapeutic factors (KOKOSZKA, 1999), which caused the changes in experiencing oneself and the world resulting in realizing the readiness to undertake actions directed at executing aims – the corrective experience of values.
5. The CEV again turns out to be a sensitive tool for measuring transitions in the course of therapy. Undoubtedly, there is a need for further research concerning the axiological dimension of therapy.

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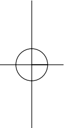
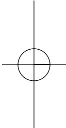
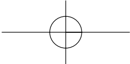

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Gernot Hauke

Self-regulation and Mindfulness

Abstract

Mindfulness is considered a pivotal mechanism of action in modern behavior therapy. Adopting the psychological conceptualization of mindfulness as a form of directed attention, we develop a framework of hierarchical self-regulation that allows a general understanding of the efficacy of mindfulness in the therapeutic process. In particular, self-regulation tends to establish and to strengthen existing structures within the person. Mindfulness contributes to the loosening of these determinate structures and allows the occurrence of potential change processes. Mindfulness is not a magic cure. In addition to the practical aspects involved in applying mindfulness to therapy, it will be shown that mindfulness training may accentuate or enhance the therapeutic process but cannot replace it.

Keywords: Third Wave Behavior Therapies, mindfulness, acceptance, self-relation, self-attention, hierarchical self-regulation, dual processing model, will

Introduction

By now many behavior therapists have somehow heard of "*Third Wave* behavior therapy." Last but not least, Heidenreich and Michalak's (2004) comprehensive handbook substantially contributed to the dissemination of this body of thought among German-speaking practitioners. What is its content?

Behavior therapy was founded on the exclusive application of principles from learning theory to human behavior. Until the emergence of the Third Wave, behavior therapy's content could be characterized by two earlier waves: Initially, classical and operant conditioning processes in combination with observational learning were thought to explain behavior. This *First Wave* of behavior therapy provided a range of interventions based upon classical and operant conditioning. The approach constituted a fruitful heuristic model for clinical work until the early 1970s, when the *Second Wave* surfaced. Its development hinged on the assumption that all human behavior is constrained by the mediating effects of cognitive constructs. Thus, therapy

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targets were expanded beyond a particular disordered behavior or symptom to include the consideration of cognitive determinants of behavior. The studies of PIAGET (1967) and KELLY (1955) affected the cognitive therapy approaches of AARON T. BECK (1979) and ALBERT ELLIS (1977). Especially the research on attribution played an important role in the comprehensive implementation of the so-called cognitive revolution within this Second Wave of behavior therapy. While in the early 1980s health insurance claim appraisers still wondered under what circumstances one might incorporate cognitive treatment components a la Beck and Ellis into therapy, nowadays both cognitive and behavioral components are unquestioningly on equal footing, as evidenced by the now commonplace term "cognitive behavioral." Then what is the Third Wave?

It is a wave that swept up the behavioral and the cognitive influences of the First and Second Waves without washing over or failing to carry forward either of them. However, even in light of the previous waves' hard-won successes, the Third Wave views the traditional behavioral therapeutic stance that targets the elimination of relatively narrowly defined problem behaviors as an ideology of change (see HAYES, 2004). The Third Wave aims to relativize and to generate flexibility in this respect to confront the limits of behavior therapy as heretofore practiced. In particular, the Third Wave raises the question whether a primary focus on change represents a dead end. Of course, the more recent behavior therapies are change-oriented, too, but they view the patient's acceptance of the problematic condition as an indispensable first step toward change. Practically, this means that therapists initially deny their patients' requests to rid themselves off the problematic condition and its accompanying unpleasant emotions. Linehan and Hayes arguably were the first representatives of this wave who elevated the dialectic of acceptance and change to an important therapeutic principle. HAYES, STROSAHL, AND WILSON (1999) juxtapose acceptance and avoidance and understand acceptance as being actively open to, rather than avoidant of, events and situations. This experiential openness manifests itself in a form of directed attention that is termed "mindfulness:" Acceptance via mindfulness. While this non-evaluative stance undermines our automatic behavioral tendencies, a lack of mindfulness is associated with processes such as rumination, experiential avoidance, and adverse metacognitive processes.

If mindfulness and acceptance are indeed the principles that are central to contemporary behavior therapy, then it seems necessary to investigate them and to understand their mechanisms of action more closely (see also SMITH, 2004). For this purpose, we will introduce a general model of self-regulation. If we conceptualize the person as a system, then self-regulation naturally aims at regenerating the system's structures. It will be shown how patients may benefit from mindfulness as a special form of directed attention, for it may undermine this particular property of the system in the service of the change process.

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Self-regulation

How are core needs met? How do people continue to fulfill their needs under changing conditions and in the most diverse situations? What does happen when circumstances become adverse? How do people overcome crises, such as loss of health, employment, or loss of a loved one? Today, these questions can be fruitfully considered within a framework that transcends theoretical perspectives and psychological schools. This framework has its roots in cybernetics. In the 1980s, building on the work of POWERS (1973), CHARLES CARVER AND MICHAEL SCHEIER (1990, 1998) undertook the formidable challenge to design a theory of self-regulation that could account for the most diverse questions raised by motivational psychology, specifically clinical psychology, social psychology, personality psychology, etc. At the heart of the approach is its assumption that all human behavior is goal-oriented and thus serves to satisfy fundamental needs or motives. Accordingly, the term "self-regulation" characterizes internal and/or transactional processes that enable a person to perform necessary goal-directed activities across time and under changing conditions. The modulation of thoughts and feelings, the activation of appropriate behavioral patterns and particularly of attention are examples of these activities. Their relative incidence correlates with the activity of either thought-out or automated mechanisms, and it also activates supportive meta-capabilities, e.g., self-monitoring during the behavioral process. Self-regulation thus denotes strategies that assist the self to direct its behavior toward particular goals. A feedback control process that provides continuous information about the operational status governs this process. Figure 1 describes the essential components of a feedback loop, the smallest unit of cybernetic control.

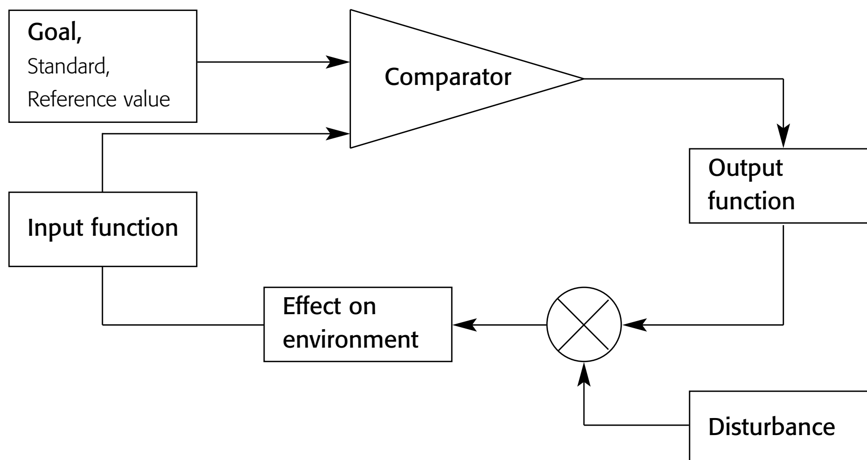

Figure 1: The essential components of a feedback loop, the smallest unit of cybernetic control

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A feedback loop may be understood as operating in the following way: Perception serves as the actual input value that is being compared with a reference value or standard. If necessary, behavior is evoked and moves the input toward the reference value, such that the outcome is recognized or felt as the one desired by the person. In other words, the person attempts to "produce" a particular perception. Of course, it is possible that disruptors, such as skills deficits or the presence of other people, may influence the behavior's environmental effects. In these cases, the discrepancy between actual and reference values cannot be removed without further processes.

Reference values of self-regulation

A person's diverse goals, derived from needs and motives, determine the reference values (see also Figure 2).

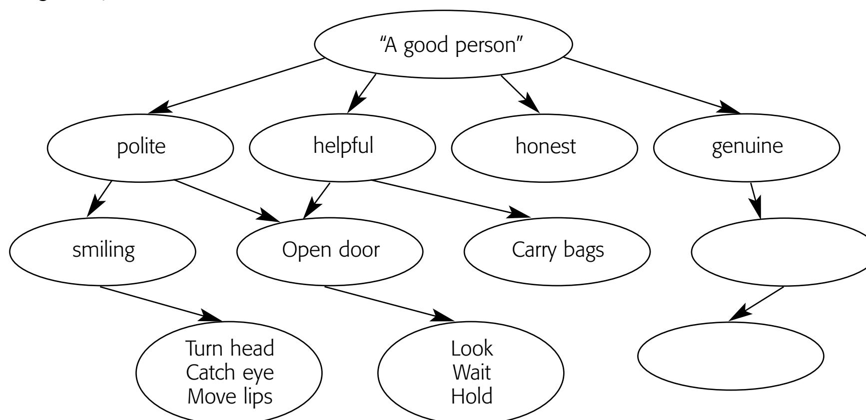

Figure 2: Goal hierarchy (adapted from Carver & Scheier, 1998, p. 91)

1. Goals are viewed as *hierarchically organized*, such that increases in abstraction correlate with higher levels of the hierarchy.
2. The output of a *superordinate level* sets the reference value of the next lower level.

Based upon the seminal works of Powers (1973), Carver and Scheier recognize four hierarchical levels:

1. The *system concept* constitutes the top of the hierarchy, e.g., the ideal self-image of being a "good person."
2. *Principles* are defined by reference values that determine how one wants to go about being one's ideal self ("be"-goals), e.g., being honest. Principles specify characteristics in the sense of metascripts. Personal values, for example, predetermine such guiding principles.
3. *Programs* determine the behavior ("do" goals), e.g., "holding the door open." At this level, the details remain unspecified. This allows opportunities for decision-making and for accommodation to situation-specific circumstances.

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4. *Sequences* are determined by the goals of motor control. Here, a particular behavioral process is fixed.

The lower levels of the goal hierarchy are more concretely organized. "Concrete" means that a goal is visibly and palpably present and achievable within the here and now. Meanwhile, the attention is focused on the respective details of the behavior. Thinking on this level is rather "narrow" and linear. This would describe the state of somebody who is completely engrossed in working with a tool, playing a videogame, conscious breathing, or chewing. Here, the "how" constitutes the center of attention.

"Abstract," on the other hand, means that perceivable proximate, sensory details are of minor importance. Being a "good person" characterizes the essence, the class, but it does not determine precise criteria, particular behaviors, or ways to implement them. This determination occurs at the lower levels of the goal hierarchies. Cognitive processes are related to the behavior's broader implications. Thus, not the "how," but the "why" of behavior occupies a central position. Here, past, present and future aspects are related. The interpretation of an event is integrated into the context of more general structures. A network of events and experiences is generated and, as an example, related to the reference values defining the self. This constructive process also produces meaning (SCHMITZ & HAUKE, 1999). Accordingly, cognitions are rather "broad" and nonlinear.

In Figure 2, the ideal self-image of being a "good person" represents the highest level. Its output sets the reference value for the next level: an orientation corresponding to the ideal self-image. This orientation might be expressed in the respective values or attitudes, e.g., being helpful, honest, etc. Thus, the output of the next level is defined, i.e., to act in a way consistent with one's preferred attitudes and values. Examples of activated behavioral programs are "holding the door open," "carrying the grocery bag," etc. Finally, these behavioral programs, whose outcomes are the reference value for the next lower level, must be executed via specific behavioral sequences at the lowest level of the hierarchy shown here. The execution of such sequences is mostly automatic, while higher levels still allow for conscious decision-making regarding a particular behavioral program, i.e. adjustment to particular situational characteristics. Behavioral sequences provide reference values for the next lower levels of motor control and physiology, not depicted in Figure 2.

Processing feedback is essential for the self-regulation of goal setting. Feedback communicates the degree to which goals on each of the hierarchical levels are realized (see Figure 3).

This diagram schematically depicts what Figure 2 had illustrated: The output of each superordinate feedback loop sets the reference value for the next lower level. This pattern is repeated until the lowest level of physiological and motor processes has been reached.

The operation of this hierarchical regulation is accomplished simultaneously at all control levels. A helpful attitude, for example, is realized by holding the door open, with strengthening and

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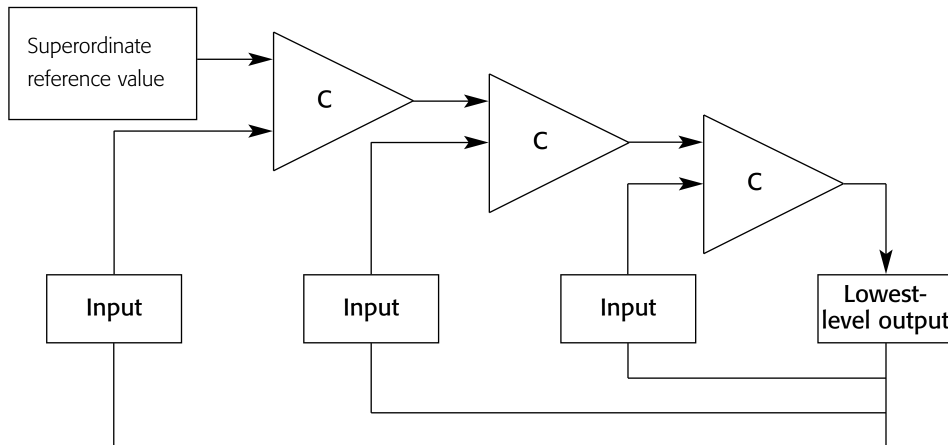

Figure 3: An example of hierarchical regulation from Carver & Scheier (1998) consisting of three nested feedback loops (three-level hierarchy)

affirmation of the attitude occurring concurrently and not upon completing the process of holding the door open. From this point of view, extraordinarily detailed actions, such as change of muscle tonus while grasping or bodily posture while moving the door, are embedded within the production of comparably abstract behavioral qualities, such as being polite or helpful. Consequently, the system attempts to generate particular perceptions, compares these perceptions with the system's reference values and, if necessary, employs behavioral patterns to achieve a match.

The applicability of hierarchical self-regulation in clinical work

A person's behavior is reference-value-oriented, and encountered events are related to these standards. Hierarchically nested feedback loops ascertain that events and behavior are understood, evaluated, and interpreted at different levels of significance. How does the setting of goals or reference values pertain to clinical questions, and how can the relationship be characterized? Based on the constructive process mentioned above (SCHMITZ & HAUKE, 1999), *Strategic Brief Therapy* (SBT) specifies the relevance of the presented model of hierarchical self-regulation to clinical questions (see also Sulz, this issue).

Figure 4 shows that everyday experience and behavior can be understood as the product of a hierarchy of feedback loops. The top of the hierarchy, the system level, lends itself to being linked to a concept that determines the person in the most comprehensive way (Carver & Scheier, 1998). As illustrated in Figure 4, the regulatory system aims for consistency with the person's *identity*, i.e., the reference value is the personal self-concept (e.g., one's social role as a provider, a boss, etc.). The person strives to affirm and to strengthen this identity in the most

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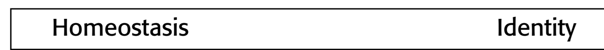
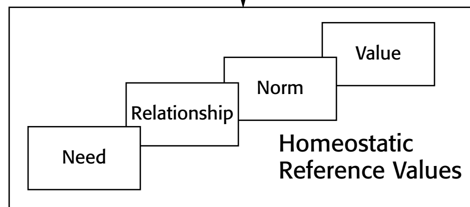
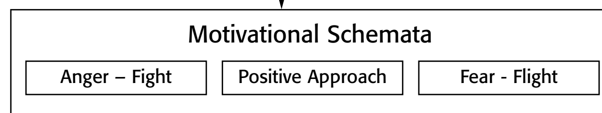
1. System concepts



2. Principles



3. Programs



4.-6. Sequences, motor programs, physiology

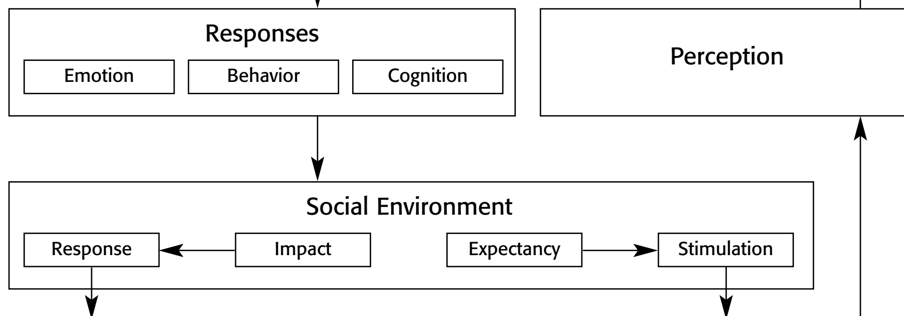


Figure 4: The self-regulation hierarchy according to Strategic Brief Therapy (SBT)

diverse contexts and, if possible, to avoid any mismatches. Problems with one's own identity or even identity disorders are commonplace in clinical practice. Issues in developmental psychopathology underline the significance of this goal category (NOAM & FISCHER, 1996).

Departing from our conceptualization, GRAWE (1998) suggests the consistency principle as the superordinate reference value at the system level. This principle, however, already governs the global logic of self-regulation and thus seems redundant. A particular identity is tied to *personal values* (HAUKE, 2001; SCHWARTZ, 1999), which function as standards at the next lower level. We find important *needs* at the next lower level, e.g., for attachment, autonomy, etc. (Sulz & Müller, 2000). These needs, in turn, set the reference values for the motivational schemata at the next level. These motivational schemata, as reference values, determine the coping style in

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certain situations: Positive approach, aggression, or avoidance (Grawe, 1998). This, in turn, necessitates certain reference values at the level of responding, e.g., certain behavioral patterns or type of responses. The behavior affects the situation (e.g., consisting of a critical decision-making point, an argument, etc.). Perceptions (e.g., of an impending flawed decision, of a cooperative family member) emerge and can be evaluated in terms of their approximation to the reference values at different regulatory levels.

In recent years, neurobiological evidence has supported the notion of self-regulatory processes (METCALFE & MISCHEL, 1999; MISCHEL & AYDUK, 2004). Accordingly, behavior results from an interaction of two systems termed "hot" and "cold." The cold system, apparently linked to the functions of hippocampus and frontal lobes, interacts with the so-called hot system, mediated by the amygdala, such that both systems affect each other. The cold system is an emotionally neutral knowledge system within which well-integrated biographical events with their respective spatiotemporal contexts are registered, for example. Its processing speed is relatively slow, and it generates rather intentional, reflective, and strategic behavior. This broad, more flexible perspective strongly contrasts with the modus operandi of the hot system, which encompasses need and motivational templates; works directly, quickly, highly affectively, and inflexibly; and heavily depends upon stimulus input. Thus, the lower hierarchical levels of the regulatory system may be categorized as a hot, the superordinate levels (i.e., identity and values) as a cold system. Behavior is a product of the interaction of both systems; the relative contribution of both systems depends upon personal and situational conditions.

Self-focus, discrepancies, and conformity with standards

- The perception of a discrepancy between reference values and sensed input temporarily evokes a *self-focus* directed toward the regulatory level at which difficulties with conformity are occurring.
- Behavior may be interpreted as a means to remove discrepancies between reference and actual values and to establish *conformity* with goals at different levels, at the most concrete levels via activation of the appropriate movement sequences, motor and physiological processes.

Based on work by DUVAL AND WICKLUND (1972), CARVER & SCHEIER (1998) assume that attention can quickly shift back and forth between the self and the respective environment. In most cases, attention focuses on the self to a degree which enables successful self-regulation with respect to self-relevant goals. Moreover, a large number of experimental findings show that an increase in the intensity of self-focus positively correlates with greater correspondence between people's behavior and their standards (SCHEIER, 1980; KEMMELMEIER, 2001).

Once the attention has been focused on the self, specific cues usually prompt the comparison of the relevant reference with actual values. Indeed, cues or signals that remind the behaving person of his or her intentions, instructions, and values, are inherent in many situations. If a dis-

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crepancy of reference and actual values is perceived, then the person has to access additional attentional resources to address the problem. An intensification of the self-focus occurs, motivates, and facilitates appropriate efforts to eliminate the perceived discrepancy. Depending upon the success or failure of these efforts, positive or negative emotions arise, respectively. Negative emotions play an especially important role in regulating and energizing the behavior necessary to persist and still achieve the end goal. The increased self-focus also strengthens internal attributions, the intensity of emotional states, the accessibility of self-relevant information, and the acuity of one's own self-perception (HAMILTON ET AL., 1993). These processes are indeed functional with respect to the person's pursuit of consistency with his or her inner reference values: The intensification drives goal-directed behavior; both the increased accessibility and the greater accuracy of self-related information support the choice of an appropriate modus operandi.

Frequently psychotherapy reveals discrepancies regarding the satisfaction of important needs, such as security, respect, tolerance, etc. Previous learning experiences involving the removal of discrepancies have seemingly solidified as general assumptions about the functioning of self and world (BECK & WRIGHT, 1986). These assumptions unfold as rules of conduct to guarantee at least the minimal fulfillment of needs and to maintain an inner equilibrium. SULZ (1994) termed these rules of conduct "survival strategies" and matched their thematic varieties with certain disorders. An anxiety disorder, for example, could reflect the following survival strategy: "Only if I actively and cooperatively conform and thereby manage to maintain access to the person who protects me, then I will be able to survive with his or her protection. If I do not succeed, then I – alone and helpless – will be exposed to the dangers of this menacing world." Consequently, a general behavioral process has been determined but is open for specification, e.g., adaptation to the particular properties of the protective person. For this reason, our regulatory hierarchy places the survival strategy at the program level described earlier, where it links reference values that are determined by the person's needs with the motivational schemata of approach and avoidance. Patients enter therapy when this heuristic ceases to be effective, i.e., it does not remove the discrepancy and thereby effect noticeable need fulfillment anymore. Finally, this leads to considerable stress, which differentially affects the hot and cold systems according to their characteristics (METCALFE & JACOBS, 1996).

As stress increases, the systems first ratchet up their activities. At this time, the situation's affect-related ("hot") and contextual and narrative ("cold") properties are processed more intensely. All regulatory levels are more involved in the regulatory task. With stress levels rising further, this involvement changes. When a certain threshold is reached, the cold system's activity decreases very quickly while the activation of the hot system continues to increase rapidly. At this point, aspects of superordinate reference values, such as identity goals, self-concepts, or values, exert hardly any influence on self-regulation. This means that at a certain stress level, self-regulation only occurs at the lower levels of the regulatory system and is increasingly governed by the hot

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system. During this time, a person's attention becomes very narrow and selective; if the stress level is traumatic, attention is directed exclusively at anxiety-producing characteristics of the situation.

Can this command structure be reversed? Is it possible to more strongly involve superordinate regulatory levels in the governance of behavior when transactions are stress-related? Here, "will" enters the analysis. KUHL (2001; KUHL & KOOLE, 2004) functionally defined "will." If the implementation of goal-directed behavior is difficult, the will has a coordinating function and synchronizes processes at various functional levels of personality to optimize perseverance and achievement of the current goal. If, for example, a difficult conversation is long overdue, will-related processes provide the necessary orientation toward the goal, e.g., tolerating the anxious tension, dosing the anger, motivating the self, correcting the mood, and heightening alertness. What may this look like? In fact, the frequency with which general intentions are translated into actions is pretty low (GOLLWITZER, 1999). As our rather abstract values fall into the category of such general intentions, this finding is of the greatest therapeutic interest. According to Gollwitzer's additional findings, general intentions are realized more frequently if resolutions also specify the conditions of their implementation. What does that mean for the support of value-directed behavior? The person should specify when, where, and how the values will be implemented; the author speaks of "implementation intentions." Such plans detail the necessary steps, prevent frustration and probable temptation and facilitate the preparation for the most proximal task demands. Thereby, the hot system "cools down," which constitutes an important prerequisite for the activation of the cold system, i.e., for the involvement of superordinate regulatory levels (MISCHEL & AYDUK, 2004). In SBT, the survival rule described in the preceding paragraphs provides a strategy for the implementation intention: The implementation intention contains the appropriate plans and behavioral instructions to proceed against the survival rule in a suitable manner, e.g., adjusting performance criteria to the degree of difficulty at each step, managing diverse contextual conditions, etc. Any anxiety and frustration that might emerge is then again managed in a mindful fashion. Thus, even in high seas, the person follows the planned course.

Acceptance via mindfulness

Self-regulatory efforts in the service of need fulfillment are closely tied to the approach of some situation and the avoidance of others. Commonly, mental problems are a consequence of a plethora of avoidance strategies in the service of desired need fulfillment and maintenance of the inner equilibrium. Painful experiences and emotional states, considerable tension, and negative thoughts must be accepted to reestablish effective behavior.

To this end, attending to all aspects of reality is honed. Direct contact with the present situation through a special kind of directed attention is sought: perceptions, thoughts, emotions, and bodily sensations are carefully observed and not evaluated as "good" or "bad," "true" or "false," "important" or "inconsequential." Initially, this stance appears to be elusive when, for example,

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painful memories, flaming rage, or nagging doubts arise, intrude, and inundate the person struggling for this "mindful" observer perspective. Of course, this happens constantly; and repeatedly, the attention is redirected, e.g., to the breath, which supports a renewed distancing. Physical sensations, emotions, and thoughts are again attentively observed without manipulation; control or change is not intended. Accepting oneself as one currently finds oneself is the objective.

Eastern meditative practices, particularly Zen Buddhism, inspire such mindfulness exercises. However, mindfulness exercises are not linked to religious beliefs. The traditional version of Zen aspires to pure experience; developing thought constructs or communicating philosophies or new belief systems would harshly contradict its nature. On the other hand, metaphors and pictures illustrate the value of this unfamiliar practice. Thus, our thoughts and emotions might be compared to a herd of wild, bolting horses. Running after them renders one breathless and is futile; moreover, one might be trampled in a stampede. Perhaps one manages to climb the bolting horse's back and attempts control. However, the poor rider is roughly shaken and finds herself exhausted and in pain, thrown off onto the ground. But there is a way to control bolting animals: One provides them with vast meadows. Here, they can roam and expend their energy. Soon, they will calm down and start grazing leisurely. The experience of distancing is accompanied by a sense of relativization: Strong emotions arise and stir us, but they wane again.

The process of acceptance is a practice of self-caring acceptance via mindfulness: All thoughts and emotions, even the unpleasant or negative ones, have free rein. One observes them without being taken over by them; without chiding oneself for their content; and without giving in to the behavioral impulses inherent in those emotions. They are not harmful, even if they scare us to our depths or simply cause a lot of noise.

Mindfulness in the context of psychological conceptualizations of attention

It is commonplace to observe not only sensory and perceptual stimuli but also one's thoughts, motives, and emotions. Consciousness encompasses awareness as well as attention (Brown & Ryan, 2003). Awareness may be compared to a kind of wide-angle perspective, attention with a close-up photograph therein. When driving a car, the attention is focused on the bounded field of the sectional path, while the awareness, akin to radar, continuously observes the global external environment (e.g., the type of scenery, the weather, etc.) as well as the internal state of the person. One can be aware of these stimuli without focusing one's attention on them. Attention is a focusing process that avails a heightened sensitivity for a particular, limited section of experience. Indeed, both processes are intertwined: Attention continuously captures "figures" from the "ground" of awareness and focuses them for various periods of time. Attention and awareness are familiar to most human beings and belong into commonplace, everyday mental functioning, just like other somato-sensory functions. This is not the case for

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mindfulness. Mindfulness is a special way of handling attention and awareness. GROSSMANN (2004) refers to Buddhist scholarly discourse when he describes mindfulness as a relaxed, non-evaluative, continuous awareness of bodily sensations, perceptions, affective states, thoughts, and beliefs. We notice that mindfulness is definitely not part of our typical day when we let our eyes wander, i.e., when we direct our attention to various aspects of the present environment. Leaves are lusciously green, rain is falling steadily; the wind and the grey skies suggest hiding away in one's cozy apartment; a glance at the pile of files prompts the unpleasant remembering of unfinished or forgotten tasks; looking at the books evokes joyful anticipation, etc. Everyday attention is an active process governed by alertness, interests, and needs, such as curiosity, security, and hunger. Attention is also selective in relation to what we should expect or ignore; what we need or plan. In the vernacular, attention consists of considerably more than the mere registration of stimuli: Attention implies filtering processes, and it equips our perceptions with emotional significance (RATEY, 2001). *Evaluations* with different degrees of cognitive complexity form the common denominator of all of these processes. It is surely not erroneous to claim that evaluations are as common in everyday life as the air we breathe. Evaluations help us to generate, access, and strengthen our cognitive-affective schemata, our self-concepts, our identity, and our worldview. In turn, such mental concepts aid the retrieval and categorization of information, our plans and our performance. On the one hand, these concepts provide us with direction, certainty, and security and, for this reason, are of fundamental significance for our survival. On the other hand, we tend to treat all perceptions and evaluations as facts and, thereby, lose a big part of our psychological flexibility. In extreme cases, we defend perceptions and evaluations tooth and nail. All of us are familiar with dogged preoccupation or an idée fixe: We cease to balance diverging worldviews and perspectives; we do not permit different views or evaluations. We live as if there were only one way to live, and as if under some conditions divergence could strike a fatal blow to our self-concept and our self-esteem. The attention focuses on stimuli; and our cognitive apparatus produces thoughts and emotions that concatenate, solidify as beliefs, and reaffirm those beliefs. We have known for a long time that considerable distortions may accompany the processing of personal information. GREENWALD (1980) compared this type of cognitive organization with a totalitarian regime. He proposed the term "totalitarian ego" to describe an organization of knowledge that – analogous to practices found in totalitarian societies – monitors and documents personal experience. This organization fabricates and revises its own history through cognitive distortions to eliminate certain weaknesses and liabilities. Not surprisingly, we also avoid everyday experiences that suggest our fragility, fallibility, vulnerability and – last but not least – our mortality. We often work hard at finding appropriate ways to eliminate or to reduce the frequency of these experiences or to alleviate the conditions under which they occur. These experiences are able to deeply touch us, e.g., via bodily sensations, emotions, cognitions, or memories. They evoke massive tendencies for avoidance, accompanied by learning processes that support the anticipatory avoidance of such experiences and even their markers, if at all possible. In this context, HAYES

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(2004) speaks of "experiential avoidance" and demonstrates the ubiquity of its dysfunctional consequences within a wide range of psychopathological symptom areas. Mindfulness undermines the tendency for experiential avoidance. It represents a continuous awareness of bodily sensations, perceptions, affective states, thoughts and beliefs without evaluation, comparison, or contemplation (GROSSMANN, 2004; KABAT-ZINN, 2004).

Our usual and familiar attentional regulation, however, is not free or without costs. Instead, our attention is seized to strengthen, affirm, and to serve our cognitive-affective constructs and last but not least our self-concept and our identity. While this is necessary and helpful in many situations, under certain conditions, for example those requiring more flexibility, there might be adverse consequences. The automatic nature of attentional processes is not easily modifiable, but the person might be able to generate conditions that favor change. This process is best understood by describing mindfulness as a kind of attention to the ordinary.

The person observes arising thoughts, emotions, and images; does not suppress their surfacing; stays relaxed; and does not evaluate these phenomena. Thus, mindfulness resembles exposure with response prevention. The stream of thoughts, emotions, and images is registered in an alert and attentive manner while being kindly accepting of oneself and suspending evaluations as well as emotional reactivity. When the attention drifts away, a phenomenon also common among practiced individuals, the position of the attentive observer is resumed, again tolerant and kind despite the drifting. Registering that certain thoughts are pursued or certain internal images are painted also constitutes mindfulness. A prerequisite for the process of mindfulness is the person's ability to turn his or her attention toward the self. This dispositional ability must be assigned an essential mediating role in the control of behavior. In this regard, DUVAL AND WICKLUND'S (1972) conceptualizations within their theory of "objective self-awareness" evoked a lot of interest. Their somewhat misleading terminology points to the self as the object of awareness. Subsequently, the construct of private self-consciousness was introduced by FENIGSTEIN, SCHEIER, AND BUSS (1975). It is conceptualized as a personality characteristic and relates to the observation of one's own emotions, thoughts, motives, and knowledge of the self, i.e., metacognitions concerning oneself. Other studies give a more detailed description of two components, namely "internal state awareness" and "self-reflectiveness" (CRAMER, 2000; TRAPNELL & CAMPBELL, 1999). All these approaches can be understood as a form of reflective awareness (BAUMEISTER, 1999). They point to cognitive activity concerning different characteristics of the self. Although mindfulness is also directed internally, it denies this type of activity. It is observing rather than evaluating. WALACH ET AL. (2004) found that their mindfulness measure correlated with private self-consciousness ($r = 0.33$) and self-knowledge ($r = 0.57$). Apparently, mindfulness must be conceptualized more broadly. Drawing from Buddhist approaches to mindfulness, these authors' measure was carefully and self-critically developed. In the meantime, it has been modified to be applicable to people who are unfamiliar with Buddhist content or with the respective meditation practice. These authors' operationalization provides a coherent characterization of mindfulness:

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- Directly contacting experience without identifying with one's thoughts or emotions;
- Assuming an accepting, non-judgmental stance regarding one's own difficulties and liabilities; patience and openness relating to oneself and others;
- Accepting experiences; not defending against painful and unpleasant emotions; and maintaining contact with these experiences;
- Realizing the steady permutations of thoughts, emotions, and sensations, the transience of all experience;

In addition to the already discussed characteristics, kindness toward oneself, open and receptive awareness, and the importance of sound error management are emphasized.

The significance of mindfulness for self-regulation

We have introduced mindfulness as a form of directed attention, which focuses onto the here and now in an accepting and friendly manner. It also perceives and registers what happens in awareness without evaluation and does not follow any behavioral impulses that might emerge. We also saw that the breath may be utilized to re-center oneself, i.e., to reassume the observer role more easily.

How do we conceptualize this process on a system-theoretical level? Centering one's attention on the here and now constitutes a narrowing of one's temporal perspective, because yesterday, one's childhood, or one's experience in the morning are not the targets of the attentional focus. Focusing one's attention onto details that are directly sensed and present, such as concentration on the breath, a sound, chewing, etc., reveals a very concrete process orientation, which precisely corresponds to the characteristics of the lower level of the regulatory hierarchy. These characteristics are rather concrete, where "concrete" refers to goals that are visible, graspable, noticeably present and achievable in the here and now.

With regard to mindfulness practice, its concrete nature suggests that our attention has been diverted to the lower levels of the regulatory hierarchy. But how can emotions and thoughts arise at these levels, for example, when we miss our partner or speculate about a shared future? Such cognitive-affective contents attest to a broader temporal perspective and more complex relations among events, which are usually typical for activated superordinate regulatory levels and their goal-setting characteristics.

VALLACHER & WEGNER (1987) have shown that attention naturally drifts toward the higher regulatory levels. This occurs automatically when a fit between reference and actual value has been ascertained on one particular regulatory level. Consequently, effective mindfulness must automatically lead to emerging images, thoughts, and emotions. This is exactly what people who practice mindfulness know very well.

Evidently, this up-drift of attention has the function to affirm and to strengthen the person's superordinate concepts. To this end, a behavior (such as opening a door for an elderly person)

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becomes more tightly linked to the abstract contents of the higher regulatory levels (e.g., the self-concept of being helpful). People then more strongly identify their behavior as part and parcel with the more abstract contents of these superordinate levels (e.g., being helpful) and thereby simultaneously confirm these contents.

Conversely, such identification with the higher levels is abandoned when the removal of discrepancies between reference and actual values is difficult. The down-drift toward more concrete identifications is helpful initially, because it fades out disturbing discrepancies in the self-concept and focuses the attention on performance details to better manage the situation and, especially, to avoid negative emotions. This protects the person not only from curbing his or her helpfulness but also from potentially brashly revising his or her defined, more abstract reference values, as they are represented by value-orientations or the self-concept, for example.

Directing attention via mindful and accepting observation now means to disrupt the automatism of this constantly self-reproducing system. Mindful behavior enables distancing from processes of continuous identification with superordinate concepts, such as self and identity; rule-governed behavior; automatic responding to discrepancies; and the attempt of the system to constantly generate perceptions that match expectancies. Directing one's attention toward the immediately present stimulus situation without being subjected to the stringent mechanics of everyday self-regulation creates new space and more flexibility, which allow openness for alternative perception and behavior.

When considering mental problems, directed attention seems almost "enslaved" in many cases, as evidenced by the confinement of attention to a certain regulatory level. Based upon their own research and on a thorough review of the literature, HAMILTON ET AL. (1993) found orderly patterns. Their relationship to the mindfulness concept, which assigns a central role to the direction of attention, shall help to further clarify the nature of mindfulness and its close link to self-regulation.

Excessive self-directed attention

When the perceived discrepancies are very large and seemingly insurmountable barriers appear in the coping process, then not only one's self-focus but also one's entire self-regulation system becomes increasingly occupied by aversion. Experiments provide evidence for the tendency to abandon the cycle of self-regulation under such conditions (HAMILTON & DEEMER, 1999). The avoidance of any further self-directed attention prevents the negative experience from becoming part of the self-schema and thus from producing affective and self-esteem affecting consequences. Negative affect, the internal attribution of errors and failures, as well as a negative self-schema are typically characteristic of depressive disorders. Indeed, depressed individuals are "stuck" within the perceived discrepancies and, as a result, self-regulation perseverates: Depressed persons maintain a very high level of self-directed attention and stubbornly persist in their self-regulatory efforts, even in the face of insurmountable barriers, personal loss, and incorrigible flaws. This perseverated self-regulation has been related to the scant

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number of self-aspects that could contribute to self-esteem. From a behavior therapy perspective, one would say that depressed individuals have difficulties expanding their "world" and because of this must cling to an already small number of reinforcing alternatives. In other words: The complexity of the abstract regulatory level (e.g., the self-concept) is not sufficiently developed to support a more favorable self-regulation in this case; the abstract regulatory level does not contain enough self-related goals.

In this context, *mindfulness* may undermine the impulse to eliminate discrepancies regardless of situational factors. This means that the person tolerates distress and emotions, such as frustration, anger, and anxiety; also, that he or she observes and does not respond to the impulses inherent in these emotions. Here, acceptance via mindfulness is illustrated in its most profound sense: The person faces the task to accept him or herself with all deficits, liabilities, and failures. While this task initially may appear as a burden, essentially, it touches on our relationship with ourselves. Occasionally, the hard nut we have to crack is our own callousness toward ourselves.

Avoidance of self-directed attention

At times, withdrawing attention from the upper level reference-values that constitute the self can be consistent with healthy self-regulation. Excessively avoiding a focus onto the self, however, seriously impairs healthy self-regulation in the long-term. How might this happen? In modern Western societies, identity development presents a remarkable challenge. Adolescents struggle with career choices, sexual orientation, group membership, the transition into adult life, etc. Adults must be able to juggle several roles, to make career decisions, to work toward long-term goals, to confront death and dying. Here, the ability to integrate is required: Very different aspects of the self must be assembled to generate a relatively coherent and acceptable sense of self. Sometimes, this process is associated with considerable stress; thus, references to identity distress are applicable beyond the context of psychiatric illnesses (BERMAN, MONTGOMERY, & KURTINES, 2004). The more we invest in our self, the more we have to lose. Often, the ambitious reference values of successful and apparently perfect individuals produce greater vulnerability and thus even greater stress. Here, BAUMEISTER (1991) refers to the "burden of self," which leads to an "escape from self" in some situations. It is not surprising that alcohol use is one of the strategies to reduce self-directed attention when self-regulation is difficult. Interestingly, however, this tendency positively correlates with dispositional self-directed attention. A similar relationship exists for eating disorders, masochism, suicidal behavior, and anxiety disorders. The mechanism underlying this escape tendency is termed "cognitive deconstruction." The process begins with the perception of flaws, inadequacies, and failures following discrepancies affecting the self and related emotions of anxiety and threat. The immediate response to a severely aversive mental state is a shift of attention from superordinate self-related reference values to the lower levels of behavior regulation. At the lower levels, thought is less integrative, i.e., limited to the here and now. Experience is not interpreted in the context

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of the self-concept or of personal values. Consequently, the meaning derived from experience is substantially diluted. Being stuck in the lower regulatory levels has further consequences. Often, a certain emotional emptiness is described. If interpretation occurs at all, it relates to the situation immediately at hand. The defense against consequential and meaningful content leaves behind an "interpretive vacuum." Thinking is rather rigid, simple, uncreative, and linear. The emotional and cognitive emptiness creates a kind of eddy for irrational thoughts and assumptions, obscure ideas, daydreams, and fantasies. The vanishing of evaluations related to the self-concept, personal values, etc., also results in a reduction and elimination of inhibitions as well as a weakening of impulse-control (TICE, BRATSLAVSKY, & BAUMEISTER, 2001; BAUMEISTER, 1997).

The practice of *mindfulness* consists of directing one's attention away from the upper regulatory levels and tying it to the concrete, direct experience that is associated with the lower regulatory levels. Can mindfulness be understood as a form of cognitive deconstruction? This question has to be answered with an unequivocal "yes." As evidenced by the preceding description, it is also possible to abuse the practice of mindfulness. BAUMEISTER (1991) describes spiritual practices that also may be abused. The field is familiar with attempts to treat mindfulness as a magic cure and to meditate away personal difficulties. Well-understood mindfulness, however, has a different motivation. Mindfulness is a valuable and helpful stance, but it does not substitute for choosing a life plan that matches a person's limits and possibilities, and it does not replace a commitment to certain values as a foundation for navigation. The path toward a concordant identity and a corresponding life plan often leads to phases of struggle, pervasive doubt and anxiety, pain, and torment. Well-practiced mindfulness registers these experiences as well as the tendency to avoid by remaining within the lower self-regulatory levels. Effectively utilized, mindfulness accepts the burden of self as the prerequisite for a responsible change process. It undermines trends for avoidance and generates flexibility in the service of elaborating abstract reference values and formulating appropriate identity-supporting goals.

Excessive focus of self-directed attention on abstract reference values

According to the hierarchical model of self-regulation, attention may focus on reference values with different degrees of abstraction: Attention may focus on walking or breathing, or on one's own self-concept or personal values. If self-regulation is preoccupied with discrepancies on the more abstract levels, e.g., the self-concept, then there is an increased risk of a disruption of the behavioral stream and errors in self-regulation. Individuals who do not consistently turn their ideas about themselves into behavior via more concrete regulatory levels do not receive the environmental feedback necessary for a confirmation and a differentiation of their self-image. They are stuck dreaming and wishing. Perhaps skills that would permit concrete behaviors are missing. Further, the exclusive preoccupation with abstract reference values may avoid potential failures that could occur if one took action. The observation that depressed individuals do

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not think in sufficiently concrete categories and tend to strive for abstract goals is well-established (HAMILTON ET AL., 1993).
The systems-theoretical perspective views *mindfulness* as a focus on "do-goals," i.e., it is process-oriented and performs the concrete aspects associated with the execution of action. Additionally, mindfulness promotes an orientation toward the present moment rather than the future goal of action. Moreover, discrepancies on the concrete levels of behavior regulation are more easily eliminated. Fear of failure, related to future events, is often the result of discrepancies on the superordinate levels of regulation. As mindfulness ties the attention to the lower regulatory levels, such performance barriers and sources of stress are minimized. Correspondingly, mindfulness may improve performance quality and, thus, also the achievement of goals. Mindfulness promotes doing and thereby enables new experiences and also behavior change.

Excessive focus of self-directed attention on concrete reference values

Goals on the lower level of abstraction, such as "Carry your wallet," clearly circumscribe and unambiguously define the target behavior at a particular time. In contrast, the abstract reference value, "Be a responsible member of your family," is rather attributive. It says more about what kind of person one is (or wants to be) than about what to do. A fundamental statement of self-regulation theory predicts that more abstract reference values exert greater influence on a person's global self-esteem. For this reason, a focus on more concrete reference values may constitute a strategy to protect oneself from painful discrepancies affecting self-esteem. Such an attentional focus disrupts the categorization of actions and behavior into superordinate concepts, so the person does not have to question the significance and meaning of his or her current behavior. If this strategy is chronic, then a severely problematic self-regulation emerges. In particular, the emergence of clinically relevant impulsive behavior may be understood as deficient abstract reference values. Borderline personality disorder patients typically show a plethora of impulsive behaviors; simultaneously, they have a sense of self that is hardly defined or integrated. For this reason, the necessity of external structure for borderline patients is understandable. They lack a well-developed ideal self and the corresponding abstract goals which, according to self-regulation theory, are necessary to regulate everyday behavior beyond the here and now. In this context, the intensive preoccupation with concrete symptom-related aspects, also seen in anxiety and obsessive compulsive disorders, also suggests that the contemplation of discrepancies on the level of the self-concept is to be avoided. Of further interest is the finding that identification with abstract reference values is associated with more thoroughly developed self-concepts. Such individuals also are less perturbed by mistaken or false feedback.
Mindfulness provides a basis for encountering difficult situations without feeling helplessly delivered to painful emotions and impulses. It facilitates initial experiences of distancing and prepares disidentification: "I am not the emotion or the pain; I have this emotion and this pain."

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Readers who are familiar with KEGAN'S (1986) cognitive-affective developmental theory know that this disidentification process is especially difficult for patients with personality disorders. Their developmental status often is in the devouring or impulsive phase, which does not involve the cognitive-affective structures required for disidentification. Here, the respective preparatory work must be completed and enabling conditions must be generated, as practiced in LINEHAN'S (1996) approach. Moreover, it again becomes clear that mindfulness must be practiced diligently and arduously. Furthermore, superordinate goals on the self-concept level have to be formulated, for they enable the person to construct his or her life beyond the here and now, to categorize experiences, and to gain a solid foothold. Otherwise, there is a risk that mindfulness misses the concerns of the whole person.

Mental problems are often associated with insufficient need fulfillment. When this is the case, self-regulation closely adheres to the survival strategy described earlier. The survival strategy is housed at the program level of the regulatory hierarchy and connects needs-based reference values with motivational schemata of approach or avoidance. Mostly, the survival strategy is acquired in childhood and loses its functionality under certain conditions as the person ages. This generates a stress-state that the mind cannot tolerate. To escape this adversity, the mind produces the symptom as a creative and best possible solution, which also leaves the regulatory system with its current reference-values untouched. Thus, the regulatory system is able to reconfirm the hitherto existing self-image and worldview. The person is caught within a cage of his or her own constructions. Given these descriptions, one can easily imagine how mindfulness frees the person from this cage, how he or she could defy the grip of the regulatory system and especially the demands of the survival strategy. In SBT, the patient and the therapist carefully work on a path that has already been determined by the survival strategy. The new, proactive rule declares: "I act against my survival strategy and confront the necessarily surfacing tensions, the negative emotions. I assume a mindful stance toward bodily sensations, thoughts, images, and emotions and will not surrender to the impulses inherent therein."

Practicing mindfulness

Mindfulness cannot be commanded or ordered. We saw that the direction of attention often occurs in the service of different feedback loops that, in turn, aim at validating and protecting our self. Directed attention that disobeys this automatism must be practiced.

GROSSMANN (2004) refers to the Buddhist tradition of mindfulness practice when he terms the breath the vehicle and the central entryway to the development of mindfulness. Our attention often drifts restlessly and only briefly rests upon a surfacing memory; it might select a bodily sensation from awareness; or it is drawn to a sudden noise that in turn evokes irritation toward its originator, etc. In Zen meditation, as I have learned it, attention focuses on the breath, or more specifically: Inhaling and exhaling are observed (ENOMIYA-LASSALLE, 1968; AROKIASAMY, 1991). As the first step in meditation, the observation of the breath teaches focused attention.

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If one has difficulty concentrating, counting while inhaling and exhaling may also support this focus. These focusing exercises help to detach from wandering thoughts, surfacing images or emotions, or external stimuli, and to return to the breath. If practitioners notice a preoccupation or even a struggle with content, they redirect their attention to the breath and attempt to stay there until another return is necessary, etc. Whatever happens within the spotlight of awareness, we perceive it and let it go. A thought arises: We register it and return to the breath. A bodily sensation emerges: Perceiving and returning. We hear a noise: Hearing and returning. If one does not have anything else planned, one can practice any time and in any situation. For our purpose, it is prudent to schedule time for regular, daily practice. Initially, five minutes per day suffice; then the duration is prolonged. Sitting on a meditation pillow or block is recommended. One may also sit on the edge of a suitable chair, with one's legs bent at a 90-degree angle and one's lower legs and torso perpendicular to the floor. The recommendation not to lean against a chair has nothing to do with callousness or discipline, but it emerges from the circumstance that most chairs do not have a straight back. Then a body scan can be conducted, i.e., one attends to the whole body from head to toe and checks whether tension is present anywhere, e.g., in the shoulders or in the jaw. Subsequently, practice begins. Overall, it is important not to force progress but to honestly contact one's limitations. A little bit of practice on a regular basis is more effective than a lot of practice at irregular intervals. Diaphragmatic breathing is preferred and initially practiced by placing one's hands on one's belly at the beginning of each exercise, such that inhalation and exhalation correlate with tension and distension of the diaphragmatic musculature. Here, an extended exhalation period is helpful.

I would like to emphasize that these techniques and methods are appropriate for training directed attention and mindfulness with regard to alternative problem-solving strategies. This does not automatically imply a certain "meditative path." Thus, the Zen culture takes care to explicitly ask participants whether they are seeking instruction to benefit from the salutary and health-related aspects of meditation, or whether they are willing to begin their journey on the meditative path. Clearly, the clinical context must emphasize the salutary and health-related aspects of practice. The decision to enter the meditation path must be the participant's personal decision and is not a matter of psychotherapy. For this reason, I prefer speaking of mindfulness instead of meditative practices. Processes related to breathing are of extraordinary significance for mindfulness and self-regulation, and I would like to summarize their characteristics (adapted from GROSSMANN, 2004):

- The breath is the only function necessary for survival that is accessible to awareness at any time and in any situation.
- The respiratory system is a powerful physiological oscillator and influences other bodily rhythms, e.g., more weakly oscillating systems such as heart rate, blood pressure, activities of the central nervous system.
- Breathing patterns co-vary with external and internal circumstances and their frequency ranges are conveniently accessible to awareness.

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- Breathing can occur as a function of almost completely conscious as well as completely unconscious control. Mindfulness focuses the attention on the intersection of controllable and uncontrollable, conscious and unconscious processes; and on the tendency to attempt to influence physiological processes.
- Breathing patterns are sensitive to emotional states and mental processes, such as problem-solving. The observation of the breath allows a more precise awareness of varying internal states and their relationships.
- Attention focused on the breath slows down and deepens respiratory activity; thus, a stronger feeling of peace and concentrated awareness of the present moment are promoted.

This practical approach trains directed attention. Usually, participants are asked to practice mindfulness in non-specific contexts of everyday life, i.e., to be mindful of what one is doing at any moment: chewing mindfully, eating mindfully, drinking mindfully, walking mindfully, etc.

Self-directed attention: Being present and intimate with oneself

In everyday life we often are caught up in thinking, dreaming, imagining, hoping, desiring, and feeling – without being genuinely present. To be mindful means to be aware of these phenomena, to perceive them, and to return to a focus on the here and now, on the breath and the body. The Jesuit priest and Zen master Ama Samy nicely characterizes this process as being present and intimate. Furthermore he says:

Being intimate with myself. Zen talks about intimacy: When I drink water and know that it is cold or hot, this is intimacy. Therefore, one says in Zen, for example: If it is hot, be a hot Buddha; if it is cold, be a cold Buddha. Also, if you are fatigued, be your fatigue. If you are empty, be your emptiness. Most of the time, we run from our emotions and sensations, and we try to manipulate ourselves into feeling something else. (AROKIASAMY, 1991, p. 92)

Mindfulness practice increases our ability to be aware of our actual state, regardless of its evaluation as “good” or “bad.” Intimacy with ourselves is generated by returning to the breath and experiencing the body as a sounding board in this intensive process; observing the painful, the abysmal, the pleasing, and the joyful arising within us. We create space for ourselves, are with us as we are, bear ourselves, and in this way are able to befriend ourselves. Self-acceptance emerges from mindfulness practice. Thus, our relationship with ourselves steadily improves and becomes enjoyable. Of course, this is a process, and the good relationship with ourselves opens up only slowly.

Psychotherapists, however, know that poor self-acceptance – the harsh, unloving, rigid, invalidating, injurious and partially cruel treatment of oneself – is one of our patients’ core problems. They often cannot endure or stand themselves and, for this reason, must resort to all kinds of avoidance strategies, e.g., alcohol, drugs, binge eating, even spirituality may be exploited to this end. As mentioned above, BAUMEISTER (1991) described these behaviors as an escape from the self, from the burden of being oneself. Individuals, who are not aware of the present and

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who do not accept the current status quo of their beings, do not have the foothold from which to effect change. Consequently, we enhance our therapeutic work on self-relation by incorporating a mindfulness theme.
Mindfulness practices increase the self-focus. In some cases with favorable outcome, mindfulness also generates a positive relationship with oneself. In other less favorable cases, for example concerning severely disordered patients, the individual's self-aversion may have reached a critical magnitude before mindfulness practice can exert its effects. Here, the initial introduction to practice may encounter great difficulties, or it might be thwarted. For this reason, it seems necessary to explicitly address the relationship with oneself and provide the respective assistance in parallel with mindfulness practice. A brief case vignette is described below to illustrate this suggestion.

Brief vignette

A 37-year old female presented with agoraphobia with panic and occasionally depressed mood. The introductory mindfulness training, particularly its home-based practice, turned out to be difficult. The client reported that she generally had trouble being alone. She stated that she kept very busy with outside activities and often went out with others. According to the client, she felt good during those times, her mood was elated, and she felt vital and fun-loving. Upon returning home, however, she had cabin-fever and felt "caved," so the client's report. She further noted that she could not find reasons to continue living anymore.
Patient: "I cannot stand myself and feel so miserable … I feel something like 'everything's in vain, you don't need to try, you won't be happy anyway!' I cannot concentrate on the breath.
Therapist: "I am hearing a voice within you that says [labored], 'everything's in vain, you don't need to try, you won't be happy anyway!"
Patient: "Yes, exactly."
Therapist: "I'd like to make this even more evident. Please stand up and stay right here!" [Patient and therapist stand next to each other and view the chairs that face each other.] "I suspect that you hear this voice quite frequently?"
Patient: "Yes, absolutely."
Therapist: "Moreover, there seems to be another side of you, fun-loving, vital, and full of gusto. This side surfaces when you are on the road, when you are with the people you like?"
Patient: "Hmm … yeah, that's right."
Therapist: Could you place these both sides of yourself on these chairs?
Patient [irritated]: "Huh? … What? I believe I don't understand. No, I can't do this."
Therapist: Yes, you're right, I'm really asking for something quite odd, and it's not easy to understand." [Repeats the description of both sides.]
Patient: "Very well. What exactly am I supposed to do?"
Therapist: "Now you role-play both of these sides by sitting first in the one and then in the other chair. I will give you the respective instructions. Okay?"

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Patient: "Am I schizophrenic or what?"
Therapist: "Hearing several voices is nothing unusual. They show that I carry several tendencies."
Patient: "Aha, very well. Okay, then I play first the negative voice and sit down on this chair over here." [Points to a chair and then sits expectantly]
Therapist: "Use your negative voice, and then listen." [Patient speaks her sentence and crumbles a bit.] "What is happening right now?"
Patient: "This is really abominable …" [Freezes and tears up]
Therapist [after a while]: "Please change chairs now. Now you are your other side. Please describe that one again."
Patient [changes chairs, sits erect, and describes her vital side]
Therapist: "Now look over to the other chair, where your other side is sitting."
Patient: "But I don't want to." [Very loud] "I hate it."
Therapist: "What is it? What do you see?"
Patient [sobs and cries hard]: "I have always been alone, nobody ever cared what was happening to me; nobody played with me or helped me to cope with my problems. I've always thought of myself as inadequate and ugly …"
Therapist [after a while]: "Please change the seat. What is your fun-loving side saying?"
Patient: "Leave me alone, I don't want to know anything about you."
Therapist [Allows some time for consideration and then ends the scene. Both therapist and patient are standing and looking at the chairs]: "What do you conclude?"

The avoidance of this particular kind of self-focus was more difficult when the client was alone. For this reason, it is understandable that mindfulness practice generated an even greater – here undesired – intimacy with herself when she was at home, for components of the negative self-concept intruded into awareness even more strongly. This illustration clarifies that the client had to avoid this intrusion for comprehendible reasons and required support to approach her neglected self-components. The externalization of both sides created a form of simultaneity and connection of both sides, which may be very unpleasant initially and, therefore, was not immediately accepted by the client. A kind of disidentification ensued: the client could not easily identify with one or the other side anymore. The suspension of both sides next to each other was maintained in awareness via the mindfulness practice. Resulting thoughts, images, and emotions were being observed without reflexive escape from the situation. The "either-or" turned into "and," relating both conditions. After some hesitation and careful experimentation, the client perceived the challenge to be mindful of her needy side, to accept it, and finally to care for it herself. The integration of both sides has been prepared. The client may question her identity ("who am I?") in a new and more accepting manner. The rest of the process is not illustrated here. At the end, the client learned to be mindful of her pain related to loss, i.e., to observe it without succumbing to reflexive avoidant templates, to support herself, and to kind-

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ly accompany herself. This was an essential prerequisite to enable the client to engage in self-directed home mindfulness practice, which is of central importance in the treatment of anxiety-related symptoms.

Difficulties during the introduction of mindfulness practice may indicate great tensions within the self, which may become unbearable with the increasing self-focus of the exercise. In severe cases, difficulties cannot be removed by intensive practice. Here, patients require insightful, and optimally also experientially oriented support, as described above. Dissociated components of the self-concept are not always the issue: Sometimes certain emotions, e.g., anger, vehemently emerge in the self-focus. In most cases, an actual escape from oneself is desired. The person cannot stand him or herself and rejects the perception of certain parts or characteristics. Only a few interventions are necessary to prompt an improvement in one's relation to oneself:

- Externalization of the different sides of self (mostly critics, pushers, and censors)
- Mindfulness exercise: Maintaining concurrent awareness of all participating sides
- Taking responsibility for oneself and developing self-care activities: engaging in valuing rituals at home, maintaining a "well-done" list, praising and encouraging oneself, increasingly attending to emotions and needs.

Further suggestions and exercises can be found in GILLIGAN (1999) and POTRECK-ROSE AND JACOB (2004).

Examples of mindfulness-based therapy forms

Mindfulness-based Stress Reduction (MBSR)

JON KABAT-ZINN (1990; 2005), who received his degree in molecular biology and was faculty in preventive and behavioral medicine, developed Mindfulness-based Stress Reduction (MBSR), the mindfulness training most frequently cited in the literature. Originally, the training was conceptualized for behavioral medicine settings and without a focus on specific disorders. Thus, it can be applied to a range of problems. Patients are explicitly challenged to learn traditional meditation practices *complementing* their medical treatment. The training program is an eight-week course that strongly emulates Buddhist practices. From chronic pain over depression and anxiety it also covers a range of psychosomatic disorders, such as eating disorders. Its efficacy has been shown in a plethora of empirical studies (e.g., BAER, 2003; KABAT-ZINN ET AL., 1992; MILLER, FLETCHER & KABAT-ZINN, 1995). In daily meditation sessions, patients acquire skills for a mindful stance, including the treatment of thoughts and emotions described above. Physical sensations receive special attention. "Body scanning" while lying and closing one's eyes teaches the patient to develop awareness for a variety of processes occurring in different bodily regions. Moreover, special mountain and lake meditations strengthen the initially unfamiliar observer position described earlier via a particularly well-done didactic teaching style. The patients are also asked to integrate their activities of daily living, such as walking, standing, eat-

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ing, etc., into their meditative practices. The point of these meditations is to completely engage with the present and to learn to redirect attention to the momentary activity upon each distraction. Trainers are explicitly required to have themselves experience with meditation practices.

Mindfulness-based cognitive therapies

Mindfulness-based Cognitive Therapy (MBCT) for depression assigns a special status to mindfulness training (Segal, Williams, & Teasdale, 2002). This approach was developed particularly for relapse prevention. The design details of the mindfulness program closely resemble the courses offered by Kabat-Zinn. They introduce the metaphor of the autopilot to illustrate the patients' automatic, often inflexible behavior. Each behavior therapist has to face his or her patients' dysphoria, which increases the patients' suffering and occasionally turns therapeutic work into tenacious labor. Segal, Williams, and Teasdale (2002) recognized the utility of mindfulness training for the prevention of dysphoria. Neglecting mechanisms for maintenance, their investigations had focused mainly on those characteristics of information-processing that reactivate a depressive episode. Segal, Williams, and Teasdale's model predicts that even mild dysphoria renders patients with a history of major depression vulnerable to another severe episode. While the traditional model proposes that emotions are directly elicited by automatic thoughts and images, Segal, William, and Teasdale's model assigns a subordinate role to these cognitive variables and suggests that their modification is only of limited value. Instead, the model conceptualizes more complex, superordinate schemata (termed "implicational codes"), which are able to directly elicit emotions. These schemata are holistic representations of emotional experiences, i.e., they are rather intuitive with implicit content. Thus, they are not subject to extensive modification by the classical methods of behavior therapy alone.

Mild dysphoria activates these complex meta-schemata, which in turn generate the dark depressive cognitive patterns that may vehemently form within a new depressive episode. The authors decided to hand patients a tool, i.e., mindful observation, acknowledging the threat posed by even mild dysphoria. Patients experience their thoughts and emotions as transient, as something that allows observation without further reaction. Here, a decentralized, i.e., dissociative, view of one's own thoughts, emotions, and bodily sensations is intended. The observation occurs in a non-evaluative manner. Because an accurate description of reality is not required and the observed thoughts, emotions, and bodily sensations do not have to constitute a part of one's own identity, they can wax and wane repeatedly.

A comparison with the classical cognitive therapy for depression reveals major differences. Instead of isolating, identifying, challenging, or directly modifying negative thoughts and the respective cognitive structures, the mindfulness-based variant of therapy changes the patients' internal relationship with thoughts and emotions of any kind. Additionally, patients are encouraged to move forward with their negative emotions. On the one hand, activity related to pleasure and joy, on the other hand mindful completion of tasks of daily living is supported.

Interestingly, striving for mastery and perfection is promoted. Efficacy studies have shown that this intervention halves the probability of relapse for those patients who have had three or more depressive episodes (MA & TEASDALE, 2004).

Dialectical behavior therapy

Dialectical behavior therapy provides a battery of cognitive and behavioral therapeutic strategies that were specifically accommodated for the treatment of borderline personality disorders (LINEHAN, 1996). More recently, this approach has been applied to anxiety and depression as they are found in outpatient practice (MARRA, 2004). It becomes obvious that Marsha Linehan incorporated influences other than behavior therapy to solve the substantial therapy problems that behavior therapy could not master in the 1980s.

The dialectic stance manifests itself in the statement that reality is a process maintained by antagonistic forces, which in a synthesis lead to a new process that is again maintained by opponent forces, etc. The core of Linehan's therapeutic perspective is the dialectic of acceptance and change. Her patients consistently demonstrated a fear of strong negative affect. This fear led to intensive control and avoidance maneuvers which did not leave any room for goal-directed change strategies. Acceptance strategies were introduced to regain the degree of psychological flexibility that is necessary for the change process. Thus, Linehan's procedure, described as dialectical, balances acceptance and change strategies.

Linehan adopted the principle of acceptance from two sources: Hayes is the first and Zen meditation is the second. For her, radical acceptance is the perfectly open experience, the complete engagement with what is and how it is in this moment. Acceptance strategies are mostly communicated by training mindfulness skills. Parallels to MBSR exist, but Linehan's concepts are didactically structured in a different fashion. Thus, Linehan categorizes mindfulness skills as three "what"-skills (observing, describing, participating without self-consciousness) and three "how"-skills (being nonjudgmental, focusing on the present, doing what works).

Moreover, Linehan's approach to the treatment of borderline personality disorder makes improved emotion regulation the most important therapy outcome. Her dialectical therapy strategies in individual sessions and group exercises in skills training sessions aim at correcting emotional dysregulation. While skill training is very cognitive-behavioral and as such widely accepted by behavior therapists, the conversational strategies in Linehan's dialectic method target an encounter with emotions. A systematic emotional roller coaster requires emotion regulation from the patient if she is to engage with the therapist's offer of interpersonal interaction. This has the effect that, at least during these brief interpersonal moments, the emotions are not controlling the patient, but that the patient governs her own emotions. Linehan's dialectical approach presents an interaction and intervention style that clearly differentiates itself from cognitive talk therapy. For this reason, we are not able to speak of a simple cognitive-behavioral approach.

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Linehan, aware of the contentious nature of her divergence from the mainstream cognitive-behavioral paradigm, chose to call her approach "cognitive-behavioral" rather than "dialectical." Only the worldwide positive response to her formidable research and therapy approach introduced and made public the term "dialectical behavior therapy" in Anglo-American-speaking parts of the world.

Acceptance and commitment therapy (ACT)

Everyday suffering, problems, and difficulties do not absolve people from realizing their values. ACT motivates patients to act – *with* their difficult thoughts and emotions.

The majority of therapists as well as their clients believe that a better and more vital life can be regained only if one's negative thoughts and emotions have been conquered. "Then why do so many people still suffer from mental disorders and reduced life satisfaction," asks STEVEN HAYES (2004), one of the founders of ACT. ACT (HAYES, STROSAHL, & WILSON, 1999) is theoretically anchored to the modern, post-Skinnerian analysis of behavior (HAYES & WILSON, 1993) and explains why a direct modification of negative thoughts and emotions, for example, has limited influence and scope. ACT is a general approach to disorders and places experiential avoidance, as putative cause of all mental suffering, into the center of its considerations. Experiential avoidance emerges when one is not willing to contact certain private events (e.g., bodily sensations, thoughts, emotions, memories, behavioral dispositions) and for this reason endeavors to change the form or frequency of the events themselves or of the contexts that evoke them. People do certain things or refrain from doing others, so that the feared events will not occur. This trend manifests in rules of conduct that control behavior, i.e., behavior is not governed by its consequences anymore but follows a template that also affects respective evaluations. The "old" behavior therapies also share this view. New in ACT is the therapeutic focus on acceptance. Through experientially oriented methods and metaphors, patients learn to identify the special problems brought about by their evaluations and control strategies. In particular, patients realize that, through the use of verbal stimuli or symbols, all verbalizations of private events generate a fusion of these events with the person. "I am a person who is observing a feeling of anxiety" turns into "I am anxious." The description of a momentary state evolves into a lasting property of one's identity. For example, "I can't" leads to not undertaking, i.e., avoiding, a task. Thoughts are taken literally, one buys them. At this point, so-called defusion strategies are used. The term "defusion" circumscribes an arsenal of techniques that facilitates viewing thoughts as what they are and not what they pretend to be by virtue of their literal content. In the course of defusion, the evaluative functions of language are reduced. The exercise "Soldiers in the parade" is typical. Patients are asked to imagine writing each surfacing thought on a poster carried by one of the soldiers in a parade and letting the soldiers pass by. Such defusion exercises help to differentiate between thoughts viewed as such and thoughts that are bought as beliefs and concepts, essentially interpreted to be the cause of the respective problem. Classical cognitive therapy would fixate and modify such thoughts. In contrast, ACT

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works toward acceptance. Undesired thoughts and emotions are explicitly invited, welcomed, and accepted. However, enduring, suffering, tolerating, or resigning *per se* are not at issue. They would imply passive acceptance of defeat. Active acceptance requires an explicit welcoming of experience and its observation in the service of valued action. Thus, this approach also employs acceptance via mindfulness, but it does not resemble the strategies of Kabat-Zinn's MSBR at any point.

Here, the concept of "self-as-context" is of interest. It is an observer perspective that clarifies the difference between the patient's self and his or her behavioral, cognitive, and affective patterns. Patients explicitly describe their thoughts and emotions instead of simply talking about their content: "I am having the thought that I do not want to go shopping in the city," or "I notice that two sides are struggling within me: one side wants to … the other side wants to …." This manner of speaking conceptualizes the self as a framework and interprets negative thoughts and evaluations as what they are, rather than as the patient's properties. This perspective, in a modified form, is also reflected by Linehan's approach. We remember that internal events are to be precisely described in the course of Linehan's mindfulness skills training. This procedure not only targets increased discriminatory skills but also facilitates the identification of any rule-governed behavior that lacks correspondence with current contingencies. In ACT, the behavioral modification per se is prepared by formulating the important values in the patient's life. The exercise, "What do you want your life to stand for," is very moving and has enduring effects supporting this process. In a next step, the values are linked to concrete behavioral targets, and willingness and commitment are strengthened. Impressive exercises, such as the "Jump" exercise, illustrate that willingness is non-gradual and follows an all-or-nothing principle. The target is an unambiguous commitment, i.e., an internalized responsibility in the sense of a promise to oneself, which is also understood as a behavior as far as it concerns actively asserting one's own values. This commitment process is intensive and binding. It returns dignity to the patient who was caught up in struggling and suffering.

Mindfulness and psychological mechanisms of action

Doubtlessly, the ability to direct one's attention is of great significance for effective self-regulation (Mischel & Ayduk, 2004). Mindfulness practice is a form of directed attention and thus should play an important role in self-regulation. So far, it is not clear whether mindfulness provides a suitable form of directed attention for all patient populations under all conditions. Here, further empirical research is necessary. We saw that self-regulation repeatedly attempts to recreate particular perceptions, which are compared to reference values or expectancies. This comparison prompts behavior when discrepancies are present. Thus, self-regulation – via behavior – typically tends to generate perceptions conforming to expectancies. Mindfulness prevents this often automatic elicitation of behavioral patterns and directs attention to the original stimulus situation that, effectively, precedes filtering within the information processing sys-

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tem. In this way, mindfulness creates flexibility, a type of discriminative agility to recognize subtle situational differences and diverse options and to utilize them toward one's own ends. The observation of thoughts and emotions without impulsive responding helps to neutralize the pressure exerted by automatic behavioral tendencies. Not only does this open up opportunities for choice, but it also conveys to the person the incisive experience of being the chooser. It makes sense and has been emphasized repeatedly (e.g., HAYES, 2004) that this experience is essential to the healing process of patients who, day after day, feel controlled by their symptoms.

Mindfulness underscores the acceptance of perceptions as well as the necessity for observing and registering without evaluating; "simply" letting them come and go. The procedures of classical cognitive behavior therapy (e.g., BECK & WRIGHT, 1986) are in stark contrast, for they comparably seem like "search-and-destroy" techniques. Indeed, recent evidence suggests that the assumptions fundamental to the model must be revised (TEASDALE, 1999a; 1999b). In particular, the role of the dysfunctional cognitive schemata that are central to the therapeutic efforts of classical cognitive behavior therapy, have become a point of contention. As more findings are arguing against the simple storage of dysfunctional beliefs in memory, one has begun to assume that the activation of specific patterns in the course of self-organizational processes regenerates rather than retrieves dysfunctional beliefs (TEASDALE, 1999a; 1999b).

While the traditional model holds that automatic thoughts and images directly evoke emotions, TEASDALE AND BARNARD'S (1993) model assigns a subordinate role to these thoughts and images. Instead, these authors conceptualize more complex superordinate schemata, so-called "implicational codes," which are able to directly elicit emotions. Implicational codes are specific learned schemata that store the prototypical characteristics of emotion-provoking situations. Bodily sensations also belong to these characteristics. Implicational codes are holistic representations of emotional experiences, rather intuitive with implicit content, such as "Something's wrong," "Trust," "On the right track," "Hopelessness." According to this model, classical cognitive behavior therapy can only achieve an improvement in mood through the modification of negative, automatic thoughts, if the superordinate schema (i.e., the actual elicitor of the mood) has also been changed.

Based upon such findings, the role of "right" or "wrong" thoughts for functional or dysfunctional experience and behavior is clearly relativized. Third-wave therapy approaches help their patients via mindfulness practice to accept their thoughts and feelings for what they are. Overall, more cognitive therapy approaches are emerging that place a greater value on the generation of alternative adaptive states than on the modification of dysfunctional beliefs. MITMANSGRUBER (2003) provides a thorough review of this topic.

The modification of self-regulation would have to address not only the departure from an undesirable state but also the construction of an alternative state if it were to reach a stable regulatory result (CARVER, LAWRENCE, & SCHEIER, 1996). An undesirable state can be left most effectively if one encounters it mindfully, that is without being overtaken by it, and if one moves

toward the new, desirable state. The direction is given by superordinate reference values. For this reason, we work with the person's personal values in SBT (HAUKE, 2004a; 2004b). ACT (HAYES, STROSAHL, & WILSON, 1999) also favors this path.

Mindfulness alone does not replace qualified therapeutic interventions. Learning to be mindful is not easy, neither for patients nor for therapists. It is easier to talk or to write about mindfulness. Some publications in reputable journals evoke the impression that their authors have very little or no experience with mindfulness at all (e.g., Brown & Ryan, 2003). Mindfulness is something "odd" and runs counter to our daily routines. Thus, therapists cannot credibly communicate mindfulness if they themselves cannot draw from their own intensive experience with it.

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Serge K. D. Sulz

From the Symptom as Strategy to Strategic Brief Therapy: Self-regulation and Self-organization as Fundamental Therapeutic Principles

ABSTRACT

Based on Kanfer's self-management therapy and concepts from cybernetics and synergetics, *Strategic Brief Therapy* (SBT) presents a cognitive behavioral approach to treatment that is compatible with other "Third Wave" behavior therapies. SBT is characterized by a strict functional-analytic case conceptualization; a formulation of the client's survival strategy and its subsequent modification; a focus on the emotional significance of intra and interpersonal schemata; and the facilitation of willingness to change. Integrating principles of self-organization and Piaget's developmental theory, SBT understands change as a process of accommodation because assimilation and thus maintenance of the existing mental system have become impossible without the development of symptoms.

Keywords: Strategic Brief Therapy – Self-organization – Control theory – Cybernetics – Synergetics – Self-regulation

1. Introduction

Analogous to Kanfer's self-regulation approach (see KANFER, 1987, 2000, KANFER ET AL., 2006), *Strategic Brief Therapy* (SBT) also builds on self-regulatory concepts. Since SBT's publication in 1994, developments in research and therapy have supported its theoretical and conceptual approach. What seemed at first a risky departure from traditional behavior therapy has become mainstream, as evidenced by SBT's overlap with key assertions of "Third Wave" behavior therapies (e.g., HAYES, STROSAHL, & WILSON, 2004; LINEHAN, 1996).

Kanfer's great accomplishment is his unprecedented and, for decades, singular integration of behavior therapy with cybernetics, i.e., the science of feedback processes. This integration freed him early on from an exclusive reliance on the psychology of learning and enabled him to integrate scientific results from all of psychology. Unfortunately, Kanfer's progressive thinking, which applied cybernetic concepts to behavior therapy and thereby went far beyond his self-management approach, did not resonate with practitioners or researchers for a long time: Behavioral analyses continued to be horizontal. In comparison, the self-regulation approach combines the vertical aspect, i.e. the analysis of organism variables, with a horizontal analysis.

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1.1 Theoretical Foundations

Beck's cognitive model (e.g., WRIGHT & BECK, 1986) is fundamental: Childhood experiences stored within an immature cognitive apparatus result in a self concept and in a worldview that, if not sufficiently modified by later experiences, might produce dysfunctional thought and behavioral patterns in adulthood. Basic assumptions regarding how the world works lead to cognitive schemata, which automatically generate cognitive evaluations in seemingly similar situations. If these evaluations are dysfunctional, a chain reaction of cognitions, emotions, and behavior produces suboptimal results for the respective person. In extreme cases, symptoms develop.

Kanfer's modification of the Stimulus-Organism-Response-Contingency-Consequence (SORCC) model still represents the most recent theoretical development in traditional behavior therapy. It contains KANFERS (1987) expansion of the model by one feed-forward loop (the organism, as a self-regulatory system, affects the perception of the situation and its impact on the person) and two additional feedback loops. The first is the comparison of the response with performance criteria and the second is the corrective feedback delivered in the form of environmental consequences (Figure 1).

Kanfer's dynamic self-regulation model (Kanfer et al., 2006)

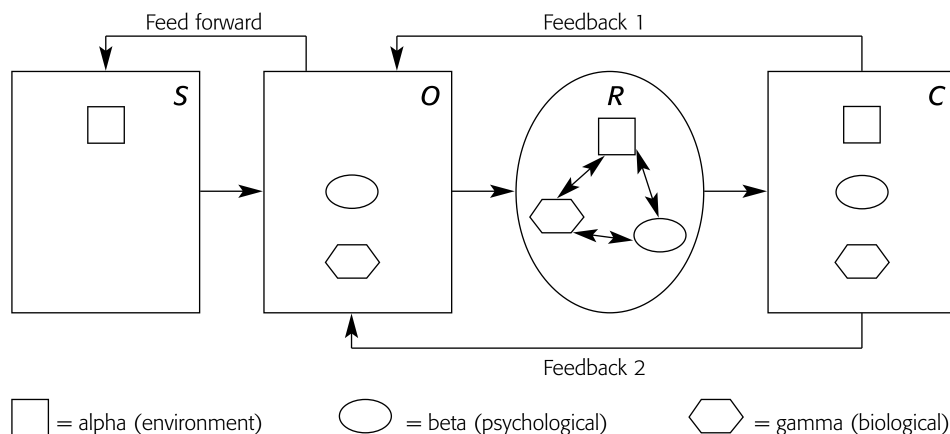

Figure 1: Kanfer's cybernetic model (adapted from Kanfer et al., 2006)

Moreover, the model distinguishes:

- alpha variables (direct influence of the external environment);
- beta variables (moderating influences emerging from self-generated processes, such as thinking, perceiving, remembering, evaluating, and self-generated content, such as statements of goals, intentions, and plans); and
- gamma variables (moderating genetic and biological influences).

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Thus, any situation S consists of alpha variables; any organism O of beta and gamma variables; and any response R (or the behavior B) and any consequence C of alpha, beta, and gamma variables. KANFER (2000) views this model as a cybernetic approach that cannot be accounted for by learning theory alone. However, Kanfer did not link this cybernetic model to the study of psychological motivation or to the plethora of models of human motivational systems. If one considers these, the extensive works of CARVER AND SCHEIER (1985; 1998) and DECI AND RYAN (1991) come to the fore.

Two variants of cybernetics can be distinguished: *Control theory* assumes top-down regulation. Here, a system has its predetermined goal, which becomes the performance criterion referenced by the executive. *Dynamic systems theory*, on the other hand, assumes bottom-up regulation without a specific performance criterion. The properties of all elements and their interaction yield a constant, stable structure, with emergent stability of the behavior of the system and of its elements. Small, unpredictable changes may prompt modifications of the entire system.

1.2 Self-regulation: First-order Cybernetics

As already proposed by Miller, Galanter, & Pilbram's 1960 test-operate-test-exit ("TOTE") model of human behavior, the negative feedback loop constitutes the basic unit in cybernetic control theory.

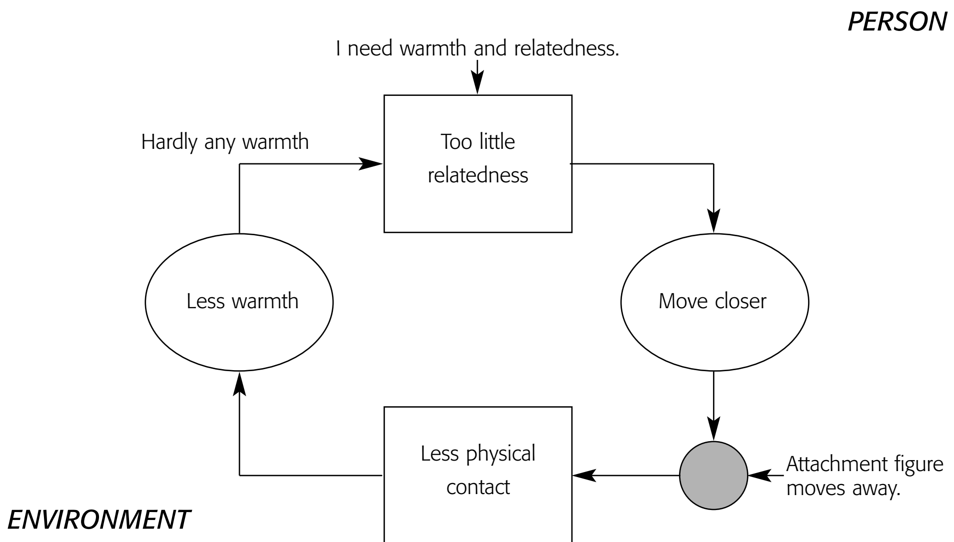

Figure 2: Simple control loop – Generating feelings of relatedness

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A person and his or her attachment figure are in the living room. The attachment figure sits on the couch. The person feels some interpersonal relatedness within the interaction. This perception is compared with an internal reference value for relatedness (Figure 2). The discrepancy between the higher reference value and the current input value generates activation, which results in behavior that produces increased relatedness. The person sits down next to his or her attachment figure. A new input measure is captured and again compared with the reference value. The reference value is still higher. Thus, activation reoccurs, and another behavior is prompted: The person seeks physical contact with the attachment figure. Given the attachment figure's willingness to engage with the person, intense feelings of relatedness arise. The input value meets the reference value, and the activation ceases. This process occurs automatically and does not necessitate conscious contemplation or decision. Only a disruption of this automatic optimization process focuses the attention onto the events. If the attachment figure had been immersed in reading a thriller, the receipt of physical attention might have interrupted him or her. The attachment figure would have moved away and shown his or her irritation. This failure could have resulted in different behavior patterns, all directed toward an increase in relatedness, e.g.:

- Simply repeating past behavior, which might be tolerated later;
- Using a cautious approach, perhaps saying, "Keep on reading while I move closer." If the attachment figure tolerates this more cautious behavior, the activation ceases.

Carver and Scheier (1998) developed a control theory of self-regulation and affect, with an emphasis on goal-oriented behavior. According to their model, the discrepancy between input and reference values yields self-regulating behavior. This monitoring occurs within a feedback and an action loop. When the comparison does not meet expectancies, positive or negative affect as well as active responding ("output") are generated. The authors posit a hierarchical organization of multiple control processes, such that the output of higher levels of the hierarchy produces the reference value for the next lower level. The following levels are distinguished (Figure 3):

System concepts (ideal self)

Principles (attitudes and needs)

Programs (complex actions)

Sequences (components of action)

Motor programs (agility, coordination)

Physiology (e.g., muscle tension)

Figure 3: Hierarchical levels of self-regulation (adapted from Carver & Scheier, 1998)

The higher levels of the hierarchy influence the self-concept more strongly than the lower ones. Barriers produce a disruption of these control processes for expectancies based on past experiences are not met. Auspicious expectancies lead to positive affect, such as joy, enthusiasm, and hope. Expectancies also mobilize efforts to reach the goal. Less promising expectancies produce negative affect, such as anger, worry, or despair and lead to disengagement.

A second posited feedback loop is the "meta-loop" monitoring the functioning and the efficiency of the first feedback loop, which measures the discrepancy between reference and input values. According to the model, only the second feedback loop produces affect. Both loops can have different reference values. If these reference values are high, negative affect arises more frequently. If they are low, positive affect occurs. Temporal pressures and the level of engagement with a particular task also influence affect. If a task is bothersome, for example, completing it as soon as possible may hardly leave any opportunity for positive affect. A potential third feedback loop that functions analogous to mechanical physics (and thus measures distance, velocity, and acceleration) is currently debated. People who disengage from tasks relatively late might become depressed, for they might pursue unobtainable goals. For this reason, disengagement is an important ability. Premature disengagement, on the other hand, prevents success. Consequently, contextually appropriate persistence and change characterize a person's flexibility.
DECI AND RYAN (1991) posit three factors influencing self-regulation: (1) the degree of intrinsic motivation ("What I'm doing is fun"); (2) the degree of extrinsic motivation ("What I'm doing produces positive consequences, such as praise and approval"); and (3) events and contextual conditions related to the external environment. These factors orient the motivational system either toward increased control (heteronomy) or toward increasing autonomy (self-determination). Contextual factors function such that
• rewards increase control and reduce intrinsic motivation;
• threat and pressure increase control and reduce intrinsic motivation;
• evaluation and monitoring increase control and reduce intrinsic motivation;
• choice opportunities increase autonomy and support intrinsic motivation; and
• positive feedback increases both autonomy and control.

Autonomy-supporting events positively influence affect, cognitive activity, creativity, and persistence. In contrast, controlling contexts (parents, teachers) might increase aggression and decrease self-esteem. While controlling factors achieve their goal in the short-term, only autonomy-supporting factors are effective in the long-term. Introjected motivational factors, such as ego involvement, might produce as much pressure and control as external factors. An increasing internalization of goals accompanies the path from unwillingness to commitment, while the progressive integration of regulation begins with an external and leads to an internal attribution of self-regulation. The authors describe empirical studies demonstrating that autonomy-sup-

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porting parental behavior facilitated school children's self-regulation, competence, and scholastic achievement. Parental involvement (in the form of actively supportive engagement) furthered self-regulation, competence, and achievement and reduced academic or acting-out problems. However, the parental provision of structure may lead children to expect external control. Especially minimally self-regulating children may demand heteronomy and penalties (i.e., the setting of boundaries) from their parents.

Norbert Bischof's *Zurich Model of Motivation* provides a heuristic that is relevant for the therapeutic process (BISCHOF, 1985; BISCHOF, 1993; BISCHOF, 1995, BISCHOF, 1996, SCHMID, MAST, & BISCHOF, 1999). He differentiates among four subsystems: Security, arousal, autonomy, and coping (Figure 4).

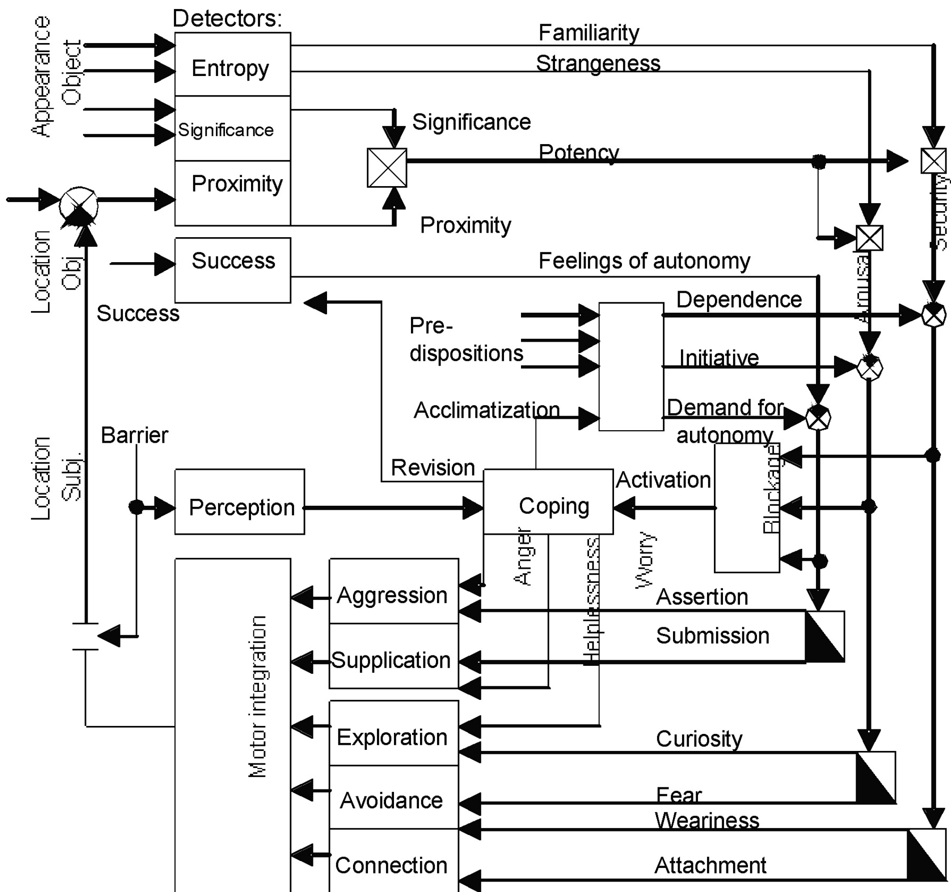

Figure 4: Norbert Bischof's Zurich Model of Self-regulation (1996), modified

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In interpersonal interactions, the *security loop* responds to the familiarity (as correspondence between expectancies and actual events), the significance, and the proximity of another person. A familiar "high-ranking" person, e.g., the parent, provides much security in close proximity. The resulting feeling is compared with the security loop's reference value, which is termed "dependence" by BISCHOF (1996). If this reference value has not been reached, then appetence for dependence, i.e., a need for attachment, develops and the following approach behavior establishes a connection with the person. An overabundance of security produces weariness and therefore may result in aversion. In this situation, avoidance behavior increases interpersonal distance. The security loop quite accurately reflects BOWLBY'S (1975) theory of attachment. It is the earliest motivational system, as evidenced by separation anxiety which emerges approximately during the seventh month of life.

The *arousal loop* responds to strangeness (as novelty, in the sense of a discrepancy between actual events and expectations). Arousal depends upon the significance of the person (characterized by their rank) and their interpersonal proximity. A high-ranking stranger in close proximity can evoke high arousal. This arousal can take the form of curiosity and interest or of threat and anxiety, depending upon the reference value of the arousal loop, which is termed "initiative" and which incorporates aspects such as willingness to take risks and need for variability. If the input does not meet the reference value, appetence for arousal, i.e., curiosity, emerges. Exploration leads to approach of the stranger. Because this approach increases arousal, it is called "general exploration." If the input exceeds the reference value, aversion occurs in the form of anxiety and avoidance. Increasing the distance to the stranger reduces the arousal. If a barrier provides protection, then approach behavior can occur in the context of this protection. This approach behavior, which is in the service of increasing familiarity, is called "specific exploration." The fear of strangers, which is typically observed to begin in the eighth month of life, demonstrates an already functioning arousal loop. This arousal loop is most active in puberty and adolescence, when the activity of the security loop is reduced. Curiosity and anxiety as two poles of the same motivational subsystem characterize the Zurich Model, while other models of motivation posit two independent constructs.

The *autonomy loop* responds to success. Success generates a "condition that connects one's self with dimensions of value, such as power, strength, influence, freedom, prestige, approval, achievement, competence, class, distinction, quality, etc" (Bischof, 1996). This experience of self is confidence, or the attribution of a high social rank or great approval by others. Bischof terms the corresponding reference value "demand for autonomy," which may manifest in a drive for power or dominance, in a need for recognition, in ambition or in the pursuit of self-esteem. If the input does not meet the reference value, e.g., in terms of social influence, the emerging deprivation leads to assertive behavior that might culminate in aggression. If the input exceeds the reference value, then the generated aversion produces submissive behavior (minimizing oneself, being shy or submissive). Supplication in the form of submission in the presence of higher ranking individuals might result. Through the security provided by their parents,

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children's initiative grows. Children explore the world and gain competencies, which increase feelings of autonomy. Basic trust, once developed, generates confidence. Children who experience insufficient security might compensate by decreasing the security loop's reference value through a process termed "acclimatization." Acclimatization also may reduce these individuals' ability to enter or maintain meaningful adult relationships. Bischof terms this constellation the "emergency ego" and compares it to Wilhelm Reich's construct of "character armor" (REICH, 1975). Excessive security or the related blocking of initiative by the caregiver may reduce the demand for autonomy ("milksop"-syndrome). ROTTER'S (1966) "internal locus of control," BANDURA'S (1975) "self-efficacy," and DECI AND RYAN'S (1991) "self-determination" are constructs related to Bischof's autonomy term.
The *coping loop* is activated upon encountering a barrier in the external environment that prevents the above systems from achieving their reference values through automatic behavior without affective engagement. The developing blockage leads to an activation of the coping loop, which brings the process into awareness. For this reason, the coping loop is also called "awareness center," analogously to Freud's ego apparatus. Awareness emerges from affective responding, which Bischof categorizes as anger, helplessness, and worry. Each affective category is tied to its respective coping strategy. Borrowing Piaget's (PIAGET, INHELDER, 1981) terms, Bischof differentiates between three external ("assimilative") and two internal ("accommodative") coping strategies.
The three external coping strategies are conceptualized as follows: Anger leads to aggression, which serves to remove barriers. Helplessness leads to supplication, i.e., to a plea for help. Worry leads to exploration (also termed "invention") to solve the problem. The two internal coping strategies are acclimatization, which adjusts the reference value to reflect what is doable, and revision, which alters the perception of the event by accentuating its positive aspects.
Bischof calls coping strategies that serve to remove barriers "instrumental." "Palliative" coping strategies are more similar to affective states that have cathartic effects but still may work to mobilize other persons' instrumental behavior without entering supplication mode, e.g., escalating to a temper tantrum.
The coping loop is clearly distinguishable from the other three subsystems, given that the latter have innate specific stimuli and specific responses apt for achieving the reference value. The coping loop, on the other hand, is non-specific. Optimal coping might consist of novel behavior or of memories of past mastery. One coping strategy might serve to remove barriers in all three specific subsystems. Thus, learning and conditioning processes play a central role. Idiosyncratic coping styles develop as a function of a person's learning history. While the cognitive coping theory of LAZARUS (1975) focuses on the role of cognitive factors in coping (reevaluation of a situation), Bischof emphasizes motivational and affective processes.

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1.3 Self-organization: Second-order Cybernetics

The modern cybernetic perspective (e.g., VON SCHLIPPE & SCHWEITZER, 1996) emerged from control theory, which focused on the observation of systems as first-order cybernetics and investigated homeostatic and stability-producing processes. Today, dynamic systems theory, as second-order cybernetics, studies the conditions for system change. Here, rather than the maintenance of constancy, the often irreversible transitional phases from one orderly, stable state to a new, reorganized stable state are of interest. MUTARANA AND VARELA (1987) proposed the construct of "autopoiesis" as an internal, autonomous self-organization. While theories of self-regulation also assume that humans are self-regulating beings, i.e., systems that construct and maintain their own reference values, theories of self-organization go beyond self-regulation theories by positing a principal uncertainty of systems. Accordingly, a system is not initially constant (and thus does not have to regain an absolute reference value); instead, it continuously reconstitutes itself as a function of ongoing processes.
We call cybernetic models "systemic" if the social structure rather than the individual forms the unit of investigation. The realization of the autonomy of living systems explains the limited influence of psychotherapy, which may be able to modify a person's psyche to the same extent to which a surgeon may alter a person's body. The acknowledgment of autonomy also implies the circumstance that, in addition to the observed system, the observer also enters into the analytical unit. Our perception constructs reality.

The notion that the perceived world is constructed by us corresponds to constructivism (GLASERFELD, 1981), applied to psychotherapeutic situations by WATZLAWICK (1981) and others. Therapists "are now less of an expert in the subject matter – nobody knows the situation better than the clients themselves. Instead, therapists are experts in the initiation of helpful processes; therapists enable dialogues that describe discrepant constructions of reality and that play with alternatives" (VON SCHLIPPE & SCHWEITZER, 1996, p. 52). Human beings are viewed as complex systems whose behavior cannot be predicted with certainty. It is emphasized that complex systems have to develop clearly defined subsystems to achieve stability (e.g., parental or sibling subsystems). A system's identity is defined by its environmental boundaries. Rather than properties of the observed system, system rules are outcomes of the observational process: An observer attempts to detect and to describe orderly patterns within the behavior of a system's members. Accordingly, psychotherapy places much emphasis on families' implicit, unspoken rules. Prigogine's discovery of dissipative structures that emerge spontaneously from unorganized conditions without the influence of an external ordering principle was crucial (PRIGOGINE & STENGERS, 1981). However, dissipative structures require a continuous exchange with the environment for their stability. Their equilibrium is contingent on communication with the environment. When the discrepancy from equilibrium is large, the smallest initial environmental influence may cause great changes ("butterfly effect"). Therapy may attempt to utilize this effect, e.g., by removing a system from its equilibrium.

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A living being is an operationally closed system, for it cannot be externally governed in a constructive, bottom-up fashion. Nevertheless, two human beings as autopoetic systems may drift together and form structurally coupled dynamical systems through the emergence of co-evolution. They represent meaningful environments to each other, and they serve as sources of perturbations for the coupled systems' dynamics. These perturbations match in that they evoke coordinated patterns of behavior.

LUHMANN (1984) adapted MATURANA AND VARELA'S (1980) biological theory to social systems. He termed social systems "self-referential," characterized by operations aimed at self-generation and self-maintenance. He differentiated three autopoetic systems: Life (biological), consciousness (mental), and communication (social). These operate orthogonally. Biology is not conscious, and consciousness does not communicate. Thus, these three systems may perturb but not systematically influence each other. Each of the three systems is a prerequisite for the others. Consciousness and communication, says Luhmann, share the production of meaning. Perceptions of a complex environment are selected such that they comprise meaning for the system. Meaning is filtered from complex perceptions in accordance with the existing belief system, values, and family rules. VON SCHLIPPE AND SCHWEITZER (1996) pointed to three implications for psychotherapy: (1) Feelings do not communicate. (2) People do not understand each other, principally. (3) Communicative patterns are autonomous from thoughts and emotions. GERGEN'S (1990) theory of social constructivism views human beings as a social or communal construction generated predominantly by language. Not the individual but the communicative space between human beings is the subject of investigation. Reality emerges from the conversation carried on by two or more persons. A monologue, in contrast, is dysfunctional. The plethora of perspectives renders the investigated subject matter itself almost arbitrary; of interest are now the manifold ways in which to view a subject. Systems destabilize when one member or the social environment outgrows it. "Critical transitions" occur and may evoke fear of identity loss. These transitions mobilize attempts of the system to stabilize itself, e.g., through symptom formation by one member who becomes the carrier of the symptom. This symptom, while a solution to the problem, also creates a new problem.

1.4 Synergetics as the Science of Orderly, Self-organized Systems

In contrast to the theories of self-organization described above, synergetics focuses on an individual's self-organization and thus gives a significant impetus to individual therapy. HAKEN (1985), HAKEN AND WUNDERLIN (1991) and HAKEN AND SCHIEPEK (2005) refer to laser beams as an illustrative example for the principle of synergetics. Disorderly, fluctuating gaseous molecules begin to "behave cooperatively" and form the constant laser beam. Particles generate light waves whose newly emergent structure (termed "order parameter") in turn enforces coherent behavior by those particles. The new structures, orders, or stable phases are also called "emergences." They are identifiable constant patterns that correspond to an "attractor." Psychotherapy promotes the transition from one stable state to qualitatively novel stable state,

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i.e., from one attractor to a new attractor. As phase transitions require high energy expenditure, they are emotionally intensive. Existing structures also constrain the possibilities for change. A change is most probable when it fits the structure already in place. GRAWE'S (1998) Chapter 4 of *Psychologische Therapie* [Psychological Therapy] provides a comprehensive account of self-organization in terms of synergetics, surprisingly without mentioning Haken's works once.

1.4.1 Haken and Schiepek's (2005) synergetic model of cognitive process

Haken and Schiepek (2005) first outline cognitive process with a basic diagram (Figure 5).

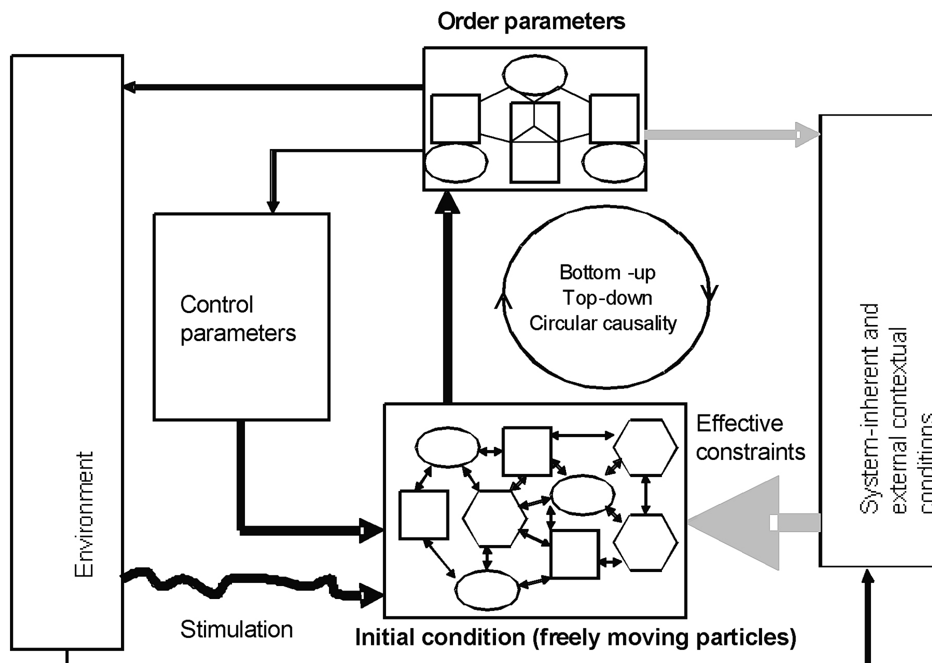

Figure 5: The synergetic model of self-organization, adapted from Haken and Schiepek (2005)

On the relative micro level of analysis, a control parameter produces an energizing excitation of particles, whose interaction results in qualitatively new behavior (emergence) such that a macroscopic pattern indicative of an order parameter is observable at the macro level. By way of a bottom-up/top-down circular causality the order parameter affects the particles that constitute its pattern and enslaves them by enforcing its dynamic. The system itself "selects its control parameters" (HAKEN & SCHIEPEK, 2005).

When considering human mental processes, one has to assume that control parameters are generated internally, within the organism. Events in the external environment set into motion

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internal processes, which evaluate the importance and the meaning of these events and thereby construct information. Top-down effects, e.g., the sensitization of perception, influence these control parameters. Memories, as crystallized system history, modify the probability with which past and novel order parameters occur. Contextual conditions that interact with components, other order parameters, or systems function as constraints. These conditions change more slowly than the order parameters. Thousands of such order parameters exist and perturb each other in a network-like arrangement. Order parameters may also interact to constitute a hierarchically higher level order parameter. Or they may become the control parameters for another order.

> In the long-term, cognitive-affective-behavioral patterns might emerge that are characteristic for and preferred by a particular person. Adopting the metaphor of a potential landscape, these patterns are valleys in a landscape that represents our personality. (HAKEN & SCHIEPEK, 2005, p. 247).

A healthy personality displays stability and flexibility in this regard.

GRAWE (1998) points to the significance of motivational, affective, and interpersonal attractors (order parameters). The formulation of a “dysfunction” attractor may be viewed as his original contribution to perspectives of self-organization in the clinical psychological and psychotherapeutic contexts. His remaining elaborations completely coincide with the synergetic approach described in the preceding paragraphs. According to GRAWE (1998), psychological or psychosomatic symptom development is a consequence of emergence. Symptoms have properties of attractors, i.e., they are functionally autonomous and enslave component parts which in turn constitute the attractor. Symptom formation initially brings about a reduction in the deprivation that led to the attractor’s emergence. Grawe cautions, however, that complete functional autonomy often does not arise because the psychosocial problem situation in which the patient’s symptoms developed might still cause severe deprivation. For this reason, it is the therapist’s task to identify the nature of the deprivation and to aid the patient in reducing the deprivation by other means. In the case of functional autonomy, an intervention specific to the dysfunction – i.e., a symptom-oriented therapy – might promise most success, for it destabilizes the symptom as attractor. To the extent that motivational attractors form the symptom’s control parameters, explicatory procedures are indicated, which may also involve a review of childhood and adolescence. Nevertheless, the consideration of past events would be necessary only inasmuch as they still may affect current motives, emotions, and relationships. In this respect, the therapy would have a present and future orientation rather than a focus on past events (GRAWE, 1998, p. 525).

While self-regulation theories posit that any therapy’s goal is the recapitulation of a stable system state and investigate how a system returns to homeostasis, self-organization theories examine the factors that lead to instability and the processes involved in phase transitions that

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result in new equilibriums. One might conclude that these theoretical approaches are complementary and that both types of system processes are operative (CARVER, 2004). However, complementarity implies that the human brain is equipped to handle both forms of regulation and incorporate both regulatory principles. In any case, we cannot deny the existence of self-regulation given the multitude of examples from biology (e.g., the countless reference values that must be maintained within a small range if a person is to stay alive, such as blood pressure, body temperature, blood sugar level, the blood's oxygen content, etc.). If we observed an individual throughout his or her lifetime, then we would find top-down self-regulation with the goal to maintain or to restore physiological and biochemical reference values as the dominant regulatory principle. With regard to mental processes, however, we are inclined to apply the principle of bottom-up self-organization to important areas, such as childhood and adolescence or to family systems development, and also to personality changes and to the emergence of psychological and psychosomatic symptoms.

Self-regulation and also self-organization theories provide an important impetus for *Strategic Brief Therapy,* extending from BECK'S (1967) and KANFER'S (2000) simple models to the self-organization and constructivism approaches.

1.5 The Neurobiology of Affective and Cognitive Self-regulation

Self-regulation and self-organization approaches are only secondarily concerned with emotions and sensations. For the latter, the work of EDELMAN (1987) is essential: He described "reentrant mapping" of neurons, a recursive dynamic process that results in the emergence of groups of neurons whose activity has been synchronized. In the therapeutic process, emotions play an extraordinary role. Their meaning is best understood considering neurobiological research. Especially the publications of LEDOUX (1996) and DAMASIO (2003) establish the scientific basis for therapeutic work with emotions, as practiced currently in cognitive behavioral therapies (for example, SULZ & LENZ, 2000; SULZ, 2002, 2004a, 2004b).

1.5.1 Emotions

ROTH (2001) noted that, without access to the emotional evaluation component of the limbic system, we could not manage our lives and our relationships – even if we had the greatest intelligence and analytic-logical cognitive capacity. Furthermore, he pointed out that our emotional evaluations, albeit momentarily conscious, find their essential role in the unconscious control of experience and behavior.

DAMASIO (1995; 2000; 2003; see also DAMASIO ET AL., 2000) differentiates between emotions and feelings. The former are physiological events and thus mostly observable. The latter are always covert, for they represent an intrapsychic mental state. "Emotions play out in the theater of the body. Feelings play out in the theater of the mind" (DAMASIO, 2003, p. 38). Temporally, emotions occur before feeling. Emotions are aspects of the human automatic

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homeostatic bio-regulation system necessary for survival, and they govern the following dimensions: Approach versus avoidance; increase of activity (arousal) versus decrease (calm, quiet); and, on a higher level, competition versus cooperation.

In the course of development, the following stages can be discerned: Basic reflexes, immune responses, pain and appetitive behavior, drives and motivation, emotions and, beyond those, feelings.

Damasio distinguishes three types of emotions: background emotions, primary emotions, and social (secondary) emotions. Mood differs from background emotions in its extended temporal duration, i.e., persistent background emotions combined with primary emotions generate mood. Background emotions themselves are most closely described by the term "state." Although they are not generally conscious, attending to them specifically enables their perception as well as their description. The primary emotions (fear, anger, disgust, surprise, sadness, happiness) are conspicuous. They are triggered by similar events across cultures. The social emotions (empathy, embarrassment, shame, guilt, pride, jealousy, envy, gratefulness, admiration, indignation, contempt) are genetically predisposed, but their expression depends upon social learning. HINDE (1989) showed that a young monkey's innate fear of snakes only manifested itself once fear hade been noticed in the mother's face. One trial sufficed.

The following brain structures are involved in the release of emotion, without being the location of the emotional response *per se*: amygdala, ventromedial prefrontal cortex, forebrain supplementary motor area, and cingulate gyrus. Damage to the ventromedial prefrontal regions impairs social emotional responding (BECHERA ET AL., 1996; 2000).

While the regions described above are associated with the release of emotions, the following areas correlate with their occurrence: the hypothalamus, the basal frontal lobes and nuclei in the midbrain tegmentum. The hypothalamus emits peptides that act upon the brain directly or indirectly through circulation. Thus, the hypothalamus causes the release of oxytocin and vasopressin from the posterior pituitary gland before social attachment or parental behaviors occur. Behaviors associated with extrinsic reward or intrinsic pleasure correlate with the release of dopamine from neurons in the mesolimbic dopamine system, which originate in the ventral tegmental area and project to dorsal structures of the basal forebrain, particularly the nucleus accumbens shell region (PANKSEPP, 1998). Following the increased dopamine concentration in these basal forebrain regions, a physical state corresponding to the emotion is generated and mapped in somatosensory brain areas. This chain reaction is, however, subject to many modifications. Activated memories may evoke competing or amplifying emotions, for example.

In this context, the characteristics of a case involving a 65-year-old woman with Parkinson's disease are especially striking. As she continued to show severe rigidity, severe akinesia, and moderate tremor despite treatment with levodopa and other drugs, continuous high-frequency stimulation of the subthalamic nuclei via four implanted electrodes was introduced. During the systematic post-surgical testing of each implanted electrode and its effects on the woman's Parkinsonian symptoms, it was found that activation of the electrode implanted in the central

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substantia nigra evoked emotions and behavior consistent with transient acute depression: crying, verbal communication of fatigue and loss of energy, sadness, guilt, hopelessness, and worthlessness (BEJJANI ET AL., 1999). The events could be temporally sequenced into the appearance of conspicuous emotions, then depressed feelings, and finally depressed thoughts. The transient depressed responding disappeared within 90 s upon termination of the stimulation. Throughout experimental testing, the patient was not aware whether the onset of stimulation actually occurred at all, or whether the stimulation was effected by another electrode. In either case, the simulated onset or the onset of another electrode did not lead to the same depressive response. Positron emission tomography detected a significant increase in blood flow in the right parietal lobe, a region involved in the mapping of physical states. DAMASIO (2000) suspects that the periaqueductal grey was involved as well.

The electrical stimulation of the supplementary motor area (SMA) of the left frontal lobe produced similar findings with epilepsy patients, namely spontaneous laughter. Subsequent to stimulation, feelings of cheerfulness and hilarity arose. Lesions in the SMA and anterior cingulate gyrus prevent *spontaneous laughter*, while *crying* is inhibited by damage in the ventral prefrontal area (FRIED ET AL., 1998). In contrast, a stroke patient with five identifiable lesions in the cerebro-ponto-cerebellar pathways engaged in spontaneous, uncontrollable episodes of crying and laughter. These areas seem to contribute to the control of emotional responding (PARVIZI ET AL., 2001).

1.5.2 Feelings

Based on this extensive body of evidence, DAMASIO (1995; 2000; 2003) has developed a "body-feeling-theory" to be outlined below. He defines "feeling" as the "the mental representation of parts of the body or of the whole body as operating in a certain manner" (DAMASIO, 2003) and continues by asserting that

> [F]eeling, in the pure and narrow sense of the word, was *the idea of the body being in a certain way* [….] [Feelings] translate the ongoing life state in the language of the mind [….] Feelings are perceptions, and I propose that the most necessary support for their perception occurs in the *brain's body maps*. (DAMASIO, 2003, pp. 103-104)

Damasio summarizes these statements in a provisional definition: "[…] *a feeling is the perception of a certain state of the body along with the perception of a certain mode of thinking and of thoughts with certain themes*" (p. 103, original emphasis). Each local bodily sensation does not enter into consciousness; instead, perception is a "composite" (p. 104). "Perceiving the body in whatever way requires sensory maps in which neural patterns are instantiated and out of which mental images can be derived" (p. 107).

DAMASIO ET AL. (2000) studied the brain areas activated by remembering intensive events that had evoked joy, sadness, fear, or anger and by reenacting these feelings. Via positron emission tomography (PET), they measured differences in the amount of blood flow in the cingulate cor-

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tex, the somatosensory cortices of insula and SII, and nuclei in the brain stem tegmentum, and found that emotional responding correlated with changes in the neural mapping of the physiological state. Changes in skin conductance reliably preceded the hand signals with which participants reported the occurrence of the respective feeling.

If a feeling, e.g., joy, is so intensive that it sends shivers down one's spine, or produces chills or thrills, one may assume that its respective physiological signals are especially pronounced. BLOOD AND ZATORRE (2001) investigated such intensive physiological responses as a result of listening to music. They discovered clear activities in the somatosensory areas of insula and the anterior gyrus. These correlated with regional cerebral blood flow increases in the right orbitofrontal cortex and in the left ventral striatum. At the same time, the activity of the right amygdala was reduced. This and many other recent studies provide evidence for the important role of the insula in the perception of emotions.
In the meantime, it has also been shown that peripheral nerve fibers that carry information from the internal body to the brain terminate in the insula and not in the primary somatosensory cortex, as does the haptic sense.

The insula receives numerous diverse physiological signals that correlate with emotions, such as pain, heat flushes, chills, thrills, shivers, sexual sensations, the state of the smooth muscle within blood vessels and inner organs, pH-values, osmolality, or inflammatory processes (DAMASIO, 2003). Importantly, a feeling does not depend on the actual physiological state but on the actual *neural mapping* of a physiological state, *which might be simulated,* e.g., pain. According to DAMASIO (2003), hysterical, conversion, and somatoform syndromes run their course in an analogue fashion.

Feelings of empathy also are produced by an "as-if-body-loop," i.e., by emotional simulation in the brain. ADOLPHS ET AL. (2000) investigated whether patients with lesions in the somatosensory areas were capable of empathy. The researchers compared these patients with healthy controls and persons who had lesions in their visual association area. Patients with lesions of the right visual area of the ventral occipito-temporal region were not able to perceive the facial configuration as a whole or to label the corresponding feeling. Lesions of the right somatosensory cortices, particularly insula, SII and SI, correlated with reduced empathy. These areas are involved in the integrated body mapping of physiological states. "[…] In the absence of this region, it is not possible for the brain to simulate other body states effectively. The brain lacks the playground where variations on the body-state theme can be played" (DAMASIO, 2003, p. 140). DAMASIO (2003) speculates that the limitation of the effect of to the right hemisphere might stem from the dominance of language and speech-related activities in corresponding areas of the left hemisphere. He describes a study by DIMBERG ET AL. (2000, cited in DAMASIO, 2003), that showed that healthy participants – as soon as they started viewing a photo –

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unconsciously activated those facial muscles required for imitating the facial expression seen in that photo. Electrodes measured and recorded the respective muscle activation.

Lesions of brain areas that correlate with feelings and emotions bring about changes in social behavior and even drastic alterations in one's personality:

- Deciding who is trustworthy;
- Evaluating the appropriateness of social behavior;
- Lack of empathy;
- Social emotions, such as shame, pity, and guilt, etc., are severely reduced;

Particularly damage of the ventromedial prefrontal cortex, but also of the parietal areas of the right hemisphere – albeit to a smaller extent, may produce these changes in the presence of intact cognitive capabilities.

Feelings are necessary for moral and ethical conduct, which cannot result from reason alone. Even more evidence comes from comparative behavioral research. Thus, vampire mice and ravens can discover and punish cheaters. Rhesus monkeys forego food for days if feeding produces an electrical shock that is received by another rhesus monkey (MILLER, 1967). Cohabitation requires cooperation, which is aided by social feelings, such as justice and honor. Displays of dominance and subordination also contribute to social regulation.

Referring to the difference between unconscious emotions and conscious feelings, DAMASIO (2003) notes that unconscious emotions do not suffice for the regulation of social behavior. The neural mapping of emotional physiological states is required, and so is the transformation of these mappings into conscious mental events in the form of feelings. Regarding the relationship between body and mind, DAMASIO (2003) writes that "the mind arises from or in a brain situated within a body-proper with which it interacts; that due to the mediation of the brain, the mind is grounded in the body-proper; that the mind has prevailed in evolution because it helps maintain the body-proper; and that the mind arises from or in biological tissue – nerve cells – that share the same characteristics that define other living tissues in the body-proper" (p. 202).

1.5.3. The Mind is our Memory

Is the mind without memory like a computer without software, like a motor without fuel, like a lake without water, like a tree without sap? Or like software without a computer, like fuel without a motor, like water without a lake, sap without a tree? It is possible to view the contents of memory as an emerging structure of the mind, or as the essential material worked upon by the mind at any moment. Are the contents of our memory like books in our private library? Does our library employ a sometimes pert, sometimes helpful reference librarian who incessantly researches a few books or passages related to each event occurring at any moment in

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time? Does the librarian deliver these references in such a lively fashion that they permeate our consciousness and seem as real as our current perceptions of the actual external and internal worlds? Yes, that we confuse our memories with the stimulation provided by our current external and internal worlds, and that our consciousness and our perceptions consist of a hodgepodge of memories and current sensations? These or similar analogies and conclusions come to mind when reviewing memory research (e.g., PRITZEL ET AL., 2003).

Associatively connecting the contents of memory and retrieving them via associative similarities with present information are essential aspects of our brain's functioning. Clinical observations of patients with circumscribed lesions in various areas of the brain show the brain's indispensability for our experience of self and environment: A woman could not recognize her mirror image anymore. A man lost his episodic memory and thus his personality. A person's being, his or her thoughts, feelings, and behavior, and also the person's view of him or herself is completely dependent upon memories. Memories generate continuity in the stream of consciousness that is our identity.

Our thinking and our remembering are mainly non-verbal activities. In the same manner in which perceptual images are constructed, images of memory arise – images that consist of past situations and of us as mind-body beings within them. Therefore, memories are the embodiment of our past. Each memory also involves the spatial mapping of our body within the remembered scene, the specific physiological state perceived proprioceptively and interoceptively, and the body that moved and acted. The physical memory contains our past feeling and thinking as well as the entire meaning of the situation. It is the key to our past. Our current body is our memory. As we walk and stand, as our body assumes a position and alters it, our body is the product of our history. Thus, we could say that our memory more strongly determines our body's present state and present responses than currently ongoing events in the external environment. Neuroscience corroborates this circumstance, which is common knowledge among body therapists, with numerous clinical observations and systematic investigations (DAMASIO, 1995; 2000; 2003, ADOLPHS 1999).

1.5.4. The Body as an Essential Medium for Experiencing, Remembering, and Behaving

DAMASIO (1995) and also LEDOUX (1996) differentiate between the primary, innate emotions of all vital, egocentric human beings and the secondary intra-familial and socio-culturally transmitted emotions acquired on an individual basis. Emotions are registered within the mind and become conscious when they engender a characteristic physiological state, which may be pleasant or unpleasant, and thereby enhance the emotional meaning of an object (e.g., a real event, a memory, or a fantasy/an idea). The emotion emerges from a comparison of these events, memories, or fantasies with their utility for the mind, i.e., for the organism (needs, values, preferences). The co-occurrence of the object and of the physiological state associatively marks the object in memory. DAMASIO (1995) termed this phenomenon "somatic marker" (Table 1, Figure 6). It is a component of secondary emotions.

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Table 1: Damasio's Theory of Feeling
- **Primary, innate emotions** use neural networks including amygdala, hypothalamus, anterior cingulate gyrus, basal forebrain, and brain stem;
- **Secondary, learned emotions** also include the prefrontal and somatosensory cortices;
- **Somatic markers** are physiological sensations that arise from the body's responses to the processes of decision-making and contemplating a course of action;
- The **mental anticipation** of an action encompasses its course as well as its immediate effects and later consequences;
- The **emotional consequences of one's actions** evoke in turn physical responses that may be pleasant or unpleasant.
- **Pleasant** somatic markers are incentives for action.
- **Unpleasant** somatic markers inhibit action.
- The **ventromedial prefrontal cortex** transmits the information gathered from the mental decision-making process to the somatosensory cortex and the **insula**.
- The somatosensory cortex and the insula provide feedback from comparing past and anticipated physiological states in an **as-if-loop**.
- This feedback also comprises emotional and autonomous-vegetative emotion information from the amygdala.
- This feedback considers cognitive information and adjusts it to reflect the respective processing results.
- A decision for goal-directed action emerges, whose emotional consequences were evaluated in advance by the feedback from somatic markers.

This cortical process occurs in the prefrontal cortex, which contains areas that generate a detailed mapping of various mental and physiological processes. The areas receive the information from the limbic system and the primary and secondary cortical fields. Moreover, similarly to the hypothalamus regulating the physiological homeostasis, the prefrontal cortex contains the criteria for the homeostatic optimizing of one's personal life based on various pleasant and unpleasant life experiences so far. The locations for this superordinate processing are convergence zones, which integrate representations from the sensory-specific areas. Knowledge of objects in the external world is gathered in the dorsolateral frontal cortex, knowledge of one's own body and one's social embeddedness is integrated in the ventromedial prefrontal cortex. Especially in the latter, a three-fold connection occurs: Among situations, physiological states, and their effectors (DAMASIO, 1995).

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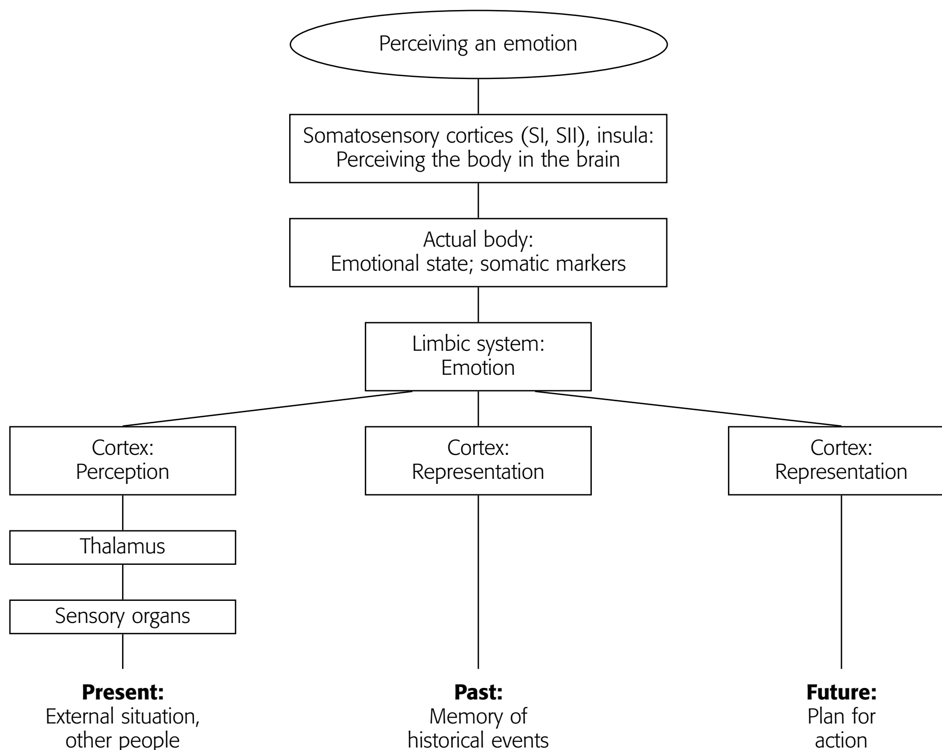

Figure 6: Present, past, and future, and the "body in the brain" as the basis for the perception of emotions

DAMASIO (1995) differentiates two types of somatic markers:

a) Somatic markers that involve the body and the receipt of actual physiological signals in the brain;

b) Somatic markers that do not involve the body or physiological signals to the brain.

The latter constitutes an *as-if-activity pattern* in the prefrontal cortex. The physiological responses are played out in the brain, for example while anticipating the consequences of an impulse for action (see Figure 4). This symbolic activity is an intelligent and economical process of the mind. However, if the evoked associations originate in childhood and belong to a completely different subject-object-interaction than would be appropriate for an adult in the present situation, then we arrive at topics that are relevant to psychotherapy.

The body may be viewed as an essential supplier of information required to evaluate the meaning of objects and events in the external environment. "If ensuring survival of the body is

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what the brain first evolved for, then, when minded brains appeared, they began by minding the body. And to ensure body survival as effectively as possible, nature, I suggest, stumbled on a highly effective solution: *representing the outside world in terms of modifications it causes in the body proper*, that is, representing the environment by modifying the primordial representations of the body proper whenever an interaction between organism and environment takes place" (DAMASIO, 1995, p. 306). The mapping of biochemical, visceral aspects is as much subject to these modifications as the mapping of the motor apparatus and the skin, which occurs in the somatosensory cortical fields SI and SII as well as in the insula.

The insula is part of the cortex. It is located lateral of the capsula externa and the nucleus lentiformis and hidden from view by the temporal and the parietal lobes. The insula integrates mappings of physiological signals into a coherent body image, which is incorporated into conscious self-awareness. Inner images are not static, but as "movie-in-the-brain" may simulate the past, the present, and the future along with the initial conditions and consequences for actions. Emotional and "as-if" physical states result and lead to consciously pleasant or unpleasant feelings, which in turn provide the basis for decision-making.

At the same time that the body perceives stimulation, it is also perceived as a perceiving entity with all modifications it might sustain during perception. According to DAMASIO (2000), the brain receives a two-fold message: on the one hand, there is the content of sensation, i.e., information about the object – seen, tasted, or heard, for example. On the other hand, each impinging stimulus also generates a physical signal containing information about the body and its sensations during the interaction with the object. This circumstance is intuitive in the case of tactile sensation via the skin, but it also applies to hearing and seeing: The seeing and the sensation that one's eyes do the seeing. This second message, however, is not conscious (i.e., we are not conscious of our bodies) and remains in the background.

In this regard, not only sensory signals are of importance. Signals about motor actions, the movement of our body in space, within the external environment, are added. Thus, mappings of the moving body combine with the sensory representations of the body to generate the perception of "self." This self-perception facilitates the reconstruction of the currently held notion of identity from moment to moment. Memories of physical experiences, which represent past encounters with the external environment as well as future intentions and plans as "memory for a possible future," form our notions of identity and self, and thus of our subjectivity. These notions arise from the convergence zones of the prefrontal cortex. Although perturbed by and reconstructed upon each new perception, these notions remain constant over long periods of time. They comprise images of the object and of the self as it interacts with the object. These notions do not require language. The respective narratives can be "told" without them.

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1.5.5. The Significance of Imitation

Recent research results suggest that the traditional separation of perceptual and motor aspects be abandoned. Both motor and sensory apparatuses are necessary to turn a stimulus into a perception. "We see with our hands, arms, and legs" (Bekkering et al., 2000). Early studies of imitation or observational learning showed that the physical goal of an action, rather than the observed, potentially faulty movement or execution of an action was learned. According to the ideomotor principle, the physical goal of a particular action is represented first, followed by the anticipation of the action's consequences (Bekkering et al., 2000). In this context, the discovery of *mirror neurons* by Rizolatti et al. (1999) was groundbreaking. Their studies of macaque monkeys showed that some motor neurons fired particularly rapidly when the monkeys observed another monkey's or a human's behavior to be imitated subsequently. The behavior consisted of reaching for a nut. This effect also occurred when the model's behavior was partially occluded by a movable wall. Because these neurons are in proximity to the Broca speech area, they are presumed to be significant for human speech and language. The imitation of other people's verbal behavior is a central component of early childhood language acquisition. Additionally, it stands to reason that mother-infant-interactions are essentially based on the activity of mirror neurons of the mother and the child (Bauer, 2002). Thus, the quick responses within the cycles of mother-infant interactions, whose facially expressive, vocal, and tactual characteristics match the infant's ability to respond, may also be understood from a neurobiological perspective. Rizzolatti and colleagues point to the central significance of mirror neurons for understanding other people's behavior. Their "direct matching hypothesis" predicts that another person's behavior is understood when it evoked a resonance in the observer's motor system. This mechanism utilizes the observer's "motor knowledge." Recent empirical findings suggest that this process also may be involved when an observer shows empathy, e.g., when watching aggressive behavior toward others (Carr et al., 2003). However, the limbic system and the insula play dominant roles in this case.

1.5.6. The Body as the Theater for Emotion and Consciousness

Neuroscience suggests that the body is the orchestra employed by the mind to express our emotionality. At the same time, the body is also the stage on which our emotions dance and sing. Without a body, there would be no emotions. We perceive the dancers, singers, and musicians as our feelings. Of course, our mind orders our body to assume states that correspond to the feelings and to proceed accordingly, just like the conductor commands the musicians, the choreographer the dancers, and the director the actors. There is nothing to see or to hear without the actors on stage. Our mind is observer and listener at the same time, deeply impressionable by music, dance, and play. It is held captive by the commotion on stage and remembers it well. This immersion into the world of emotions colors most of the mind's experience and state. If the mind's eye turns to the second theater, i.e., the external environment that evoked the emotions, then it has no primary influence on its dramaturgy. However, the exter-

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nal drama is experienced differently when the mind is equipped with a firm evaluation of its emotions; it can judge the relevance of particular persons and their behavior based on these feelings. The mind designs a plan for behavior in the improvisational theater of the external world. The idea for this plan originates in the box that stores the costumes for different roles. Some roles are suggested by the emotional significance of the situation. When a role is chosen, it is the one that has garnered the greatest success in all previous performances. At rehearsal, the planned performance is acted out mentally; the mental scenario is internally experienced as if it were reality. The theater of emotions aids this process. The idea to behave in a certain way induces the body to act, to dance, to sing, and to play its musical instruments. Physiological states and activities generate emotions that are perceived by the mind and that, as somatic markers, transmit a clear message recommending acceptance or rejection of the rehearsed role. If pleasant feelings arise from the rehearsal, they motivate action; unpleasant feelings generate avoidance of the behavior. If avoidance is not possible, then the behavioral engagement is hesitant or halfhearted, and its positive effects are reduced accordingly.
The body's central significance in the here and now also implies that a person's most important experiences from birth to present day are stored mostly as physical memories, i.e., that implicit as well as explicit episodic memory is physical to a large extent. If experiences are not verbally anchored, their memory traces cannot be retrieved via the cognitive-verbal top-down pathway. They must be prompted in a bottom-up fashion. Here, the therapy room is a third theater that presents opportunities for the body to position itself, to move, and to relate, and thereby to recognize and remember earlier scenes and relationship patterns. Body therapists know that such recognition often begins with an intensely painful feeling followed by the memory of the associated childhood event. After the client has reached this point, body therapists use different procedures. Regardless of method, in this moment, the therapist's physical, protective, and supportive presence provides a correcting emotional experience that is the first component step in the healing process. The temporal contiguity of painful remembering and benevolent companionship ensures that the memory trace, which had been destabilized in the process of remembering, is not returned to memory as exclusively negative (see above). If the awareness of any child's right to the satisfaction of his or her needs supersedes self-blame for past events and is experienced physically in the here and now, then this painful childhood memory does not continue to distort the adult's self-esteem to quite the same extent.

2. Strategic Brief Therapy (SBT): A System-theoretical Approach

A focus on strategies and goals seems to be a genuine characteristic of behavioral and cognitive therapies. Indeed, both terms are mentioned frequently. Cognitive behavioral therapies have long left the exclusive footing of learning theory and now build upon all areas of scientific psychology and the neurosciences (Grawe, 1998; 2004). Practitioners exert a large, innovative force as well. They attend schools of therapy, apply scientific trends in their practice, and

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on a daily basis learn from their patients about the workings of the human mind. For this reason, primarily practitioners summon strong integrative forces that result in convergent developments, well-described by the heuristic of self-organization. The common denominator among practitioners seems to be a distillate of the most important scientific findings, tenets from the most important schools of therapy, and the individual experiences of practicing psychotherapists. SBT emerged and continues to evolve through a similar process.

2.1 An Affective-cognitive Developmental Systems Theory of Psychological Disorders

An affective-cognitive developmental systems theory of psychological disorders (SULZ, 1994; 1998; 2003):

a) explicitly contains a theory that underlies cognitive and behavioral therapy;
b) has at its core a child's emotional development during the preschool years;
c) articulates as goals the development of the self and its central relationships, and simultaneously constitutes a theory for disorders and therapy.

2.1.1 Assumptions

Three assumptions are:

1. The human mind autonomously regulates human sensation, perception, affect, cognition, and behavior according to *homeostatic principles* (self-regulation and self-organization) (see also SULZ, 1987; BISCHOF, 1995). "Autonomous" means that consciousness, as "capricious mind," has no governing influence on self-regulation (KANFER ET AL., 2006; see also SULZ, 1986) but only provides a reference value within this control system according to cybernetics. Behavioral goals are not only a function of reference values generated by the output of superordinate regulatory levels, but also of new order parameters established in a bottom-up process involving the coaction of lower system levels.
2. The development of emotions (PIAGET & INHELDER, 1981) and interpersonal relationships (KEGAN, 1986) is a *lifelong process* that is inherent to human beings. Although large developmental changes transpire primarily in preadolescence, especially during the preschool years, the developmental process can be resumed anytime, through psychotherapy for example (SULZ 1994; 1998). Development from one stage to the next occurs in accordance with the laws of self-organization. The order parameter changes; a new attractor emerges.
3. Life and relationship formation follows the *principle of construction* and self-organization rather than the principle of causality. This is the hypothesis of constructivism according to the Palo Alto School (WATZLAWICK, WEAKLAND, & FISCH, 1979). Strictly speaking, the homeostatic principle already applies this assumption in the sense of goal-directedness, instrumentality, and functionality (SULZ, 2000). The self-organization of subordinate components of the mind, however, leads to the emergence of new order parameters, which also construct the social external environment.

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2.1.1.1 The Assumption of Homeostasis

During the first three years of life, human self-regulation functions as a *"psychosomatic" homeostasis*, based on the primacy of somatic and then of psychological survival as well. The child adopts a survival strategy of intermediate duration: "I have to make it through my childhood passably safe and sound." This implies that any severe disadvantages that might arise from this strategy in adulthood must be accepted. Adult psychotherapy deals with the disadvantages associated with the successful survival strategies of childhood. Nevertheless, these survival strategies may have produced formidable advantages during the individual adult's life as well; and there are certainly more than a few people who enjoy a preponderance of advantages – perhaps throughout their lives, perhaps until early retirement from a professional sports career, or until the midlife crisis of the careerist who never had a breakthrough, or until retirement of the professionally really successful person.

One of the major degradations of the childhood homeostasis results from being forced into a *"psychosocial" homeostasis* and thus into the primary regulation of the social environment's (i.e., parents' and family's) wellbeing and contentment at an early age, when children's cognition and behavior may not yet be prepared to accomplish the task. For this reason, children may have to resort to aversive emotions, such as fear, guilt, shame, or disgust to regulate their own behavior, not for their own good but for the good of the social environment.

An example: A mother was not intuitively sensitive to her one-year-old daughter's needs for protection and shelter and left the child to her own devices precariously frequently and for unmanageable durations. To meet her own social needs, the daughter was forced to develop an extraordinary sensitivity to her mother's and subsequently others' needs for affiliation. Moreover, as soon as her development permitted, she learned to quickly generate intense emotional encounters within conversations, which appealed to her conversational partners. This survival strategy worked: Being alone was successfully avoided as often as possible. Only in adulthood, agoraphobia with panic emerged. The woman's excellent childhood survival strategy had the disadvantage that she never had to experience being alone. For this reason, her self-concept was never corrected to include that she was very well capable of being alone. SBT provides experiences that result in a permanent correction of the self-concept.

Figure 7 shows the Strategic Model of Self-regulation. An individual's perception of encounters with others results in a comparison of the discrepancy between actual and reference values on the system level. Thus, one's own expectancies in the respective situation and with regard to the respective human beings, as well as one's anticipations based on prior experiences, are assessed and updated. This assessment activates motivational schemata differentiated as follows: Anxious expectancies are realized as core fears, which activate situational schemata that offer a range of escape and avoidance maneuvers. If past experiences have led to an associa-

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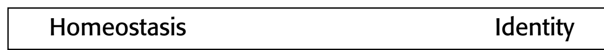
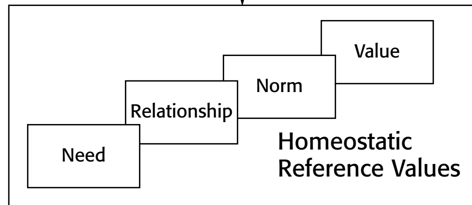
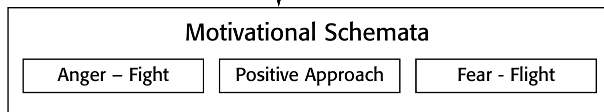
1. System concepts



2. Principles



3. Programs



4.-6. Sequences, motor programs, physiology

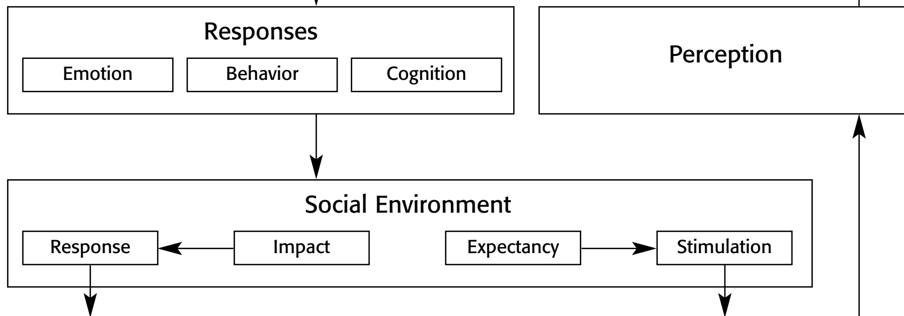


Figure 7: Strategic model of self-regulation (adapted from Sulz, 2000)

tion of anger with the situation or the person, then schemata are activated that might lead to aggressive behavior. If need fulfillment is expected in a specific situation or from a specific person, then a schema that leads to positive approach becomes active. Whether a fourth schema, namely a conflicted one, is activated instead of these three schema types, as postulated by GRAWE (1998), or whether conflicting schemata are simultaneously active, remains to be seen.

The next step consists of responding in the context of the specific situation. Cognitive, affective, and behavioral properties or physiological correlates of responding may be assessed. We may also describe the purpose of responding as managing needs, fear, anger, values, relationships,

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or situations and thereby include the motive in our assessment. Alternatively, we could consider the functionality of responding and evaluate whether it is functional or dysfunctional.

The behavior impacts fellow human beings in the social environment, and they engage in responses which are in turn perceived again by the actor. These responses of the social environment are the consequences produced by instrumental behavior. That behavior may have been effective, i.e., it resulted in the intended satisfaction of needs, the avoidance of a threatening event, or the abreaction of anger. However, it may be the case that conflicting schemata led to ineffective behavior. Thus, because of persisting anger, a grudge, or fear of the person, the positive approach behavior may have been half-hearted. Alternatively, a "fight"-response may have been inhibited by feelings of liking for the other person, which may have dammed the release of anger. Fear of the person also may have thwarted fight responses or rendered them ineffective.

The environment does not only respond. It also demands actions; wishes or fulfills wishes; challenges or meets challenges; threatens or feels threatened; attacks or is attacked by a third party; protects or requires protection; gives or wants to receive; loves or wants to be loved. The stimulation provided by an active social environment is perceived, and the process described in the preceding paragraphs is repeated. We can assume that schemata optimize the process of perception, for they enable a fast categorization of a particular situation even before our higher cognitive functions have captured the situation via cerebral activity. Often, the recognition of the situation is not even processed by the cerebrum: We are not aware that a particular person is as subtly dominant and disrespectful as a problematic person in our history, for example. Even before the particular person says something, we cannot help but adopt a certain defensive stance that now actually makes room for dominant and disrespectful behavior. Thus, in the sense of a self-fulfilling prophecy, our perception frequently produces behavior that harms us. This pattern can also explain a person's repeated victimization. Surely, the opposite happens, too: Our perception prompts a benevolent and inviting stance (which is generated and maintained without our awareness) that opens the door for the other person's genuine approach.

2.1.1.2. The Assumptions of Developmental Theory

Piaget's stage model of emotional development (PIAGET & INHELDER, 1981) provides an excellent additional foundation for SBT. Its basic assumptions correspond most closely to those inherent in the self-organization principle. The highly disputed model of stepwise development gains new support from the theory of self-organization: Although control parameters exert a gradually increasing effect, this graduated effect remains unobservable until, suddenly, a qualitative shift occurs and a new order parameter emerges. Exactly this process is described by a stage model of development. KEGAN'S (1986) conceptualization clarifies that each stage rep-

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resents a developmental plateau with relative emotional stability. If reaching a particular plateau is associated with the termination of a severe crisis, this plateau is only reluctantly left behind. After all, the movement to the next higher level brings about instability and, for many, a transitory emotional crisis. Fear of change as well as an actual deficit in emotional, cognitive, or behavioral skills might also thwart attempts to move toward the next developmental level. Encountering the disadvantages and limitations of the current developmental level seems to be more acceptable than risking failure on the next higher plateau. The motto is: Surviving one's childhood is more important than progressing. Or: Survival by developmental stagnation. Thus, developmental psychologists who assume that development does not occur in an incremental but rather in a more continuous fashion, primarily may work with those children whose development progresses smoothly and gives rise to the phenomenological observation of continuity (Figure 1).

Piaget (PIAGET & INHELDER, 1981) interprets development as equilibriation, as an interplay of assimilation, i.e., the principle of homeostasis described above, and accommodation, i.e., the step toward each following developmental stage conceptualized as emergence via self-organization. KEGAN (1986) views Piaget's stages as periods during which meaning develops, where each level redefines the child's conception of self (subject) and relatable other (object). From this perspective, development consists of the change from embeddedness to interpersonal relations.

An example: A child with a dominating mother had to leave the two earliest developmental stages as quickly as possible:

a) The incorporative stage during which the child was dependent upon the mother's balanced nurturing and holding and could not defend against the mother's excesses; and
b) The impulsive stage during which the mother squelched all defiantly aggressive impulses and during which the child could not develop longing for the mother, whose proximity occurred too frequently and with too long a duration.

Only after the girl had rescued herself to the next higher stage, the imperial phase during which she became able to manage the mother's behavior so that the mother rarely came too close, she was able to acquire self-confidence. She grew up to be a very successful professional, and she mastered interpersonal relationships in the course of her work. What one could achieve professionally, she did. Nevertheless, she became depressed upon entering her first meaningful intimate relationship. Through this love, her needs for affiliation reemerged vehemently and unmanageably. On the one hand, she was not able to suppress them by resorting to her "imperial" way of managing relationships. On the other hand, she was not capable of being emotionally present within the relationship. She could not live differentiation or affiliation exclusively. Her life could neither return to the old way nor fathom a new one. Depression was all that was left. SBT can assist her in taking the developmental step to the next higher "interpersonal" developmental level, required for conflict resolution. Exactly this step and not one bit more is the therapeutic task.

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2.1.1.3. Assumption of construction and self-organization

This assumption is especially important for it is routinely neglected by classical cybernetic approaches. It posits that our autonomous mind, in the sense of active life and relationship building, generates its own world that makes us happy or unhappy. Human beings *construct their own lives* in accordance with the autonomous mind's inner construction plans. Consequentially, life-event research as it investigates stressful life events in adulthood represents a worthless effort in the study of causes. Nevertheless, our approach preserves the significance of these events of adulthood as symptom-evoking life situations. In contrast, however, the construction of a life that must fall apart is the product of an entire lifetime.

Two examples: *Pathogenic life formation.* Individuals who arrange their lives to either reach the highest professional heights or to fail, expose themselves to exhaustingly chronic stress, for each incremental step of the professional ladder is associated with an even greater fall. An increase in stress in turn leads to more frequent tumbling and stumbling, etc.

Pathogenic relationship formation. Individuals who construct a dependent relationship produce a similar escalation: Excessive compliance with a dominant partner who provides shelter and warmth deprives the partnership of the tension that is necessary to sustain mutual attraction, so that the partner will turn toward more interesting alternatives. More of the same (compliance) leads to a further reduction of attractiveness for that partner. This chronic unhappiness gradually turns into depression.

2.1.2. Development and Function of Symptoms

The explanation of symptom development derives from these three assumptions:

The symptom is embedded in:

- pathogenic life formation;
- pathogenic relationship formation; and
- a particular, evoking situation.

The symptom is thus an emergency response of the autonomous mind, and presents the only remaining opportunity to prevent

- damage to the survival strategy of the psychological homeostatic process (self-preservation through assimilation)
- a change in the self-concept (accommodation) and change within the psychosocial system.

The affected person arrived at the individually optimal survival strategy for his or her childhood and thus displayed an extraordinary capability to adapt. However, the success of his or her survival strategy in the face of childhood threats produced rigidity. This rigidity and a concurrent narrowing of experience and behavior, while maintaining the psychological homeostasis, obstructed a complete transition from childhood to adulthood. For a long time there was no

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compelling reason to abandon the time-tested survival strategy, given that it was somewhat adequate in adulthood. Problem-solving strategies adopted in childhood suffice for everyday life and everyday difficulties, particularly because the adult's reason, knowledge, and experience can improve upon these strategies. Only the symptom-evoking life event brought about the failure of the childhood homeostasis and revealed its dysfunctional nature. There is only one possibility: The creative invention of a symptom that fits like a key into the lock of the problematic situation and thus keeps one's self-concept and worldview intact. Again, this is a remarkable success. The threatening destabilization of the psychosocial system is hereby avoided. The symptom formation itself may be explained by the self-organization principle at the micro level. The destabilizations of the psychosocial systems produce the emergence of a qualitatively novel order parameter – the symptom that, as an attractor, reduces deprivation and stabilizes the old system.

An example: A teacher had tamed his impulsive tendencies through unassertiveness and obsessions and had turned into a compliant and dependable husband. After several years, his wife became dissatisfied, took a lover, and moved. When his spouse returned after a six-week separation and subsequent reconciliation, the teacher felt such anger that he had the impulse to stab his spouse with the knife he was currently holding. He was so shocked that the impulse disappeared. However, from this point on, he feared that he might drill a sharp object into his own heart. The reconciliation with his spouse continued without further disruptions.
To be an equitable partner to his spouse, the teacher would have to manage his aggressive emotions by increasing his assertiveness, i.e., he would have to change his self-concept. His survival strategy prophecies the definitive loss of love in the case of change and therefore prohibits it. The symptom-evoking life situation overwhelms this regulative homeostatic process. Lacking the development of a civilized coping pattern for aggression, an inappropriate, intensive impulse arises which, of course, has to be overpowered. To this extent, the symptom was the only accessible emergency measure.

2.1.3. The Process of Symptom Formation

The example above illustrates symptom formation as a general process. A concrete situation (here, return of the spouse) produces
- a primary natural feeling (anger at his spouse for leaving him), which leads to
- a primary natural behavioral impulse (fight; here it manifests inappropriately because a history of lifelong suppression prevented opportunities for the potential civilizing of aggressive impulses)
- the anticipation of harmful behavioral consequences (definite loss of love, subjectively more significant than consequences imposed by the judicial system) leads to
- secondary, counteracting feelings (fear, guilt), which result

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- in the suppression of natural coping because of avoidance of its putative consequences (e.g., constructively and assertively representing one's own concerns is hypothesized to result again in the loss of a loved one)
- novel, behavior-governing emotions (discomfort, fear) evoke
- the symptom (here, obsession). Only the symptom can sustain the survival strategy. This is a system rule that guarantees homeostatic self-regulation.

2.2 Targets of Therapy

Consequently, SBT has two essential targets:

1. Modification of the psychosocial homeostasis of the autonomous mind to achieve mastery of the symptom-evoking life situation (self-preservation, or assimilation). If this is not sufficient, then
2. Development of the autonomous mind to the next higher developmental level (change in self-concept, or accommodation).

Example: The patient is able to sustain his old, impulsive developmental level if he learns to express his feelings spontaneously and to articulate his needs so that his spouse may be responsive to them. From a behavior therapy perspective, this could be accomplished through social skills training and by practicing the expression of emotions. However, if his spouse is not willing to respond to him but needs somebody who sets boundaries and manages her behavior, the patient requires a developmental step toward the institutional developmental level. Here, he experiences that he indeed can influence his spouse's behavior and learns to do so in his interest and in the interest of a more functional relationship. "If I interact with her in a way that she finds pleasant, she will be ready to spend time with me in a way that is pleasant for both of us."

Thus, SBT first represents an attempt to optimize self-regulation. This optimization may result from altering the executive means required to achieve a certain, unaltered, goal; or it may be a function of altering the goal direction or location *per se* (self-regulation therapy). Second, this therapy also may assist patients in transforming individual or social systems from a state of pathological stability and rigidity to a novel, viable state. Finally, this therapy may simply help to support an ongoing change process that is already at the point of critical phase transitions, without requiring the therapist's preconception of the emerging novel state by the therapist (self-organization therapy).

2.3. Therapy Strategy

The following illustration of the strategic course of SBT demonstrates how it prods the patient's development, which then continues after termination. This strategic course represents a consequential application of an affective-cognitive developmental theory and overlaps with the dis-

order-specific targets and interventions of behavior therapy. Without this specific therapy content, the strategic implementation of the brief therapy shown here would be an elaborated therapeutic approach to the treatment of personality disorders. For this reason, important components are directed at recovering the patient's psychosocial homeostasis, which was blocked by a dysfunctional "reference value" originating in a childhood survival strategy, such that a healthy dynamic equilibrium may be restored. To this end, the balancing of needs for dependence and autonomy is required (*motivational therapeutic strategy)*. Furthermore, access to blocked feelings has to be enabled (*affective therapy strategy*). These previously blocked feelings have to be linked to the respective cognitions representing affective-cognitive meaning (*affective-cognitive therapy strategy*). Then the self-concept and the worldview as well as the basic assumptions of how the world works, all acquired in childhood, must be corrected, and the dysfunctional survival strategy must be falsified (*cognitive therapy strategy*). Finally, the reduction of dysfunctional behavioral topographies is needed (*behavior therapy strategy*). Once these barriers toward psychosocial development have been removed, the transition to the next developmental phase may be enabled (*developmental strategy*). The procedure is directive, with continuing cognitive clarifications and confrontations of "pathological or pathogenic" emotions, such as fear, guilt, shame, as well as the inhibited "primary, i.e., healthy" emotions, such as anger, joy, grief, love. The procedure transfers applied exposure techniques, originally used with anger, obsessions, and grief, to generally all emotions:

a) Exposure to the emotion is followed by
b) Association of emotions with cognitions for affective-cognitive meaning. This is the prerequisite for behavior contrary to the old survival rule to falsify this rule and to prove that alternatives for survival can be found. Thus, SBT is the beginning of a development that leads from survival to living.
c) The *mindfulness strategy* reduces an over-selective focus of attention and, thereby, achieves the initial emotion regulation. The mindfulness strategy provides an optimal basis for the summoning of psychological energies and thus occupies a position at the beginning of the therapeutic process.
d) The *acceptance strategy* prevents the frustration of change efforts by rejecting oneself or the problem situation.

2.4. Progression of therapy

The therapy progresses in six major steps:

1. Utilize the patient-therapist relationship in a therapeutic manner.
2. Learn to manage my symptoms.
3. Understand my personality as a function of my childhood experiences and emotionally cope with those experiences.
4. Notice how I am still applying my childhood survival strategies and experience that the reality of my adulthood affords living without these struggles for survival.

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5. Experiment with myself and others, to feel my strengths, my competencies in managing my life.
6. Comprehend my developmental level and start the progressive developmental process on myself and my relationships.

2.4.1. The Therapeutic Relationship/The Therapeutic Interaction

2.4.1.1. The Therapeutic Interaction

The therapist actively designs the relationship with the patient under consideration of the following points:

1. The therapist is directive.
2. The atmosphere reflects respect concerning the dignity of the patient, regardless of the severity of his or her psychological dysfunction or of the deficit of his or her personality development.
3. A contract is agreed upon with the healthy side of the patient. This side is the partner on the level of decision-making and actions. This healthy side is affirmed, promoted, and challenged.
4. The patient's underdeveloped side experiences unconditional acceptance and empathy. It thus experiences as much positive affect as the competent side.
5. The counter-transference response of the therapist is indicative of transference phenomena. These phenomena constitute further examples of interactions and relationship formation not different in kind from those brought to session by the patient; they are also processed as such.

2.4.1.2 The development of the therapeutic relationship in the course of therapy

The therapeutic relationship unfolds by satisfying the patient's needs for affiliation appropriate to the form and extent of adult emotional relationships.

- Welcoming
- Warm
- Dependable
- Being liked
- Attention
- Empathy
- Valuing

The therapeutic interaction and collaboration increasingly communicate an experience of

- Autonomous doing and accomplishing
- Autonomous decision-making
- Encountering boundaries
- Being supported

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- Being challenged
- Having a model
- Responsiveness regarding the patient's gender identity
- Being an equal

2.4.2. The Symptom as a Foundation for the Relationship and a Primary Task of Therapy

As the patient contacted the therapist exclusively because of the suffering generated by the patient's symptom, a detailed exploration of the symptom honors the patient's initiative:

. The presenting problem
.. The assessment
... The syndrome diagnosis
.... The symptom-evoking situation
..... The function of the symptom
...... Coping with the cognitive-affective symptom
.... Coping with the behavioral symptom
.... Replacing the symptom with alternative solutions

Because the symptom represents a creative solution to an unmanageable situation, an alternative behavior must be identified that manages the situation without producing the disadvantages of the symptom.

2.4.3. Thematic Reconstruction of Early Childhood Development and the Maintenance of Childhood Survival Strategies

The developmental history of those personality aspects that contributed to symptom development is systematically explored, whether excessive needs and fears led to a rigidity of experience and behavior or whether emotional development was blocked. The steps to reconstruction consist of:

A. Deriving childhood characteristics from the parents' characteristics
   a. Identification with father or mother?
   b. Selection of a partner resembling the father or the mother?
B. Remembering important frustrating or traumatizing parental behavior patterns
C. Remembering frequent feelings during childhood
D. Identification of core needs in adulthood
E. Tracing the path from current core needs, over frequent feelings in childhood, to the frustrating or traumatizing parental behavior patterns.
F. Identifying core fears
G. Remembering the expected and useful behavior patterns toward the parents
H. Remembering the forbidden and harmful behavior patterns toward the parents

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I. Noticing emotional coping patterns
 a. Which emotions were expected or useful?
 b. Which emotions were forbidden or harmful?
J. Reconstructing the self-concept to date
K. Reconstructing the worldview to date
L. Reconstructing the homeostasis to date by referring to the survival strategies to date
M. Describing the behavioral invariants, i.e., the personality to date
N. Experiencing one's emotional developmental level
O. Being emotionally present with important relationships as a criterion for emotional development
P. Coping with conflict to date
Q. Understanding myself as a function of my history and accepting myself

2.4.4. Development of a Change Strategy

After the present has been clearly constructed from past events and one's history has been reformulated, an alternative future based on a mindful and accepting stance may be constructed.

a) Compiling one's personal goals and values;
b) Differentiating between extrinsic and intrinsic goals (redefinition of resistance);
c) Mobilizing resources;
d) Letting go off dispensable goals, saying farewell to regressive fulfillment of wishes, mourning losses;
e) Managing the fear of change;
f) Developing my emotional coping skills in regard to anxiety;
g) Developing my stress management skills;
h) Confronting feelings I have avoided so far (exposure);
i) Increasing my emotional coping skills (emotional learning);
j) Gaining assertiveness through failure;
k) Learning to solve conflicts through integration and value orientation;
l) Developing new routines;
m) Developing interpersonal skills.

When implementing a psychoeducational variant of SBT (SULZ, 1995a), the patient prepares for each session by working through one or more worksheets covering the preceding topics. The subsequent processing of these themes, i.e., the attempt to experiment with them in real life, occurs by engaging in well-defined experiments for strategic development (SULZ, 1995b) Even without the concrete systematic and labor-intensive developmental steps by the patient, a 25 to 30-session brief therapy is possible when sessions are implemented as described by SULZ (1994).

3. Conclusion

Strategic Brief Therapy (SBT) is a cognitive behavioral therapy based on a self-regulation approach (KANFER, 2000; CARVER & SCHEIER, 1985; 1998), Piaget's cognitive developmental psychology (PIAGET & INHELDER, 1981) and its further elaboration by KEGAN (1986). It also integrates principles of self-organization (HAKEN, 1995) and constructivism of the Palo-Alto-Group (WATZLAWICK, 1981). SBT builds upon an affective-cognitive developmental systems theory of psychological disorders and also defines this theory. The therapy implements consequential strategies to optimize psychosocial homeostasis and to promote a transition to the next stage of emotional and relational development.

SBT is applicable to all psychogenic psychological and psychosomatic disorders, especially personality disorders. The therapist must have completed a qualified psychotherapy education and must be able to demonstrate sufficient clinical experience.

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Strategic Brief Therapy: A Step-by-Step Manual for the Reduction of Symptoms, the Development of Personality, and the Establishment of Effective Interpersonal Skills

ABSTRACT

Optimizing emotion and relationship management, Strategic Brief Therapy (SBT) focuses on the core mechanisms for human experience and behavior on the one hand and on the use of personal resources and skills on the other. The result is (a) the trichotomy of symptom-directed therapy, skills training, and personality or identity development; and (b) the emergence of SBT's sixteen therapeutic steps ((1) assessment; (2) behavior and context analysis of symptom development; (3) biography and family; (4) needs, personality, survival strategy; (5) resource and goal analysis; (6) symptom-directed therapy; (7) affective therapy; (8) cognitive therapy; (9) coping with fear, need, anger; (10) coping with social situations; (11) letting go of old issues and coping with fear of change and failure; (12) personal values; (13) development as therapy; (14) automatization, generalization, self-management; (15) dissolving the therapeutic relationship; (16) relapse prevention, planning for the future). These steps in turn contain aspects of mindfulness, acceptance, exposure, and self-reinforcement as process components.

Keywords: Strategic Brief Therapy, mindfulness, acceptance, resources, affective therapy, survival strategy, identity development, symptom reduction

A. Introduction

Having applied a cognitive-affective developmental and systems-theoretical model to mental disorders (for more details, see SULZ, 1994; SULZ, this issue) and consequently derived theoretical implications for therapy (SULZ, 1996), clinical evidence now supports the corresponding cognitive-behavioral therapy approach, which will be described below.

The therapy assumes that the personality of an individual is a result of the interactions between a child with his or her inherent dispositions and the parents[1] with their acutely traumatic or chronically frustrating parenting styles (LEWIS & MILLER, 1990; SULZ & TINS, 2000). The child's

1 The word "parent" is used throughout the translation to mean any man or woman who assumes parental responsibility toward a child (e.g., a grandparent, stepparent, adoptive parent, etc.).

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still immature mind (Kegan, 1986; Piaget & Inhelder, 1981) is not able to respond to these threats and frustrations with already developed behavioral repertoires. Anxiety results and is alleviated by an array of avoidance responses. If avoidant behavioral patterns successfully reduce anxiety, they are learned; if they are unsuccessful, they extinguish; and if they increase anxiety, they are suppressed (cf. Reinecker, 1994). If need fulfillment corresponding to the child's respective age and developmental level is lacking, the child expends extraordinary effort to satisfy the currently pressing needs. Most of his or her efforts are frustrated. A few, mostly child-inappropriate or – conversely – regressive behavioral patterns lead to success. These behavioral patterns move the parents to gratify the child's need, and the behavior is reinforced (see also Petermann, 1997). Even in adulthood, this need will be maintained as a primary reinforcer within the hierarchy of the motivational system. To understand the person's subsequent responses, or to comprehend why he or she does or does not engage in particular behaviors, familiarity with the significance of the concrete situation as well as the reinforcer hierarchy is necessary (Blöschl, 1986; Ullrich & Ullrich, 1980). The sum total of these mostly trans-situational experiential and behavioral tendencies may be termed "personality" (Mischel, Shoda, & Smith, 2003). To the extent to which behavioral patterns correlate more strongly with the person than with any particular situation, one may term them "behavioral stereotypies" (Sulz, 2001). If these behavioral stereotypies produce considerable disadvantages for a person in the medium or long-term, then they are dysfunctional (Beck, 1979).
For our consideration, the distinction of conditioned behavior, which is accounted for by the psychology of learning, and rule-governed behavior is of major significance (Hayes, 1989; Hayes & Hayes, 1989; Hayes, Brownstein, Haas, & Greenway, 1996; Hayes, Strosahl, & Wilson, 2004). The latter suggests that not only dichotomous information processes such as "reinforced/non-reinforced" or "punished/non-punished" govern human behavior but that the mind integrates these learning experiences, e.g., into basic assumptions about the self and the world, and then derives general and situation-specific behavioral plans (Grawe, 1998). Both, i.e., Beck's fundamental assumptions and Grawe's behavioral plans, may be incorporated into a cognitive statement about the homeostatic regulation of the human mind: the survival strategy (Sulz, 1994; 1996). An interpretation in the context of self-regulation enables a categorization of Beck's and Grawe's views with Kanfer's self-regulation approach (Kanfer, Reinecker, & Schmelzer, 1995).

Any human behavior that is observable in principle (i.e., ideally everything a person does, thinks, feels, or perceives) may be reduced to the homeostatic regulation described by the survival strategy. It is as important to determine what a person does not do, does not think, does not feel, does not perceive, when compared to many or a few other people in similar situations. According to our conceptualization, the avoidance and suppression of opportunities for experience and behavior following the traumatic or frustrating experiences described above are significant. In any given situation one must ask: What doesn't this person perceive? What

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doesn't he or she think? What doesn't he or she feel? What doesn't he or she do?
Acculturation and socialization processes require lasting inhibition and suppression of impulses that could potentially harm the self or the community. Among other things, this ability to inhibit characterizes a healthy human being. However, the ability to inhibit can only be developed once a certain developmental level has been reached (KEGAN, 1986; PIAGET & INHELDER, 1981). If this demand is placed on a child prematurely (i.e., the child is younger than three years of age), then he or she is able to meet this demand only via fear conditioning and the establishment of avoidance patterns that are relatively resistant to extinction. These learned patterns strongly determine the child's later personality. In principle, an individual may deem the suppression of any kind of impulses and emotions necessary, joy as well as grief, love as well as hatred, liking as well as aversion. The suppression of tendencies for anger and attack are central, however. The stronger my anger, the more harm it may cause; the less developed my self-regulation skills, the more likely it is that anger, left unrestrained, may lead to harmful behavior. The less my self-image and worldview have been shaped by experiences indicating that the greatest anger still does not have to turn into a behavioral impulse, that I can keep my anger to myself, or that even intensive expressions of my anger do not cause harm in the world, the more credibility I will attribute to my fear that my anger will cause great harm. Thus, I must suppress this feeling and these impulses even more rigorously.
Our therapeutic assessment should capture the nature and the degree of suppressed anger and tendencies to attack as well as the nature, the flexibility or rigidity, the degree of maturity, and the effectiveness or the side effects of habitual inhibitory or suppressive patterns related to primary impulses. Together, the actual and the suppressed or avoided behavior give a complete picture of the individual. These assessments enable a categorization of behavior into dimensions of psychosocial effectiveness or ineffectiveness. As a matter of principle, we are able to explain situational failures prospectively and retrospectively in this fashion. If the dysfunctional proportion of these behavioral stereotypies dominates, then pathogenic life and relationship styles result and lead to symptom formation when specific triggering situations pose challenges that overwhelm the homeostatic system. The survival strategy's rigidity prohibits the person's adaptation to the situational tasks at hand and so necessitates symptom maintenance. The symptom or the symptomatic behavior is reinforced when with its help problematic life situations or constellations are overcome without having to alter the time-tested homeostatic mental system. Any disadvantages brought about by the symptom are more than outweighed by the advantages of maintaining intra-mental stability. The latter appears as the greatest good, as the fundamental guarantee for emotional survival.
An example may illustrate homeostatic self-regulation (Figure 1): A person's self-conscious and dependent behavior serves to generate a rather self-confident vantage in others, from which they respond benevolently and acceptingly. In turn, the person's fear of rejection and loss is reduced, and his or her need for affection and security is met.

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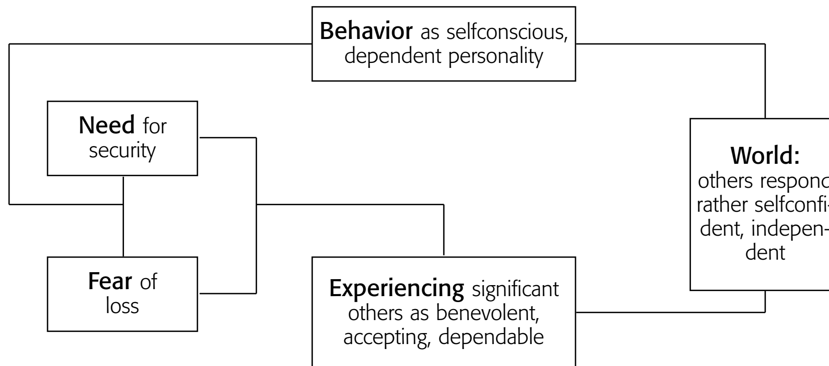

Figure 1. The homeostatic self-regulation of a self-conscious and dependent individual

If these individuals cease to respond in a fear-reducing or need-gratifying manner, or if a novel need comes to the fore, e.g., for autonomy and self-determination, then the probability of non-self-conscious behavior increases drastically and jeopardizes the survival strategy, such that symptom formation is the last resort and functions as a virtual "emergency break." Depressed or anxious behavior, or low back pain, forces these novel behavioral trends into the background. Interacting with people in the familiar self-conscious manner becomes possible again. The psychosocial homeostasis has been preserved.

A polarization of the initially introduced roles occurs over time as people tend to respond to any disruption in the homeostatic process according to the principle, "more of the same old," i.e., influencing the reduced benevolence of others by engaging in even more self-conscious and dependent behavior. Ultimately, this process will reach a point at which the costs greatly exceed the benefits of self-regulation as effected so far. Referring to the example described above, the maintenance of a sufficient sense of self-esteem or the suppression of the growing anger induced by constant frustration will become impossible at last. Finally, the homeostatic process will fail, and only symptom formation will be able to halt this escalation.

In the example, my partner needs me less, and I have become progressively unattractive in his or her eyes. There only appear to be two ways in which I may be able to preserve my sense of self-esteem: To leave him or her and then feel lost, or to express the full range of my anger and then feel culpable and lose all affection. I would not be able to emotionally survive either. The symptom frees me from the pressure to choose; it renders me, as the patient, unable to act and to decide. My environment is forced to acknowledge my symptom, and this initially occurs in a caring and affectionate manner. Now I am receiving differential treatment without having to change anything or myself. Some tasks are removed and novel entitlements without strings come my way. My self-regulation has regenerated an advantageous situation. Nevertheless, I rightfully fear that I will have to forego these advantages again if my symptom disappears. And this I cannot afford.

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The symptom and its immediate negative consequences considerably narrow the individual's mental functioning, often to an extent to which they make the psychotherapeutic process impossible. For this reason, symptom management is a required first step: Learning to cope with the symptom such that its negative effects are reduced to a point at which the psychotherapeutic process may occur.

These considerations suggest that any intervention must occur at three levels (Figure 2):

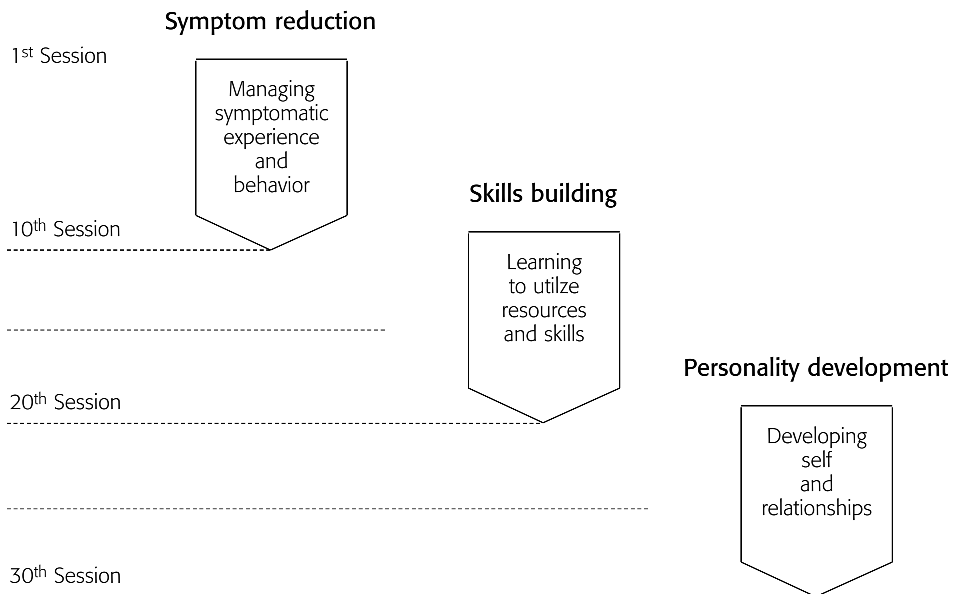

Figure 2. The trichotomous strategy of SBT

1. Learning to cope with the symptom;
2. Establishing interpersonal skills that facilitate the building and maintenance of fulfilling relationships;
3. Personality development.

People who develop mental and somatic symptoms generally lack interpersonal competence. Even if excellent skills seem to be present at times, these skills are not available at the right moment; individuals are unable to apply them to the critical relationship. Because of this circumstance, it is worthwhile to analyze these deficits and practice the corresponding skills as soon as the intervention for symptom reduction permits additional time. Simplified, the questions are:

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What does he/she do? What doesn't he/she do?	Avoidance.
What is he/she able to do? What is he/she unable to do?	Skill deficits.

The main interest is in the interpersonal situation that led to symptom formation. Which concrete behavior would have been required to master this situation? What other situations are experienced as difficult, or as a setting for failure? What relationships are experienced as difficult? Which dysfunctional interpersonal and relationship patterns go unnoticed by the patient (and are only indirectly deducible from the patient's reports)? Based upon KANFER'S (1998) self-regulation model, we may distinguish three areas of interpersonal competence:

1. Observation of self and others (perceptual regulation)
2. Evaluation of self and others (behavioral and cognitive regulation)
3. Reinforcement by self and others (motivational and emotional regulation)

"Observation of self and others" implies the realistic perception of my own and others' needs, fears, and emotions. "Evaluation of self and others" comprises the social and cognitive judgment of interpersonal processes as well as the situational appropriateness of my or others' needs, fears, and behavior, but also the trans-situational internal establishment of my attachment figure as an invariant component of our lasting relationship. Reinforcement by self and others entails the effectiveness of my behavior, such as my ability to

- express feelings directly;
- behave in accordance with my affect;
- assert myself and to say, "no;"
- influence the behavior of my vis-à-vis;
- consider the needs, fears, and emotions of my vis-à-vis;
- argue;
- lose/fail;
- generate a balance between self and relationship-directed behavior;
- care for my relationships with an eye to the future and to enter lasting commitments;
- mourn a loss or a separation.

After the individual deficits and avoidance patterns have been assessed, the building of interpersonal skills may begin. Table 1 provides suggestions for this progress. The respective situation is practiced with role plays in session and as daily homework out of session. The practice is identical for deficits and avoidance patterns. On the one hand, practice reduces situational fears and avoidances; on the other hand it leads to the acquisition of new skills.

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Table 1: Interpersonal Skills Training Practice

Problem situation ....
Significant person ....
His or her concern ....
His or her behavior ....
My interpretation of his/her behavior ....
My response so far ....
My deficit or avoidant behavior ....
What exactly will I practice (novel skills, now permissible behavior)? ....
How will I practice? ....
Where will I practice? ....
When will I practice? ....
How often will I practice? ....
Practice results: ....

B. Strategic Brief Therapy (SBT): Planning content and designing individual sessions

SBT: Outline of therapy progression

Topic 1 Intake, assessment, diagnosis
Topic 2 Behavior and context analysis concerning symptom development
Topic 3 Organismic variable – history: Biography and family
Topic 4 Organismic variable – current: Needs, personality, and survival strategy
Topic 5 Analysis of resources, targets; therapeutic plan and contract
Topic 6 Intervention for symptom reduction (mindfulness, acceptance, willingness, exposure)
Topic 7 Affective intervention (deep emotional experience; affective coping)
Topic 8 Cognitive intervention (modification, survival strategy, reevaluation)
Topic 9 Behavior change I: Novel management of anger, need, and fear
Topic 10 Behavior change II: Novel management of social situations
Topic 11 Resistance: Letting go, fear of change and failure
Topic 12 Personal values: From need to value-directed behavior
Topic 13 Development as therapy
Topic 14 Automatization, generalization, and self-management
Topic 15 Dissolving the therapeutic relationship
Topic 16 Relapse prevention, planning for the future

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The following sections detailing each topic are organized by topic number (in parentheses).

SBT: Required duration of therapy

On the average, five assessment (diagnostic) sessions plus 25 therapeutic sessions for a total of 30 sessions are necessary. Some topics (3-10, 13) require 100 minutes. While some therapists complete therapy in 40 sessions, others conduct 60 sessions, i.e., therapy is brief in the most optimal case, it is long in the most difficult case.

(1) Intake, assessment, diagnosis

- 20 minutes: The patient freely voices his or her concerns, to reveal him or herself in this way, as a human being with difficulties, his or her psychosocial problem and the symptom-evoking living situation.
  - o The therapist does not ask any hypothetico-deductive questions.
- 20 minutes: Mental and somatic assessment (possibly according to BDS14) (SULZ, 1999a).
- 10 minutes: Diagnosis and differential diagnosis according to ICD-10.
- Patient has completed BDS90 (symptom checklist) and BDS30 (personality scale)

(2) Behavior and context analysis concerning symptom development

a) Exploring the client's **living situation**, including relevant relationships, at the time of symptom development (macro level)
b) Exploring the client's **response chain** (primary emotions → primary behavioral impulse → anticipation of consequences → secondary emotions → avoidant behavior → symptom → short-term consequence (micro level, see also Figure 3)
c) Exploring the **consequences** of symptom formation on the macro level: What would mastery look like, what life event did the symptom prevent?

(Proceed according to BDS21 (behavioral analytic interview) or *.ppt file[2]"analysis of symptom.")

(3) Organismic variable – history: Biography and family

The patient has brought the completed assessment questionnaire BDS1 to session, and the therapist has read it before session.

- o Vivid memories of the parents and their frustrating parenting behavior (possibly role-play)
- o Deep emotional experiences in childhood (frequently deep pain, anger, grief)
- o Promoting acceptance that I (after these experiences) have become the person I am today
- o Introducing the worksheets SBT06 and 07
- o If possible, maintaining a prolonged focus on and elaboration of the topic by assigning completion of the worksheet SBT20 (writing one's life history) for homework

2 These files may be ordered in *.pdf format via email: SergeSulz@aol.com

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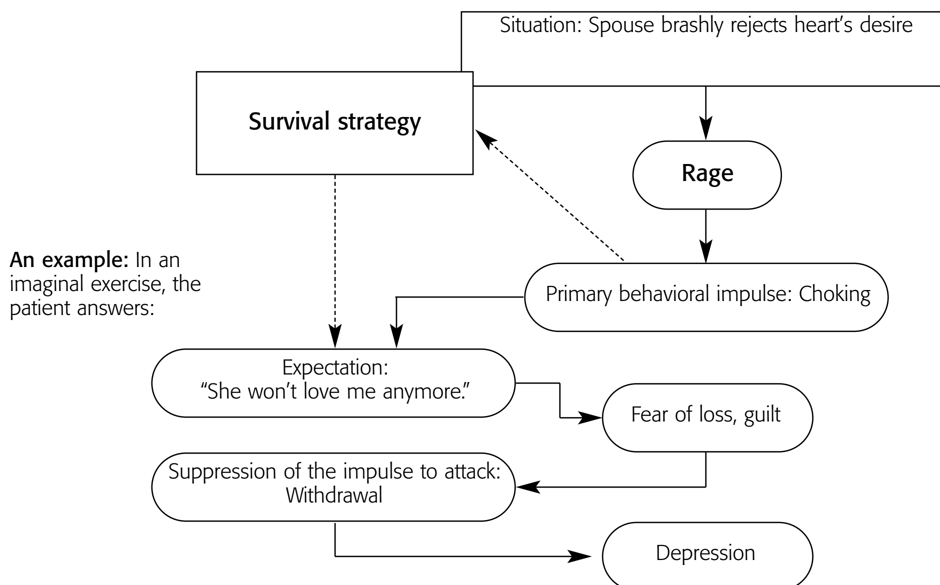

Figure 3. Behavioral analysis (micro-level) example: Depression as avoidance behavior.

(4) Organismic variable – present: Needs, personality, and survival strategy

The patient has brought the completed worksheets SBT9, 11a, 11b, 13 and 18 to session. The therapist has copied them.

- Imagination: How does a lack of basic need gratification feel? In what context?
  - o Generate a deep emotional experience in the subsequent processing period.
- Exploration: How have I coped with my need so far? What has the outcome been? How would I like to change this? What would I like to be able to do, achieve?
- An analogous procedure is applied to core fears, core anger, and the most important personality traits
- Summarizing the survival strategy
- My survival strategy: Its costs (what opportunities are lost?) – generate a deep emotional experience.
- How would I like to change this? What would I like to be able to do, achieve?

(5) Analysis of resources, targets; therapy plan and contract

The patient has brought the completed resource questionnaire BDS26 to session; the therapist has copied it. The patient has read the therapeutic contract and may have proposed changes (see Figure 4).

- What are the most powerful resources?
- Imagination: Being able to use these resources, associated emotions?
- Exploration: How may I use these resources, take them into difficult situations?

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- Imagination: What is my life's desire, my goal?
- Noticing somatic markers associated with wish fulfillment
- Outlining effective action toward goals (according to M. STORCH, 2004)
- Establishing a concrete plan for future resource utilization (what resources facilitate which goal?)
- Formalizing the therapeutic contract

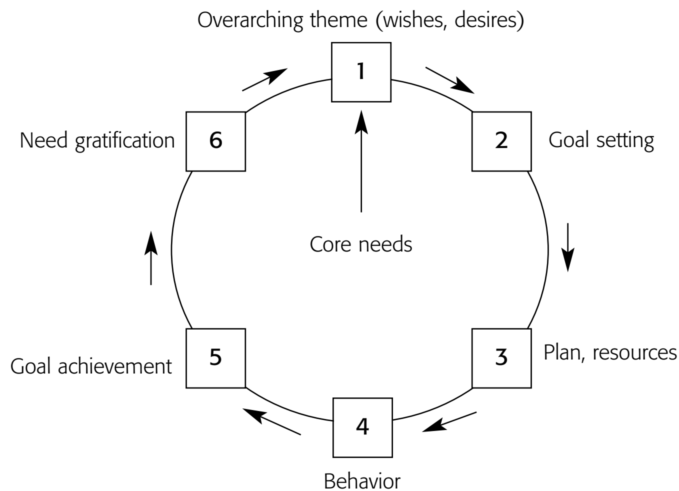

Figure 4. The cycle of motivation: From wishes and desires as central themes to need gratification.

(6) Symptom reduction (mindfulness, acceptance, willingness, exposure, self-reinforcement)

First, it is determined whether routine behavior therapy has to be applied using a disorder-specific manual, or whether an intervention for non-specific symptoms is appropriate:

(i) Mindfulness: Noticing early signs of the symptom in a non-evaluative manner
(ii) Acceptance: Accepting the symptom and making space for it
(iii) Willingness: Choosing to stay in the situation, in the encounter with the symptom
(iv) Exposure: Feeling and tolerating the symptom and all associated emotions, the progressively increasing intensity, the long duration, and the slow reduction
(v) Self-reinforcement: I have managed to confront my symptom; even if I had difficulties, I am content with my achievement

(7a) Affective intervention

Strategies:

- Mindfulness and acceptance
- Exposure

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Interventions:
- Microtracking: Deep emotional experience[3]
- Coping with inappropriate emotions – not doing what the emotion wants
- Coping with appropriate emotions – behaving effectively[4]

(7b) Affective therapy (deep emotional experience)

(i) The patient reports his or her currently most troubling difficulty

(ii) A **contract** is agreed upon that stipulates the patient's tasks within the conversation:

a) The patient will return to his or her painful emotions and images repeatedly.

b) The patient is committed to engage in emotion work to bring about a good solution/perspective

c) The therapist will accompany and follow the patient's lead in the process

(7c) Affective therapy (procedure – see also *.ppt file "Emotion work in VT")

- Noticing *emotions*
- Acknowledging the emotion-evoking context
- Understanding the relationships within which events evoke emotions
- Defining *cognitions* as mere thoughts
- Hearing cognitions as non-self-generated statements and as the internalized messages of significant others
- Expressing affect upon the articulation of these internalized messages
- Noticing *needs*
- Noticing who is responsible for satisfying the need
- Noticing the *frustration* associated with ungratified needs
- Remembering the *learning history* of these frustrations
- What was needed back then, and from whom?
- What would need-gratification have felt like?
- Visualizing wish fulfillment and remembering it as a vision
- Articulating goals that might lead to an approximation of this vision
- Planning steps toward change that facilitates the *partial achievement of the goal*

(7d) Coping with inappropriate affect (mindfulness, acceptance, willingness, exposure, and self-reinforcement)

The patient has brought the completed SBT-worksheet 13 to session.
- Imagination: A situation is chosen that evokes emotions which are subjectively interpreted as being too intensive.

(i) Mindfulness: Noticing early signs of the feeling in a non-evaluative manner

(ii) Acceptance: Accepting the feeling and making room for it

(iii) Willingness: Choosing to stay in the situation, in the encounter with the feeling

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3 According to Pesso (2005)

4 According to Linehan (1996)

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(iv) Exposure: Feeling and tolerating the emotion, the progressively increasing intensity, the long duration, and the slow reduction (*without doing what the emotion suggests*)

(v) Self-reinforcement: I have managed to confront my feeling; even if I had difficulties, I am content with my achievement

(7e) Coping with appropriate affect (mindfulness, acceptance, willingness, exposure, behavior, and self-reinforcement)

The patient has brought the completed SBT-worksheet 13 to session.

- Imagination: A situation is chosen that evokes emotions which are subjectively interpreted as being too intensive (anger, fear, grief)

(i) Mindfulness: Noticing early signs of the feeling in a non-evaluative manner

(ii) Acceptance: Accepting the feeling and making room for it

(iii) Willingness: Choosing to stay in the situation, in the encounter with the feeling

(iv) Exposure: Feeling and tolerating the emotion, noticing the impulse to act and making such action appropriate

(v) Effective action: Communicating emotional experience and its context as well as my concerns (demand or saying "no"); persisting until the other person is responsive

(vi) Self-reinforcement: I have managed to make use of my feeling; I have achieved a good result with which I am content

(8a) Cognitive intervention (reevaluation of self and world; modification of the survival strategy)

Strategies and interventions:

- Articulating the old self-image and worldview
- Formulating the survival strategy
- Enabling a wish for change
- Generating emotional distance from the old perspective
- Modification of the survival strategy or discovering a new survival strategy

(8b) Cognitive analysis (self-image and worldview, dysfunctional survival strategy)

The patient has brought the completed worksheets SBT16a and 16b to session. The therapist has made a copy.

- Once again, the patient is directed to notice the emotional significance of his or her core need and fear.
- He or she feels the imperative force of the proscription, "Only if I always…" and his or her prohibition, "and if I never …," implied by the survival strategy
- Collaboratively, therapist and patient articulate the dysfunctional survival strategy in its final form.
- How well has it guided the patient in his or her life so far?
- What kind of life has been denied due to the survival strategy? (Enable feelings of longing and sadness!)
- Does the patient want to free him or herself from this shackle? May he or she choose to do so?

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(8c) Cognitive therapy (Reevaluation of self and world; modification of survival strategy)

- Mindfulness: Non-evaluative attention
- Acceptance: I accept myself and others
- Resource orientation: I am present with my powerful resources (…)
- New self-image and worldview:
  - o I can/have …. You are …
- My new survival strategy is:
  - o I trust myself and others and do not have to behave _______ in the future anymore; I may have _______ feelings and will still be able to satisfy my core needs (…) without being delivered to my core fears/threats (…).

(9) Behavior change I: General

- Engaging in mindfulness
- Accepting that I used to behave in a ____________ way
- Change target (what?)
- Commitment to change
- Planning change (how, when, where, with whom?)
- Practicing change (role-play, mental training)
- Imagining success (positive somatic markers)
- Implementing the change (what was good, what could I still change and how?)
- Self-reinforcement

(9b) Behavior change I: Learning to manage core fears

- Engaging in **mindfulness**
- I **accept** that I am scared of … (core fear)
- I accept that I have managed my fear by (…) so far, even if I knew it was an irrational fear
- From now on, I will cope with my core fear differently by (…)
- **Imagining** the *new management of core fear*, the distancing of the feared event, and the perception of safety in the here and now.
- Noticing and remembering the **positive somatic marker** while imagining safety in the here and now.
- Implementation, evaluation of the result, and self-reinforcement

(9c) Behavior change I: Learning to manage basic needs

- Engaging in **mindfulness**
- I **accept** that I need … (basic need).
- I accept that I have managed my need by (…) so far.
- From now on, I will cope with my need differently (…).
- **Imagining** the *new management of the need* and the successful gratification of this need.
- Noticing and remembering the **positive somatic marker** while imagining
- Implementation, evaluation of the result, and self-reinforcement

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(9d) Behavior change I: Learning to manage core anger
- Engaging in **mindfulness**
- I **accept** that I have the impulse to … (core anger) because of my anger.
- I accept that I have managed my core anger by (…) so far, even if I knew that this behavior was ineffective.
- From now on, I will cope with my core anger differently by (…).
- **Imagining** the *new management of the core anger* and the positive *effect* on me and my relationships.
- Noticing and remembering the **positive somatic marker** while imagining the positive effect
- Implementation, evaluation of the result, and self-reinforcement

(10) Behavior change II: Learning to manage social situations (relationship competence)
- Engaging in **mindfulness**
- I accept that I have interpreted situations as if (…) so far and because of this I have engaged in (…)
- From now on, I will **interpret** situations **differently** (…) and thus I will be able to engage in different **behavior** such as (…).
- Other people as well as I give me **the right** to act in this (…) way.
- Other people as well as I understand that I still need to practice the new behavior (**make mistakes**).
- **Imagining** the *novel behavior* and its *positive effect*.
- Noticing and remembering the **positive somatic marker** while imagining
- Implementation, evaluation of the result, and self-reinforcement

(11a) Resistance: Letting go and farewell, fear of change, coping with failure

Any resistance to novel behaviors is due to
a) failure to let go of old issues;
b) fear of change; and
c) discouragement as a function of unexpected failures.

(11b) Resistance: Letting go and farewell
- Engaging in **mindfulness**
- I accept that resistance is occurring.
- What are the (actual) disadvantages of my novel behavior and its effects?
- What do I have to surrender, give up, **let go** in order to free myself for the path toward my goal?
- **Imagining mourning** for (…) (Worksheet SBT26)
- Accepting my grief for the loss of …
- Accepting life without …
- Remembering the **positive somatic marker** while viewing a life without …

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(11c) Resistance: Discouraging failures

- Engaging in **mindfulness**
- **Learning from mistakes**: Did I evaluate the situation incorrectly? …
- Did I respond incorrectly? …
- Was my behavior clear enough? …
- What should I do differently next time and how? …
- **Acceptance** of the current failure
- **Imagining** novel behavior, failure and coping with failure (reevaluation, acceptance) (worksheet SBT31)
- Remembering the **positive somatic marker** while imagining the positive outcomes of my novel ability to cope with failure

(12a) Personal values: From need to value-directed behavior

- A need-directed person is subconsciously governed by his or her needs throughout life. He or she has only a few degrees of freedom in choosing a lifestyle and thus is frequently helpless in the face of failure
- Mindfulness and acceptance facilitate active coping with needs and fears. This generates energy and the freedom to build a life according to one's own values.
- If a need is important to me, it becomes a personal value. However, I also derive values from my experience in the world. If I am able to manage my values in a directive manner and if my values constitute guiding principles for my behavior, then I am a **value-directed** person. I attempt to fulfill my life's values and, within this context, I am free to choose a path of action.
- Values provide a **future-oriented perspective, meaning, and fulfillment** in my life. As values specify only a direction but no destination that I could ever reach in my lifetime, I can never lose my values.
- A mindfully performed value analysis (BDS33) may assist in the discovery of values and their examination as to balance, lopsidedness, or overemphasis.
- **New behavioral goals** that effect positive change in life and in important relationships emerge from values.

(12b) Personal values: From need to value-directed behavior

The patient has brought the completed BDS33-Value Analysis to session. The therapist has made a copy (see also Figure 5).

- Engaging in **mindfulness**
- **Exploring** and **enhancing** the personal significance of important values
- **Accepting** my values and my management thereof so far
- **Imaging** the fulfillment of important **values (vision).** Noticing the associated **positive somatic markers**
- Which behavior patterns contribute to the fulfillment of these values?
- **Imagining value-directed behavior.** Noticing the **somatic markers** associated with the

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behavior. Maintaining the image until partial value fulfillment occurs in the short or medium term. Concluding the exercise with the initial imagination of fulfillment of my important values. Noticing and remembering the associated **somatic markers.**

- **Behavioral plan**: What will I do (including when and how) in a value-directed fashion?
- **Mental training**: Daily imagination of value-directed behavior, including noticing the positive somatic markers
- Daily mindfulness while observing one's behavioral patterns
- **Daily recollection** of the value-directed behavior emitted during the day. Imagining the contribution to value fulfillment. Working with the experimental booklet SBT34
- Perceiving feelings of satisfaction and associated somatic markers

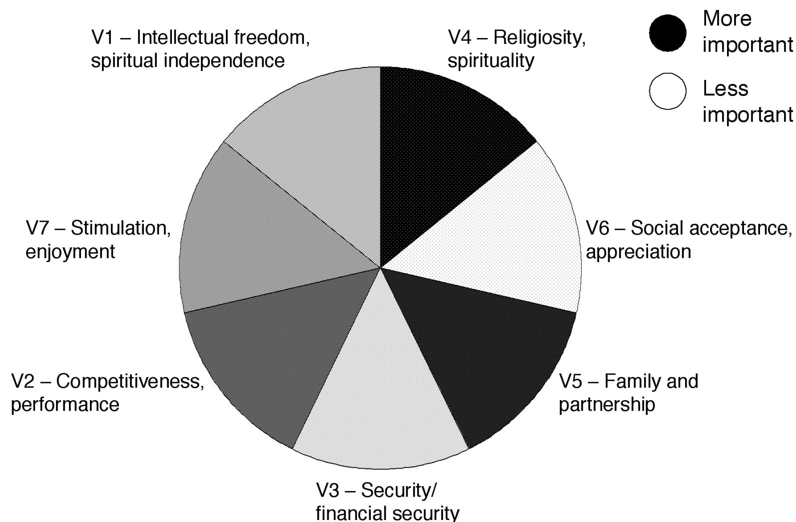

Figure 5. The value cycle: Assigning individual priority to human values

(12c) Personal values: Value balance

- Engaging in mindfulness
- **Filling in personal values** into the cycle of values
- Which poles of the value structure are well represented? How does this affect my life and my relationships?
- Which poles of the value structure are hardly represented? How does this affect my life and my relationships?
- **Accepting** my values so far
- **Exploring** the heretofore uncharted continents of my values. What attracts me, what frightens me, what leaves me indifferent?

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- **Imagination**: If I had a magic wand and these values could be fulfilled without encountering anything frightful, then …. Perceiving the associated **positive somatic markers**.
- Is there an opportunity to gain entry to novel value domains in a non-threatening way (concrete situation)? Am I tempted enough to give it a try?
- **Behavior plan:** What will I do when and how in a value-directed manner?
- **Mental training:** Daily imagination of novel value-directed behavior, including noticing the positive somatic markers
- Implementing new value-directed behavioral patterns
- Evaluation of these behavioral patterns and self-reinforcement

(13) Development as therapy

Behavior is not only conditioned: It also develops. It is not possible to modify an undeveloped behavior via conditioning or to cognitively regulate the behavior. Thus, therapy may have the additional task to facilitate the development of yet undeveloped experience and behavior. People who enter therapy frequently display **insufficiently developed** emotion regulation, cognitive self-regulation and behavioral repertoires as well as an underdeveloped relationship style and values system. The determination of *therapy targets* must consider whether these targets are attainable and functional at all, given the patient's current developmental level (as if a person were asked to climb from the basement to a non-existing first floor while the stairs from the basement to the ground floor are also nonexistent).

For this reason, the developmental assessment (BDS31) should precede the setting of therapy targets. The introduction occurs with worksheet SBT22. Our approach is based upon KEGAN'S (1986) neo-Piagetian cognitive developmental model.

(13b) Procedure: Development as therapy (see also *.ppt file "Development")

To transition from my developmental level number … (………………………) to the next higher level number … (………………………) (see Figure 6), I must learn to

- be able to: . . . .
- not need anymore: . . . .
- not fear anymore: . . . .

I will practice this in the following situation: . . . .
and with the following person: . . . .
I will behave and will be able to: . . . .
I will not need from the person: . . . .
I will not fear with regard to the person: . . . .

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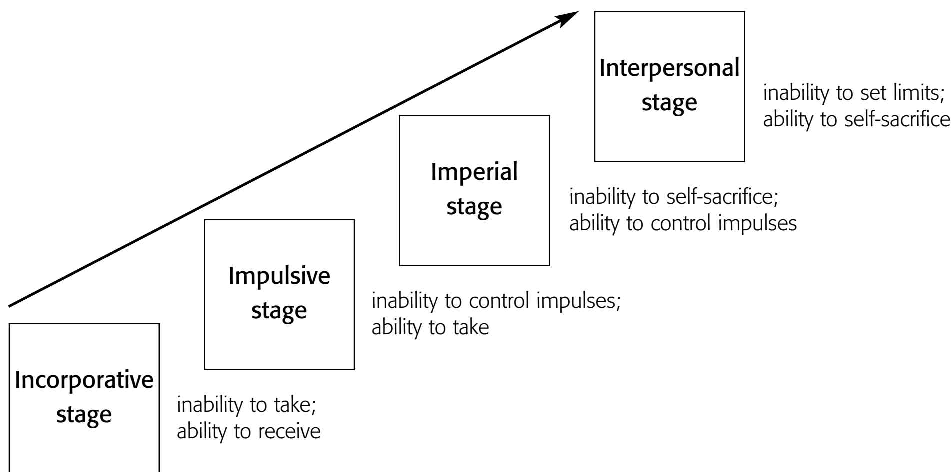

Figure 6. Developmental levels and abilities (competencies and deficits

(14) Automatization, generalization, and self-management of novel experience and behavior

Automatizing the novel behavior and experience

- through practice and habit-building
- through reduction of competing behavioral patterns in the respective situations

Generalization of novel behavior and experience

- through transfer of responding to similar situations
- through definition of a class of situations for which this behavior is appropriate and success is probable
- through flexible variability in the behavior according to the differences inherent in appropriate situations

Self-management of behavior and experience

- by fading therapeutic support
- by the patient's responsibly taking on decisions for change
- by self-evaluation and self-reinforcement

(15) Dissolving the therapeutic relationship

The termination of the therapeutic relationship already begins with the transition from external to self-management of the therapeutic process and the fading of therapeutic initiatives and activities.

Farewell, grief, and separation

- Feeling the emotional significance of the therapeutic relationship
- Mourning the loss associated with the end of therapy and the end of this relationship
- Deciding to dissolve the bond

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- Maintaining the connectedness and availability in times of crises
- Engaging in an emotional farewell ritual
- Continuously noticing the many attempts to avoid the associated emotions
- Both patient as well as therapist engaging in this process

(16) Relapse prevention, planning for the future

Relapse prevention

- Which situation could trigger a relapse? ....
- What do these situations have in common? ....
- How can I cope with these situations? ....
- What responses signal a beginning relapse? ....
- What do these responses have in common? ....
- How can I cope with these responses? ....
- Mindfulness, acceptance, emergency kit, asking for help

Subsequent to therapy

- Discovering the therapist within
- Expanding the achievements rather than letting them fade away
- Transferring some of the qualities of the therapeutic relationship to a significant other person

Worksheets selected from Sulz's (2002) Therapy Manual:

06 Parents
07 Frustrating parenting styles
20 .... Writing the life story
09 .... Core needs
11a .... Core fears
11b .... Core anger
18 .... substitute BDS30, possibly already in the diagnostic phase
13 .... My emotions
16a .... Survival strategy to date
16b .... Novel survival strategy
26 .... Letting go, mourning
27 .... Fear of change
31 .... Failures
34 .... Experimental workbook (including value-directed behavior)
22 .... Development

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Additional SBT Scripts (.ppt files, see also Sulz, 2001)*

- Analysis of symptom
- Emotion work
- Resource utilization
- Development

Suggested questionnaires and interview schedules from the BDS-System (Sulz, 1999a; 1999b; 2005)

- BDS1 . . . . Assessment (history – life and presenting problem)
- BDS90 . . . . Symptom checklist
- BDS30 . . . . Personality scales
- BDS14 . . . . Diagnostic interview schedule
- BDS21 . . . . Behavior analytic interview schedule
- BDS26 . . . . Analysis of resources
- BDS31 . . . . Analysis of development (substitute SBT22)
- QMP04 . . . . Session feedback questionnaire (completed by patient)
- QMT04 . . . . Session rating (completed by therapist)
- QMT06 . . . . Relationship rating (completed by therapist)

In addition to these non-specific opportunities to change and develop the personality through training, more specific and individualized demands emerge from the concrete work with the patient during skills training. Thus, SBT maintains a balance of acceptance and change on the one hand as well as of emotional exposure and skills building on the other. Learning processes are facilitated while developmental steps are promoted. The development of self and relationships progresses. This psychoeducational approach may be applied in individual as well as in group settings. A combination of individual with group therapy is ideal, as the psychoeducational elements and the skills training are shifted to the group environment which provides additional opportunities for social learning and for the development of relationships. If different therapists conduct the group versus individual sessions, the patient is asked to brief the therapist in individual sessions on the results of each intermediate group session. Accordingly, a release for the exchange of information between individual and group therapists is obtained.

Even without the use of these particular worksheets and questionnaires SBT may be conducted. In this case, the therapist is required to apply the planned therapy strategy within the context of the current therapeutic relationship and the interpersonal events in session. To this end, the complex structure of the patient's mind must be actively and consciously available to the therapist. This availability develops with experience but is initially overwhelming. For this reason, the reader who is unfamiliar with SBT was provided with the psychoeducational version only, for which in-session written work is not necessary.

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C. Recommended Literature

Therapy:

- Sulz, S. (1994). *Strategische Kurzzeittherapie: Wege zur effizienten Psychotherapie* [Strategic Brief Therapy: Toward effective psychotherapy]. Munich: CIP-Medien.
- Sulz, S. (2001). *Von der Strategie des Symptoms zur Strategie der Therapie: Gestaltung von Prozess und Inhalt in der Psychotherapie* [From the symptom as strategy to strategic therapy: The process and content of psychotherapy]. Munich: CIP-Medien.
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- Sulz, S. (2003). *Als Sisyphus seinen Stein losließ – oder: Verlieben ist verrückt (*3. Auflage) [When Sisyphus released his rock – or falling in love is crazy (3rd ed.)]. Munich: CIP-Medien.

Assessment

- Sulz, S. (2005). I*nternes Qualitätsmanagement in der psychotherapeutischen Praxis und Ambulanz* [Internal quality management for private psychotherapy practice and outpatient settings]. Munich: CIP-Medien.
- Sulz, S. (1999*a). Verhaltensdiagnostiksystem (VDS) Materialmapp*e (VDS1-VDS17) [Behavioral diagnostic system (BDS) materials (BDS1-BDS17)].
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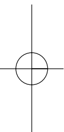

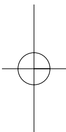

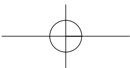

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Gernot Hauke

Values in Strategic Brief Therapy: From Need to Value-directed Living

ABSTRACT

Based on SCHWARTZ'S (1992) empirically supported value structure and the theory of hierarchical self-regulation (CARVER & SCHREIER, 1998), the significance of personal values for behavior will be clarified. In particular, it will be shown how people manage to steadfastly maintain a valued direction and not to succumb to their needs or their impulses. Patients may learn democratic governance as a form of self-management that does not suppress counter-intentional tendencies and impulses but rather invites and utilizes them. Schwartz's value structure not only supports the categorization of motivational goals; it also elucidates their relationship. In this context, their antagonistic structure not only suggests functionally matched interventions but also a dialectical therapeutic style. A psychotherapy case will illustrate exactly how values, as a navigational tool, might serve the selection and application of effective interventions.
Keywords: Personal values, hierarchical self-regulation, dual process model (hot/cool system), will, mindfulness, dialectical work with values

Values in Psychotherapy

Strategic Brief Therapy (SBT) assists people in developing effective behavior that may enable them to attain their chosen goals. Moreover, SBT provides support to people who are questioning their life direction: "What will I do with my life? Which life direction will I choose? What meaning shall I give to my life?" Such questions are best answered by working on and with personal values. Personal values are characterized as directional goals. In contrast to the typical behavior therapeutic targets, values can never be completely met or attained. Instead, concrete action must consistently affirm them. Values define an orientation, a direction, or a path within which a person's behavior occurs. HAYES, STROSAHL, AND WILSON (1999) concisely defined values as a type of verbal glue that binds a plethora of goals into coherence. Numerous authors have emphasized the significance of values for psychotherapy (HERMANS, 1992; STIKSRUD & WOBIT, 1983; WIRTZ & ZÖBELI, 1995), and hardly any practitioner would deny their importance. Nevertheless, approaches that move the topic from theory to therapeutic applica-

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tions, with increased allocation of session time, are few. A time-limited therapeutic approach, developed by STRASSER AND STRASSER (1997) in the context of existential psychotherapy, incorporates values work. However, as values and attitudes are not differentiated, the core effect of values work is lost. Behavioral therapists have approached values with more precision. Using an empirically derived questionnaire, ULLRICH AND DE MUYNCK (2001) analyzed their patients' values. The authors view this task as central to the assessment process. KANFER, REINECKER, AND SCHMELZER (2004) reached a similar conclusion regarding the importance of their assessment module "Goal and Value Clarification" for Self-management Therapy and suggested that a concentration on goals and values in particular may terminate patients' paralyzing lack of perspective. SULZ (1999) also developed an empirically based questionnaire and challenges patients to analyze their values at the beginning of therapy. In Acceptance and Commitment Therapy (ACT), HAYES AND COLLEAGUES (1999) focus the initial therapeutic work on undermining experiential avoidance as a critical requirement for being able to discern and to follow a direction at all. The authors emphasize that chosen values may present a stable compass within the turmoil of emotions, physiological states, thoughts of the past, etc. While cognition and affect often may concern irrelevant process goals, values may motivate effective behavior even in times of great personal crises. Accordingly, values work receives a relatively extensive treatment in Hayes et al.'s approach.

We place our work with values on solid conceptual ground. First, we refer the reader to SCHWARTZ'S (1992) approach. Clearly, this approach provides the most elaborated and empirically based conceptualization of values to date. We have adapted it for practical application (HAUKE, 2001) and use it as a heuristic for a dialectical psychotherapeutic style, the work with antagonists (HAUKE, 2004a; 2004b). As mentioned before, personal values constitute a special kind of goals. How are they related to a person's other goals, e.g., needs? In the context of a self-regulatory framework, we introduce a hierarchical regulation in which values occupy a well-defined position. This perspective will clarify why people encounter great difficulties being true to a previously chosen direction (i.e., their values) in problematic situations and, instead, are being governed by their immediate needs or their impulses. To support patients' behavior in accordance with their values even in the face of adversity, the workgroup around HAYES (2004) utilizes attention-directive methods termed "mindfulness." We take this approach one step further and add a therapeutic style that allows patients to manage their counter-intentional impulses in a responsible, self-caring, and resource-oriented manner. During this process, patients learn to manage themselves. We call this competence, conveyed in the course of value-oriented work, the ability for "democratic governance."

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Personal values work: Definitions and conceptualizations

In the vernacular, the term "value" is not only well-established but also has positive connotations. For this reason, our patients usually bring curiosity and interest to this topic. The manner with which people engage in everyday life simply depends on what they deem worthwhile and important at any moment and in any way. Exactly this engagement around personal values may bring about great success and moments of happiness, but also failure, harmful entanglement, stress, frustration, rage, etc.: Engagement with values may have been extinguished (as is the case when burnout occurs) or it may be accompanied by a vital striving for identity. Therefore, this type of work examines the patient's "personal values:" "What is important to you in this context? What has special significance for you?"

What are personal values? Definition.

The classics of modern values research, such as Rokeach (1973) and SCHWARTZ (1992; 1999), define values as temporally stable cognitive conceptions of the desirable that serve as a person's guiding principle. In the language of hierarchical control theory, personal values function as reference values. They are rather abstract and therefore occupy a relatively superordinate position in the regulatory hierarchy. This level of abstraction becomes understandable if one imagines the innumerable ways in which a personal value, such as "security," may be operationalized. Values motivate behavior and are thus similar to needs, motives, and goals (ROHAN, 2000; SELIGMAN & KATZ, 1996). Nevertheless, their trans-situational nature distinguishes values from concrete goals (KING, 1995) and reemphasizes values' relatively high degree of abstraction.

Values, needs, and personality characteristics.

Values arise from human core needs (e.g., for stimulation or self-direction) and from social demands (e.g., successful interactions, group stability). Then, do personal values consequently encompass human core needs? This was indeed shown. Evidently, basic needs as well as needs concerning growth or self-actualization, as defined by MASLOW'S (1943) Pyramid of Human Needs, for example, correspond to respective value statements. Values imply motives, and motives imply behavioral dispositions. BILSKY AND SCHWARTZ (1994) empirically confirmed the hypothesis that behavioral dispositions, based on a need for growth for example, positively correlate with corresponding values (e.g., curiosity and simultaneous valuing of novelty) and that behavioral dispositions based on a basic need positively correlate with values that signal the satisfaction of these needs (e g., anxiety correlates with security as a pronounced value).

Thus, we have identified a particularly important function of our value system: It not only directly relates to the basic needs arising from our individual humanness, but – because of its superordinate position – it also governs the behavior that leads to the fulfillment of these needs. Values always have a positive connotation, while needs per se are neither good nor bad, nei-

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ther positive nor negative. However, the latter often prompt subsequent evaluations, albeit implicitly or automatically. Furthermore, it is important to note that values may be present at a time when the corresponding needs are not calling for gratification. Consequently, values are constructs that transcend the present and point to the future. They provide the individual with a direction and enable navigation, which is of great significance for planning, for example. BÜHLER, EKSTEIN, & SIMKIN (1976) speak of "constructive intention" as an essential property of personal values and as an active orienting toward generating an optimal future, i.e., to accomplish something, to build something, to manifest something that is understood as "good" or "true."

The relative stability of values across time and contexts suggests a conceptual kinship with personality characteristics and points to an interesting comparison (ROCCAS ET AL., 2002). Personality characteristics are lasting dispositions and describe "how people are." Values, in comparison, are lasting goals and reveal "what is of importance to people." Personality characteristics vary in frequency and intensity of occurrence; values, in comparison, vary in their importance as guiding principles. People judge values as desirable, while personality characteristics may be evaluated as positive or negative. Although people may explain their behavior by referring to characteristics or to values, people decidedly invoke their values when justifying choices or actions as legitimate or worthwhile. Also, values – but not personality characteristics – serve as standards against which one's own and others' behavior is evaluated. Finally, a person might have a particular personality characteristic, such as being "extraverted," and thus displays extraverted behavioral patterns with a certain frequency and intensity. A corresponding value would indicate the importance a person assigns to this display of extraverted behavioral patterns. Yet, there surely are extraverted people who would not endorse a corresponding value as a guiding principle in their lives.

The cognitive affective representation of personal values.

Therefore, it is no surprise that personal values do mold one's identity and color one's self-image! Empirically oriented developmental psychology qualifies a person's commitment to values as virtually identity-constituting (NUNNER-WINKLER, 2000). Today, it is assumed that values in the form of schemata are part of a person's fundamental self-concept (cf. SCHMITZ, 2000). A value schema is viewed as a complex, stable structure that emerged within the course of an individual's learning history and that may be modifiable and extendable via existing gaps. It contains cognitive, motivational, and affective components, and may be connected to other schemata more or less strongly. The following paragraphs will address this schematic nature in more detail.

Needs are sensed without delay. Values, in comparison, provide a more complex experience that results from the representation of values as complex schemata of needs, cognitions, and affect. A value does not equal a need, but it points the direction to the satisfaction of a need. Needs are represented by images of the conditions under which these needs might manifest

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and their meaning for the person. Assimilated to these schemata are the corresponding perceptions, pathways toward need satisfaction, probabilities of need satisfaction, causes and consequences of frustration, etc. These affective and motivational components of the "value schema" enable the person to judge the importance of a particular value, to choose a certain class of goals, to seek out and generate situations that correspond to the respective valued direction and to evaluate the effects of discrepancies regarding this value for the personal situation (cf. SCHMITZ, 2000). The author notes that the affect and the needs associated with the schema are relatively stable and lasting. Thus, the future-oriented aspect of values is emphasized as well, albeit in a different way. ULICH, KIENBAUM, AND VOLLAND (1999) also point to the close tie between emotional responses and personal values: Emotional responding signalizes the value-related relevance or the personal significance of an event for a particular person. We only feel compassion, for example, if our values include the wellbeing and welfare of another person. Values are like a screen on which personal experiences are reflected and evaluated regarding their trans-situational and temporally enduring aspects. Following well-established theories of cognitive psychology, the authors also developed an idea of how these schemata are activated: "Values are placeholders that fill in for certain actually occurring property configurations of triggering events. If an event activates a schema, then the properties of this event will replace the values in the gap structure according to best fit" (p. 59).
In addition to physical attributes, personal characteristics, and the image a person has of him or herself (the identity), values are decisive criteria supporting a person's definition of self. He or she determines what is worthwhile or important and limits his or her involvement. In this context and during any exchange with the environment, conformity with the respective value schema is always attempted.

An activation of the schema occurs if an actual context contains stimuli or cues that the person then relates to a value. This activation process is conceptualized as a change within the working self-concept (MARKUS, 1980; MARKUS & WURF, 1987). Psychologists who study affect agree that emotional responses signal the degree to which an event pertains to a person's values (ULICH, KIENBAUM, & VOLLAND, 1999). Emotional responses are "significance indices" that represent individual emotion-relevant value preferences, i.e., the extent of personal involvement and affectedness. Here the authors refer to an "emotional commitment to values."

Values and development.

In the course of socialization, humans find out what may engage them, or what may matter to them. The experience of need satisfaction is of course related, for this learning process depends on a number of conditions that promote or hinder the gratification of important psychological needs. If the developmental conditions support a child's needs for autonomy and affiliation, then one may predict that the values representing these needs will be preferred in adulthood. If, to the contrary, such childhood needs are blocked or frustrated, then one may

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predict a possible preoccupation with aspects of security and safety. KASSER, KOESTNER, AND LEKES (2002) conducted a comprehensive 26-year prospective longitudinal study to test these predictions. Archival data on parenting style, socioeconomic status, etc., collected when the participants were five years of age, were carefully analyzed and related to the results of the *Rokeach Value Survey*, completed by the participants when they were 31 years old. The study suggested that a restrictive parenting style positively correlates with a later preference for conformity values (e.g., obedience, politeness) and negatively correlates with a preference for self-actualization values (e.g., openness, autonomy). At the same time, a positive relationship was shown between socioeconomic status and restrictive parenting style. The one significant finding concerning those adults who were raised with a rather warm parenting style is also of interest: The preference for values that entail different aspects of security, such as security for the family, inner harmony, self-control, etc., decreased with a more pronounced warm parenting style. Consequently, the authors proposed that parenting style influences the manner in which childhood needs are satisfied. Such experiential guidelines for the satisfaction of needs apparently crystallize and emerge as values in adulthood.

The prerequisite for the transfer of experiences related to need satisfaction into the value system is the ability to perceive and acknowledge one's needs. Moreover, the concise nature of needs is a function of the person's current cognitive-affective developmental level. KEGAN'S (1986) approach seems particularly applicable to practical clinical purposes. He describes six developmental stages that are distinguished by characteristic patterns of interactions between a person and his or her environment (termed "the culture of embeddedness" by Kegan). With each stage, the person develops a broader and more differentiated perspective. Each respective preceding stage is integrated into the following one. Kegan calls this process "the development of cognitive-affective meaning:" The person's internal world is enriched, and the probability increases that higher levels enable a more complex understanding of other people's thoughts, feelings, and behavior as well as the contradictions therein. HAUKE (2001) shows the developmental stages that must be transitioned if experiences with certain needs or their satisfaction are to be possible at all. Power, for example, emerges as a thematic concern in the so-called imperial stage (between 6 and 10 years of age). The person identifies with his or her needs and acknowledges the role of social influence and control in the service of satisfying one's needs. Only if this role has been acknowledged, i.e., the so-called "interpersonal" level has been reached, then agreement and harmony – and therefore the restraint of impulses, tendencies, and conduct that could hurt other people or social expectations – come to play an increasing role. Indeed, this developmental step would be necessary for the exploration and integration of values concerning conformity and tradition.

While these developmental levels may be assigned to particular age groups, psychotherapy often provides services to adults whose functioning in certain areas of their lives may be best

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described by the first three levels of development and whose values are therefore imbalanced: These adults need excessive degrees of interpersonal or material security, for example; they require too high a level of group affiliation, too many guidelines, etc. As these adults evidently did not experience the satisfaction of their particular needs, these needs did not transfer to the value system and rather remained at the need level. Value-directed behavior implies being able to delay or postpone gratification and to know different alternatives for need gratification. In the preceding cases, values may have been "adopted" by imitation, but they never really developed.

Is a bird in the hand worth two in the bush?

Values should give direction and fulfillment to our lives. Sometimes we have to maintain the valued direction for a while until the goal comes within reach. Yet, sometimes we stray from the initially chosen path because something else, seemingly more attractive at this moment, has appeared on the horizon. For example, a person may drop out of a time and labor-intensive college education to take a job and finally afford certain things. Soon, the long overdue job change will be forgotten, entering exposure therapy will be postponed again, an impending conflict will be avoided, the next cigarette will be lit (albeit with a feeling of guilt), the weight gain will be accepted, etc. One lives a life one never intended.
Again and again people do not behave in accordance with their values but rather surrender to momentary impulses. From a psychological perspective, this conflict is about receiving small rewards now versus larger rewards later. Frequently, this dilemma ends when the vernacular heuristic of "one bird in the hand being worth two in the bush" is applied.
In these cases, are we simply too undisciplined, too lenient with ourselves, or are our values the wrong ones? All of this may be true. Our self-regulatory approach, which will be briefly described below, offers yet another alternative (for more detail, the reader is referred to my article *Self-regulation and mindfulness* in this issue). This approach assumes that all human behavior is goal-oriented and thus serves the gratification of various motivational goals. A person's most diverse goals, as they emerge from needs and personal values for example, are termed "reference values" (e.g., a certain degree of proximity).

Figure 1 illustrates that these reference values are ordered hierarchically, such that the degree of abstraction increases toward the top of the hierarchy, i.e., the more abstract personal values are superordinate to needs. Furthermore, it is important to note that the output of the preceding superordinate level sets the reference value of the next subordinate level. Thus, a certain identity determines the respective personal values and these in turn establish needs. If a discrepancy between reference and actual values is perceived, then behavior targeting the discrepancy's removal occurs. In other words, while steadily monitoring reference values, the system attempts to generate the corresponding perceptual experiences.

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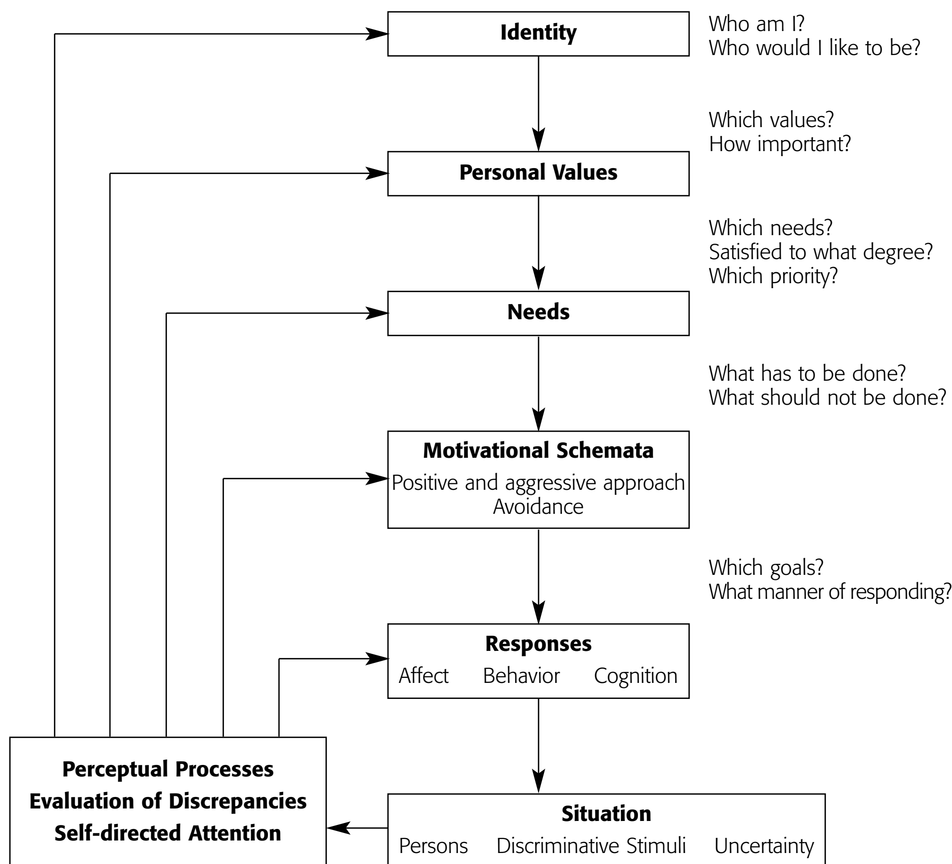

Figure 1. The location of personal values in the regulatory hierarchy

The regulatory system operates with different speed on different levels. The fastest processing occurs at the lower control levels (e.g., approach and avoidance programs or immediate motor control), simply because of the short paths involved. A plethora of experimental findings demonstrate the fundamental significance of a dual process model for regulation, the so-called "hot/cold-system" (MISCHEL & AYDUK, 2004). According to this model, the hot system enables simple and fast affective processing. It permits quick flight, fight, or appetitive approach-responding, probably mediated by the amygdala, and may be identified with the lower levels of the regulatory system. The cold system is an emotionally neutral knowledge system. Its processing speed is comparatively slow, and it seems to be linked to the hippocampal and frontal lobe modus operandi. It generates rational, reflective as well as strategic behavior and is identified with the higher levels of regulatory control. The respective representations are termed

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"hot spots" and "cool nodes." Both are connected via a parallel distributed neuronal network and exert reciprocal influence. Hot spots may be evoked when corresponding cool nodes are activated. However, because of this strong interconnection, the effects of hot representations may be weakened, or "cooled" as a manner of speaking, by the corresponding cool nodes. Figure 1 depicting the regulatory hierarchy thus illustrates: The processing mode of the superordinate regulatory levels prevents a disproportionate influence of the lower regulatory levels within the operation of the regulatory system. The person does not succumb to his or her impulses if the prevention of excessive overheating, i.e., intense activation of the hot system within the described interplay, is achieved via access to cool nodes. However, the balance of both systems depends on a person's current stress level. High levels of stress activate the hot system and decrease the cold system's activities (METCALFE & MISCHEL, 1999). Therefore, in stressful conditions, the lower regulatory levels are more involved in self-regulation than the superordinate regulatory levels.

This circumstance has received experimental support with regard to value-directed behavior (REITHER, 1997). The author assumed that participants would resort to their current value system to obtain a global direction and guidelines for their behavior, when faced with particularly indeterminate and complex situations that typically lacked unambiguous criteria for evaluation or decision-making. This was not confirmed. Instead, the initiation of crises and stress was consistently accompanied by a rise of considerable discrepancies between value-directed goals and intentions on the one hand and actual behavior on the other. While the frequency of value-discrepant decisions already amounted to 17 to 22% in stress-free routine situations, it increased to a remarkable 64% in critical situations (Figure 2).

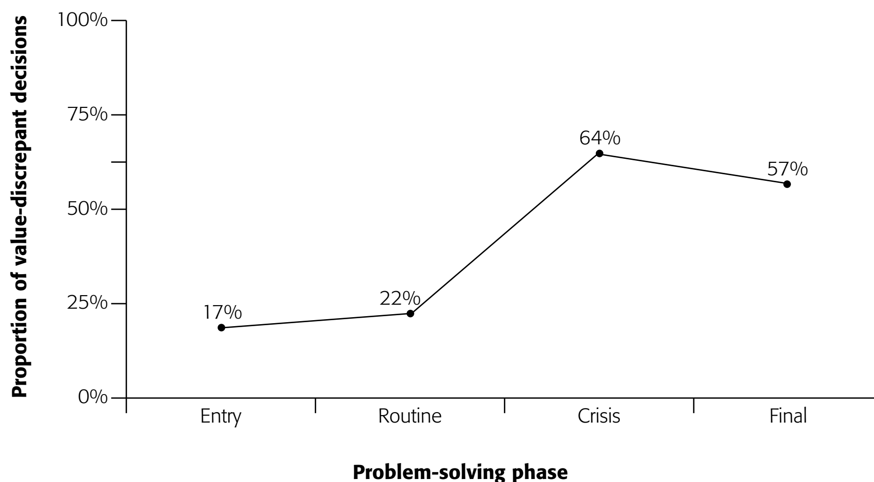

Figure 2. The decreased influence of values on behavior under stressful conditions (adapted from Reither, 1997).

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The stress that arises from deprivation or experiential avoidance, for example, may also be able to divert us from a chosen, value-oriented direction. The struggle with impulses that defy the original intentions flames up repeatedly until the struggler, weary and exhausted, drifts through life like a piece of wood in the open sea. The person has given up efforts to regulate him or herself. Evidently, such cases are accompanied by a shift in priorities, such that the weakening of impulse control serves to regulate stress (TICE, BRATSLAVSKY, & BAUMEISTER, 2001). Emotionally burdened humans succumb to their impulses in the hope to elevate mood and to reduce stress, if only temporarily. Many behavioral programs that target an increase of impulse control prohibit exactly those pleasures that are especially sought after by people who experience stress. In stressful times, the desire for immediate emotion regulation conflicts with other forms of self-regulation. Neglecting superordinate perspectives, this conflict is often decided in favor of the immediate elevation of mood. This is a different but significant aspect of the dilemma described above.

The control theoretical perspective interprets a person's behavior in these cases as governed by impulses and needs that generally produce short-term effects. For this reason, dangerous or critical situations related to the satisfaction of a vital need – in short, massive stress – trigger reflex-like, often also rule-governed, schematic emergency responses.
Values, survival strategies, and mindfulness. Such schemata comprise a strategic directive that instructs a person to initiate some behavior patterns and to strictly avoid others, so a particular need may be satisfied yet. We call this directive the "survival strategy," as its goal is emotional survival. Survival strategies are located at the program level of the regulatory hierarchy and connect reference values determined by needs with the motivational schemata of approach and avoidance (for details, the reader is referred to Sulz, this issue). Often, survival strategies are learned in childhood and, under certain conditions, lose their functionality as the person ages. An example clarifies that survival strategies are statements of beliefs and convictions: "Only if I exceed all expectations, if I never make mistakes, and if I avoid conflict as well as negative emotions, then I will receive protection and respect from significant others." If one now imagines this particular person angry in adulthood, the anger would threaten the person's fundamentally submissive stance and thereby generate stress. This stress would be reduced by the person's meticulous adherence to his or her survival strategy. The hot system would take over more of the control and, due to the reduced activity of the cold system, behavior would not be influenced by the superordinate regulatory levels, e.g., by values. Given the description so far, one may easily imagine how one may utilize mindfulness to break free from this trap; how one may escape the "grip" of the regulatory system in general and the demands of the survival strategy in particular. Strategic Brief Therapy (SBT) carefully prepares the path with the patient that has already been laid out by the survival strategy. The new, proactive rule for behavior says: "My behavior will counter my survival strategy, and I will expose myself to the inevitably arising distress as well as associated negative feelings. I will be mindful of physiological sensations,

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thoughts, images, and emotions; and I will not give in to the impulses inherent therein." A change in self-regulation not only implies leaving an undesirable state but also concurrently establishing an alternative state for a stable regulatory result (CARVER, LAWRENCE, & SCHEIER, 1996). An undesirable state is best left behind by encountering it mindfully, without being overtaken, and while seeking out the desirable state. Values indicate this direction. The value-directed path into the future is only possible, however, if consistency with the chosen direction can be maintained.

Democratic self-governance.

Here, volition comes into play. KUHL AND KOOLE (2004) functionally defined "will:" If the implementation of goal-directed behavior is difficult, the will has a coordinating function and synchronizes processes at various functional levels of personality to optimize perseverance and achievement of the current goal. If, for example, a difficult conversation is long overdue, volitional processes provide the necessary goal-directed patterns, e.g., tolerating the anxious tension, dosing the anger, motivating the self, correcting the mood, and heightening alertness. Contrary to the vernacular, which ties will to consciousness, this conceptualization includes processes concerning the formation and application of self-representations that may not always be conscious. Next, the authors make a for therapeutic purposes extremely important distinction: They describe a *democratic* and a *dictatorial* kind of will (*termed "self-maintenance" and "self-control," respectively, by the authors*).

The "democratic will" implies a volitional mode that "listens to many voices" (KUHL & KOOLE, 2004, p. 419): Counter-intentional impulses, feelings, interpretations, knowledge, etc., thus can come to bear upon the current decision-making process.

The dictatorial form of volition, in contrast, suppresses these processes and especially counter-intentional aspects of the self that might not support the current objective. An extremely restricted range of positive emotional resources – whose full spectrum is obtainable only when access to the self is comprehensive – is available. For this reason, great effort is necessary to accomplish the current objective. The danger of this "inner dictatorship" (FUHRMANN & KUHL, 1998, cited in KUHL & KOOLE, 2004, p. 416) lies in the chronic avoidance of the self-system and, therefore, in the loss of intrinsic pleasure. Goals and obligations cannot be checked for compatibility with the self and then integrated, if necessary. The sheer effort to be a determined human being lets the person progressively forget who he or she really is, what deeply touches him or her, and what makes him or her vulnerable.

Will is the "responsible mover" (YALOM, 1989). If therapy signifies movement and change, then therapy should develop and support volition, or more precisely its democratic form. Most people first have to learn democratic self-governance.

Democratic self-governance maintains an open, nonjudgmental, and invitational stance toward all feelings, impulses, internal images, and tendencies, especially counter-intentional ones. Spoken metaphorically, these are guests within my self. All of these guests use their voices to

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be noticed by me and to defend their requests. One request could be the completion of a particular task; another voice could demand off-time and leisure. Now, if we imagine that a careful, high-quality performance corresponds to my values, the call for off-time and leisure would be viewed as counter-intentional from an "undemocratic" point of view. Both voices become increasingly antagonistic. The more I demand to perform, the louder and more urgent becomes the wish to finally receive some time off and some leisure. Stonewalling occurs: What one side demands, the other denies. Democratic self-governance first and foremost means to acknowledge both voices and tendencies in a non-evaluative manner. To manage this burdensome situation appropriately, I must initially endure this dispute without taking sides, i.e., I may not allow either voice to take a hold of me. The required stance is best described by the term "mindfulness" (for a detailed review, the reader is referred to my paper, *Self-regulation and mindfulness*, in this issue). Mindfulness is the practice of self-caring acceptance. In a kind and serene manner, one turns toward one's self. All thoughts and emotions, even the distressing or negative ones, are encouraged. They are observed and acknowledged without yielding to them, without evaluating their content, and without giving in to the behavioral impulses inherent in our emotions. Thoughts and feelings are not harmful, even if they are able to terrify us or if they simply cause a lot of noise. Mindfulness generates psychological distance to content. Defusion occurs; the person views the appearing and disappearing contents as what they really are, rather than as indicative of his or her identity (Hayes, 2004). The effect of automatic behavioral tendencies is thus undermined, and internal flexibility increases again. Theoreticians with a self-regulation orientation repeatedly point to experiments demonstrating that suppression and avoidance are counterproductive; at the same time they are employing strategies of directed attention – mindfulness is a form of directed attention – to cool the "hot spots" (Mischel & Ayduk, 2004). Thereby, the person gains inner freedom. The reference values of superordinate regulatory levels, such as personal values, begin to contribute to self-regulation again and enable corresponding behavior.

When a standoff occurs, democratic self-governance would attempt to stimulate an internal dialogue involving both opponents. This stimulation may occur quite literally by juxtaposing two chairs within the therapeutic session and letting the patient take first the one and then the other side. The goal of clarifying and bargaining would be the unification of both parties into one team that represents the interests of both sides.

The implementation of the gained insights is especially important. The vernacular claim that "the road to hell is paved with good intentions" is not so wrong after all. Indeed, the frequency with which general intentions are translated into actions is pretty low (Gollwitzer, 1999). As our rather abstract values fall into the category of such general intentions, this finding is of the greatest therapeutic interest. According to Gollwitzer's additional findings, general intentions are realized more frequently if resolutions also specify the conditions of their implementation. What does that mean for the support of value-directed behavior? The person should specify when, where, and how the values will be implemented; the author speaks of "implementation inten-

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tions." Such plans detail the necessary steps, prevent frustration and probable temptation and facilitate the preparation for the most proximal task demands.
We take our work one step further. Patients do not only learn to be mindful and to acknowledge. As could be seen above, mindfulness *per se* would already produce more effective self-regulation; but we also help patients to develop implementation intentions according to democratic self-governance, so that the probability of behavior that actually reflects their chosen values increases. This generates an atmosphere of commitment, for the patient as well as for the therapist. At the core of the implementation intention is the survival strategy, already described above. This cognitive-affective schema is triggered by particularly stressful situations that threaten need satisfaction. The survival strategy activates behavior patterns that aim to guarantee the person's internal equilibrium and at least the minimal satisfaction of needs. The implementation intention contains instructions to engage in appropriate behavior that *counters* the survival strategy, e.g., with appropriate approximations depending upon the level of difficulty. In a "democratic manner," the selection of steps approximating the target behavior takes into account a certain need for security on the one hand and also a certain need for value-directed growth on the other. Any anxiety or frustration that may emerge in the process is again to be treated mindfully, i.e., the person follows a previously determined path even if the ground is repeatedly giving way. Under the influence of mindful self-observation and the direction-giving "guiding beam," the person engages in actions that run counter to his or her survival strategy and are at a selected level of difficulty, until new behavioral patterns have been stabilized. Figuratively speaking, stable ground is generated and can be firmly stepped upon in the pursuit of chosen values. This firm ground protects the person from being delivered to his or her impulses, fears, and stress-related schemata.

Types of values.

While people determine what is valuable and important to them and define the limits of their engagement, conformity to their respective value schema is always attempted in any interaction with the environment. Thus, among other things, different realms described by content or, more concisely, value domains such as achievement, hedonism, benevolence, etc., define a person's identity (Figure 3).

From a schema-theoretical perspective, these are meta-schemata. If these domains lead to favorable experiences, then feelings of fulfillment, worth, i.e., self-esteem, arise. While searching for the most comprehensive systematic approach to human values, a two-dimensional value structure was established empirically. Its validity has been demonstrated in more than 70 countries since (SCHWARTZ, 1999). Ten different kinds of values may be delimited and distinguished (statistically and by content): Segments, termed "value domains," emerge. Each of these ten segments contains compatible motivational goals, such as "selecting one's goals," "independent thinking," "creativity," etc., categorized as "self-direction." The segment termed

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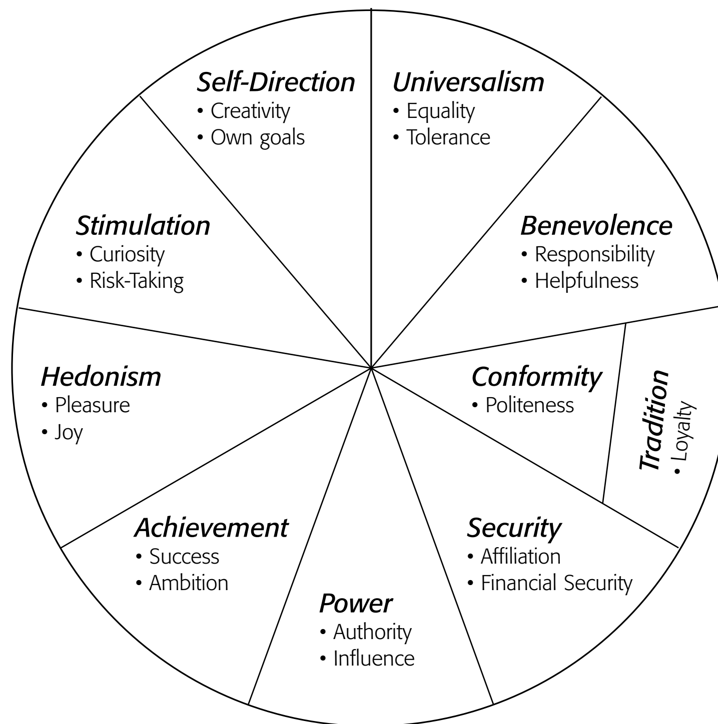

Figure 3. Empirically derived value structure (adapted from Schwartz, 1992)

"power" summarizes, for example, "position," status," "authority," "influence", etc. (see also Table 1).

Value domains as the subject matter of psychotherapeutic work

While the description of the contents of specific value domains has been very abstract up to this point, one's therapeutic work may be enriched if one is familiar with and able to evaluate the characteristics of a person's motivational goals. Core themes in psychotherapeutic work are generated in the process. For this reason, a more detailed characterization of value domains will be provided.

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Table 1. Description of value domains according to Schwartz (1992).

Domain	***Description***
Power	Social status and prestige; control or dominance over people and resources (social power, authority, wealth)
Achievement	Personal success demonstrating competence with regard to social standards (successful, industrious, ambitious, influential)
Hedonism	Enjoyment and emotional satisfaction for oneself (joy, pleasure)
Stimulation	Excitement, novelty and challenge in one's life (risks; diversified, eventful, and exciting life)
Self-direction	Independent thinking and acting, creating, exploring (creativity, non-conformity, freedom, selection of one's goals)
Universalism	Understanding, grateful, tolerant and protective of people's and nature's welfare (generosity, wisdom, equality, social justice, peace, beauty, environmental protection)
Benevolence	Maintaining and increasing the wellbeing of people with whom one has frequent contact (helpful, honest, forgiving, loyal, committed)
Tradition	Respect, duty, and acceptance of customs, conventions, and cultural and religious ideas (humble, accepting the givens of my life, ready to sacrifice, respect for tradition, moderate)
Conformity	Restraint of those impulses, tendencies, or behaviors that might violate other people, social expectations, or norms (politeness, obedience, self-discipline, respect for parents and the aged)
Security	Security; social, interpersonal and intrapersonal harmony and stability (family security, national security, social order, etiquette, reciprocity of benevolence and complaisance)

Power.

Opportunities to exert power may be taken or avoided. The core goal of the power domain is the maintenance of social status and prestige as well as influence and dominance over people and resources. Resources may consist of economic and psychological rewards, the control of information, expert knowledge and skills, entitlement through position in a group, material and personal equipment, and finally personal attraction and persuasiveness. HECKHAUSEN (1989) describes the process of motivational power as striving to induce another person to do or to feel something that he or she would not have done or felt without this influence. If we add that this circumstance may also apply to control over resources, then both definitions are congruent. Effective behavior motivated by power waxes and wanes dependent on the activation of goal-directed behavior associated with access to positive emotions. Thus, the topic of "self-assertiveness" is introduced, which characterizes one's striving to affirm needs and goals even and especially when others resist. Here, the experience of control is essential, i.e., the experience that the employed behavior actually effects the intentioned influence. One may

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conclude that power may be an issue in a person's life when powerful, supportive, and other controlling behavioral patterns are described; when these evoke stronger emotions in others; and, finally, when somebody is preoccupied with his or her reputation and social status.
In general, the social conduct of individuals who are primarily motivated by power is facilitated by a lower motivation for secure attachment (BISCHOF, 1998). If these individuals are threatened or challenged, they are able to bring their entire hitherto existing experiential knowledge, their expertise, to the situation in a relatively assertive manner. Thus, while they are engaged in behavior, perceptions that run counter to their wishes or expectations hardly affect these individuals; assertive aggressiveness and readiness for combat play a critical role. Under some conditions, this may also apply to ethical and moral aspects. KUHL (2001) characterizes more variants of these "core components" of behavior motivated by power.

Achievement.

The value domain termed "achievement" characterizes striving to prove one's industriousness in relation to social norms for excellence. The following goals, which may be pursued by individuals for whom achievement is a motivator, also hold as core properties (see also SCHNEIDER & SCHMALT, 2000): Doing something as quickly and well as possible; overcoming barriers; expending effort; achieving high standards; striving for recognition; distinguishing oneself; competing with others and attempting to outperform them; serving one's self-interest through the adroit use of one's talents. The proximity to the power domain becomes evident. Not only curiosity but also the associated exploratory behavior is an important component of the achievement domain. However, as they constitute their own value domain ("stimulation"), we will not detail them at this point. Curiosity and achievement as motivation are essentially different because the latter is more strongly directed toward concrete results, or at least toward an explicitly desired cognitive aim.
It is especially this focus on concrete results that generates opportunities for social comparison and thereby produces a certain pressure. The better, the more successful and the failing person are immediately recognizable. In this respect, this value domain also involves a latent anxiety component. Typically, performance anxiety is a fear of social evaluation and the subsequent devaluation of one's person in case of failure. This anxiety does not have to manifest itself; instead, in the most constructive case, it may lead to an active examination of socially anchored performance standards, e.g., in the form of competition. Anxiety manifests in people who maintain vague and abstract projects and goals; who rather than transitioning to behavior, stay with their imagination for – if their goals were binding – a comparison would produce negative results. An avoidant tendency may also be present when standards are set extremely high and extreme efforts are invested consequently. In this fashion, any risk of an unfavorable social comparison shall be precluded. This is a characteristic of achievement-motivated individuals: They are able to actively manage the negative affect that accompanies a risk of failure and to sort out their problems in specific ways. They are able to switch between problem-solving and

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action, and they also have the courage to problem-solve creatively. This ability and their willingness to persist and expend effort enable them to accomplish even difficult tasks.

Hedonism.

The value domain termed "hedonism" contains motivational goals that relate to the experience of joy, zest, and sensual pleasures. GRAWE (1998) precisely defined this domain: "A person strives to attain the most positive pleasure/pain balance. This is a matter of Freud's pleasure principle: Seeking pleasure and avoiding pain" (p. 393). The experience originates in the satisfaction of needs; the appearance of appetitive sensations; the reduction of painful sensations. The human biological blueprint firmly anchors pleasure and pain. From birth to death, they are the most important feedback for shaping behavior that is environmentally appropriate. The exclusive satisfaction of needs may be pleasurable but does not have to be. For example, being guided by an ethical maxim may provide greater satisfaction than the immediate pleasure derived from satisfying a "forbidden" need. Despite the apparent limitation of the pleasure principle, or its supplementation by the reality principle, the role of pleasure and pain as the great taskmasters is plain: People repeat those behavioral patterns whose immediate or long-term consequences are experienced as pleasurable; and they forego those behavioral patterns whose consequences are related to pain. Happiness, in particular, appears when there is an abrupt change in need level and sensations. The range of possible goals is enormous: Eating and drinking well; having good sex; achieving demanding performance standards; solving protracted problems; listening to certain pieces of music; experiencing nature; drawing people's attention, etc. All needs that we have mentioned so far may be involved. For classification purposes, contentment and satisfaction are more associated with a balanced need level and much less abrupt change. In this context, the effect of a joke may serve as an example: Any joke first manifests a phase of uncertainty (increasing arousal) followed by clearness and certainty (rapidly decreasing arousal). An aesthetic experience is similar: Uncertainty and obscurity play a role initially, too, until cognitive and emotional activity produce a change and a solution directed at "ordering the chaos," for example while viewing scenes, works of art, or listening to music, etc.

Stimulation.

The motivational goals described in the value domain "stimulation" are important for maintaining an optimal mental activity level and meeting the need for diversification, variety, and stimulation: Doing something enthralling and sweeping, new and different; experiencing regeneration and diversification within one's daily routine; challenging oneself in novel professional situations; examining unfamiliar situations; traveling; meeting strangers; taking on different or even unfamiliar roles; being open for new trends, etc.
Clearly, this search for stimulation links to behavioral patterns containing a curiosity motive, related interests and exploratory behavior. More or less salient external cues and changes there-

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of may intersect with a correspondingly developed tendency for curiosity and may mobilize energies for exploratory behavior. In this context, the perceptual system works more "generously" as a whole. Stimuli are treated as acceptable even if they are not familiar. KUHL (2001) calls this behavior more "impressionable," in that the consequences of exploratory behavior do not have to strictly match the intended result or precisely defined expectations; deviations from certain anticipatory stances are more acceptable. General curiosity is more "shallow:" Because of a perceived poverty of stimulation or even boredom, this type of curiosity expands into all possible directions, probes here and there. Here, people do not seek information concerning a concrete issue but distraction and stimulation. Specific curiosity, on the other hand, is induced by a concrete issue, e.g., creative problem-solving, and targets the thorough exploration of an object. It is evoked by novelty, complexity, ambiguity, objective uncertainty, or unpredictability of a spatial or temporal succession of events that prompt perceptual attention, approach, manipulation, and investigation (SCHNEIDER & SCHMALT, 2000). Because the clear aim of specific curiosity enables the fading of the broader environment and irrelevant stimuli, the qualities of objects and events – particularly with regard to their harmful potential – can be more thoroughly examined and evaluated. General curiosity, in contrast, is triggered by a person's temperament, impulsivity, and his or her degree of extraversion. The fewer the number of warning signs perceived in a certain situation, the smaller the subjective risk or the greater the experienced security, and the more pronounced the general curiosity: the person's behavior does not have to focus on problematic, perhaps even anxiety-producing events that must be kept in check. It can maintain its broad course and draw from a range of possible operations. Conversely, people who discern a very high subjective risk of danger are very security-oriented and tend to avoid the unfamiliar and unexpected. They strive for the greatest amount of certainty, which produces the rather anxiety-motivated curiosity (described above), but does not result in pleasurable exploration, interested sampling or experimentation. This kind of pleasurable curiosity is shaped by a person's learning history, such that parents generally communicate a feeling of security and provide the child with opportunities to experience feelings of self-efficacy, especially while exploring novel environments. These interrelations also clarify the conflicted positioning of security and stimulation in our value spectrum.

Self-direction.

Self-direction is almost a general stance toward life and as such represents a valued domain described as: Autonomous thinking and acting, creating and exploring (creativity, zest for knowledge, freedom, selecting one's goals). This interpretation suggests an intensive examination of the goals involved in the quest for autonomy and dialectical learning as well as forms of intrinsic motivation (KUHL, 2001).

Autonomy is closely tied to independence, self-sufficiency, individuation, and personal control. BISCHOF (1998) defined a demand for autonomy as a reference value that denotes governing one's own life; setting one's own standards; exerting a meaning-giving influence on events

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occurring in one's personal sphere. At the same time, Bischof stipulated a striving for hierarchical status, which concurrently reduces external demands for autonomy. A high demand for autonomy curbs dependencies and increases initiative. It generates independence from feelings of security, permits the perception of weariness related to excessive familiarization and entitlement, and urges a person to undertake the fascinating adventure of encounters with strangers. In this context, the achievement of concrete results and the associated management of latent performance anxiety are not the primary concerns. Instead, the main issue is the process necessary to acquire and further the skills necessary to consistently manage new challenges. Indeed, for this reason positive interpretations of failure may emerge at this point. Negative emotions are not ignored but are managed by reframing any threat to self-esteem as a challenge. Any difficulties or problems that may arise are viewed as opportunities for learning and growth. KUHL (2001) analyzed this circumstance from a cognitivist perspective and described the capacity to hold both positive and negative affective states – the so-called "emotional dialectic" – as a core characteristic of self-actualization. A pendulum swing toward negative affect requires the willingness to permit and tolerate negative emotions, so that the important information contained therein may be perceived and processed. Conversely, this means: Tolerating the inhibition of positive emotions – tolerance of frustration – is prerequisite for further developing expanded, more efficient problem-solving and planning structures. Such persons are able to constructively manage the distress that is produced by crises and by substantial environmental change processes. They are able to detect the positive in the negative (dialectic).

At issue may be the need to familiarize oneself with different facets of one's personhood and so growing to be a more comprehensive personality who knows and accepts his or her bright as well as the dark sides. Essential characteristics are: Taking responsibility for one's personal fate and for one's decisions; active doing and detecting opportunities for choice even in difficult situations; not feeling helplessly determined; never leaving decisions to others. People who are self-directed are not quite as worried about themselves. Usually, they have identified a task or a mission in their lives, a problem external to themselves that requires much of their energy. Self-direction demands lifelong struggling, overcoming difficulties, and integrating of the most diverse goals and motives. Obviously, this motivation may only be effective if people have the skills to reliably satisfy their basic needs. For this reason, not the motivation to meet basic needs but a motivation to grow has taken the developmental center stage and enables a relative independence from environmental factors through relative stability, also with regard to hard blows, deprivations, frustrations, and the like. This relative autonomy from their respective social environment is typical for intrinsically motivated people. They strive for goals that are not externally dictated and have to be adopted. Feelings of external pressure are nonexistent. Some cases may involve an escape from a pressuring performance comparison in one realm into other realms of activity. However, intrinsic performance motivation can be identified if engagement with an activity occurs for the activity's sake. In contrast to the classical variant of perfor-

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mance motivation, the engagement is not understood as instrumentally related to an ongoing social comparison. Here, the person has nothing to prove. This form of performance motivation has an experimental, yes, even an almost playful character. Often, an attempt is made to discover novel, exciting aspects of an activity.

Persons who are motivated by basic needs always must have others available to satisfy core needs, such as love, security, respect, prestige, and closeness. Growth-motivated individuals are not very conforming, in that many aspects of their worldview, their thinking, and their behavioral patterns may not quite correspond to the zeitgeist.

Benevolence.

Based on their studies, SCHWARTZ AND BILSKY (1987) abandoned their original conception of "prosocial behavior" for the "benevolence" category which, according to the authors, represents a more precisely defined version of the original. This distinction is very significant for our purposes: A prosocial orientation considers the welfare of all people in all possible settings, while benevolence only applies to the welfare of persons with close emotional proximity in everyday interactions – and exactly those are of interest here. This latter conception targets the need to contribute positive interactions to promote and support the development and maintenance of those social groups with which the person affiliates. The driving force is, of course, the elementary basic need to affiliate with and attach to others, which indeed may be directly experienced within the family, the workgroup, the circle of friends, etc., on a daily basis. This value domain is defined as "maintaining and increasing the wellbeing of people with whom one cultivates frequent personal contact."

As different motivational goals may underlie specific values, they may be operationalized in different ways. The motivation for affiliation is closest to the need to initiate and maintain contact with other people. However, it was shown that different forms of this motivation for affiliation have to be distinguished (see also KUHL, 2001). One form of motivation for affiliation is directed at personal encounters and entails a positive affective core with regard to curiosity and interest. It occurs in connection with symmetrical communication, or an encounter at eye level. The dialogues do not involve dominance patterns, i.e., any motivation related thereto is non-directive. Positive feelings are expressed, people disclose, talk about themselves and their experiences, and listen empathically. They carefully select their conversational partner and pay more attention to details. Another form of motivation for affiliation is characterized by the wish to establish friendly contact with previously unfamiliar individuals. Here, gregariousness, interest, and entertainment matter, rather than personal encounter and self-disclosure. The construct of extraversion applies here. Fun and entertainment are the goals, rather than a meaningful human encounter or the comprehensive comparison and alignment of one's own needs with those of the partner in the interaction.

Yet another version of the motivation for affiliation must be distinguished. It may be characterized by a primarily protection and support-oriented need for the maintenance of social affilia-

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tion. This need for affiliation is based on the regulation of negative affect, even if it is not always accompanied by consciously experienced anxiety. This negative affect is to be avoided, i.e., insecurity and loneliness are to be prevented. The fear associated with a jeopardized need for security is of the issue. These persons require protection and security and hope to gain them by affiliation. Such motivational goals are better categorized in the "security" domain.

Universalism.

This value domain expands the perceptions concerning immediately affiliated groups to a broader context: "Understanding, appreciation, tolerance, and protection regarding the welfare of all people and nature," is SCHWARTZ'S (1992) definition. If the previously described domains still attended to differences, contrasts, and distinctions with regard to less familiar groups, then this present category emphasizes the common ground that unites the entire human population. The corresponding motives incorporate themes such as equality, freedom, social justice, and peace.

Here, thinking occurs in the context of a large network and highlights the trans-cultural aspects of human thought and behavior. Understanding and empathy for other cultures, groups, interests, and customs belong into this category. Another aspect is the appreciation and reverence for everything that is. This also involves connectedness with nature and engagement for its protection. Not all motivational goals in the guise of universalism are accordingly motivated. For this reason, this value domain is the direct neighbor of self-direction. Genuine universalism is therefore associated with a certain level of maturity, yes, perhaps even wisdom.

Tradition.

The motivational goals of this value domain are respect, participation, acceptance, and an internal commitment to the goods and ideas that tradition or religion provide to the person. Tradition presupposes origination in the past as well as continued influence of the past in the present and in the future. It strengthens group coherence and identity and thereby also the social basis of an individual's social identity. Thus, certain time-tested habits may traditionalize, and for this reason the term "tradition" already implies a value judgment. Tradition is associated with a person's subordination to more abstract events, such as religion, culturally determined fashions and values, for example, some forms of etiquette, avoidance of particular topics, appropriate dress for specific occasions, etc. If individuals want to affiliate with a certain group, they demonstrate their willingness to subordinate when they participate in ceremonies and rituals and display particular symbols. Usually, the norms are set by the respective culture; however, subcultures, such as respective teams and workgroups, cliques, associations, etc. may affect the individual's behavior even more immediately. There are entrance and exit rituals, conference rituals, boozing ceremonies, joint breakfasts, outdoor events, yearly acceptance speeches, symbols such as the corporate car, cell phone, etc.

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Why should an individual subscribe to such values? Let us look at two extreme cases: People high in individualism would associate such traditional values with a demand for subordination. They derive their identity mainly from contrast and distinction; the core of their identity in this case is rather tied to uniqueness. A personality with a collectivist orientation would, of course, be more likely to emphasize the positive aspects of traditions, e.g., communal experiences and actions, while occupying a clearly assigned position within the group. Here, the identity derives mainly from the group, from the participation in its realm of strength and influence. Most people will vacillate between these two poles. For this reason, it is necessary at times to emerge from the group, to feel oneself, to clarify one's own standards, and to experience relative independence. On the other hand, it may be markedly relaxing and supportive for people with a strong identity as an individual to submerge in a group once in a while and to permit being carried by the identity of the collective. Thus, adopting certain traditions may be worthwhile here and there.

Conformity.

Conformity symbolizes one's subordination to people with whom contact is frequent: Superiors, mentors, teachers, parents, but also more generally social groups, acquaintances, friends, etc. Accordingly, the motivational goal of this value type is the "restraint of those impulses, tendencies, and behaviors that may hurt other people, social expectations, or norms" (SCHWARTZ, 1992). Subordination to individuals or to groups may also be required. Particularly to preserve the interests of group or team goals, the individual must restrain behavioral tendencies that are disruptive in interactions or present barriers to goal-directed group processes. The definition also implies the entire or partial withdrawal of one's demand for autonomy. Social groups develop hierarchies for this purpose. Hierarchies determine who precedes others in accessing a shared desired resource (BISCHOF, 1998). They may be formally or informally established and become tangible and visible through rituals and symbols. In this context, one's relationship with powerful individuals becomes a theme. Accepting the hierarchy and displaying the respective conforming behavior are accompanied by relief; struggles and disputes disappear for the time being. As one's identity is to be strengthened and expanded, and as one's status has to be maintained and protected, the quality of the relationship with the powerful person gains in importance. If this person is perceived as an expert with credibility and legitimacy, then the subordinate is most likely to adopt this person's values and standards. The individual member may display conformity with the group in three ways:

(1) *Conformity by compliance* characterizes a situation in which the individual's values overlap only partially or not at all with the group norms. The individual still behaves in accordance with the group: (a) because of actual or perceived group pressure; (b) because the group's approval is sought; and (c) because resisting conformity is associated with great "cost."

(2) *Conformity by identification* characterizes a situation in which a group member establishes and intensifies a relationship with the group or with particular group members and identifies with the goals or values of the group during this process.

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(3) *Conformity by internalization* characterizes a state in which the norms completely overlap with the group member's personal values.

Security.

SCHWARTZ (1992) conceptualizes this value domain as containing two classes of motivational goals: Those that refer to the individual's security and those that concern the security and the preservation of social structures. But why should a person value the preservation of a social structure? Only because this stable social structure communicates security to the person. Here, people believe their needs and concerns in good hands, perhaps they even feel secure. Individuals need the "security good" to different degrees. BISCHOF (1998) explains this with his Zurich Model. A security reserve that ideally is neither depleted (insecurity, seeking affiliation) nor overflowing, is fed from the outside through the security found in the proximity of familiar people and from the inside (1) through self-confidence supported by the demand for authority and (2) through memories of external security reliably experienced in the past and internalized in basic trust. Preferences for the value domain "security" will be especially apparent when both conditions have not been met for a person. Our values spectrum (Figure 3) shows that the value domains associated with autonomy (self-direction and stimulation) oppose those related to security. This indicates a value conflict: People with a high demand for authority soon will respond with weariness and boredom to a high degree of security and begin to avoid it. However, the Zurich Model also notes that the container may not be emptied, i.e., even for persons with a high demand of authority does security matter, albeit not explicitly: There is no urgent need for security from the outside because these individuals are able to access an "internal" form of security, self-confidence.

In our context, we have to consider the different classes of security-related goals:

- *Financial security*: Secure employment; protection against loss of income.
- *Health*: Protection against illness and disability.
- *Process security*: Keeping things clean and in order; advance planning; organizing work to the tee; arranging one's affairs so that they progress smoothly and without unexpected changes; knowing one's options and forecasting all possible consequences of decisions; avoiding tasks and decisions that are associated with risks or failure.
- *Relationship security*: Keeping promises; reciprocating positive behavior and favors; harmony; honesty; trust; fairness; being accepted; affiliation.

Furthermore, this domain comprises motivational goals that are connected to national security and the social order.

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Value structure: Synergists and antagonists.

The proposed circular structure has several important consequences. Similar value domains, such as achievement and power, are proximal to each other. Both symbolize social superiority and social privilege. The pair "power/security" is also of interest: They share the elimination of indeterminacy, which like a thorn may cause a high level of distress (security, for example through secure relationships, harmony, social order; power through governance, exerting control, etc.). The values that conflict with each other are found far apart from each other in the circular structure, e.g., security and stimulation.

Further studies have shown that these ten value domains can be described by two bipolar dimensions of a higher order (SCHWARTZ, 1992; 1996). This circumstance is illustrated in Figure 4.

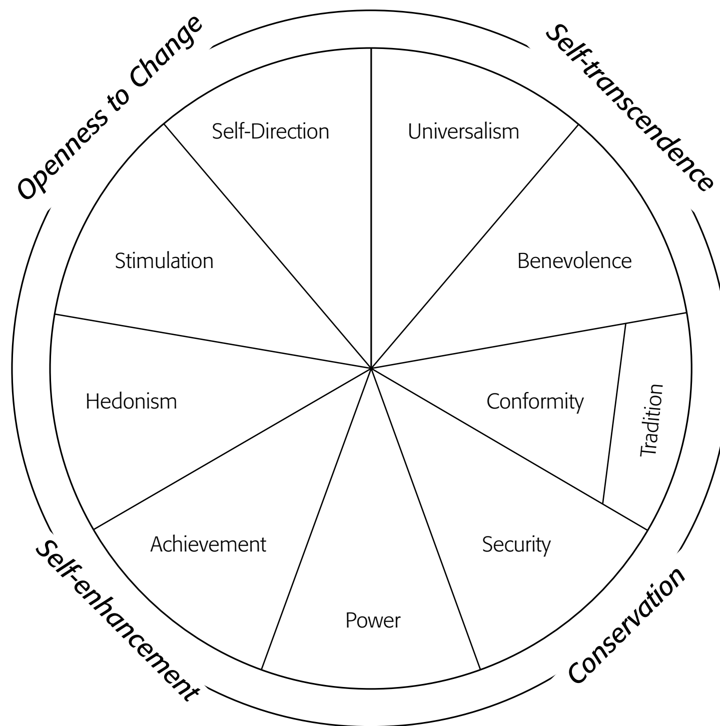

Figure 4. Superordinate characteristics of ten value domains.

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Conservation (tradition, conformity, security)
versus
Openness to change (self-direction, stimulation)

Self-enhancement (power, achievement, hedonism)
versus
Self-transcendence (universalism, benevolence)

One realizes – and the labels already point to it – that the value structure indicates conflicting constellations. Certain value orientations fit together at first go because their goals assume similar directions; we call these synergists (e.g., achievement and power). Other value orientations oppose each other and are incompatible; we call these antagonists (e.g., power and universalism). On the one hand, all poles denote a general style of coping with complex situations; on the other, they also mark the fundamental conflicts that have to be confronted or avoided. The psychological significance arises from the following juxtapositions (see also ROHAN, 2000):

Conservation versus openness to change.

On the one hand, the status quo has to be protected and maintained (e.g., relationships with significant others; material possessions; tried-and-true coping patterns; rituals). Here, organization and predictability play a great role in all respects. For this reason, appreciation for time-tested objects and events and concern for their persistence have great significance. Under given circumstances, projects, operations, and procedures are meticulously planned. Preventive behavior as well as caution and possibly trepidation are characteristic.
On the other hand, opportunities and possibilities for the development of variability await their discovery and utilization beyond the beaten path. Accessing new horizons and forging novel opportunities require interest and curiosity. So does the readiness to follow one's own intellectual and emotional interests, even if one is not quite certain of the outcome. Obviously, risk-taking is also required, but so is the capacity to learn from one's mistakes.

Self-enhancement versus self-transcendence.

Self-enhancement clearly focuses on self-interest. It is about striving for success and dominance over others – for a higher position, better looks, greater influence, or better performance, for example. This orientation leaves nothing to self-organization or to chance. Instead, intervening, governing, and controlling behavioral patterns are involved, so that processes may be directed to serve one's own interests.
Self-transcendence, in contrast, focuses on the general social context. Here, the world is to be accepted as it is; everybody is an equal. A benevolent acceptance of others as equals, and

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interest in as well as action for their welfare exist in this realm. Everything, including the people, is essentially good; every event is harmonious and has meaning; self-organization is desired, hierarchies are foregone. The goal is the harmonious integration within the respective environment instead of dominating it or putting it into the service of any particular interests.

Prerequisites for psychological flexibility: Antagonists become synergists.

God is day night, winter summer, war peace, satiety hunger. **Heraklit**

Without further explanation, the preceding paragraphs clarify that people are not able to effectively cope with the challenging, diverse and complex situations of everyday life in the long run if they lack the feel for the necessity of all four poles of the value structure. The lopsidedness of values may produce pleasurable consequences in the short term. However, in the medium or long-term, the person and his or her system suffer. More than ever in times of great change, sought particularly in psychotherapy, patients have to be able to establish a balance among antagonistic value domains. The setting of antagonistic goals has to be constructively managed. When "either-or" becomes "as well," then value conflicts constructively dissolve:

Conservation as well as openness for change.

Openness for change protects the objects and events worth preserving. Often, change is virtually forced by external factors or psychological strain. Those resisting change first cause subtle damage to the system, then fail, fall really ill or break down, so that nothing is left in the end. However, those open to change are able to generate conditions that also support the conservation of time-tested events within the changed situation. Change is often accompanied by turbulence and uncertainty. In such stressful times, those who want to successfully change their lives need some continuity to which they may resort. Here, the person is in the eye of the storm, rediscovers familiar ground, is able to refuel for further taxing change processes.

Self-enhancement as well as self-transcendence.

Self-transcendent goals promote self-enhancing goal-setting. By broadening their perspective, patients integrate their self-enhancing goals into the larger context and thus achieve control of reality. At best, they stick up for the interests of all involved and thereby increase the probability for their own success: "If I open up to others' interests and if I show understanding and empathy for their concerns, then I am most likely to encounter acceptance and empathy for my self-enhancing goals and more readily obtain support for their implementation." Barriers can be dissolved, social support becomes more probable. Exclusively self-transcendent individuals are at risk of losing themselves and the respect of others. They avoid displaying themselves or getting noticed. Their focus on others carries a risk of entering dependent relationships.

Given these considerations, it becomes clear that conflicting value orientations in effect need each other and produce synergies. All four realms are obviously important for individuals as well as for smaller and larger social systems. Nevertheless, the respective opposing areas are

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not easily integrated into action, especially during stressful times. This circumstance defines a further task for Strategic Brief Therapy (SBT): the mitigation of value conflicts, the formulation and support of the "as well as" concerning antagonistic value domains. Thus, our direction-giving compass needle has two "halves" – just like a real compass. One half points north or west, the other south or east. This multipolarity ensures flexibility: If barriers appear, a step into an old, familiar direction may be taken until an opportunity presents itself and sufficient strength is accessible to change the course into the new direction again. This also clarifies that the old direction constitutes a resource that only brings disadvantages if it is excessively present.

SCHWARTZ'S (1992) value structure not only aids the categorization of motivational goals but it also illuminates their relationship to each other; moreover, functionally matched interventions emerge from their antagonistic structure.

A case vignette

We have laid the groundwork to examine a psychotherapy case and to demonstrate how the value structure may provide a navigational aid for the selection and dosing of effective interventions.

My patient, V., is 22 years old and suffers from a major depressive episode with pronounced features of a borderline personality. She is the middle one of three daughters. Since graduation from *Gymnasium* she has attended a music school with a focus on "Modern Jazz" and has lived alone in an apartment. Her father financially supports her. Severe anxiety and feelings of panic have been present since she has been eight years old. Both parents are medical doctors and work together in private practice.

The patient reported that everything had been about her mother: She always had taken center stage with her depressions and had complained about pain and somatoform problems. The patient had been closest to her mother and constantly had to listen to her mother's complaints and problems with the father. Conversely, the mother had responded with anger and contempt to the patient's problems. She had never been able to tolerate stress but always had demanded to be made to feel like a super mom. The father had always been preoccupied with work. He had been present only if he was needed as a helper, and then rather cold and functional. Otherwise, he had not been that interested in his daughters but had been rather jealous of their close relationship with their mother. If something had not gone according to plan, he had tended to become very devaluating, hot-tempered, and unpredictable and had beaten the children. The older sister had been dominant and aggressive toward the patient and extremely jealous of her.

The emotional atmosphere within the family clearly seemed to be permeated by strong negative emotions. Even if isolation had felt bad, the patient had felt most secure alone. In relationships, she had tended to lose the feel for herself, for good and bad, false and true. In relationships, she had had knee-jerk responses from great tension to fantasies involving hate and

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violence that had terrified her and – incomprehensible for all – had forced her quick withdrawal. She had experienced this as physical pain, had cut herself under these circumstances, and had only wanted to die.

Strategy 1: Mindfulness and values work.

Regardless of therapy, effectively unearthing resources already takes us one step closer to the desired therapeutic target. Most patients do not easily enter therapy. The necessary, upcoming examination of problems, difficulties and deficits is not quite conducive to self-esteem building. On the other hand, patients need to believe in themselves if they are to successfully complete therapy. For these reasons, resource activation occurs right at the beginning of therapy: valued directions are identified and the skills for directed attention, i.e., mindfulness, are taught for they permit a more successful distancing from distressing thoughts and feelings (for further details, the reader is referred to my paper *Self-regulation and mindfulness* in this issue).

In the first phase of therapy, the patient was instructed to observe her thoughts and feelings while focusing on the breath two times a day for ten minutes, and to practice mindfulness in daily routine situations. She kept a diary monitoring her progress. According to her experiences, corrections were discussed if necessary and an intensification of practice jointly planned. After a while, she was also asked to observe whether there were some daily, rather mundane events that touched her, e.g., the special illumination at dawn, leaves changing color, dew on leaves of grass, etc. This work generates an appropriate context to initiate the value work.

Values are guiding principles that render a life "good," "true," or "right;" they reveal what patients deem important. They vary in their priorities as guiding principles and are future-directed. Especially the future-related aspects were clearly obscured in the face of urgent mental difficulties; and when the questions as to her future were introduced, the patient initially seemed a bit uncertain. There are several possibilities for introducing the values work: A conversation or the completion of a questionnaire does not seem to produce sufficient results. For this reason, the combination with an experiential exercise is recommended.

In the context of homework, the creation of a collage concerning the question, "who am I and who would I like to be," is very intense and strongly targeted at values as constituents of the self. In addition to the self-defining aspects of values, this question also brings to bear their desirability characteristic. The patient was asked to be mindful of her daily activities for a while. Then she was to leaf through magazines she had at home; to cut out any pictures that struck her as pertaining to the question; and to glue them onto flipchart paper. There were no instructions as to the arrangement. She was also free to supplement the display by painting it with oil-chalk or ink.

The patient was very engaged in this value assessment from which the following values emerged:

- "Nature:" Respect and appreciation for creation;

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- "Gaining insight into broader contexts:" A philosophical question as to the origin of human beings and their fate;
- "Security in god:" The meaning of security;
- "Music:" A medium for self-expression and in the sense of power and harmony;
- "Harmonious relationships with other people:" A foothold, support, and security, but also a little "wish for interchange and competition."

Considering the description of our value domains, we may preliminarily categorize the first two values as "universalism," the third as "security." The fourth value, described as "music," may be sorted into the "self-direction" value domain. The fifth guiding principle more strongly refers to the value domain "security" and less pronounced into the value areas "achievement" and "benevolence." These categorizations already indicated that directions promoting action and self-enhancement were underrepresented.

Values constitute crucial criteria for a person's self-definition. They determine what is valuable and important and limit her involvement. For this reason, it was asked which past or present projects would express these values. These questions produced some movement in the discussion. The patient declared vehemently that the first three values were important to her, but:

"[…] I want to make music with people; nature, philosophy, and religion are important to me as well; they are initially calming and then inspiring while I write music. After a while, they prompt me to brood, somehow pull me down, and then I lose the energy to practice or really profit from the band's playing. It's like I'm in a fog. Somehow, I can't find a foothold."

After some contemplation, she identified the area "harmonious relationships with other people" with regard to the values security, benevolence, and achievement as most important. She noted she was least content with their implementation.

Strategy 2: Using democratic governance to turn the antagonist into an ally

"The good that does not entail the transcendence of evil is not the real, vital good."

F. W. J. Schelling

Because of her decision, the patient was encouraged to plan a variety of endeavors. This increasing activity level brought about contact as a theme. In the meantime, there was a dramatic intensification of fantasies related to hate and violence that scared the patient. The patient resisted all interpersonal contact, felt like a "garbage can:" used by others, unnoticed, and "kicked into the dirt." Throughout these events, the patient was hardly able to manage a mindful stance or to maintain her mindfulness exercises. An increase in her amount of practice was not indicated. In our opinion, a special acceptance principle must be communicated in these cases.

Accordingly, we chose to explicitly invite the disruptive and the negative, i.e., the antagonist, and to welcome them into session. We have termed the perception and management of counter-

intentional tendencies "democratic governance." Given a patient's difficulties with implementation – as they emerged in this case, for example, with the appearance of these terrifying fantasies – the employment of volition aims at harmonizing the processes occurring in the person's most different areas, such that the maintenance of the chosen values and the achievement of goals may be optimized.

Therefore, we took the time to thoroughly discuss the violent episodes in all details, which was experienced as very liberating by the patient. Moreover, she was also able to record observational data in the context of journaling, which helped her to detect patterns related to the occurrence of these bothering problematic responses. The risk inherent in this type of observation is that it may maintain its aversive properties, so its terrifying content may not be sufficiently integrated. In this case, an initial value-directed intervention is indicated. Its motto could be, "Each event in opposition to a value is a debased value."

The first step consists of exposure to non-values, i.e., to the fantasies and images of choking, stabbing, blood-drenched corpses, hateful and hostile thoughts. Exposing oneself to these contents and tolerating them with the therapist's support is a first step toward their integration. Creative media, painting, and experiential techniques are helpful. The terror becomes more graspable, tolerable, and finally in some sense also more familiar. By incorporating the daily diaries, a process of sorting, categorizing, and lastly understanding the problematic responses could be induced: "When do I respond in this fashion? What antecedents were there? When are my responses especially blatant? What are the conditions for differential responding?" More and more, two identities seemed to emerge: V. (22 years old), who is ambitious, wants to be about something, would like to approach others; who is curious and wants to try many things, etc. The second part of her identity initially seems to be negative and repulsive with its fantasies, impulses, and feelings. I continue to find it interesting that patients are able to picture this part very clearly, often are able to name it and to pinpoint its age, appearance, and preferences. This also happened here:

The patient was asked to take on this role (X), to imagine it as a person, and then to begin a dialogue with the therapist (T): "I am Xenia, 14 years of age, and I am very powerful."

T: "You are very powerful …"

X: "Yes, I am incredibly powerful like a monster! I am like a cold-blooded robot and steamroll everything. I walk across corpses in cold blood."

T: "What corpses are they? What do they look like?"

X: "They are torn to shreds and blood-drenched! These are the corpses of those who mocked me, who want to use me, who wanted to steamroll me and make me small!"

T: "You got pretty angry …?"

X: "I hate it when I go unnoticed, when I'm portrayed as a failure."

T: "Are there other feelings that are similarly strong?"

X: "I am always so scared of loneliness."

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The daily diary clearly indicated Xenia's appearance. Whenever somebody moved in too close with positive emotions, perceived or actual criticism, she showed up. Soon it was found that Xenia's responses were excessive and hyperbolic; however, the patient realized that they were functioning to protect V. Thus, the patient managed to accept Xenia as an important component identity of V. that functioned to ensure survival. V. and Xenia were able to develop their relationship and to merge into a team. Although they still had to work on Xenia's excessive responses, she had turned into an understandable and effective component. Practically, early warning signs could be established with the preventative aim to enable effective stress management and especially to maintain mindfulness at the point at which Xenia's responses had not escalated yet. A difficult situation turned into a value that as such may be more easily integrated and that may be of great significance for all further identity development.

Strategy 3: Work with particular values in the value spectrum.

The work with Xenia brought the issue of "relationships" into our focus; additionally, and partially closely related to the topic of "relationships," "education and employment" emerged as a theme. In-depth conversations repeatedly challenged the patient to formulate what was valuable and important to her in each respective area. The most precise understanding possible was jointly achieved. This understanding, the clarity, and the precision of value statements are increased with the following additional question: "How do you know that you are living a value, such as harmony; how do you know you are behaving in line with it?" This question has two effects:

(1) It establishes a criterion that generates clarity concerning the path toward and the degree of goal achievement in the course of valued living.

(2) The appropriateness of these criteria can be examined, and jointly they may be corrected for increased achievability.

In a next step, the value statements are categorized according to their respective domains within the value spectrum. During this process, the following values were formulated:

Security: "Not to be hurt by others; not to cut; not to be devalued; harmony, reciprocity of investments and favors, spirituality, and to find a job."

Performance: "I want to accomplish something; I want to have a niche within which I outperform anybody else; routine practice is very important to me; high standards regarding discussions and the writing of song lyrics; want to be respected for my abilities."

Power: "I want to have a voice in the band; want to influence the program and the stylistic orientation; want to implement (musical) plans and projects; I do not want to be helpless and powerless; want to put my foot down once in a while; want assignment of the lead part more often."

We proceeded to evaluate the position of these three value orientations in the value spectrum (Figure 5).

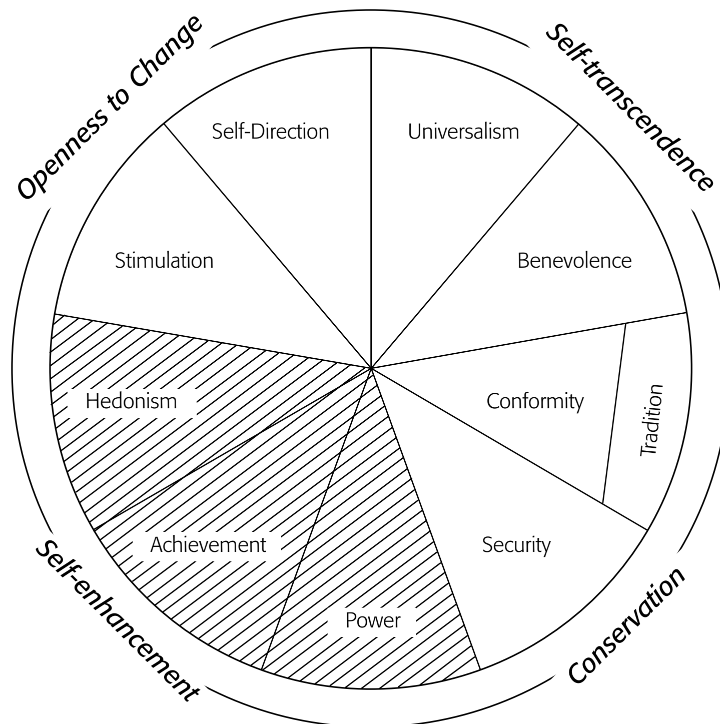

Figure 5. The patient's core values resulting from work on the target area "education and employment."

The result corresponds to our general practice experience: People who find themselves under great pressure first and foremost (and often exclusively) endorse the value domains "self-enhancement" and "conservation." This also corresponds to the circumstance that they cling to the time-tested and the habitual (conservation) and, finally, limit their attention to personal interests and survival (self-enhancement). Skills and goal-setting for the implementation of these valued directions are important resources and deserve respect. However, people with mental problems, especially severe ones, want to maintain their equilibrium almost exclusively with the two types of resources just described and also use them to solve their problems.

Strategy 4. Formulate Survival Strategies.

Without any doubt, the orienting and aiming toward goals found in the domains "self-enhancement" and "conservation" are in the service of personal protection and internal stabilization. Thus, the patient has access to important resources. In extreme cases, such as acute mental problems and due to high levels of anxiety, patients use up a big amount or too much of their

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resources and are literally blocked by juxtaposed demands. These resources have ceased to be functional. Different combinations of values and goals from these domains often mirror strategies that exacerbate a person's stress level. We call response templates that are reflectively activated "survival strategies." They are hardly ever conscious. Survival strategies characterize the behavior under stressful conditions. They are acquired in the course of life history. They have helped to maintain a person's internal equilibrium. Here: The patient, V., completely withdraws to the value domains of security, power, and achievement for the purpose of increasing the safety, strengthening, and consolidating the self. However, the momentum necessary for an effective interpersonal interaction is lacking. Together, the therapist and the patient distill the survival strategy from multiple stressful situations, make it concise, and finally formulate it: "In stressful situations, I behave as if I were a lone wolf with superpowers in a life or death struggle. I avoid at all cost proximity to people who could hurt me, who could jeopardize my momentary stability. I limit myself to the familiar and time-tested and rely solely on myself."
It is noteworthy that (1) the survival strategy indeed reflects the goals set within the value domains of "conservation" and "self-enhancement;" (2) the operative goad is "a life and death struggle." Jointly, the patient and the therapist attempt to verify this survival strategy with further exemplars to provide the patient with a feel for the automatic, unconscious nature of these strategies.

Strategy 5. Increasing Flexibility by Turning Antagonists into Synergists.

"From a transcendental perspective, good and evil are as illusory and relative as all other dichotomies: warm-cold, pleasant-unpleasant, short-long, visible-invisible, etc." **Mircea Eliade**

If we imagine our value spectrum to be a Frisbee, then a wonderful trajectory results when a practiced thrower initiates the disk's course. Important prerequisites for a stable trajectory are the disk's symmetric form and its balanced, even distribution of mass. Now let us further imagine that somebody disrupts this equilibrium, for example by installing additional tiny massive balls at the locations that correspond to the three adjoining value domains in Figure 5. The disk's ascent becomes laborious. It goes into a tailspin and crashes. This metaphor suggests that we are able to maintain the equilibrium only if we juxtapose or, better, occupy domains within the global areas of "self-transcendence" and "openness to change" that counterbalance the three already occupied domains of "self-enhancement" (here, achievement and power) and conservation (here, security), as shown in Figure 6.
Aiming for a stable trajectory, we choose "antagonists:" Self-direction, universalism, benevolence now have to be considered and integrated in the sense of "as well as." Now our Frisbee is in equilibrium and flies.
The choice of antagonists is not only suggested by our metaphor of the Frisbee, but it is also demanded by the patient's social reality: Personal, self-enhancing values of the patient (such as achievement and power) are most likely to be supported and develop best within a system

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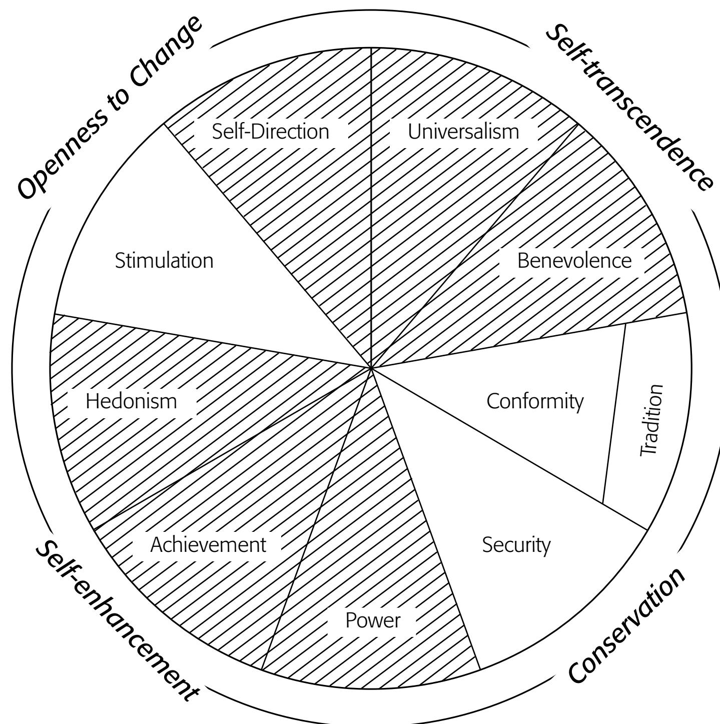

Figure 6: The occupation of antagonist value domains.

that also serves other people's interests. The value domains "benevolence" and "universalism" represent this circumstance.

The patient's performance motivation and her demand for leadership require the trust of other group members; otherwise, they may turn from her, form fractions against her, reject her, or even exclude her. These events would correspond to V.'s traumatic expectations.

The value domain "security" presents a similar context: Security in relationships, refuge, etc. are indeed important and their maintenance is worthwhile. But: If a person consistently avoids the challenges posed by the necessary self-determination and refuses to develop or change, isolates, and exclusively or excessively demands support, protection and security, then that person will fail in the long run, will not be able to achieve his or her goals, will not find a satisfying lifestyle, and – last but not least – will lose everything that was to persist, in extreme cases even his or her refuge.

The indispensable antagonist is the willingness to explore oneself and aspects of an unknown or unfamiliar context; to tolerate negative emotions and criticism as well as to interpret failures

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as opportunities for learning. But also to take appropriate risks, to follow one's insight, etc. These are the core components of the domains "stimulation" and "self-direction." As an example for the work with antagonists, the patient whose case was discussed in the vignette set the following goals:

TABLE 2. The patient's goal-setting as an example for the work with antagonists.

Security …	… ***as well as self-direction and stimulation***
Self-protection - Regarding others: o Developing necessary boundaries; o Pacing the level of contact and proximity; o Developing plans for action and self-competence - Regarding self: o Noticing Xenia; o Observing self-critical dialogues self-critically and mindfully; o Being kind to oneself; o Pampering oneself	**Risk-taking** - speaking with an unfamiliar band member very briefly - expressing own thoughts; - giving one's opinions regarding other band members' proposals - expressing diverging opinions; - testing novel ideas and experimenting with other styles; - allowing unconventional ideas **Tolerating negative emotions and learning from them:** - Tolerating anger at small and intermediate levels without leaving the situation; - Being mindful of negative thoughs and feelings; - Analyzing and evaluating the registered emotions later: o What percentage originates in the past? o What percentage is warranted by the current situation? - Interpreting failures and mistakes as an opportunity for learning
Achievement …	… ***as well as benevolence***
Personal standard for excellence: - Knowing, formulating, and reality-testing one's standard; - Formulating intermediate goals; - Scheduling work and practice; - Learning to manage barriers and distractions **Distinction:** - Acknowledging one's own strengths and talents within the context of the band; - Acknowledging the benefits of own solutions and defending them; - Being able to describe one's stylistic preferences	**Positive interactions:** - Expressing positive feelings and praise; - Being interested in others' opinions; - Participating in gregariousness, fun, and entertainment; - Listening actively; - Contributing one's own experiences **Maintaining and increasing other people's welfare:** - Preparing tea for everybody; - Bringing cookies; - Initiating shared activities, e.g., going out, listening to music

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Strategy 6. Value development through need gratification.

Initially, the goal-setting within antagonistic domains will challenge the patient to tolerate a "straddle" as if she were standing within a chimney. In many cases, this tolerance has to be attained first. For this reason, different "as-well-as-scenarios" are developed and imagined. Then they are ranked according to level of difficulty and thoroughly prepared for their practical implementations.

Therefore, practical action takes center stage. A mutual agreement is made regarding concretely circumscribed tasks with defined goals, so-called developmental projects, which contain the "antagonists" in small doses, as described in the preceding paragraphs. Support is provided by an implementation intention (what, where, how). The "how" is determined by the dysfunctional survival strategy: "Counteract your survival strategy. Adjust your step size to enable maintaining your chosen direction." The "what" and "where" is defined by the selected situation. The patient is especially instructed to adjust her step size to keep her emerging anxiety in check. Such a strategy cools down the hot system. Thereby superordinate regulatory levels, particularly personal values, begin to contribute to self-regulation again. The patient was able to notice more frequent steps into her chosen direction and was visibly encouraged by this process.

In the course of our work, the Frisbee becomes balanced. More frequent successful experiences result in favorable encounters with regulation and positive emotions. Xenia rarely appears in the foreground and when she does, she is not as shrill and incomprehensible as before. She can be consistently connected to practical democratic governance and progressively integrated.

Coincidentia Oppositorum:

Coinciding opposites, this is the moment from which sustainable values emerge.

Conclusion: From need to a value-directed living

The frequent practice of "straddling" that is defined by the work with the antagonists of the value spectrum generates what is essential for valued living:

- Not only reliable paths for the satisfaction of important needs evolve, but the certainty of positive outcomes increases.
- Thus, the capacity for delayed gratification also increases, i.e., it is possible to generate distance to needs and impulses, and the person is not delivered to his or her needs and impulses anymore.
- Now he or she is able to take a position with regard to his or her needs.
- This opens up a future-oriented time horizon.

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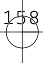
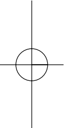
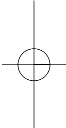
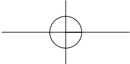

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Jasmin Annette Richter

Strategic Therapy for Adolescents

ABSTRACT

The following article applies Strategic Brief Therapy (Sulz, 1994; 2001; 2002) to adolescence. Approaching adolescence from a developmental perspective, Strategic Therapy for Adolescents, a therapy concept that combines individual and group components, represents an attempt to adapt Strategic Brief Therapy to this age group. In addition to symptom reduction, Strategic Therapy for Adolescents emphasizes effective emotion regulation and relationship building. The theoretical foundations and the therapeutic foci as well as the concrete course of therapy will be outlined. Moreover, the duration of therapy, financial considerations, and quality control will be discussed briefly. Finally, a case study will illustrate this therapeutic approach. Data to date, albeit not statistically significant because of small sample size, point to the effectiveness of this approach.

1. Introduction

Strategic Therapy for Adolescents takes into account the dynamics inherent in the social-emotional development of adolescents. As suggested by the construct of "developmental tasks" (OERTER AND MONTADA, 1995, OERTER ET AL., 1999), adolescence is understood as a critical period for personality development, particularly with regard to individuation. This latter process, as it relates to functional and dysfunctional coping mechanisms, is viewed as central to all further development. In the context of intrapersonal physiological and psychological changes, adolescents enter into altered relationships with their social environment: Their increasing ability to self-reflect enables steadily growing personal commitment as well as self-management.

Attachment and autonomy, within the context of adolescents' interactions with their parents[1], seem to represent areas especially significant for (dys-)functionally managing the developmental tasks of adolescence. A review of the current literature shows that, in addition to peer influences, parent-child interactions predominate in the direct and indirect shaping of the com-

[1] The word "parent" is used throughout the translation to mean any man or woman who assumes parental responsibility toward a child (e.g., a grandparent, stepparent, adoptive parent, etc.)

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petence necessary to complete the tasks confronting adolescents. Individuation requires a precise definition, for it cannot be equated with adolescents' emotional autonomy from their parents. While increasing separation may take place on the behavioral level, it may not be accompanied by an emotional distancing of the adolescent from his or her parents. Rather, successful separation must be understood as a kind of individuation process that involves qualitative, albeit less quantitative, emotional changes in the presence of a continuing parent-adolescent bond. In particular, adolescents' emotional needs, directed at their parents, may persist but change in content.

Thus, in the context of an attempted differentiation, Strategic Therapy for Adolescents assumes that not only needs for autonomy but also needs for belonging characterize the developmental stage of adolescence. SULZ'S (1998; 2001; 2003) Cognitive-affective Developmental Model offers a conceptual approach that posits the emergence of specific needs, fears, types of anger, and personality patterns as a function of an individual's learning history and his or her related developmental level. Within the Strategic Therapy for Adolescents, these comprise central components or working hypotheses, which allow the promotion of salutary or the prevention of pathological developmental tendencies in addition to symptom reduction as therapeutic goals.

2. The therapeutic approach and its individual components

Strategic Therapy for Adolescents is designed for adolescents between 13 and 18 years of age, regardless of any specific disorder. In our institute, the presenting problems of patients treated with Strategic Therapy for Adolescents range from anxiety disorders (test anxiety, social phobias, panic with and without agoraphobia), depressive symptoms with suicidal ideation and self-injury, eating disorders, simple activity and attention deficit disorders, to social conduct or hyperkinetic disorders. Some patients show tendencies indicative of personality disorders. Commonly, dyslexia and dyscalculia are also present.

SULZ'S (1998; 2001; 2003) Cognitive-affective Developmental Theory and its therapeutic implications form the theoretical background of the Strategic Therapy for Adolescents. Accordingly, each individual patient's biography renders potentially protective as well as limiting risk factors, which constrain individual psycho-social growth (socio-ecological constraints) and affect personality development. Individual patterns of managing needs, anxiety, and anger (i.e., dysfunctional emotional coping strategies) crystallize as essential factors governing behavior. Additionally, dysfunctional personality tendencies, individual values, norms, resources and the patient's cognitive-affective developmental level co-develop. Many of these components make up the individual's personal survival strategy. The severity and the extent of stressors encountered during development determine the degree of rigidity with which a person adheres to a particular survival strategy. In this context, it is important to note that adherence to a survival strategy, with its action-governing and psychologically homeostatic functions, is not a conscious process.

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The path to symptom formation and maintenance may be described as follows: Symptom-evoking situations are those requiring problem-solving behavior that is incompatible with the existing survival strategy. Symptom formation and maintenance may be viewed as attempts to sustain the former developmental level. In other words: Symptom-evoking situations are typically associated with (primary) emotions, such as anger, disappointment, grief, or discontent. However, in the presence of a particular survival strategy, these emotions may not be activated and their action-governing function must be prevented. For this reason, they are replaced by counteracting (secondary) emotions, such as helplessness, anxiety, restlessness, or self-doubt. At the same time, psychological and somatic stress syndromes may occur. The development of the symptom reduces the stress-related syndromes, as the capricious mind now must deal with the symptom rather than with the underlying respective developmental conflict. Thereby, the earlier homeostasis is restored. Additionally, symptoms are usually in a form that is reinforced by the environment, for they also protect close attachment figures from uncomfortable change, i.e., the patient experiences comfort, attention, and (presumably) the opposite of what challenges to his or her survival strategy would have produced. But even in lieu of environmental feedback, the old self-concept and worldview are maintained by avoiding novel experiences per se.

Table 1: Eligibility criteria for Strategic Therapy for Adolescents
• At the time of the intake, the adolescent must be between 13 and 18 years of age; the therapy is not gender-specific.
• An outpatient setting must be appropriate for treatment; no specific diagnoses are excluded.
• The adolescent must be able to envision participating in group therapy and must consent to such participation as a prerequisite for treatment.
• The patient's parents must consent to therapy and to parent skills training. Consent to parent skills training is a prerequisite for treatment. Exceptions must be well-justified and are rarely granted.
• The patient's parents must agree to therapy outcome monitoring and to completing the associated questionnaires/surveys.

Given the above conceptualization, the therapeutic goal of Strategic Therapy for Adolescents is to reduce symptoms and, beyond that, to assess intra and interpersonal dynamics particular to each individual patient. Processing these dynamics shall enable adolescents to manage themselves and their environment more effectively, so that developmental tasks specific to adolescents may be tackled and, lastly, development in the tenor of Cognitive-affective Developmental Theory may occur.

Strategic Therapy for Adolescents assigns a central role to parenting skills: Parents, as co-therapists, are coached to work against symptom formation and maintenance and towards more

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self-"conscious" parenting. Therefore, the target of Strategic Therapy for Adolescents is to generate conditions that enable symptom management and, finally, developmental growth. To this extent, adolescents receive a combination of individual and group therapy that applies methods at the cognitive, affective, and behavioral levels. The parental involvement occurs in the form of family and parent meetings, and during specific parent skills training sessions.

2.1. The therapeutic approach and its individual components

A relatively detailed assessment phase leads to the formulation of therapeutic targets, primarily by the therapist and the adolescent. Moreover, the first phase of therapy involves psychoeducation regarding symptom formation and maintenance, such that the therapist, the parents, and the adolescent work toward a common understanding of the respective disorder. This understanding provides the basis for all further work and is also reflected in the specific therapeutic targets. After this introductory phase, individual therapy sessions with the adolescent initially implement a mainly symptom-directed intervention and build a base for later therapeutic work on building relationships and regulating emotions and needs. Parent and family meetings occur in parallel and aim at managing dysfunctional, symptom-maintaining interpersonal processes. In the second phase of therapy, weekly alternating individual and group sessions address the syndrome-underlying themes of need and emotion regulation and the formation of interpersonal relationships in a more detailed and differentiated fashion. At this point in therapy, the mandatory parent training begins. The last phase of therapy consists of continuative individual and family sessions that are faded out sooner or later, depending on the severity of presenting problems.

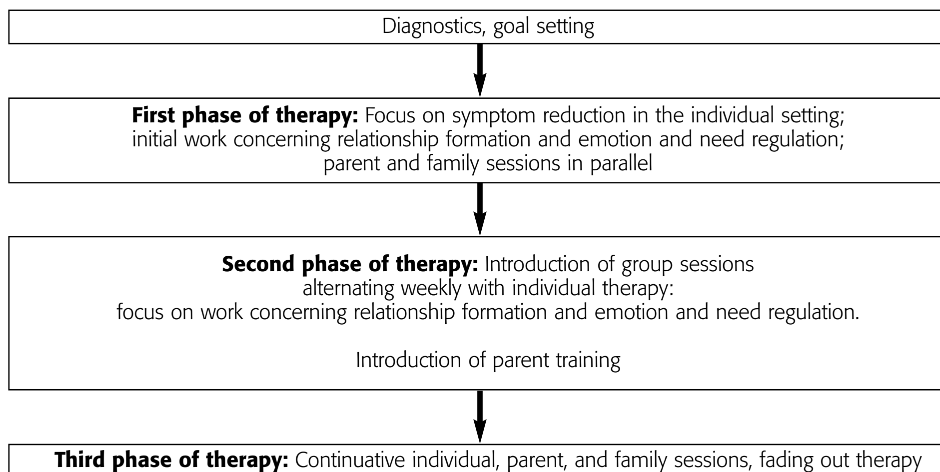

Figure 1: Outline of Strategic Therapy for Adolescents

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2.1.1. Individual therapy: Content and process

The therapy starts with an intake session involving the parents and the patient, so that preliminary hypotheses may be derived from the observation of parent-adolescent interactions. During the first part of the intake session the adolescent and the parents describe what necessitated the request for services, i.e., the nature of the encountered difficulties. After approximately 25 minutes, the therapist begins posing hypothesis-driven questions to reach a concise understanding and specification of the presenting problem. If the patient meets the eligibility criteria for participation in Strategic Therapy for Adolescents, four further diagnostic sessions are scheduled. The diagnostic phase consists of the completion of detailed questionnaires by the adolescent and the parents for a behavioral and contextual analysis of symptom formation and maintenance.

Concerning the *micro level* of symptom formation and maintenance, the Brief Symptom Inventory (German version, FRANKE, 2000) and a clinical interview schedule (VDS-14J) (UNPUBLISHED) closely matching the diagnostic criteria of the ICD-10 (DILLING ET AL., 1999; REMSCHMIDT ET AL., 2001) are used. If not already evaluated, intellectual functioning and potential performance deficits are also assessed. Subsequently, the response chain of primary emotions, primary behavioral impulse, and anticipation of long-term consequences; secondary emotions, avoidance behavior, symptom, and short-term consequence are examined (see SULZ, 2000; 2001; 2003).

The living situation and all relevant relationships at the time the presenting problem surfaced enter into the assessment of particular factors at the *macro level.* Moreover, consequences are explored that might explain symptom formation and maintenance in the adolescent's and his or her family's life and relationship context. Parents and adolescents also complete assessment questionnaires that the therapist subsequently discusses with them. The patient's organismic variables are examined via respective questionnaires exploring the areas "Essential Needs," "Frustrating Parent Behavior," "My Fear," "My Core Anger, My Rage," "My Feelings," "My Personality," and "My Developmental Level." These areas serve to pinpoint the adolescent's survival strategy, i.e., his or her self-concept and worldview. As therapy progresses, this survival strategy is converted into a central theme, processed and emphasized in its function. After completion of the questionnaires, the therapist and the adolescent collaboratively choose three therapy targets, in accordance with SULZ'S (1998; 2001) therapeutic goal setting ("My Therapy Targets"). Here, the main intent is to make the therapeutic process transparent and thereby to strengthen the therapeutic bond. Additionally, the method may serve to monitor the progression of therapy – as subjectively evaluated by the patient or the therapist. The assessment instrument itself may be used as a "therapy progress thermometer," measuring the perceived status of therapy repeatedly throughout. It may be interpreted as mirroring the therapy process by reflecting already achieved past and unattained future goals.

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Table 2: Assessment instruments in the introductory phase of therapy

Micro level	• VDS1-KJa Basic questionnaire • VDS1-KJe Supplementary questionnaire for children and adolescents • VDS1-KJf Subjective assessment for school age and adolescence
Macro level	• VDS1-KJa Basic questionnaire • VDS1-KJe Supplementary questionnaire for children and adolescents • VDS1-KJf Subjective assessment for school age and adolescence • "My Essential Needs" (SJT09) • "Frustrating Parent Behavior" (SJT10) • "My Fear" (SJT11) • "My Core Anger, My Rage" (SJT11b) • "My Feelings" (SJT13) • "My Personality" (SJT18) • "My Developmental Level" (SJT22)
Goal setting	• "My Therapy Targets"
Miscellaneous	• Standardized testing re: intellectual functioning • Assessment of performance/skill deficits

* VDS = Verhaltensdiagnostiksystem (Behavioral diagnostic system), Sulz (2000)
* SJT = Strategische Jugendlichentherapie (Strategic Therapy for Adolescence)

After this initial phase and during the following psychoeducational phase of treatment, the therapist begins to clarify the specific presenting problem with the patient and his or her parents. A general model of symptom formation and maintenance is conveyed and enhanced to fit the individual presenting problem by engaging in a Socratic dialogue with the adolescent and the parent. The approach to disorders is based upon SULZ'S (2001; 2003) conceptualization of symptom formation and maintenance described above.

Therapy proper consists of the application of symptom or disorder-specific evidence-based behavior therapeutic interventions, which are combined with Sulz's (2001) symptom-directed therapy exposing the adolescent to sequential phases of mindfulness, acceptance, willingness, exposure, and self-reinforcement (see 2.2.1 below). The approach used in group sessions will be covered under 2.1.2 below. At this point, the purpose of alternating group with individual sessions will be elaborated:

The individual sessions function to reflect the group sessions, with which they alternate on a weekly basis. Furthermore, the individual sessions address any of the adolescent's individual difficulties emerging from the group sessions and thus resolve any initial or social skill deficit-related resistance to the group setting. Individual sessions also promote the adolescent's inte

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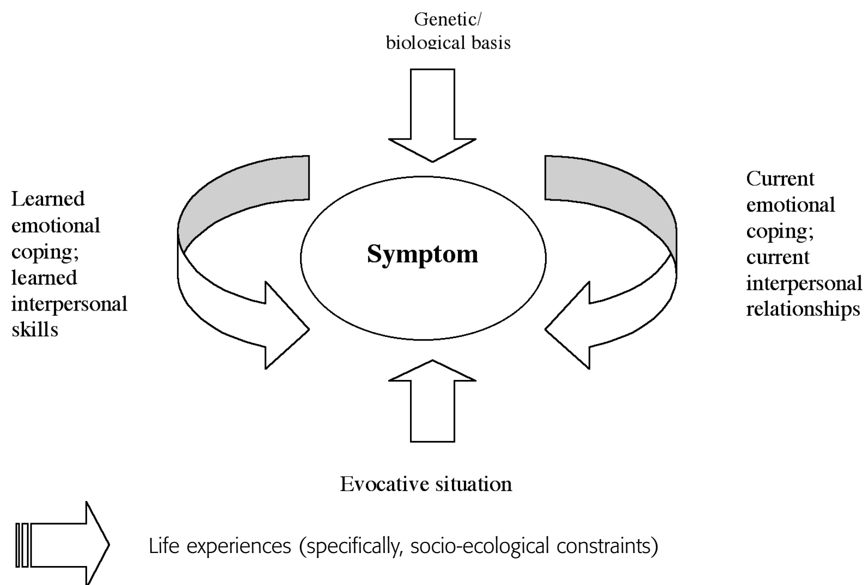

Figure 2: Symptom formation and maintenance

gration into a group of similarly aged peers in the service of the separation process specific to adolescence. Individual sessions also provide a space for the discussion of topics the adolescent might avoid in public, and they sufficiently sustain the therapeutic relationship by providing paced and reduced, albeit unreserved, attention.
During the last phase of therapy, a return to the individual setting and an increased frequency of parent-adolescent sessions serve to strengthen the adolescent's interpersonal and emotion regulation skills in confrontation with the most proximal attachment figures. This phase also promotes the growth potential of the family, i.e., it enables a (more) functional individuation by the adolescent while taking into account and reducing symptom-maintaining intra-family dynamics.

2.1.2. Group setting: Content and process

Regarding the framework for adolescent groups, it is noteworthy that the therapist who conducts the individual sessions also runs the group therapy. A co-therapist, ideally selected to form a male-female therapist dyad, participates in all group therapy sessions that take place in our adolescent outpatient setting. The change from individual into the combined (alternating) setting occurs after approximately nine months. For the next six months or for a total of 15 group sessions, the adolescents receive two 50-minute individual and two 120-minute group sessions per month. Groups consisting of six persons each are separated into two age categories: 13 to 15 and 16 to 18 years old. Neither gender nor the presenting problem is a crite-

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rion for further categorization, for the group concept used here sets goals that are relevant to all adolescents and explicitly ignores the topographical differences among symptoms.
The targets of group therapy are presented as "an approximation or an answer to five questions:"
• What do I need from my fellow human beings?
• What do I enjoy, what do I fear, and what makes me sad or angry?
• How do I treat myself and others?
• How would I like to treat myself and others?
• What are my liabilities, and what are my strengths?

The focus of this phase of therapy is to enhance the reflection on intrapersonal and interactive processes and to promote functional emotion regulation and relationship formation skills, as mentioned above. The essential purpose of the **first group unit** consists of a general introduction communicating transparency and straightforwardness of the therapeutic process to the adolescents. Collaboratively establishing group rules serves to reinforce a feeling of control, influence, and security; and the communication of a clearly delineated and protected realm simultaneously implies an aspect of establishing "personal boundaries." The **second group unit**, in addition to increasing contact among the participants, aims at facilitating social perspective-taking. Being skilled at interpreting the interaction with others is a significant impetus for building functional relationships. Furthermore, the topic of reality construction is considered and its influence upon social interactions elaborated. Ultimately to hone increasingly subtle perceptions in social situations and to stimulate the adolescent's self-reflection, experiences involving social perceptions are intensively analyzed and factors are identified that contribute to a reduction of objectivity. The **third training unit** illustrates the construct of a survival strategy as a cognitive framework for thoughts, affect, and behavior to clarify how one's biography shapes one's personality. At the same time, one's ability to affect situations in the sense of self-efficacy should be communicated, i.e., the realization should be prompted that adolescents can exert control over their feelings and their behavior in any given situation, shaping biographical influences notwithstanding. The **fourth training unit** is to be viewed as a first step to more intensive processing of one's own emotions. First, "human feelings" are identified and their function and expression analyzed broadly. Essential to this approach is the general acceptance of all emotional experiences. Moreover, this unit consists of honing the perception of physiological reactions and of the effects of body language on social interactions, i.e., an increasing awareness of the role of body language in the management of emotions. The **fifth training unit** serves to categorize one's own emotional experiences as frequent, rejected, or feared: frequent, rejected, and feared emotions are elaborated and analyzed in collaboration. The exposure to frequent, rejected, and feared emotions teaches the adolescent to differentiate and better understand his or her range of emotions. Furthermore, effective and healthful emotional coping is to be supported by the promotion of acceptance and the integration of different emo-

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tional qualities into the self-concept. The following **sixth training unit** reviews the adolescents' emotional coping history and distinguishes functional and dysfunctional ways to handle frequent, rejected, and feared emotions. The **seventh training unit** exemplifies effective coping with the most disparate emotional qualities, so that the introduction of a communication training component that demonstrates the importance of "emotion and need communication" for adolescents is a sequitur. In this context, social competence and adequate management of failure and success – both eventually contributing to functional emotion regulation – should be increased. As the topic "aggression" and its management are difficult for many adolescents, the **eighth training unit** is reserved for this purpose. The **ninth training unit** is dedicated to the discovery and reinforcement of one's own strengths in the context of the group, which serves to increase self-esteem and self-efficacy within a resource-oriented therapeutic model. Honoring the long period of intensive collaboration, the impending farewell and its associated feelings should be the target of the last shared **tenth unit**.

The following table summarizes targets, content, duration, and active factors of the group therapy module:

Table 3: Summary of the group concept in Strategic Therapy for Adolescents

Targets	• Reflection of intra and interpersonal process with regard to important relationships • Functional emotion regulation and functional relationship formation • Promotion of functional coping with the developmental tasks of "adolescence" by adolescent and parents
Content	• Honing of social perceptions • Formulation of the survival strategy • Compilation of frequent/rejected/feared emotions • Compilation of the emotional coping history • Increase in functional emotional coping through the respective skills-building techniques • Compilation of problem-solving strategies • Formulation of strengths and resources
Duration	15 sessions at 120 minutes each
Active group factors	• Self-disclosure and awareness • Motivation for change • Concrete (behavioral) exercises and generalization exercises for everyday life
Active therapist factors	• Clarity and transparency (see also psychoeducation) • Respectful stance • Validation and confrontation in balance • Involvement of all participants, if possible • Acceptance of boundaries and their differentiation from dysfunctional resistance

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2.1.3. Parent skill training: Content and process

Parent skill training, mandatory for each parent (see Table 1: Eligibility criteria for Strategic Therapy for Adolescents), occurs in parallel to the group therapy module outlined above. Parents are presented with opportunities to identify, to reflect, and to promote functional developmental conditions for the adolescent. Given their intrapersonal physiological and psychological changes, adolescents contact their social environment in an altered fashion: They are now understood as self-organizing, individual reality-constructing beings within a social context. In addition to the peer group, the parents are the most significant attachment figures. Typically, they hold strong emotional bonds with the adolescents, such that developmental challenges and demands are posed to the entire family system. After all, adolescence holds functional and dysfunctional potential for the parents' and adolescents' (shared) future, i.e. adolescents and their parents require coping mechanisms that increase the probability of salutary developmental trends.

The time allocation for parent group sessions parallels those of adolescents with 120 minutes, but parents receive ten units across twelve sessions. It seems important to assign members of parental dyads (e.g., spouses) to different groups, so that the dynamics inherent to the dyad occur less frequently. Considering family systems approaches, such a separation of dyadic members facilitates the contemplation of the particular dyads' dynamic, which often represents a stressor for the adolescent and thus must be viewed as a potential vulnerability factor. Like the adolescent groups, each parent group consists of six to eight people. Experiential exercises aimed at increasing awareness are interspersed with psychoeducation components. The following targets are agreed upon with the parents initially and at the beginning of skills training:

- A better understanding of my child's symptom formation and maintenance and of "adolescence" as a life stage.
- The joint management of "adolescence" as an unsettling period in one's life through
- A better understanding of myself
- A more satisfactory treatment of myself and others: My emotions and needs, my interpersonal style and my management of conflict, especially with my child and my partner
- My own role in the development of a shared language between me and my child
- Recognizing and fostering my own contribution to the establishment of wholesome family conditions

The aspects listed below seem central to these targets, which closely follow the content of the adolescent group:

a) Parent training aims at facilitating the parent-adolescent interaction. It does not assign blame to parents, i.e., it does not understand them as "culprits" or sole "causers" of their children's psychological problems. Instead, it conveys joint responsibility for recovery.

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b) At any given point in time, the family members' contributions match their abilities, and the therapeutic work must meet them at their current level.
c) Parent training requires a more intensive emotional self-reflection than other types of training. For this reason, the parents' engagement with the training deserves recognition.
d) The target of parent training is the identification and the utilization of family resources.
e) Each family has resources to be discovered in therapy.

Like the adolescent group sessions, parent training consists of several training units with specific content focal points, which comprise both psychoeducation and self-reflection components and may be described as follows: The **first group unit** for parents also establishes a space that evokes a protective, trustworthy and understanding, non-accusing and non-blaming atmosphere. The general introduction, the formulation of group norms, and the highlighting of "personal boundaries" generate controllability, transparency, and perspective. Psychoeducation components divert the attention from "too personal and too emotional" issues and present a framework for shared initial conditions. The **second training unit** illustrates the developmental tasks of adolescence in a psychoeducational context for parents. The model of symptom formation and maintenance, already described during previous individual sessions, is repeatedly presented for further contemplation and adaptation to the parents' current understanding. The content of the parent training units also gains acceptability through repeated references to the model from which it is derived. The **third training unit** introduces "Human beings and their relationships" as a theme, so the "survival strategy" construct and its influence on individual relationship formation can be communicated in the subsequent **fourth training unit**. Parents are also prompted to examine and to formulate their own survival strategies with the help of questionnaires to achieve greater insight into their own behavior and to establish more satisfactory relationships. The **fifth training unit** calls attention the parents' emotional coping history in concert with the formulation of their respective survival strategies completed in the previous unit. This provides parents with the opportunity to contemplate their own emotional experience and its effects on important attachment figures, including their own children. The **sixth training unit** deepens the parents' understanding regarding the effects of their emotions on thought and action. Moreover, parents learn to identify and to formulate their emotional coping strategies. In addition to deepening psychoeducational elements, the **seventh training unit** builds concrete skills (perception and evaluation of emotions, distraction, and communication of emotion) for more functional emotion regulation and, finally, improved interpersonal relationships. The **eighth training unit** directs attention to coping with frustrating situations (setting limits, "letting go"), i.e., managing anger in a functional manner for more satisfactory relationship formation and functional self-regulation. Components from the previous training units are utilized and adapted to managing anger specifically. With the ninth training unit parents learn to increasingly attend to the positive and to cease perceiving exclusively or mostly negative aspects of relationships. The **ninth training unit** focuses upon the parents' stress

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management skills to foster a long-term preventative, salutary approach to self and others, i.e., to consciously mobilize one's own resources in a concerted fashion. A summary, a review, and the farewell are taken up in the **tenth training unit**. Accordingly, the parent training targets, content, duration, and the notable active factors can be outlined as follows:

Table 4: Summary of parent skill training in Strategic Therapy for Adolescents

Targets	• Reflection of intra and interpersonal process with regard to important relationships • Functional emotion regulation and functional relationship formation • Promotion of functional coping with the developmental tasks of "adolescence" by adolescent and parents
Content	• Formulation of the developmental tasks of adolescence for parents and adolescents • Identification of symptom-forming and maintaining conditions • Formulation of the survival strategy • Compilation of frequent/rejected/feared emotions • Compilation of the emotional coping history • Increase in functional emotional coping through the respective skill-building techniques • Compilation of problem-solving strategies • Work on "positive attention"
Duration	12 sessions at 120 minutes each
Active group factors	• Self-disclosure and awareness • Motivation for change
Active therapist factors	• Concrete (behavioral) exercises and generalization exercises for everyday life • Clarity and transparency (see also psychoeducation) • Respectful stance • Validation and confrontation in balance • Involvement of all participants, if possible • Acceptance of boundaries and their differentiation from dysfunctional resistance

2.2. Therapeutic approach of Strategic Therapy for Adolescents

The concept of Strategic Therapy for Adolescents outlined above, while concretely addressing the symptom level, has as its goal to affect intra and interpersonal dynamics associated with symptom formation and maintenance and to modify them such that the adolescent's further development renders them "unnecessary," i.e., long-term symptom reduction results. From our conceptualization of disorders it follows that this goal implies interventions at the affective, cognitive, and behavioral in addition to the symptom level. Correspondingly, these individual lev-

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els are conceptually closely intertwined. Once the adolescents have learned to manage their symptoms, emotional engagement with the correlated contextual factors follows. These are reframed via cognitive interventions, and they receive concrete alternatives and functional modifications through the behavioral therapeutic work.

2.2.1. Approach to symptoms

The therapeutic work at the symptom level requires
a) mindfulness of symptoms;
b) acceptance of symptoms;
c) willingness to engage with the symptoms;
d) willingness to confront the symptoms; and
e) self-reinforcement of the components described above.

Mindfulness. In the context of the therapeutic relationship, the adolescents learn to notice their symptoms without evaluation and to manage these symptoms mindfully by discriminating early warning signs. In this context, the introductory psychoeducational elements covering symptom formation and maintenance gain a central role: The adolescents come into contact with an explanatory model that takes them and their symptoms seriously without inducing shame or blame. At the same time, the model offers new perspectives implying opportunities for behavior change. Thus, the first step is to notice early signs of symptom formation as psychological stress responses (see SULZ, 2001; 2002).
Acceptance. The neutral treatment of one's own symptoms, initiated as a first step, is explicitly strengthened by taking a second step. Instead of avoiding any encounter with the symptoms, the adolescent chooses to respect the symptoms as the "soul's voice" (see SULZ, 2001; 2002).
Willingness. The third step involves the conscious decision to confront and engage with the situation evoking the symptoms. The adolescent declares his or her willingness to undertake the upcoming symptom confrontation because he or she is mindful of the symptoms and has accepted them (see SULZ, 2001; 2002).
Exposure. Confronting the symptoms and all associated emotions occurs at this point. The adolescent lets the symptoms persist until they slowly wane (see SULZ, 2001; 2002).
Self-reinforcement. At the end of this process, the adolescent is mindful of the courage and effort required for exposure exercises. He or she also acknowledges this accomplishment even if it was the result of an ongoing struggle.

In parallel with these steps, established evidence-based and symptom-directed behavior therapeutic interventions are combined with the first need and emotion-regulation exercises to foster the formation of more functional relationships. The following outline categorizes some of these interventions by disorder:

Table 5: Interventions of Strategic Therapy for Adolescents (STA) in the individual setting

Disorder	***Interventions***
Anxiety	1. Self-monitoring protocols 2. Determination of the fear hierarchy 3. Exercises, initially in sensu then in vivo, according to the fear hierarchy 4. Diaphragmatic breathing / progressive muscle relaxation 5. Positive self-instruction 6. Reduction of avoidance behaviors / anticipatory anxiety 7. Introduction of STA exercises to discriminate and to verbalize emotions and needs, in connection with emotion questionnaires, in sensu exercises, creative techniques according to the STA approach 8. Reattribution of dysfunctional cognitions (see "dysfunctional survival strategy") 9. Fostering a more functional relationship formation in connection with exercises and detailed situational analyses, also role play and generalization exercises according to the STA approach 10. Caregiver training according to the STA approach to promote a functional individuation process
Obsessive-compulsive	1. Self-monitoring of obsessive-compulsive behaviors 2. Exposure in sensu and subsequently in vivo, in connection with response prevention to reduce obsessive-compulsive behaviors (see also progressive muscle relaxation, jogging, listening to music, etc.) 3. Introduction of strategies that distract from obsessive-compulsive behaviors 4. All further steps: see 7 through 10 above
Depression	1. Self-monitoring 2. Scheduling activities and structuring daily plans to improve mood and increase motivation 3. Processing of depressive cognitions 4. All further steps: see 7 through 10 above
Simple activity and attention deficit/ attention deficit	1. Attention and self-management training a. Scheduling routines and practicing self-instruction techniques to improve self-regulation and to reduce impulsive departures from planned actions b. Training and increasing attention using visual and acoustic materials c. Training organization of the workplace and of school materials; generalization of organizational skills to other activities d. Establishing an individualized lesson plan considering appropriate breaks or individual performance curves and generalization to everyday activities 2. Training of impulsive control and reduction of hyper-motor activity a. Introducing relaxation and mindfulness exercises b. Practicing positive self-instruction

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Table 5: Interventions of Strategic Therapy for Adolescents (STA) in the individual setting

Disorder	***Interventions***
Simple activity and attention deficit/ attention deficit	3. Increasing social competence and self-esteem via role plays, discrimination training of social events, generalization exercises and related experiences of receiving attention as a consequence of more appropriate means 4. All further steps: see 7 through 10 above
Bulimia	1. Establishing eating protocols 2. Formulating a balanced meal plan 3. Introducing response prevention measures regarding vomiting (see also progressive muscle relaxation, jogging, listening to music, e.g.) 4. All further steps: see 7 through 10 above
Anorexia nervosa	1. Establishing eating protocols 2. Shaping regular eating behavior 3. Reducing weight-loss measures 4. Addressing body image distortions via body-oriented exercises (e.g., mirror confrontation, etc.) 5. Training the ability to experience pleasure 6. All further steps: see 7 through 10 above
Social conduct disorders	1. Teaching anger management strategies a. Psychoeducational component: "Constructive and destructive anger" b. Perception of early warning signals indicative of anger c. Strategies for cognitive and behavioral management (the time-out principle, distraction, and self-instruction) d. Problem and goal analyses e. Exposure to anger 2. Teaching strategies to increase social competence a. Role plays b. In sensu exercises c. Exercises for generalization to everyday life 3. Teaching de-escalation strategies within the family a. Monitoring protocols b. Analysis of problems and shared problem-solving c. Practicing time-out principles d. Communication training 4. All further steps: see 7 through 10 above

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2.2.2. The approach to emotions

Adolescents are often so completely self-absorbed in this developmentally and psychologically intensive and incisive stage of life that they first have to build sensitivity for their own situation and for interpersonal relationships of importance to them (mostly involving parents, peers, and partners). For this reason, emotion-focused therapy concentrates on differentiating and identifying emotions and needs. Quite frequently adolescents present with such themes as authoritative pressure, difficulties with their best friend, and lack of understanding by their parents. The relevance of these themes for their own affect, however, remains rather elusive, abstract, or not at all graspable for some adolescents. The Strategic Therapy for Adolescents calls for a concrete intervention at this point and partially implements it with the aid of emotion questionnaires and emotion cards. Moreover, nonverbal, creative media (colors, material for crafts, acoustic material) and therapeutic aids, such as Playmobil® figures, bats of foam, etc., find an application. The Strategic Therapy for Adolescents has a strong experiential orientation, which allows adolescents to experience emotional situations that do not evoke anxiety or emotion-phobic responses. During the therapeutic process, the adolescents come to experience and to know appreciation and respect for their own emotions, as these exist in their lives. Adolescents frequently interpret their emotions as a burden, do not know how to manage them, and feel at their mercy (see also SULZ AND LENZ (2000) and SULZ (2000; 2001) for emotional coping patterns and their functional and dysfunctional potential). The therapist, through modeling and validating, communicates a fundamental respect for all emotional qualities: Envy is as human as joy, shame, happiness, or hatred. Moreover, responsibility for one's behavior and thus the controllability and malleability of emotion-governed behavior are made explicit and are illustrated with concrete, individualized themes throughout the therapeutic process. Of course, some emotions are preferred to others. Yet initially, even irrational and symptom-related fears and severe, presumably uncontrollable rage, for example, are to be fundamentally and radically accepted as well. This stance, communicated by the therapist within the therapeutic work, facilitates the adolescent's engagement with his or her emotions and prevents the occurrence of dysfunctional coping patterns associated with the adolescent's shame or guilt.
The emotion-focused level of Strategic Therapy for Adolescents has the following foci (see also SULZ & LENZ, 2000; SULZ, 2001; 2002):

- Noticing and differentiating emotions through graduated confrontation, also integration of feared and rejected emotions (while observing the associated physical sensations)
- Functional coping with socially inappropriate emotions
- Functional coping with socially appropriate emotions

Strategic Therapy for Adolescents achieves increased noticing and differentiating of emotions by conducting detailed analyses of the situations and states that enable affective response chains and the associated opportunities for noticing and differentiating. The adolescent imagines emotion-evoking situations and processes them micro-analytically in the therapeutic con-

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versation. If the emotional access is blocked despite graduated introduction of the emotion, "emotion cards" displaying different feelings on each card (SULZ, 2001; 2002; 2003) are used. With their help, the adolescent is able to match associated emotions to particular situations.

For functional emotional coping, the Strategic Therapy for Adolescents uses the "Emotional coping aids" listed in Table 6. Which "aid" is applied depends upon the individual situation and the person him or herself. Adolescents do not equally prefer all aids.

Table 6: My emotional coping aids

"Calming/ comforting"	**"Cheerleading"**	**"Processing"**	**"Advocating"**
• CC1: "The power of thought"	• C1: Rooting for oneself	• P1: Writing a poem or a story	• A1: Sending "I"-messages
• CC2: Breathing exercises	• C2: Writing a letter to the emotion	• P2: Journaling	• A2: Listening actively
• CC3: Fantasy travel	• C3: Writing a letter to oneself	• P3: Translating emotions into color, form, or sound	• A3: Expressing wishes and feelings
• CC4: Writing a letter to the emotion	• C4: Mood improver	• P4: Confiding in another person	• A4: Compromising
• CC5: Emotion-taming	• C5: Selecting a goal and moving toward it	• P5: Writing a letter never to be sent	• A5: Letting one's body speak
• CC6: Engaging in a pleasant and distracting event	• C6: Turning back from the emotion tunnel		
• CC7: Obtaining comfort from another person			
• CC8: "Calming / comforting box"			

a) Calming and comforting aids

- "The power of thought" (CC1) requires the adolescent to replace dysfunctional with functional self-statements.
- Breathing exercises (CC2): Breathing exercises provide a calming opportunity by concentrating the adolescent's attention on the breath and by practicing diaphragmatic breathing
- Fantasy travel (CC3): In a broadened form, fantasy travel lends itself to fostering functional emotional coping

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- Writing a letter to the emotion (CC4): This exercise is about beginning a dialogue with the emotion and thereby handling the emotion more constructively
- Emotion-taming (CC5): The "emotion-taming" aid attempts to provide an opportunity to handle strong, intensive, and overwhelming emotions by putting them into visible form. The adolescents visualize their emotion and tame it using different materials, so the emotion loses its frightening properties.
- Engaging in a pleasant and distracting event (CC6): The adolescents identify actions and activities that might help them out of an emotional down.
- Obtaining comfort from another person (CC7): More than a few adolescents have difficulties talking about their stressors or disclosing to others. Associated fears and worries, such as, "I'm going to be a laughing stock and outcast if I don't stay cool and aloof," or "Nobody talks about this," should be processed in this context, and potential confidants should be identified.
- Calming/comforting box (CC8): Adolescent and therapist fill the "calming/comforting box" with the most diverse materials that could evoke pleasant emotions. Adolescents pinpoint their own calming/comforting aids, build their own calming/comforting box and equip it with their individual calming and comforting items (such as rocks, seashells, feathers, glass nuggets, soft cloths/kerchiefs/furs, aromatic oils, dried flowers, chimes, musical pieces, postcards, vacation photos).

b) Cheerleading aids

- Rooting for oneself (C1): Corresponding to the skill "the power of thought," the adolescents learn to engage in encouraging inner monologues to handle potentially anxiety-producing situations.
- Writing a letter to the emotion (C2): This skill can be modified (through presentation of a different text example) to function as "cheerleading."
- Writing a letter to oneself (C3): Alternatively, the adolescent may write a letter to him or herself. Here, the inner dialogue – prompted by the presentation of a default letter – occurs with oneself and is directed toward a constructive treatment of one's emotions.
- Mood improver (C4): The emotion-tamer (see CC5) does not serve as a calming/comforting aid only. It can function easily as a cheerleading aid.
- Selecting a goal and moving toward it (C5). Impulsive and spontaneous responding evoked by emotions is especially incompatible with goals and wishes in the case of strongly expansive, uncontrolled, and aggressive adolescents. The realization of this incompatibility should be fostered by collaboratively determining the unpleasant consequences of strongly impulse-governed and inconsiderate actions.
- Turning back from the emotion tunnel (C6): This skill applies to emotions interpreted by the adolescent as too intensive and thus uncontrollable. It is recommended to purchase a crawl tunnel, available in toy stores, to facilitate the visualization of this technique, which

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promotes the detection of triggers and early warning signs and the development of strategies for a timely "turning back."

c) Processing aids

- Writing a poem/a story (P1): Processing emotions by composing poems or stories, often already accomplished by a few of the adolescents, may become a utilizable therapeutic tool for explication.
- Journaling (P2): A diary may provide yet another form of processing events and associated emotions. Some of the adolescents also have a history of journaling.
- Translating emotions into color, form, or sound (P3): Depicting emotions or setting them to music has the effect of rendering them more concrete and, by way of the creative process, more vivid. At the same time, depicting emotions or setting them to music generates distance, leading away from "being the emotion" and towards "having the emotion." This healthy distancing enables processing and reflection.
- Confiding in another person (P4): Confiding in another person and talking about particular issues may evoke emotions and thoughts and thereby facilitate coping. This aid is similar to "obtaining comfort from another person" (CC7).
- Writing a letter never to be sent (P5): This coping aid may be used with severe anger or disappointment, for example, to express the evoked emotion by first writing a letter to the respective person and then never sending it. The initial "venting" may generate the space for subsequent responding of a more functional nature.

d) Advocating aids

- "Advocating" aids represent skills established in psychotherapy or communication psychology, such as sending "I"-messages, active listening, expressing wishes and emotions, compromising, and letting one's body speak. These are taught to the adolescents via particular role plays in individual therapy and strengthened via specific communication training in group therapy sessions.

In general, increased awareness of dysfunctional emotional coping (and, at the same time, increased constructive coping) pivots on supporting the adolescents with the help of the above aids, such that the adolescents

- reflect on the appropriate role of emotions,
- inhibit behavioral impulses evoked by situation-inappropriate emotions
- turn behavioral impulses evoked by situation-appropriate emotions into functional solutions (see also Sulz & Lenz, 2000; Sulz, 2001; 2002).

2.2.3. The approach to cognitions

Strategic Therapy for Adolescents assigns importance to a cognitive intervention, in addition to the emotion-oriented approach outlined above. In this context, formulating the adolescents' individual survival strategies (i.e., their self-concepts and worldviews) in an age-appropriate

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manner is of issue (SULZ, 2001; 2002; 2003). This cognitive framework also seems to be relevant to the work with adolescents and offers an opportunity to explore and identify the context of their reality construction. A first topic of discussion is the adolescents' understanding of why people interpret the same situation more or less differently or similarly. Especially in adolescence, patients, as "marginal figures," might feel isolated and not understood. Frequently, literature refers to "adolescent egocentricity," which assumes that adolescents see themselves in the spotlight or in the center of attention, albeit not in a positive sense: Adolescents associate discomfort and insecurity with this context. Although the literature is replete with controversial and inconsistent findings and results, this critical and – in its dynamic and its developmental potential – exceptional period of life often brings about insecurity. The personality evolves, identity work is accomplished – more or less successfully and satisfactorily (HÖFER, 2000; KOHNSTAMM, 1999). Considering this background, especially adolescents with psychological problems frequently see the adult world as strange, hostile, and insensitive – even if such an interpretation sometimes serves the individuation process. Equipped with new cognitive structures and confronted with novel developmental tasks (HURRELMANN, 1997; OERTER & DREHER, 1995; REMSCHMIDT, 1992), the adolescents' reality construction incorporates dysfunctional perceptions. Individual life history is also held as formative. Exactly these circumstances must be communicated to the adolescent, "Your reality is not my reality," while taking into account overlapping and conforming elements of perception without which interpersonal communication would be impossible. Certain social cues can be defined as clearly interpretable and thus must be recognized as such by the adolescents. Using exercises and reflections, the adolescents are encouraged to rethink their experiences and to take the observer position, which – as a meta-perspective – is able to stave off reflex-like, habitual and inconsiderate or strongly affectively motivated behavior.

Furthermore, the adolescents learn to cognitively comprehend the potential effects of core needs, fears, or anger impulses on behavior. To this extent – utilizing need, fear, anger, and self-efficacy questionnaires – the individual survival strategy and the personal self-concept and worldview are formulated collaboratively. It seems important to choose descriptive metaphors for the "survival strategy" construct to provide the adolescents with a comprehensive explanatory model for emotions, needs, and relationship formation. This model should not accuse or blame; rather, it should illustrate "becoming" based on past experiences and appreciate it as an achievement in the context of the survival strategy. As difficult as such appreciation may be for the therapist or for the adolescent, it is essential for the therapeutic relationship and the therapeutic target of promoting developmental growth. This increasing understanding of the survival strategy and its associated personality trends as achievement in the context of the adolescent's biography, for they made emotional survival possible, represents a functional change in perspective. The necessity of "becoming" is appreciated without absolving the human being from personal responsibility and influence.

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Strategic Therapy for Adolescents enables adolescents' change in perspective and highlights alternatives for life and relationship formation in particular areas. First, one's own effectiveness is contemplated, and one's experience of self-efficacy is clarified. Considering the marginal position of adolescents, this is a significant theme: In the time between childhood and adulthood, personal influence and environmental demands shift in an inconsistent and discontinuing fashion. Thus, the integration of quite diverse experiences within one's self-concept is required. The adolescent learns to increase his or her self-efficacy and, ideally as a function of the therapeutic process, to appropriately handle boundaries and authority.

2.2.4. Approach to behavior

The behavioral level mirrors the modifications on the emotional and cognitive levels, such that the adolescent demonstrates clearly more functional behavior in connection with cognitive changes and emotional regulation; or, conversely, such that emotional and cognitive modifications arise from concrete behavioral changes. The therapist makes these behavioral changes explicit and reinforces them verbally. Alternatively, or in addition, self-reinforcement of the more functional behavior may occur when the adolescent, in a Socratic dialogue, identifies those components of more functional behavior that are viewed as satisfactory or are associated with pleasant emotions and experiences. The Strategic Therapy for Adolescents, similarly to the Strategic Brief Therapy (SULZ, 1998; 2000; 2001; 2002; 2003), views central fears, needs, and anger impulses as action-governing mechanisms, which are collaboratively identified and validated in connection with the adolescent's observable behavior. In therapy, the adolescent is prompted to take seriously and to respect his or her fears, needs, and anger impulses, so that they do not need to be ignored or avoided and may be accepted as action-governing. At the same time, therapist and adolescent collaborate to discover alternatives for more functional, i.e., successful, management of needs, fears, and/or anger impulses. Here, imaginal exercises and role plays are employed.

According to SULZ (2001; 2002), Strategic Therapy for Adolescents posits the following process for behavior modification regarding coping with central needs, fear, and anger impulses:

- Mindfulness practice to notice core fears, anger, and needs
- Establish acceptance for the historical coping patterns involving core fears, anger, and needs
- Change target: What would the adolescent like to change about his or her coping patterns?
- Change decision point: The resolution that the adolescent will handle his or her core fears, anger, and needs differently in the future.
- Change plan and trial: Imaginative or role-play tested novel coping with core fears, anger, and needs
- Change implementation: Generalization of the tested alternatives for coping with core fears, anger, and needs to the actual situation

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- Self-reinforcement: Raising awareness that the change attempt was a success. First and foremost, therapy is about doing!

2.3. Financing, duration, and quality control in Strategic Therapy for Adolescents

This section briefly describes the financing and the duration of Strategic Therapy for Adolescents. Moreover, I will highlight our efforts for quality control in short. In Germany, mandatory and private health insurance companies are billed via a long-term treatment request for the Strategic Therapy for Adolescents. The old standardized fee-for-service scale only partially covered the expenses for group and parent sessions, thus the new fee scale seems to be better matched to the billing modalities of Strategic Therapy for Adolescents. The estimated duration of therapy is usually two to two-and-a-half years. However, more difficult cases, such as those involving personality disorders, involve an even slower fading of therapy.

Our effort to increase quality control resulted in the use of several methods for quality assurance:

a) Regular individual and group supervisions;
b) Session documentation incorporating rating and evaluation measures for the therapist and the patient
c) Pre and post-measures utilizing different questionnaires (e.g., symptom-specific questionnaires, emotion questionnaires, personality scales, developmental questionnaires, questionnaires covering the family situation, adjustment/change questionnaires and outcome scales) at the beginning and end of therapy
d) Third-party evaluations: Psychiatrists specializing in childhood and adolescence evaluate the degree of psychological difficulty and the level of psychosocial functioning at the beginning and at the end of therapy
e) Follow-up measures: Data are again collected six and nine months after termination

2.4. Case presentation – illustration of Strategic Therapy for Adolescents with a concrete therapy case

To further illustrate Strategic Therapy for Adolescents, I would like to present a specific case, and I selected patient "Sarah" for this purpose.

2.4.1. Sarah's presenting problem and history

Sarah began therapy at the Center for Integrative Psychotherapy (CIP) when she was 17.5 years old. A counseling outreach program for eating disorders had referred her to the adolescent outpatient clinic. In our initial meeting, during which her mother was present, she appeared very friendly and rather reserved. Her mother dominated the conversation and seemed perplexed and very worried while describing her daughter's problems. As the presenting problem, she stated that approximately one year ago Sarah had begun to self-induce

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vomiting after meals. Sarah herself associated fear of academic failure and repeated weight-related remarks, especially by her brother, with triggers for the eating disorder. She noted that vomiting gave her a "good feeling of control."

The patient lived with her mother (42 years old, administrative employee) and her stepfather (32 years old, technician). The sporadic contact to her biological father was viewed as "obligatory." Her two-year-older brother was in training to become a firefighter and returned home on weekends. The parents separated when Sarah was 7 years of age. The mother remarried when Sarah was 14 years old. The mother stated that Sarah's psychological history comprised nocturnal fear from age 5 to 8; fear of beetles and spiders to date; somnambulism from 5 to 16 years of age. Sarah had a high school diploma (Germany's tenth grade graduation) and was attending the second year of nursing school. Her academic performance in nursing school was motivated and eager in nursing school, yet in ninth grade she had encountered severe difficulties with mathematics. In her final high school year, she was able to clearly improve her class rank through extraordinary performance in all subjects. Concerning her social behavior, Sarah had always been popular with adults. Her verbal expression was good, and she seemed mature. She reported problems with female peers: they judged her to be arrogant and precocious, and she quickly dismissed them, too. She had always felt strain and shyness with boys. Her first menstruation at age 13 was welcomed by Sarah, for it contributed to making her feel "grown up." The first sexual contacts occurred at 14 years of age. Her time in kindergarten starting at age 3 was unremarkable. She did not like attending elementary school because she "was not as popular as her best girl-friend."

2.4.2. Diagnosis, context analysis, and therapy target determination

Based upon the symptoms captured in the diagnostic phase (no ravenous appetite or adephagia after meals; but self-induced vomiting and fear of "being too fat"), Sarah received a diagnosis of atypical bulimia nervosa (F50.3) and of a moderate depressive episode (F32.1) as a secondary development. The associated context-analytical working model (according to SULZ, 2000) can be described as follows:

Situation: Increasing disparagement by the rival brother correlated with increasing academic success accompanied by her mother's great idealization ("Sarah is sensible and mature. She's going to make it."). While her stepfather was emotionally absent, her relationship with her biological father was characterized by excessive demands and emotional abuse ("You have to take care of me, as I'm doing badly," "When I am dead, you'll have to care for my grave").

Organism: Sarah was cognitively very reflective and mature. She demonstrated a great longing for harmony combined with a simultaneous inability to set boundaries (especially with the father and the brother). Furthermore, she experienced intense feelings of guilt when establishing boundaries or voicing criticisms. A great longing for warmth and security was present, together with a noticeable fear of losing love or control and a strong inhibition of aggression.

Separation and loss were the impetus for anger. Histrionic and insecure personality trends were present. Sarah had an above-average aptitude (IQ of 124).
Response: The primary anger was directed at the frustrating environment (especially family). The expectation was: "I will be lonely. I won't belong. I will be hurt." Angry impulses were replaced by depressive mood in combination with compensatory eating and vomiting.
Consequence: Fear of loss and fear of helplessness were reduced, and the feelings of control and security could be sustained.

In this context, the three targets of therapy developed in collaboration with Sarah were:
1. Managing the eating disorder.
2. Increasing well-being in relationships, i.e., receiving more from others and reducing the constant feelings of guilt ("What have I done wrong?").
3. Changing one's approach to emotions, i.e., not to feel sad without knowing why but to recognize contributing factors and engaging in action more confidently.

The therapeutic targets, derived within the framework of Strategic Therapy for Adolescents, were:
1. Sarah shall learn to engage in balanced eating behavior. She shall reduce vomiting by taking the appropriate steps for response prevention.
2. Sarah shall learn to limit her fears of loss and her longing for harmony (especially with regard to the father and brother) and to reduce her associated feelings of guilt, i.e., to handle her anger constructively instead of showing depressive coping mechanisms and compensatory eating or vomiting.
3. Sarah shall learn to develop an affirmative self-concept (especially with regard to her own gender identity) and to reduce her anxiety with men, i.e., to partially revise her conception of men.

The patient's intelligence, ability to reflect, and creativity seemed to contribute to a favorable prognosis. The extreme conflict avoidance within the family and the severely strained father-daughter relationship seemed unfavorable.

2.4.3. Therapy progression and parent work in the individual setting

The duration of individual therapy was approximately nine months and involved the mother and the stepfather. Upon Sarah's request, Sarah's then 48-year-old biological father (electrical technician) did not participate in therapy, justified in this case by Sarah's believably limited ability to set boundaries in the presence of his severe alcohol abuse and boundary-transgressing behavior.
Regarding the progression of therapy, after a general psychoeducational component covering "eating disorders and symptom formation" with Sarah, her mother, and her stepfather, individ-

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ual sessions focused on maintaining the structured eating behavior already initiated by the community counseling program and on practicing methods to stop self-induced vomiting (response prevention through jogging, listening to music, and progressive muscle relaxation). Central to the emotional work was Sarah's understanding of her symptoms as a "voice." To this extent, the eating disorder was personified, and Sarah could address the following letters to her eating disorder as "enemy/stressor" and as "friend:"

Dear eating disorder, my enemy,
You! You, you are so, so stupid. Do you know what you are doing to me? Of course, you're always here, but you encompass me. You have settled with me without my permission. That's a real drag! Without you, this "Help, I have eaten too much" would not happen. You determine my – no – your ideals. See, I don't even know if they are mine or yours, because you take over my entire "me" far too often. When I'm scared, you pull me down even more. You don't know anything about boys. You let me avoid them. Stop it! Let me be Sarah. You devour all of my courage and my hope. Do you even know happiness? Because that's what I want. But you are self-centered and only feign happiness. I don't want you anymore. Where do you live? In my head, in my stomach, in my heart, or where? I want you to leave. Become my past. I don't want these little feigned moments of happiness anymore.

AND
Dear eating disorder, my dear friend,
You are always with me and never leave my side. You are steadfast. I don't have to fight for your presence. You are the way, the help, when I have eaten too much. You are a way out. You have impressed me. You are so simple. With you, I don't need willpower to lose weight. You take care of me and attend to my ideals. You shelter me when I'm scared. You give me a way out of hurt. You want me to get along with boys, for you pursue the ideals. You are here when I am doing badly. You belong to me, just me…

These letters principally mirror all essential relationship and emotional themes that entered into therapy: As therapy continued, Sarah was able to sort out her "emotional chaos" and to feel frustrated without resorting to vomiting. Therapeutic nonverbal materials aided Sarah in the discrimination and identification of emotions that her eating disorder avoided. Sarah drew a picture showing how the "chops" of her eating disorder devoured emotions, such as love, sadness, hope, and longing. Through the drawing Sarah realized and sensed the importance of noticing, articulating and tolerating emotions. She formulated new, comforting thoughts to counter old thoughts that had fostered the eating disorder and the depression. The work on emotional and relational themes in the individual setting already reduced the patient's depressive coping mechanisms. Vomiting did not occur for a while and only reemerged in the con-

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text of an acute crisis in the group setting. In the individual setting, Sarah began to cope with her father's frustrating behavior, to define her boundaries and to withdraw from his influence by reflecting the frustrating situations and engaging in respective imaginal exercises. Role plays concerning the relationship with her brother led to Sarah's expression of needs and her setting of boundaries. Sarah was able to take a leap toward partnership and relationship.

Sarah described her relationship with her mother and her stepfather as rather difficult and characterized both parents as not understanding her. During parent work in the individual setting, the mother seemed to avoid and invalidate problems, hardly able to tolerate her daughter's emotional crises. Her mottos were, "Everything's fine," "Tomorrow's another day," and "Close your eyes and march ahead." Similarly, the stepfather minimized Sarah's psychological difficulties, thereby rendering both spouses' helplessness clearly noticeable. The stepfather refused to "question his insulated, sheltered home" under any circumstances. For this reason, discussions with both parents focused on intensive psychoeducation, a reduction of minimization and an increase in the sensitivity regarding Sarah's needs.

2.4.4. Therapy progression in the combined individual and group settings

A central theme that spanned individual and group settings was Sarah's fear of loss, especially pronounced in her partnership at the time, and her responses to unmet needs for security and understanding. The group members challenged Sarah's tolerance of disharmony and discord and also her ability to defend herself, which increased gradually. Sarah learned to voice criticism within the group and to defend against verbal boundary transgressions by a conduct-disordered adolescent. At the time of termination, Sarah could clearly articulate the gains she made in the group.

2.4.5. Progression of parent training

At the start of parent training, the patient's mother still could be described as "defended." As the training progressed, the experiential components "my survival strategy" and "frequent, intense, feared, and rejected emotions" aided her identification of her position within the family, which involved covering up, dismissing and not tolerating difficulties. Especially within the relationship with Sarah, the mother was able to formulate alternative responses to Sarah's emotional problems. Instead of the usual "Tomorrow's another day," and "It's not that bad," the mother began to hear her daughter's pleas for help and assumed a supportive, more understanding role. The mother recognized that, previously, she had warded off the daughter because of her own feelings of helplessness, especially when dealing with sadness and despair. Now comforting physical contact could be permitted. The mother also made an effort to balance supporting Sarah with leaving her to her own devices in the service of individuation. Recovering the ability to make room for conflicts especially benefited the mother-daughter relationship. Both sides interpreted this recovery as a relieving and clarifying cloudburst: Anger was allowed and did not destroy the relationship.

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The stepfather developed more tentatively. For a long time, he continued to minimize Sarah's difficulties, also in session. It appeared as if he were competing with Sarah for her mother's attention and was not open to change for this reason. Only during the last third of therapy, when the relationship between mother and daughter improved, did the stepfather for the first time verbalize that he felt locked out. He is now reflecting upon his opportunities to engage in alternative relationship formation and is trying to be more understanding of Sarah.

3. Final evaluation of Strategic Therapy for Adolescents

The data collected to date do not reach a sufficiently large sample size to permit the evaluation of statistical significance; however, our anecdotal observations and experiences concerning Strategic Therapy for Adolescents indicate that the work on central relationships and associated needs, fears, and anger impulses seems important and salutary. Throughout the therapy, the adolescents learn to discriminate their emotions, to sense and to regulate their needs. They demonstrate a global improvement of their psychological state. In our opinion, especially the combined individual-group-concept and the very intensive parent work have proven of value. Particularly in the areas "Behaving with respect to one's boundaries," and "Dealing with frustrating situations" changes within the family, or changes by specific parents or adolescents take place. Some adolescents enter therapy with markers for emotional instability, which can be treated within the intensive emotion regulation component. Self-injury or self-harm can be reduced in all cases or completely eliminated in some. The adolescent groups present a great challenge for the patients. Indeed, adolescents can use each others' feedback and our observations within the group framework to learn to work out issues and cope in a group context. The group can provide relief concerning the shame associated with one's symptoms. In the context of peer dynamics in adolescence, the adolescents also learn to engage with their own age-group and to handle problems within that group.

The approach of the Strategic Therapy for Adolescents is also supported by the adolescents' and the parents' commitment to therapy and the relatively low drop-out rate. Also the shared parent-child discussions that follow the group sessions show effects of learning. Many parents give positive feedback, even after having clearly articulated initial difficulties at the start of parent training (e.g., speaking about one's own issues in front of others, etc.). After parent training, the parents report less helplessness and more empathy in their relationships with significant others and an improved ability to reflect upon their own and others' psychological processes. The parent group seems particularly important where feelings of guilt toward the children are concerned. By assigning members of the same parental dyad to different groups, couples conflicts and lacking parental alliance can become a topic to be worked out. Some parent groups continue privately; several couples decided to enter couple therapy or individual therapy after training.

An adolescent's refusal to enter therapy with his or her parents and the parents' refusal to collaborate present a conceptual problem. In such cases, we work to achieve the parents' collaboration or to improve the adolescent's motivation, but we do not continue therapy if the situation does not change. This practice might sound radical, but it directly derives from our understanding of disorders and of the recovery process. Difficulties are also encountered when the parents themselves have diagnosable psychological disorders and cannot be convinced to enter individual therapy. At the beginning of training, many parents require convincing and compelling (a common comment is, "My child is in therapy, not I!"). There are parents who "cannot attend therapy as it competes with other important appointments." In such cases, sessions are made up later. It seems to be essential for the implementation of Strategic Therapy for Adolescents to conduct the parent training in a second therapy phase, after initial preparatory work has been completed and collaboration has been ascertained in the individual setting. Otherwise, the group situation and the large experiential component might overwhelm parents. The parent training situation can provide solid support, but in some individual cases it might present an anxiety-provoking situation. The Strategic Therapy for Adolescents thus encounters its limits in the implementation of these comprehensive procedures, but has proven mostly efficient and practically feasible so far.

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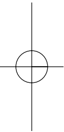
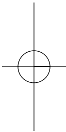
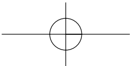

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Gernot Hauke

Treating Anxiety with Strategic Brief Therapy

ABSTRACT

We will approach anxiety from the perspective of security regulation and modern attachment theory. This point of view also introduces questions from existential psychotherapy. More recent behavior therapies of anxiety developed from the experience that mere symptom reduction did not produce a treatment outcome that was stable across time. Considering primary and secondary emotions, response chains may be conceptualized that enable a more thorough understanding of the anxiety syndrome. The present therapeutic approach also takes into account cognitive-affective schemata, termed survival strategies, whose characteristics determine the therapy strategy in a decisive manner.
Keywords: security regulation; primary and secondary emotions; cognitive-affective schemata; personal values

Preliminary considerations:

Anxiety patients experience insufficient subjective security

Fear of real danger is a thoroughly healthy response pattern. It ensures survival and belongs to the basic configuration of human existence. This quite reasonable behavioral pattern may lead to a maladaptive cycle, however, when it occurs frequently and intensely and is accompanied by an experience of the underlying threat as an overwhelming existential danger, i.e., as a dramatic loss of subjective security.

A large part of our lifelong endeavors aim at gratifying our basic needs for security. As we know, security may spring from the most different sources and may be based on the most diverse foundations. Thus, we seek security within our families, partnerships, friendships, employment; we buy insurance and build financial equity, engage in preventive healthcare, etc. Finally, we look for security in a multitude of communities of the religious, spiritual, or political kind or, more generally speaking, in common worldviews and perspectives.

Consequently, many very different efforts are directed toward one aim, namely the generation of security. How may the psychology of motivation understand this phenomenon? The Zurich

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Model of social motivation (BISCHOF, 1993; 1998) convincingly answers this question within a system-theoretical framework (Figure 1).

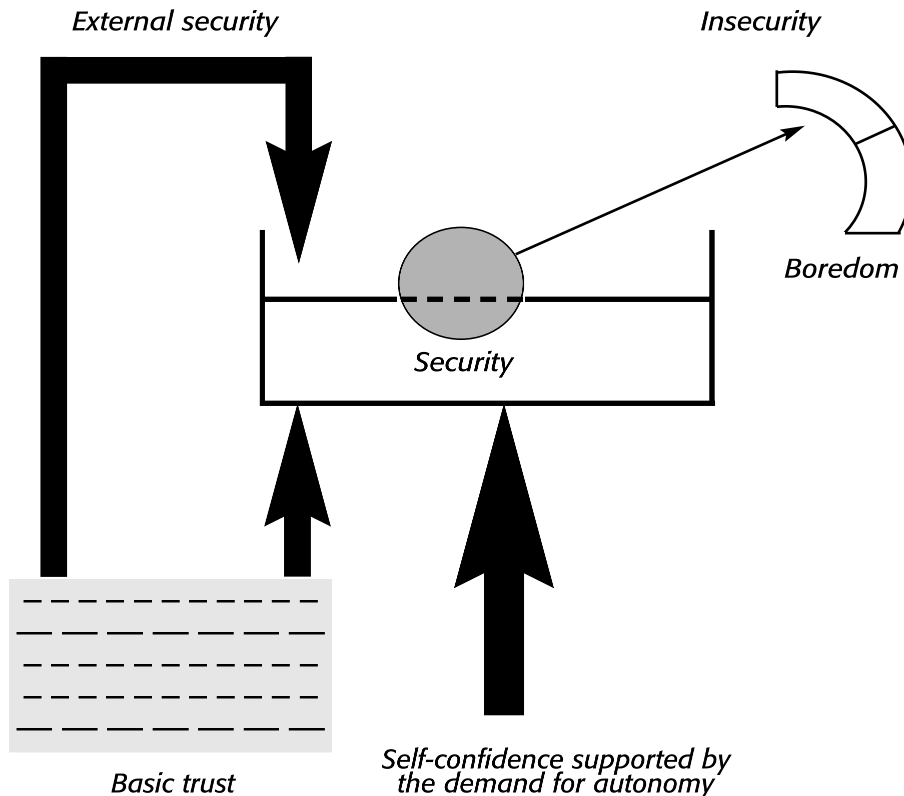

Figure 1. The regulation of security according to the Zurich Model of social motivation.

At the center of the author's considerations is a security reservoir, which optimally should neither be empty nor overfilled. The optimal level represents the subjective security reference value, which varies from person to person. Emptying the reservoir evokes insecurity, anxiety, and a search for affiliation. Weariness and boredom result from overfilling the reservoir. It is fed by several wellsprings: Externally, by the proximity of familiar persons who communicate protection and shelter; internally, (1) by the individual's self-confidence that is supported by a demand for autonomy, and (2) by the memory of reliably experienced past external security, internalized as basic trust. A high demand for autonomy curtails dependence and increases motivation. In itself, it constitutes a source of security because it generates self-confidence internally and thus decreases the need for external security from familiar individuals. Basic trust rep-

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resents an individual's early learning history and internally, analogue to the demand for autonomy, buffers the security gauge against fluctuations in situational environmental influences. The learning history is shaped by the experience of secure attachment on the one hand, and on the other hand by self-efficacy that has been encouraged and affirmed at an early date.

Table 1 specifies the different needs that may arise from the realms of "security" and "autonomy:"

Table 1. Needs characteristic of the realms of security and autonomy

Security	Autonomy
o Experiencing dependability	o Wanting influence, leadership
o Having a vis-à-vis, an ideal	o Distinguishing oneself
o Being challenged and nurtured	o Overcoming barriers
o Receiving love and affection	o Performance
o Experiencing empathy and understanding	o Distinction
o Being given respect and praise	o Competition
o Receiving set boundaries	o Assertiveness
o Being welcome	o Status and esteem
o Harmony	o Scope for development
o Protection	o Doing oneself, being able
o Shelter	o Determining one's path
o Warmth	o Playful experimenting
	o Risk-taking, experimentation

The relevant motivational significance of a demand for security or a deficit of security, as seen in anxiety patients, suggests a close examination of the special aspects of security regulation. Attachment theory offers a thematic fit.

Attachment theory.

The theory of attachment was originally formulated by John Bowlby (1988) and substantially developed by Mary Ainsworth and colleagues (1978). The theory builds on the assumption that human beings, like other primates, are innately motivated to engage in social behavior. This innate motivation, viewed as a continuously present human characteristic that exerts its influence from birth to death, also comprises the ability to form strong emotional bonds with other special individuals. The purpose of the attachment system is to maintain and guarantee protection and security by establishing contact to appropriate attachment figures. These figures may be persons but also – especially in the case of adults – symbols or representations of the

respective security-relevant objects or events. The attachment system is activated mostly when the person – scared, stressed, tired, or sick – feels the urge to seek out protection, coziness, or support with a primary attachment figure who seems appropriate. Obviously, attachment theory is suited to explain the special kind of relationship that forms between a parent and his or her child. Bowlby himself pointed out, however, that attachment theory does not only pertain to children. Indeed, attachment is clearly observable in adults, particularly when some form of stress is experienced. Adults seek the proximity of significant attachment figures, usually the respective partner, in the case of illness, pain, anxiety in the presence of novel situations, feelings of rejection or affront, problems at the workplace, personal loss, etc. In these situations attachment-related behavior and the associated desire for protection are rather typical, even if adults have a higher threshold for activation of the attachment system than children.

Forms of insecure attachment and anxiety: In addition to the attachment system, the theory conceptualizes two further biologically based systems: A protective and an exploratory system. Not all attached relations are the same: Different attachment patterns emerge from the way in which the protector responds to the attachment-related efforts of the child. Children tend to engage in "secure attachment" if their efforts are met by responsive, warm, sensitive, and emotionally present attachment figures. Children with secure attachment patterns are distinguished from insecurely attached children in several aspects. For example, in times of stress securely attached children tend to quickly seek out their attachment figure and to calm down faster and more completely within the contact. Insecure attachment patterns lack exactly these properties. The *anxious-ambivalent* attachment style, for example, shows all characteristics of an approach-avoidance conflict involving the parent. Here, the children's upset and agitation persist, and a return to baseline activities is not possible. An *avoidant* attachment style is present when the child ignores or even actively avoids the parent. These children seem indifferent, withdrawn, and preoccupied with activities that serve to distract from the actually experienced distress. AINSWORTH ET AL. (1978) empirically supported this taxonomy by classifying infant behavior using the "strange situation" test.

Today, there is hardly any doubt that the quality of childhood relationships with significant others is internalized and maintained into adulthood as an "internal working model of relationships." Therefore, interview schedules were developed to assess such attachment representations in adults. MAIN AND GOLDWYN'S (1994) *Adult Attachment Interview* (AAI) is the most popular instrument. Adult attachment styles may also be described by self-report measures using two continuous dimensions, i.e., avoidance and anxiety (RHOLES & SIMPSON, 2004). In this context, avoidance characterizes an adult's discomfort with psychological proximity and his or her desire to maintain emotional independence even in intimate relationships. *Insecure attachment*, associated with anxiety as the core emotion, refers to the strong need for receiving care and attention from attachment figures and to a deeply pervading insecurity concerning the ability or readiness of attachment figures to gratify the respective need.

These three attachment styles were validated by the AAI; we relate them to the "precocial" versus "altricial" anxiety styles:

1. Rejecting (deprecating/avoidant): precocial
   a. The emergence of needs for comfort and support is non-permissible.
   b. Reminders of vulnerability and rejection by attachment figures in childhood are suppressed.
   c. The importance of attachment is strongly qualified.
   d. Autonomy is overemphasized. Such patients fill their security reservoir with an excessively high demand for autonomy.

The search for proximity is impeded by internal barriers: The attachment system is deactivated by a range of strategies. Anything associated with a denial of attachment-related needs and a withdrawal of exclusively individualized activities as a form of coping may be interpreted as a deactivating strategy (e.g., downplaying a threat).

2. Worried (possessive): atricial
   a. Deeply pervading uncertainty regarding the availability of attachment figures.
   b. Clinging, dependent.
   c. The inability to process unpleasant experiences with attachment figures in childhood and adolescence leads to lifelong entanglement and often deeply rooted anger at parents and other attachment figures.
   d. Emotional dependence is overemphasized. This anxious type of person fills his or her anxiety reservoir by producing excessive external security.

In this case, the search for proximity is essentially possible. Hyperactivating strategies are involved. They serve to signal danger to the reachable but unresponsive or inattentive attachment figure, so that he or she may be moved to provide security and protection. Exaggerating the threat as well as anxiously monitoring the attachment figure's behavior may occur. Corresponding coping strategies are directed at the removal of the barrier that impedes the adjustment of the actual sense of security to the respective demand. Aggressive, supplicatory and further exploratory measures may be employed, with supplicatory and exploratory strategies possibly being the most frequent.

3. Secure
   a. Strong optimism concerning security and protection within intimate relationships; basic trust.
   b. A sense of personal autonomy and the ability to view past and current attachments without denial or entanglement, unresolved feelings or thoughts.
   c. Ability to switch relatively well between dependence and independence.

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The secure attachment style implies the critical ability to buffer the mental effects of external threats with internal security.

In adulthood, internal images or the respective internal working models of important attachment figures may be activated and thus supplant actual external attachment figures (see also "sense of secure base," BOWLBY, 1988). Thus, mere thoughts of attachment figures may produce a psychological proximity that replaces the physical one. Once activated, they are able to provide protection and security symbolically. The activation of mental representations of external or internalized attachment figures in time of danger and stress does not seem to be the only way to increase the sense of secure base. Expanding their original model, MIKULINCER AND SHAVER (2004) suggested that feelings of relief and increased security may be achieved via activation of security-based self-representations. Such self-representations are typically generated in security-promoting interactions with attachment figures. The authors distinguish two kinds of security-based self-representations: (1) an internalized representation of the self in relationship-specific interactions with an attachment figure; and (2) an internalized representation of the self that emerges from identification with the properties and characteristics of an attachment figure.

1. Representation of self-in-relationships: Pleasant, security-promoting interactions constitute an important source of positive information about the self. When effectively coping with the threat situation that originally activated the attachment system, the person may experience him or herself as active, strong, and competent. In this context, the presence of a "stronger," "smarter," and "wiser" other additionally contributes to feeling calm and safe. The respect and acceptance put forth by the attachment figure not only leads to the development of appreciation for oneself but also to the conviction that one is capable of mobilizing close, satisfying relationships with others and their support. These representations are stored in semantic memory and probably reach from relationship-specific to more abstract and generalized concepts.
2. Self-care: The security-based self-representation comprises the internalized characteristics of particular, supportive attachment figures. The respective interactions are not only important sources of information about the attachment figure's intentions and responses, but also an important foundation for our perception of other people. Positive interactions let the attachment figure seem available, sensitive, empathic, caring, and warm. The assumption that our self-representations could resemble the representations of significant attachment figures originates in psychodynamic and object relations theories. Important regulatory functions provided by external attachment figures are first internalized via mechanisms of incorporation, introjection, and identification and then gradually transformed into internal regulatory mechanisms that progressively increase their autonomous functioning: People treat themselves in the same manner as they used to be treated by significant attachment figures. In this context, the authors MIKULINCER AND SHAVER (2004) speak of "expansion of the self." Accordingly, close relationships prompt the integration of characteristics and resources of the attachment figure into the self-concept.

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When working with personal values in the context of anxiety disorders, the following finding may also be of interest: In a carefully controlled study with adult participants, Mikulincer and colleagues (2003) showed that priming attachment security, i.e., lower scores along the dimension of attachment avoidance, correlated with a significantly higher endorsement of self-transcendent values.

Existential anxiety. Unfortunately, we must admit that nothing protects us from an event that all of us will encounter with absolute certainty: Death signifies our final obliteration and annihilation. The fear of death moves like a subterranean stream through our lives. Yalom (1989) correctly pointed out that our typical mental problems and fears pale in comparison to our fear of death. How do we manage to live with this?

One answer to this question is supplied by *Terror Management Theory* (TMT), which has an extraordinarily extensive empirical base (SOLOMON, GREENBERG, & PYSZCZYNSKI, 1991; 2004). According to this theory, humans and other species share a kind of biological predisposition for self-preservation on the one hand; on the other hand, humans' highly developed cognitive capacities generate an awareness of the inevitability of one's own death, which produces a potentially paralyzing terror. This existential anxiety is reduced by a cultural anxiety buffer which consists of an individualized cultural worldview that adds order, meaning, and permanence to the subjective reality. This worldview also provides a sense and structure to life and offers explanations for the creation of the world and for what happens after death. Finally, it defines the legal and ethical standards according to which conduct is judged "good" or "bad." According to TMT, self-esteem increases to the degree to which these standards are met. The role of self-esteem, i.e. the associated self-confidence in the production of security, is more precisely understood in the context of the security regulation model described earlier (Figure 1).

Meeting the standards prescribed by the worldview generates a sense of self-esteem, particularly the promise of completeness and security. After all, this is a fundamental experience in our learning history. A sense of secure base and the gratification of needs occur more reliably if children comply with the demands of their adult attachment figures. Therefore, in the course of socialization a disastrous conclusion is drawn: Conforming and "being good" imply security, and non-conformity is associated with anxiety and insecurity. This experience of security is later broadened to include one's relationship with society and culture. The possibility of a fundamentally threatened existence motivates the maintenance and the strengthening of adherence to the cultural worldview as well as the attempts to do justice to standards and values associated therewith.

SOLOMON, GREENBERG, AND PYSZCZYNSKI (2004) report some findings of interest to our discussion: The cognitive salience of one's own mortality (e.g., contemplating one's death; being in proximity to a cemetery; subliminal priming, etc.) leads to a defense of one's cultural worldview, particularly increased affiliation with and acceptance of persons who share one's worldview and increased antipathy, aggression, and rejection of persons who question or do not share one's worldview.

As indicated earlier, self-esteem serves to buffer potentially debilitating existential anxiety. Correspondingly, experimentally induced or dispositionally high self-esteem reduces the level of defensiveness. In turn, the cognitive salience of one's mortality increases the tendency to maintain or increase self-esteem. Mortality salience may, for example, increase one's readiness to engage in risky driving practices if one's driving abilities impinge upon self-esteem; or it may emphasize a focus on one's physical appearance if the body is relevant to self-esteem. One may suggest that, due to a particular worldview and/or lack of self-esteem, people manage their existential anxiety more ineffectively and therefore are generally more susceptible to anxiety of different kinds and associated mental disorders. This suggestion has already received some converging support in the context of anxiety disorders (ARNDT, ROUTLEDGE, COX, & GOLDENBERG, 2005).

Anxiety from an SBT perspective

Figure 2 shows the context for the development and persistence of mental disorders in general. We would like to apply this context to anxiety disorders specifically.

Self image and worldview. Patients with anxiety symptoms are in some regard predisposed to responding in this manner. In particular, a special kind of self image and world view has been developed. Perceptual patterns are directed at recognizing and utilizing conditions that further the required degree of subjective security and maintain it in all circumstances. Generally, anxiety patients experience their environment as unsafe or even threatening. It is a place where "altricial" individuals must receive attention from important, security-providing persons at all costs to survive. "Precocial" individuals, on the other hand, gratify their needs while not falling short of a certain security distance from such persons. These individuals fear for their autonomy, which they need in any case as they are not able to simply depend on a reliable attachment to a preferred environment.

Survival strategy. Anxious persons struggle to gratify their need for security. They have learned to produce minimal security even in difficult situations. To attain this goal even under aversive conditions, a time-tested program or a procedural rule is executed. We term this part of the response process "rule-governed," for it runs its course on the "program level" of hierarchical self-regulation (HAUKE, 2004), where the procedural organization of goal-directed behavior is controlled. In contrast to the sensory-motor regulatory level, cognitive effort and directed attention are relatively important at this level. More recently, this distinction has also been accepted in the development of clinical behavior therapy. In this context, conditioned behavior to be accounted for by a theory of learning is differentiated from rule-governed behavior (HAYES, BROWNSTEIN, HAAS, & GREENWAY, 1996; SULZ, 1994). Here, the extensively documented human ability to process complex information is taken into account by acknowledging that not only dichotomous information (such as reinforced/non-reinforced, or punished/non-

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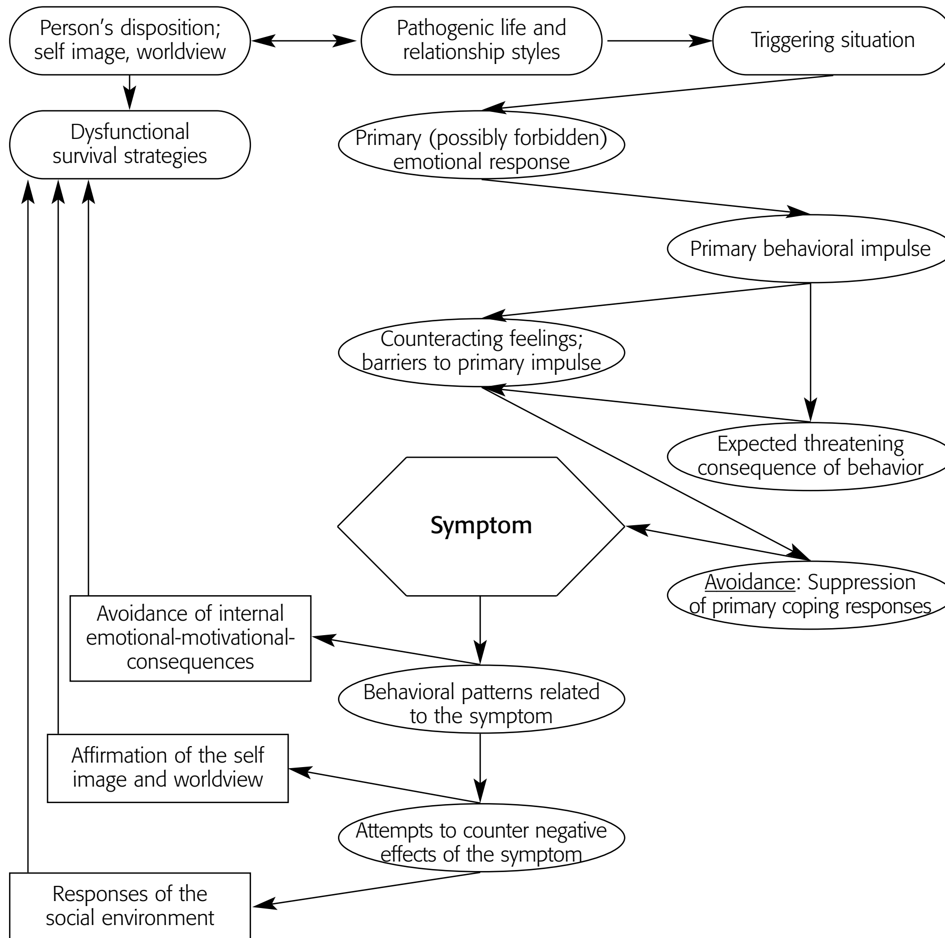

Figure 2. The development and maintenance of mental disorders from SBT's point of view.

punished) regulates human behavior, but the mind integrates this learning history, e.g., in the form of general assumptions about self and world (BECK & WRIGHT, 1986), and derives situation-specific behavioral plans (GRAWE, 1998). The hierarchical self-regulatory model would locate these processes squarely at the rule-governed level. Especially important for clinical work are the so-termed "survival strategies" (SULZ, 1994). Considering anxiety disorders, the survival strategy could be explicitly stated as, "Only if I manage to maintain complete accessibility to my protective person through active-cooperative conformity, then I will be able to survive with his or her protection. If I fail, then I will be alone and helpless in facing the dangers of a threatening world." As a result of an early learning history described as attachment experiences in the

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preceding section, survival strategies always contain "instructions" detailing in a context-specific manner which behavior must be activated or avoided, so the responses required to guarantee emotional survival may be obtained from the social environment.

Pathogenic life or relationship style. Environmental conditions continuously interact with the person and are also characteristic of the person, for these conditions – rather than constituting an entirely independent cause – are the individual's construction. Therefore, anxiety develops in the interaction of personal characteristics and the situation, which then merge into a unit or a system. This unique dynamic relationship is termed "transaction" (LAZARUS, 1994). Each emotion is associated with a specific, behavior-governing significance that is also constructed by the person within his or her reciprocal relation with the environment. This significance is described by "core relational themes." Consequently, anxiety results when such a theme contains aspects of threat as a dominant appraisal category. Pathogenic life patterns (e.g., persistent avoidance of activities that require autonomy) predetermine a breaking point that finally must lead to symptom formation. The problem situation would not have evoked symptoms in the absence of a dysfunctional lifestyle, as the person would have been able to access sufficient resources to increase the probability of coping with the problem. People who limit their experience to a sole domain, e.g., job or partnership, are deprived of access to alternative sources of reinforcement when this one domain is extremely compromised. However, people who avail themselves of one or, better, more domains of personal significance are able to gain strength from those domains when others are diminished, inaccessible, or toxic.
Frequently, a dysfunctional or pathogenic relationship style underlies symptom formation in anxiety disorders. The triggering situation virtually functions as the last straw that broke the camel's back. Here, we often discover a distribution of roles that is indicative of a rather dependent relationship style. Some anxiety patients, the "altricial" ones, assume a protection-seeking stance and become emotionally dependent on the person who provides guidance and protection. They try to strengthen the relationship by fulfilling the needs of the protector and foregoing their own needs far too frequently, so that an unacknowledged desire for separation may become explosive. Other anxiety patients, the "precocial" ones, avoid emotionally intimate relationships to the best of their ability. They view their inner equilibrium as jeopardized when the relationship partner falls short of a certain security distance.

Triggers. The experience of an actual separation or an unacknowledged desire for separation in a controlling partnership may constitute triggers. "Precocial" individuals develop a phobia when they have committed to a partnership; they are less often affected by the loss of a partner.

Primary and secondary emotions and responses. Most researchers who study emotion acknowledge the extraordinarily nuanced richness of emotional experience encountered by the practitioner in everyday work. In particular, the significance of higher order cognitions and the

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appraisal of emotional components are more recognized. Indeed, psychological models are emphasizing the role of the person's responses to his or her own inner or emotional experience (e.g., CHAMBLESS & GOLDSTEIN; 1981; GREENBERG & SAFRAN, 1987; HAYES, WILSON, GIFFORD, FOLLETTE, & STROSAHL, 1996). GREENBERG AND SAFRAN (1987) proposed the distinction of primary and secondary emotions.

Primary emotions are affective responses that may be conceptualized as a bundle of sensory and perceptual information, i.e., communicated via physical experience. "Primary" indicates that these emotions are temporally first and immediately result from the transaction of person and environment. Primary emotions such as fear or grief are triggered rapidly, for example by stimulus constellations relating to a physical threat or the loss of a loved one, respectively. Their level of cognitive processing is comparatively shallow, occurs subcortically and non-consciously, and facilitates quick responding. Secondary emotions are responses to primary emotions and are also well-established by neuroscience (GREENBERG, 2000; LEDOUX, 1996). Here, learned emotional responses are at issue. Often, anger – a primary emotion – is followed by massive anxiety: "If I express my anger, then she will leave me," or "if I express my anger, then I will produce counter-responses that I won't be able to handle." The more frustrated or dramatic the situation, the stronger is the primary emotion and the more intense the primary impulse for action. As the anticipated consequences seem unbearable, they may not be risked under any circumstances. Everything must be tried to avoid executing the primary impulse. The mind manages this situation by replacing the primary with the secondary emotion (GREENBERG, RICE, & ELLIOTT, 1993). Consequently, the transaction of person and environment has been altered, as demonstrated by a change in self perception shifting the balance of power in the other person's favor, for example. Therefore, the primary action impulse ceases to be the optimal response and the primary action intention is suppressed. It is not the original situation anymore in which the other person has displayed highly irritating frustration or provocation. Instead, the individual finds him or herself in a situation of helplessness and takes the blame for the sequence of events. Rather than the other person, "fate" will be identified as the cause. At this point, the secondary evaluation and the associated secondary emotion result in observable behavior that aims at conflict avoidance and the prevention of any possibly negative consequences of assertion. Viewed from a different theoretical perspective, the behavior has a self-protective function and refills the security reservoir. Figure 1 points to the "external" source of security that may not be risked. The cognitive-affective survival strategy that corresponds to this stance could read, "Only if my cognitions, emotions, and behavior correspond to the wishes of significant attachment figures, if I never express needs that could be incompatible, then I will maintain the protection, the warmth, and security and I will avoid loss." However, as frustration and threat levels increase further (i.e., the security reservoir is emptying to balance self and relationship interests or person and environment) a more effective measure must be found. If the survival strategy does not allow any other potentially effective behavior, then the symptom is the last resort. On the one hand, it maintains the survival strategy; on the other hand, it pro-

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vides relief in the interpersonal realm by substantially changing the symptom-evoking situation. The transaction between the individual with the symptom and the environment has been altered completely. Everybody is alarmed, and the problem of an acute anxiety disorder is appearing within the relationship. Now the relationship is not jeopardized by the original problem, i.e., the intent to separate, anymore. The social system has been stabilized until further notice, and the self is protected from a loss of social support. From the perspective of self-regulatory efforts, yet another aspect is relevant. The attention is focused on the very concrete and direct level of cognition and behavior: The constant management of physical and emotional symptoms of anxiety and the constant preoccupation with details of avoidant coping in everyday life do not leave much room for a reflection on superordinate life contexts, for a contemplation of one's understanding of self, goal setting, values, and future plans. This fixation of attention on the lower levels of behavior regulation leaves the hitherto existing self-concept untouched, protects the existing identity (Baumeister, 1990). The consequence of the symptom is its maintaining function: The avoidance of a loss of affiliation or relationships; the upkeep of self-protective gratification (e.g., protection, affiliation) or a minimum of independence and autonomy are the saving result of symptom development. The affirmation of self-image and worldview as a cognitive representation of the self and the social environment is as important a consequence. The transitory discrepancy has been removed; for the time being, the mind has managed to clear the conflict zone.

A case vignette

For one year, a 32-year-old patient (Ms. R.) had been suffering from agoraphobia with panic. She reported panic in crowded settings, such as in waiting lines, shopping malls, and in the subway, but also with unpredictable onset, for example being alone at home. The patient also stated she experienced nausea, dizziness, and sudden hot flashes at work. She worked in tourism and was responsible for program design within a team.

Relevant current situation. Ms. R. reported loving her partner and desiring a child with him. She said that, as her wish for a child intensified, her partner threatened separation and temporarily moved out of the joined apartment. In terms of other relevant situations, she reported that two months ago management had offered her a promotion associated with increased professional responsibility and nationwide coordinative activity. The patient noted that upon this offer her anxiety had reached maximal levels that prevented her attendance at work.

Pathogenic lifestyle. The patient had devoted her life to her relationship. During the day, her work was easy and not particularly challenging. She had neglected her hobbies and interests and had limited her social contacts to colleagues. Otherwise, she neither nurtured friendships nor acquaintanceships, excluding some occasional telephone contacts. She had abandoned a non-traditional college-level education when her partner reacted irritably to her frequent absences and complained that she was not dedicating enough time to the relationship.

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Pathogenic relationship style. The patient nurtured her partner with great devotion and attempted to pamper him with homemade meals, small favors, and care. She felt successful if he was able to shed bleakness, irritability, and weariness in her presence and to display good spirits and optimism. As time passed, she noticed that he increasingly sought this kind of interaction. If he met with his peers at the pub or if he went to ballgames, she stayed home and longingly waited for his return.

What *personality characteristics* did she bring into this life situation?

Historical disposition. The patient's learning history may be understood as a transaction with her familial environment. She described her father, an officer in the German army, as strong, protective, yet hardly available. She always enjoyed his proximity and was able to influence her relationship with him, particularly their level of closeness, by poking fun and being in good spirits. Nevertheless, she rarely managed to establish a complete emotional connection with him. She constantly had the feeling that he was not fully present; that she could never really live up to his standards. The patient reported that her mother had talked about herself exclusively; that she had appeared generally overwhelmed, anxious, and moody; and that she had demanded strict obedience. As a child, the patient had been gregarious and bright, an excellent student.

The patient's self-image and worldview: "I need protection, security, and dependability, which my father will provide only if I am a bright daughter, and my mother will provide only if I am a compassionate listener to remain under her supervision and avoid threats and challenges."

The following survival strategy emerges: In general, a rather insecure attachment style resulted; a minimum of security and protection was communicated only if the patient did not express her own needs, avoided or suppressed negative feelings, and gratified her attachment figures' needs as much as possible: "Only if I am a pleasant daughter to my parents and only if I never go my own path, then I will maintain protection and security and will avoid being thrust into a strange and threatening world by myself." This survival strategy, dysfunctional in adulthood, led to a narrow behavioral repertoire.

The patient's dysfunctional behavioral rigidity. The patient consistently engaged in relationships that were lively, intimate, and directed at gratifying the other's needs to ensure his or her reliable accessibility. If possible, she never left the house by herself. With time, the following dilemma developed: The patient's dependency-related needs, her reference values regarding protection and dependability, could be sufficiently met only by a correspondingly dependent relationship style. The thus gratified need for security provided a context in which needs for independence and autonomy could emerge but could not be realized within the relationship. Consequently, tension increased within a latent conflict between security and autonomy.

The patient's responses. Her responses in the symptom-evoking situation may be explored via the response chain illustrated by Figure 2. Her primary emotion was feeling hurt and angry when the partner threatened to terminate the relationship. Her primary behavioral impulse was battering and choking him. The consequences anticipated by her were the complete loss of the relationship and subsequent loneliness, which she had reliably avoided in the past. In other

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words, her primary behavioral impulse would have jeopardized her survival strategy and resulted in the loss of protection, security, and dependability.

The counter-regulating emotion of fear as an emotional stopper came into play. For some patients, this is already the first panic attack. The emotion targeted the suppression and avoidance of the originally intended behavior. The further development of symptoms could have been prevented if fear had caused the patient to completely abandon all tendencies for autonomy. However, anxiety flared up repeatedly, its intensity was maintained, and it served as a reminder of the survival strategy. The patient was not able to continue living as before, but she also could not change her life. This unbearable conflict had to be resolved.

Phobia, as a symptom, provided the necessary relief. Certain areas, such as elevators, subways, or a heavily frequented department store, are as anxiety-provoking as unfamiliar surroundings and wide open spaces, in which any individual human being seems small and lost, without immediate access to help. Anxiety occurred especially when transitioning from the home to the outside. The possibility of a professional change with frequent travel challenged autonomy-related behavior patterns and so produced a peak in panic. The patient strictly avoided all phobic stimuli and attempted to leave home only with her partner.

The consequences of the symptom maintain the anxiety disorder. The anxiety disorder persists for it prevents challenges to the survival strategy on the one hand and therefore an unprotected and lonely existence in a threatening world on the other. Particularly from an operant perspective, the patient received affection from the partner as well as never before experienced concern from her family of origin. The downward regulation of the patient's demand for autonomy reduced her anxiety. Therefore, the anxiety disorder maintained and strengthened relationships that guaranteed protection, security, and reliable access to the attachment figures.

The therapy

Strategic Brief Therapy (SBT) conceptualizes the development and maintenance of disorders from a cognitive-behavioral point of view (Table 2).

This kind of therapy shows similarities but also differences in comparison to other cognitive-behavioral interventions for anxiety (e.g., BARLOW & ALLEN, 2004; EIFERT & FORSYTH, 2005; GRANT, YOUNG, & deRUBEIS, 2005):

- A superordinate target of therapy for anxiety is the facilitation of a life change. Patients learn to flexibly manage the core conflict between needs for autonomy and attachment, i.e., they learn to take care of both needs concurrently.
- The therapy views the therapeutic relationship as instrumental in the processing of the patients' interpersonal problems.
- The therapy is resource-oriented. Usually patients have established a plethora of resources over a lifetime, some of which may have to be reactivated, some rediscovered and made accessible.

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Table 2. Outline: The course of anxiety treatment in Strategic Brief Therapy.

1. *Assessment phase:* The survival strategy is formulated considering access to sufficiently secure, nurturing, and challenging relationships.
2. *Symptom reduction:* The relationship between survival strategy and symptom is tested, and the survival strategy is appreciated as a resource. In vivo exposure is heavily utilized.
3. *Emotion therapy:* Deep emotions are experienced while transgressing the rules stipulated by the survival strategy; alternative coping with mostly primary emotions, such as anger and rage, occurs; the survival strategy is processed as a regulatory principle within the psychotherapeutic relationship.
4. *Behavioral therapy:* Extracting strategies for behavior change from the survival strategy; developing implementation intentions and detailed plans of change projects: What, when, where, how, with whom.
5. *Future planning:* Work with personal values, survival strategy and antagonistic values pertaining to selected future projects; relapse prevention.

- The therapy is target-directed. The particularly future-oriented work with personal values considerably extends this aspect.
- The therapy is educational. It communicates knowledge and transparency regarding the development and the maintenance of the disorder, thereby drastically promoting self-exposure and, more generally, self-management.
- Both patient and therapist assume an active role demonstrated by a practice-intensive and experientially oriented style that should facilitate novel experiences. True behavior change can only be effected in this fashion.
- The therapy teaches effective coping and problem-solving skills, such as
  - o Mindfulness (directed attention),
  - o Relaxation,
  - o Systematic self-monitoring,
  - o Emotion perception and discrimination,
  - o Self-instruction and self-reinforcement,
  - o Shaping one's abilities in a stepwise manner,
  - o Self-exposure.

Building relationships. The preliminary considerations of motivational processes as well as the case vignette pointed to the extent to which interpersonal factors influence the development of symptoms and the course of the disorder. Relatively recent behavior-therapeutic approaches, such as the "Third Wave" behavior therapies, incorporate such factors by requiring the therapist to respond contingently when a certain patient (target) behavior occurs, for example (KOHLENBERG ET AL., 2004; KOHLENBERG & TSAI, 1991). SBT also attends to the therapeutic

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relationship, as particularly evidenced by its attachment-theoretical approach to the regulation of security. From an ideal-typological perspective, two types of relationships may be distinguished based on their balance of autonomy and attachment. "Altricial" individuals are encouraged to demand a minimum of attachment and, instead, to fuel their self-confidence with self-efficacy in the context of autonomous behavioral patterns. The autonomous behavioral patterns of "precocial" individuals, on the other hand, are validated and appreciated; at the same time, "precocial" individuals are encouraged to experiment with different levels of attachment. Moreover, the therapeutic relationship is seen as a realm in which therapist and patient together may study the factors of crucial interpersonal influence and explore and test alternative interpersonal styles. Indeed, we hold that many problems in the life of the patient are also represented within therapy. In this context, the patient's survival strategy is developed as a theme in therapy, carefully observed and later challenged by the therapist, albeit mildly at first. Together, a space of opportunity is created where the exploration of behavioral alternatives and their effect on the survival strategy may be explored via experientially oriented experiments. Accordingly, the patient described in the earlier case vignette formulated alternatives to her dependent survival strategy and tested them within the therapeutic relationship. The therapist's feedback and validation generated much movement in the patient's relationships outside of the therapy room. Exposure therapy very quickly prompted a first opportunity for bringing up the patient's survival strategy as a theme in the therapeutic relationship: Difficult exposure work in rain and sleet for six to eight hours a day evoked rage and anger that were directed also at the therapist. The patient tried hard to suppress and hide her anger but did not fully succeed, which allowed for a discussion of the survival strategy in the "here and now" of the therapeutic session. Finally, alternatives could be developed and reinforced. Subsequently, other, similar everyday experiences in different life domains of the patient were compared and goals could be set accordingly.

Therapeutic process: The strategic nature of the symptom implies the strategy used in therapy.

Assessment phase. The therapy plan strictly develops from the core piece of SBT, i.e., the survival strategy. Of course, first the context in which the survival strategy is embedded must be assessed and understood. Intake, assessment, diagnosis as well as a behavioral and a contextual analysis of symptom development are routine steps. Initially, patients learn to develop systematic self-monitoring and directed attention (mindfulness) skills. Thus, the initial primary goal is to live with one's symptoms and to carefully observe them using mindfulness skills. The patient's need to get rid of his or her anxiety as soon as possible is gently but decisively denied. In the framework of a psychoeducational module, we explain that the effectiveness of our treatment for anxiety hinges on the patient's ability to experience anxiety in the first place. Here, we describe experiences and findings from the literature on exposure. Thereby the effectiveness of this phase is clearly improved. Most patients consider mindfulness practice unfamiliar and

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initially difficult. To explore their possibilities and limitations with regard to mindfulness, patients are asked to sit and to direct their attention to their breath for ten minutes a day; to notice upcoming thoughts and emotions in a non-evaluative manner; and to refocus on the breath immediately. Further, patients are asked to practice being completely present with an activity of daily living, i.e., to direct their attention fully to the respective execution of the task, such as eating, walking, etc. If one notices a preoccupation with thoughts, emotions, or internal images, then the attention is redirected toward the precise details of the performance, e.g., the motion of the chewing jaw, the meeting of feet and floor. Initially, it may be easier for patients to engage in the corresponding imaginal exercises described by HAYES, STROSAHL, AND WILSON (1999). During the first phase of therapy, organism factors are also assessed, including a person's learning history but also relevant needs and resources. These data are organized according to Figure 2, and the target analysis and therapy plan directly emerge from the assessment summary. Both are preliminary and must be readjusted and refined in the course of treatment. In the following section, we will describe the required process modules. Their sequence characterizes the course of therapy, but often modules are applied in parallel.

Symptom reduction. Systematic self-monitoring enables the construction of a hierarchy describing problematic situations. The judgment of the degree of discomfort and especially subtle avoidance strategies are discussed. Referring to the earlier case vignette, the patient quickly learned from self-monitoring that symptoms were more intense when the survival strategy was strained or not followed precisely, e.g., when her parents disapproved of her, there was trouble with her apartment rental management company, etc. These observations were addressed and corresponding hypotheses formulated, such as, "If I get angry, I need a lot of fear to keep my anger in check."

Symptom reduction I: The next step tests such hypotheses with behavioral experiments. Here, an intentional challenge to the survival strategy in interpersonal situations is of issue. This challenge is located relatively low on the gradual fear hierarchy and has to be implemented and supported with great care, for it occasions a general switch in perspectives from helpless victim to observer. Although her symptoms continued to flare up intensely, the patient clearly experienced a certain degree of distance. Apparently, her regular mindfulness practice had greatly supported this change in perspectives. Thus, the patient realized—not from extensive cognitive deliberation within session but from experience—that feelings of anxiety and particularly physiological symptoms kept her demand for autonomy in check and maintained her "extremely low maintenance" level with a range of interpersonal partners. She already knew at this point that this circumstance denied her desired improvement in professional status.

Respecting the survival strategy: Discovering the good in the bad. At this time, the patient experienced outrage and anger regarding her conformity and different interpersonal partners who readily enjoyed her "low maintenance" stance. Thus, it is necessary to emphasize the significance of the survival strategy as a cognitive-affective emergency tool that did not have any

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alternatives within the historical context of its emergence. The notion of the survival strategy as a potentially useful resource regularly meets with surprise (HAUKE, 2004), as again demonstrated in the context of the case vignette. Through lifelong adherence to the survival strategy,

- The patient had become highly emphatic and able to quickly grasp the situation of the interpersonal partner. This is an important competence. But here, an internalized "stop sign" had to be implemented that allowed room for her own goals, needs, and emotions. Self-neglect must be replaced with stronger self-referential behavior to enable a more precise evaluative process.
- Early detection of signs of conflict and negative emotions is advantageous when used for preparation. Behavioral processes thus may be regulated more effectively.
- Security is important and its provision is an essential part of self-care. However, too much security may be paralyzing and make life boring. Consequently, different degrees of autonomy are required.
- The avoidance of relationship loss also entails the thoroughly positive ability to develop and maintain close and committed relationships. Here also, the cost must always be calculated.

The patient was touched by this collaboratively formulated perspective. Repeatedly, memories of frequent internal struggle and fatigue were linked to her learning history.
Symptom reduction II. The process so far has emphasized insight into the necessity for a direct encounter with the anxiety symptoms. Willingness and commitment related to anxiety reduction through massive *in vivo* exposure represent an important keystone of therapy. In the meantime, sufficient skills have been developed to mindfully observe other emotions that may accompany anxiety.

The survival strategy within the therapeutic relationship. The difficult exposure homework in rain and sleet for eight to ten hours per day evoked anger and rage, also targeted at the therapist. With special consideration of the primary emotions of frustration and anger that only appeared in an emotional cocktail with anxiety, shame, and embarrassment, the survival strategy became a theme in the "here and now" of the therapeutic session. As a goal, the description of the patient's anger at the therapist was to be facilitated and validated. Other, similar experiences in the patient's everyday life were compared and the appropriate goal-setting occurred.

Emotion therapy. The patient's response chain clarified that her anxiety symptoms essentially functioned as a barrier for her primary emotions of frustration, anger, and rage. The patient's survival strategy in particular assigned a "forbidden" status to such emotional qualities. An exclusive focus on symptom reduction would have surely helped the patient already. But it would not have taught her to manage those primary emotions that were functionally linked to anxiety. Being able to have, regulate, and modulate such emotions constitutes an especially

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important competence in psychosocial contexts. For this reason, emotion therapy first teaches patients to notice and discriminate their primary emotions. Then permitting such emotions, letting them be, giving them space, comprehending their origin, understanding their meaning, and explaining their function is of issue. Subsequently, the patient learns which behavior patterns are prompted by respective emotions, and which aims a certain emotion sets out to achieve. Additionally, patients acquire the skill to clarify whether the emotion and its intensity are situationally appropriate and if the behavior that would be evoked by the primary emotion is situation-appropriate or promising. Thus, the development of a skill is achieved that produces a behavior corresponding to the emotion and appropriate to the situation. This gradual shaping process is supported within SBT by experimental learning through success. The content of our structured procedure focuses on primary emotions, thoughts in connection with emotions, and expression and communication of emotions and behavioral impulses that directly result from primary emotions (SULZ, 2000).
In this context, the patient had to confront anger and rage. She quickly realized that these emotions often arose when she allowed other people to interfere with problem-solving that would have been effective for her in certain situations. The resulting frustrated need gratification frequently evoked anger. Here, as a form of exposure to anger, the patient was asked to imagine different everyday situations that would elicit anger and rank them according to degree of difficulty. With role plays and experiential exercise, the generalization to everyday life was prepared. Catharsis is not our target. Our interventions occur in the mental realm, i.e., we exclusively condition covert responses. In the context of the case vignette, we prepared the conscious cognitive regulation of anger and constructive negotiation, so that the patient was able to represent her concerns early and competently. Now her consciously noticed anger became a reliable crutch, in some sense a measure that the gratification of her needs was still lacking.

Behavior therapy. True behavior change is only possible in the context of new experiences. For this reason, this building block of the therapy process refers to the development and testing of behavioral plans, the content of which is implied by the survival strategy. This means that the patient was asked to develop behavioral plans that helped her to counter her survival strategy, initially in small steps. These behavioral plans are integrated into the construction of concrete projects that serve to gratify the most diverse current needs: Discussions with supervisors regarding professional change or vacation planning with a friend, both requiring the acknowledgement of own needs, interests, and boundaries; negotiations with parents regarding an estate, etc. Commitment and the prospect of success are considerably increased by detailing the intention for implementation (Gollwitzer, 1999), i.e., the what, when, where, and how of behavior that counters the survival strategy. The patient learned to gratify her need for security to a realistic degree and concurrently engaged in a self-regulated, successive increase of autonomous behavioral patterns.

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Designing a future: Working with personal values. Personal values always have a positive connotation and thus virtually contain a constructive intention. This intention is an active directedness toward the generation of a most optimal future, i.e., to establish or build something, or to realize something that is understood as "good" or "true." Once the patient had sufficient evidence that she could live relatively well without her avoidance strategies and could tolerate distress, primary emotions, and delayed gratification with respect to her need for security, then a temporal perspective that extends beyond the immediate gratification of needs – the future – becomes accessible. The therapeutic process now focuses on the direction that life should take, influenced by directional goals that are determined by personal values stated as future intentions. They constitute the context in which goal-setting occurs. To avoid the usual difficulties in working with values (social desirability, absence of contingencies, illusions) the work is tied to concrete future projects (see WILSON & MURRELL, 2004).
In our work, we are convinced of the credibility and potential of the patients' personal projects if we are able to locate their origins and roots in the person's self-concept. Referring to the case vignette, creative work with the self-concept and personal identity in the form of a collage generated two projects that were associated with corresponding values:

- Entering a partnership that allowed for self-actualization and mutual growth;
- Professional growth consisting of increased mobility, diversification of tasks, and increased contact with others.

Further processing of these projects (e.g., "Imagine you would meet the respective partner, how would that be? What would be important to you?") produced additional guiding principles 70% of which could be categorized into the domains of security, conformity, and tradition. Here, a certain polarization of the patient's value orientation emerged (cf., *Values in Strategic Brief Therapy: From need to value-directed living*, this issue). A more detailed examination of this finding reestablished an excessive need for security and risk aversion in the approach to these projects. The patient also recognized that the desired need-appropriate and constructive, sustainable changes were virtually blocked. This finding was further emphasized by a newly formulated survival strategy that was quite similar to the original one. The patient was amazed that an old topic could reemerge in a new guise. She noticed how rapidly stress incurred during change or simply habit may lead to "relapse" and to which degree preparation, planning, and commitment were required to produce real and sustainable change. In this context, our work with personal values offers an appropriate solution: Within the value spectrum and antagonistically located to the domains of "security," "tradition," and "conformity" are the value domains "stimulation" and "self-actualization" (i.e., essentially the qualities desired by the patient). These must be occupied by concrete behavioral targets. Thus, the value spectrum suggests a strategy for change that initially preserves a bit of the familiar ground but simultaneously and at controlled levels tolerates uncertainty, risk, etc., so that the new may emerge and be nourished (HAUKE, 2004).

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The careful dosing of antagonists resulted in the following: In the partner domain, the patient was able to meet several men at after-work parties. She was able to notice and resist her security-oriented guiding principles and became increasingly convinced of the necessity for a new orientation. Furthermore, she reestablished contact with an acquaintance who offered her a position in the context of self-employment. She introduced herself to the new team and utilized a severance pay period within her company to begin establishing the newly desired way of life. Formally, we utilized the "mental contrast" method as an intervention targeting the emergence of developmental goals. An action-oriented, proactive approach replaces freely fantasizing, basking in a desirable future, and also obstructively ruminating. Deliberate mental contrasting of positive fantasies about the desired long-term outcome (e.g., discussing differing life expectations or lifestyles with a partner, preparing the new work situation) with negative aspects of the impeding reality (e.g., low distress tolerance in conflict situations involving specific discrepancies, outdated learning style) should lead to the formulation of binding goals for action and the discovery and creation of opportunities for learning that results in coping with future challenges. Contrary to basking and ruminating, which only lead to moderate commitment regardless of the probability of success, mental contrasting activates the relevant chances for success (or expectations of success) and utilizes them for goal-setting. If the relevant expectations of success are low, people shy away from committing to binding goals, but if the expectations are high then people tend to bindingly commit to the realization of the desirable future (OETTINGEN, HYEON-JU, & SCHNETTER, 2001).

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Ute Gräff-Rudolph and Serge K. D. Sulz

Strategic Therapy for Depression: Learning to use emotional energy for more fulfilling relationships

ABSTRACT

Assuming a functional perspective of depressive symptom formation, depressive behavior is interpreted as an avoidance strategy that prevents intensive emotions and thereby averts potentially escalating conflicts with important figures. Depression as a strategy is countered by a therapeutic strategy that aims at reconnecting the depressed mood with the avoided emotions through the use of mindfulness, acceptance, and exposure strategies followed by interpersonal skill building. Exercises for pleasure, anger, anxiety, and grief exposures are described. The therapy duration is brief, i.e., 25 sessions.
Keywords: Cognitive behavior therapy, depression, functional analysis, strategic approach, mindfulness, acceptance, emotion, exposure

A. Introduction

Within the last 20 years, cognitive-behavior therapy has widened its scope considerably. The behavioral and cognitive models of dysfunction have become unsatisfactory. Recent studies (e.g., SOLOMON ET AL., 1998) have demonstrated that never depressed and recovered depressed groups do not differ in the frequency of their dysfunctional thoughts. However, only in the recovered group, dysfunctional thinking correlated with increased negative mood. This and similar findings suggest that, rather than cognitive dysfunction, emotional dysregulation occurs in depression. For this reason, the direct modification of emotions as well as the management of emotions and interpersonal relationships is replacing the former focus on cognitions as the point of therapeutic intervention within the depressive response chain. A functional analysis of symptom formation and maintenance provides the optimal intervention point. When the privileged explanatory status of cognitions is abandoned, emotions, needs, and interpersonal relationships become equally valid concepts. Exposure methods, whose efficacy has been shown in studies of anxiety and obsessive-compulsive behavior, are used to modify other emotions, such as shame exposure for social phobia or anger exposure for borderline personality disorder (LINEHAN, 1996a; 1996b, 1998). Even in cases of major depression, depressed affect wanes temporarily if a sufficiently intensive competing emotion is evoked. Accordingly, anger-

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whether imaginary or induced in a role-play—may produce anti-depressive effects (BURNS ET AL., 1998).

SEGAL AND COLLEAGUES (2002) examined the relapse risk of individuals with remitted depression and concluded that temporary dysphoria might automatically activate depression-typical cognitions beyond conscious control. This automatic rumination does not result in problem-solving but in "mental grooves," i.e., self-perpetuating and escalating cycles that impede psychological functioning and may lead to a full-blown depressive episode. Over time, ruminative depressive processing may be evoked by previously undisruptive events until, finally, spontaneous relapse occurs. Segal and colleagues developed an approach to relapse prevention that does not intervene at the level of the depressive cognitive content but at the level of this ruminative depressive process. Their Mindfulness-Based Cognitive Therapy (MBCT) is based on KABAT-ZINN'S (2001) Mindfulness-based Stress Reduction Program (MBSR): Concentrating/being mindful of thoughts, feelings, and physical sensations – being in the present moment – acceptance and kind awareness – letting go – "being" rather than "doing" – drawing attention to the physical manifestation of a problem (see MICHALAK & HEIDENREICH, 2004).

Behavior therapists confront the contradictory situation that they are unable and unwilling to invoke a psychological framework to explain endogenous depression, yet they must assume a psychological model to optimally intervene in depression – just as interpersonal therapists (KLERMAN ET AL., 1984) must posit an interpersonal depressive etiology. Similarly, here too, a heuristic model of dysphoria (rather than depression) is formulated to provide the conceptual foundation for the recent cognitive-behavioral approaches. The following discussion of the proposed functional heuristic model and the resulting strategic therapy approach extend SULZ'S conceptualizations (1993; 1994).

Dysphoria may be interpreted in terms of its effects on a person's mind. How does dysphoria affect behavior and experience? The consequences of dysphoria may be provisionally viewed as the functions of depression. Dysphoria serves to produce these consequences – as long as they are advantageous.

What differentiates feelings and mood? Feelings, such as pleasure, anger, or grief relate to an event or to a person. They are responses to somebody's behavior, arise suddenly, change quickly, have the potential to intensify, and are of a short duration (minutes). In comparison, moods, such as depression or irritability, are unrelated to events or persons, are not responses to somebody's behavior, do not arise suddenly or change quickly, do not have the potential to intensify, and are not of a short duration.

If one interprets these differences teleologically (i.e., functionally) rather than causally, the following heuristic emerges: The function of a depressive episode is the avoidance of intensive feelings with disadvantageous consequences. Depressed or irritable moods thus avoid relating to an event or to a person. They inhibit responding to somebody's behavior and thereby prevent sudden reactions, emotional behavior, and intensive feelings. However, moods last considerably longer than these avoided feelings.

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Consequently, the cognitive-behavioral depression heuristic posits that depression constitutes avoidance behavior. Depression serves to avoid intensive affect (pain, anger, grief) and emotional behavior. Negative reinforcement, i.e., the avoidance of aversive events, maintains the depression. This rule results in the following cognitive-behavioral intervention strategy: If the strategic aim of depression is the replacement of certain feelings with depression, then the therapeutic strategy consists of replacing depression with these feelings. This replacement occurs via exposure. Considering the four major affective categories, we may speak of pleasure, anxiety, anger, and grief exposure. Subsequent to exposure, the patient learns to manage these emotions, usually via cognitive self-regulation and competent relationship building and maintenance. Thus, the therapy has three foci:

1. Exposure to emotions;
2. establishing cognitive self-regulation of emotions;
3. establishing and maintaining interpersonal competence.

B.An overview of prevalent approaches to depression

1. The reinforcer loss model (Lewinsohn, 1974)

The event triggering my depression is the loss of a person, of a situation in which I was rooted, of a life goal, or of my future. This loss is so significant that nothing else is left. There are no alternative reinforcers. All behavior patterns weaken: Passivity results.

2. The learned helplessness model (Seligman, 1979)

Particular events and circumstances preceding the depression demonstrated that I cannot do anything to obtain the support necessary for my emotional survival. I helplessly confront my circumstances. Any effort is futile, and my situation is hopeless.

3. The cognitive model (Beck, 1976)

Dysfunctional basic assumptions (survival strategies) determine a person's experience and behavior, e.g., "I will be liked only if I always give and never take." Dysfunctional cognitive schemata produce automatic thoughts that lead to depression.

4. Cognitive behavior therapy for depression (Hautzinger et al., 1989)

Increasing pleasant events; planning successful activities; replacing depressive thinking with anti-depressive cognitions; practicing interpersonal behaviors that produce social reinforcers.

5. Behavior therapy for depression (de Jong-Meyer et al., 2000)

"Final common pathways of improvement:" Behavior therapy, cognitive therapy, interpersonal psychotherapy (IPT), and couples therapy are deemed equally effective.

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Behavioral activation, rather than reliance on cognitive intervention strategies, is the first-line intervention for *severe depression*. Maintenance interventions targeting the treatment of residual symptoms or lifestyle modifications are necessary for *relapse prevention* (e.g., see FAVA ET Al., 1998, or TEASDALE ET AL., 2000), especially in cases of chronic depression or of endogenous depression with frequent episodes.

Psychological resources and the selection of interventions for depression

Based upon the varied results of the NIMH depression study (Elkin, 1994), GRAWE (1998) concludes that cognitive therapy is most effective with cognitively competent people, while interpersonal therapy is most effective with interpersonally competent people. Thus, none of the therapeutic approaches produces effects according to their therapeutic conceptualization. Cognitive therapy, for example, assumes that it helps patients to rectify their depression-based cognitive distortions and to adjust their thinking to match that of non-depressed people. This assumption was not supported by the above study. Rather, cognitive therapy assists patients to use their cognitive resources as an anti-depressive strategy. Cognitively competent patients benefit the most. Therefore, cognitive therapy works best for those people who have the fewest cognitive deficits. An analogue situation exists for interpersonal therapy. Hence, the indicators for both therapies have been turned on their head.

Consequently, the most recent trends (see DE JONG-MEYER ET AL., 2000) suggest that

- identifying and incorporating an individual's existing strengths (resources),
- actively managing emotions (emotional competence), and
- actively arranging relationships (interpersonal competence)

constitute the process and the outcome of therapy and are often aided by the mediating use of functional cognitions.

Depressive strategies and the strategic therapy for depression

The following sections consist of patient handouts and exercises for the development of a disorder-specific therapeutic strategy, elaborating earlier presentations of this intervention for depression (SULZ, 1987; 1993).

C. Treatment manual

What is depression?

Depression is an illness.
Depression is a mood.
Depression is an affective disorder.

What differentiates feelings and mood?

Feelings, such as pleasure, anger,
Relate to an event or to a person.

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They are responses to somebody's behavior,
Arise suddenly,
Change quickly,
Have the potential to intensify,
And are of a short duration (minutes).

Personal examples 1 – When do you feel pleasure?

My pleasure relates to

An event ....
A person ....
A specific behavior ....
How suddenly does it arise? ....
How quickly does it change? ....
How intensive is it? ....
How long does it last? ....

Personal examples 2 – When do you feel anger?

My anger relates to

An event ....
A person ....
A specific behavior ....
How suddenly does it arise? ....
How quickly does it change? ....
How intensive is it? ....
How long does it last? ....

Moods, such as depression or irritability,

Do NOT relate to an event or to a person.
Are NOT responses to somebody's behavior,
Do NOT arise suddenly,
Do NOT change quickly,
Do NOT intensify,
Are NOT of a short duration (minutes)

What is the purpose of moods?

Moods, such as depression or irritability,
Avoid relating to an event,
Avoid relating to a person,
Avoid responding to a person's behavior,
Avoid a quick response,
Avoid emotional behavior,
Avoid intensive emotions.
But moods last considerably longer!

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Does this hold true in your case? What is the purpose of your mood?

My mood avoids

Relating to an event . . . .

Relating to a person . . . .

Relating to a specific behavior . . . .

My prompt response . . . .

My emotional behavior . . . .

My intensive emotions . . . .

What are the consequences? . . . .

An affective-behavioral hypothesis of depression

- Depression is avoidance behavior.
- Depression serves to avoid intensive emotions (pain, anger, grief) and emotional behavior.
- Depression is maintained by negative reinforcement (preventing an aversive event).

What is avoided by depression?

- According to behavior theory, depressed behavior is operant or instrumental in kind.
- Depression is maintained by its consequences.
- To understand depression, we have to discover precisely what is being avoided.
- Usually, anger, pain, and grief are avoided.

What are you avoiding?

- What happened immediately before you became depressed? . . . .
- What could you or others have done to manage the situation? . . . .
  - ◊ In addition to positive effects, what negative consequences would you have expected? . . . .

Frustration → aggression → depression hypothesis

- Anger?
- We remember the frustration-aggression hypothesis of motivational psychology:
  - ◊ "Frustration leads to aggression."
  - ◊ This is a common reaction!
- What frustrating, disappointing, rejecting, disadvantaging events did you encounter?

  . . . .
- What angered you? . . . .
- How angry should you be? . . . .

Loss is a form of frustration

And anger is a common response.

Anger says: "I do not want to give it up. I want it back!"

Anger does not want to accept the loss.

Anger struggles.

Anger may be deadly.

Depression avoids deadly anger.

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What does the anger want to do? . . . .
How much does the anger want to do it? . . . .
If anger could turn back time, how far would this anger go? . . . .
Anger is also a phase in the grieving process.
We know the phases of grief:
Denial – anger – grief.
Depression avoids transitioning to the next phase of grieving: Letting go.
What I do not let go, I do not lose.
Or: I cannot live without it. Therefore, I cannot let it go and mourn it.
Or: Letting go is painful. I would not be able to endure this pain.
What loss would you have to accept? . . . .
What would you lose? . . . .
Without what would you have to live? . . . .
What pain would you have to endure? . . . .

The targets of therapy for depression

- Replace powerlessness with equal opportunity
- Replace surrender with compromise
- Replace proscription with personal responsibility
- Replace needing with wanting
- Replace complementing with encountering
- Replace polarized with balanced relationships

Therapeutic strategy – The paths of therapy for depression

From Acceptance + satisfaction → reinforcement
Love + being loved → self-esteem
Mastery + effectiveness → self-efficacy
Arguing + defending → self-determination
Giving up + tolerating → autonomy

The emotional star – a person's vitality

A person's vitality is characterized by his or her affect in perception and expression. We may posit four main dimensions of emotional vitality. These emotions are evoked by events and situational circumstances (Figure 1).

Depression "devours" these feelings and replaces them with a sad mood. The therapy for depression aims at the reversal of this process (Figure 2).

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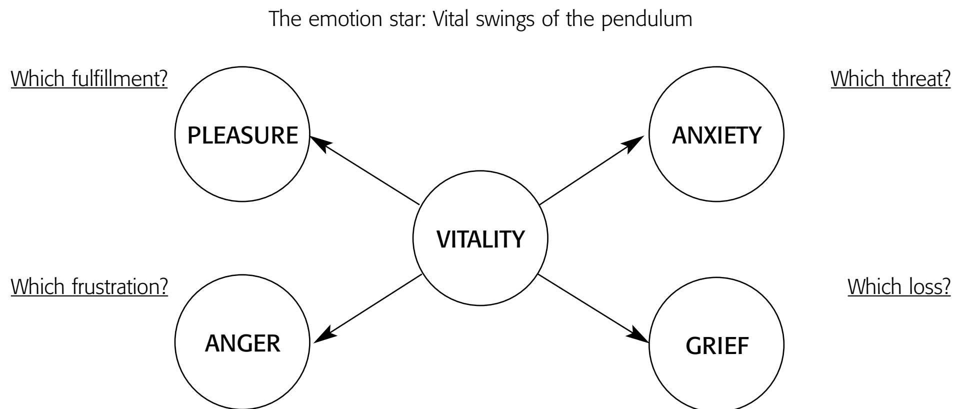

Figure 1: Emotions and a person's vitality

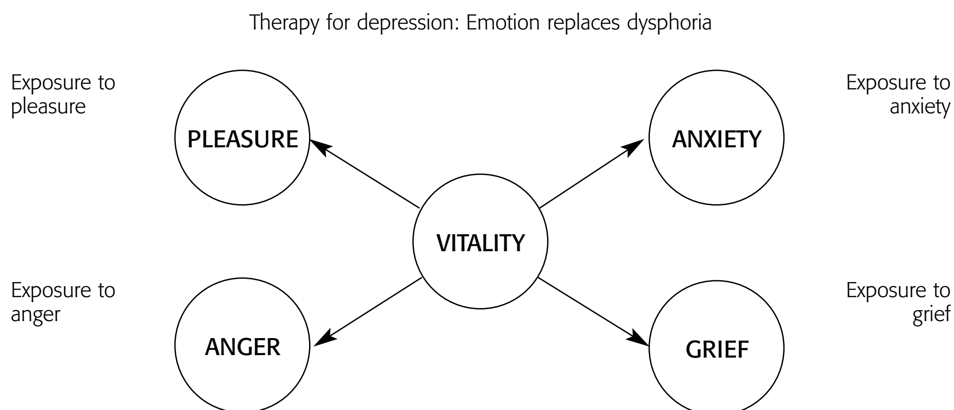

Figure 2: Therapy for depression: Emotion replaces dysphoria

This general therapeutic strategy leads to four anti-depressant strategies related to these emotions:

a) Exposure to pleasure
b) Exposure to anxiety
c) Exposure to anger
d) Exposure to grief

The selection of any of these four strategies depends first and foremost on the function of depression for each individual patient. At the same time, exposure inevitably provides opportunities for emotion management (i.e., reducing or changing the emotions).

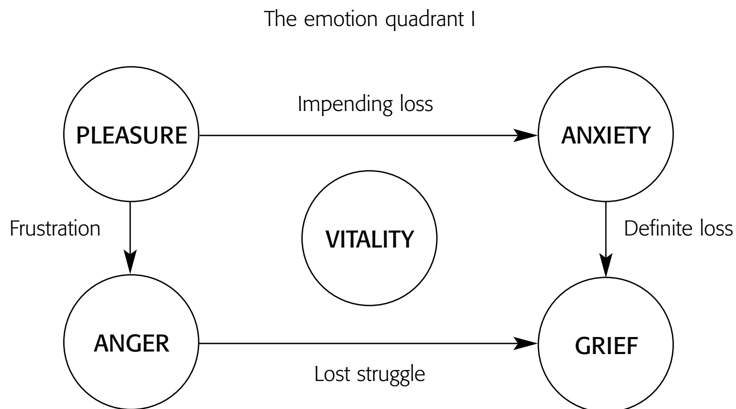

Figure 3: The emergence of emotions

Starting with the pleasant state of satisfaction, anxiety is produced by an impending loss. If satisfaction is frustrated, anger arises. Beginning with the anxiety related to an impending loss, the realization of a definite loss can lead to grief. If one assumes anger is the starting point, then a lost struggle might also end in grief. Anxiety and anger defend us against a past, present, or future reality. The acceptance of an unalterable reality might also lead to grief. The selection of the therapeutic path is contingent on the patient's concrete situation.

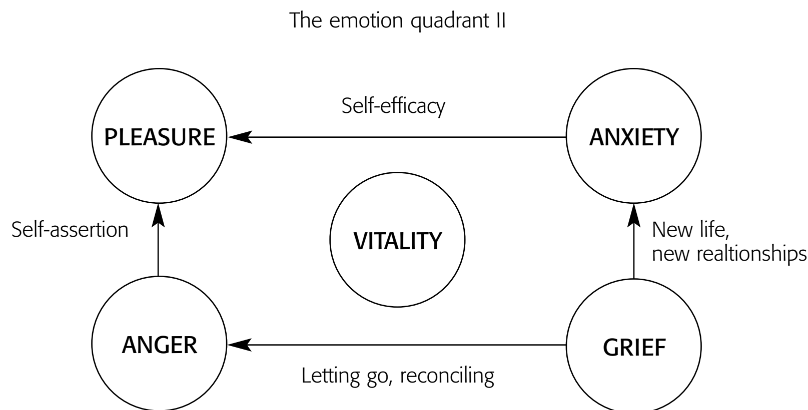

Figure 4: The therapeutic modification of emotions

One can overcome anxiety by engaging in behavior that ends the threat. Successful self-assertion, but also letting go and reconciling, terminate anger. If the grieving process is complete, a new relationship or a new life phase begins. Big changes might produce temporary anxiety related to novelty. Experiences of one's self-efficacy reduce this temporary anxiety.

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Therapy for depression = Pleasure replaces dysphoria

Exposure to pleasure*

a) Enjoyment training
b) Increasing positive activities
c) Relaxation training
d) Receiving attention from others
e) Exercise and sports

*positive reinforcers (need fulfillment, pleasant experiences, success)

a) Enjoyment training

- Practicing enjoyment of pleasant visual, acoustic, olfactory, gustatory, and kinesthetic perceptions (collection of and exposure to reinforcing stimuli in all sense modalities)
- Perceiving with awareness and focus (What? How? What is evoked? How am I doing?)
- Sustaining one's memories of the event (remembering well, experiencing the pleasantness through memories)
- Increasing the number of opportunities for mindful sensory experiences
- Directing one's mind toward the present moment and away from rumination.

Exercise 1

***Collecting** enjoyable sensory impressions (five each):*
- Eye candy: . . . .
- Enchanting sounds: . . . .
- Charming smells: . . . .
- Scrumptious tastes: . . . .
- Soothing touches: . . . .

Exercise 2

***Practicing** enjoyable sensory experiences:*
Eye candy – enchanting sounds – charming smells – scrumptious tastes – soothing touches
Situation: . . . .
Time: . . . .
Sensory mode: . . . .
Perception: . . . .
Subsequent feeling: . . . .

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Exercise 3

Remembering *enjoyable sensory experiences:*
Eye candy – enchanting sounds – charming smells – scrumptious tastes – soothing touches
Situation: ....
Time: ....
Sensory mode: ....
Perception: ....
Subsequent feeling: ....

b) Increasing positive activities

Positive activities have reinforcing* effects. They improve one's mood and prevent depression.

- List activities according to their reinforcing effects (weak, medium, strong)
- Plan activities for the next day
- Document each activity immediately upon completion
- Rate mood during the activity (0-10)
- Each evening, evaluate the average mood of the day
- Plan to engage more frequently in those activities that correlate with greater enhancements in mood

*Engaging in the activity feels good or has positive consequences, such as meeting needs or values

Exercise 4

List activities according to their reinforcing effects (weak, medium, strong)
What I used to like doing several times a day: ....
What I used to like doing once a day: ....
What I used to like doing once a week: ....
What I used to like doing once a month: ....

Exercise 5

Plan activities for the next day		
My positive activities on _________________ [date]		
No.	Time	Activity
1	____	....
2	____	....
3	____	....
4	____	....
5	____	....

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Exercise 6

Rate the mood during each activity (0-10)

0 = severely depressed 10 = completely free of depression

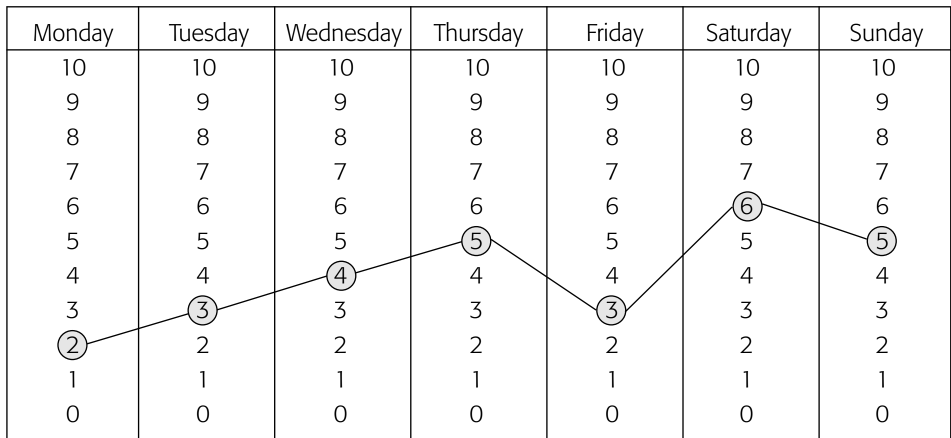
My positive activities on ________________ [date]

No.	Time	Activity	Performed?	Mood rating
1	____	....	Yes / no	....
2	____	....	Yes / no	....
3	____	....	Yes / no	....
4	____	....	Yes / no	....
5	____	....	Yes / no	....

In the evening, evaluate the average mood of this day (0-10): ....

Exercise 7

Graphically depict your weekly moods using a filled circle (0 = severely depressed; 10 = completely free of depression) and the number of activities using a triangle (e.g., 4 = 4 activities)



Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
10	10	10	10	10	10	10
9	9	9	9	9	9	9
8	8	8	8	8	8	8
7	7	7	7	7	7	7
6	6	6	6	6	6	6
5	5	5	5	5	5	5
4	4	4	4	4	4	4
3	3	3	3	3	3	3
2	2	2	2	2	2	2
1	1	1	1	1	1	1
0	0	0	0	0	0	0

Exercise 8

Engaging more frequently in those activities that correlate with greater enhancements in mood

The following activities were associated with a great improvement in my mood:

1. ....
2. ....
3. ....
4. ....
5. ....

I will schedule the following activities again soon: ....

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c) Relaxation

A few studies have shown relaxation training to be more effective than behavioral activation.

- Introducing to progressive muscle relaxation (PMR)
- Practicing PMR once per session (initially for 20 minutes, later for 10 minutes)
- Providing a PMR tape to the patient with the instruction to practice PMR twice a day
- Assigning a self-monitoring task to the patient detailing the effects of PMR per practice (e.g., tension reduced from 70 to 30%)
- Demonstrating to the patient the use of PMR in everyday life

d) Receiving attention from others

Learning to accept reinforcement from others.

- Arranging one hour of quality time with a significant person in one's life (e.g., after dinner, in the evening)
- Getting comfortable together in the living room
- The significant person thinks of little gestures and gifts to pamper the patient (e.g., a soft cushion, a drink, something for a sweet tooth, illumination to enhance mood, pleasant music, a good smell, a selection of interesting literature, a massage (with the patient's consent))
- Focusing on the pleasure associated with the gesture or gift
- Expressing pleasure
- Thanking the significant person for the pampering

Exercise 9

My significant person is ______________________.
We agreed on _______________________ [weekday and time] for *quality time*.
Our alternative time is ______________________ [weekday and time].
My significant person thought of the following gestures and gifts:

____

( ) I concentrated on the pleasure associated with the gestures or the gifts.
( ) I expressed my pleasure.
( ) Finally, I thanked the person for pampering me.

e) Exercise and sport

Physical exercise is an anti-depressant for many people.

- Is there a daily exercise routine in place that can be extended (e.g., walking, bicycling)?
- Which sport is associated with the highest level of motivation (e.g., gymnastics, jogging, hiking, swimming, working out in a gym)?

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- Is it possible to engage in team sport that increases social contact (e.g., volleyball, badminton, ping pong, tennis)?
- If the person does not express his or her anger, are martial arts a possibility (e.g., aikido, karate, fencing)?

Exercise 10

Orientation and information. The following types of sports are available:

1. ....
2. ....
3. ....
4. ....
5. ....

What fits best into a daily routine? ....

What fits best into a weekly routine? ....

Exercise 11

My exercise schedule for the week starting on ____________ until ______________

Day	Sports scheduled	Accomplished?	Mood (0-10)
Monday	________________	Yes / No	________________
Tuesday	________________	Yes / No	________________
Wednesday	________________	Yes / No	________________
Thursday	________________	Yes / No	________________
Friday	________________	Yes / No	________________
Saturday	________________	Yes / No	________________
Sunday	________________	Yes / No	________________

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Therapy for depression = Anxiety replaces dysphoria

Anxiety exposure*

a) Assertiveness training
b) Communication training
c) Autonomy training
d) Want-replaces-must training

*Replacing proscriptions with personal responsibility

a) Assertiveness training

Asserting oneself means two things: (1) saying "no" and (2) being able to make demands

- Document everyday situations under consideration of these two themes
- Conduct situational and behavioral analyses
- Define the desired assertive behavior
- Practice the target behavior in a role play
- Determine when and where the behavior should occur for the first time
- Enter a behavioral contract
- Document results
- Revisit in the next session: Reinforcement and/or modification of behavior. Continued practice until performance is automated.

Exercise 12

Saying "no" and being able to make demands

What situation? ....
Significance of the situation? ....
Who is the person? ....
What is his or her intent? ....
What is his or her behavior? ....
What is my intent? ....
What is my behavior? ....
How do I do it? ....
What result do I achieve? ....

Exercise 13

In session:

1. Writing scripts (determining the dialogues)
2. Preparing the role play (What do I do/say? To what do I attend? What don't I say/do? How don't I say/do it?)

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3. Engaging in role play
4. Receiving feedback (with video, if possible)
5. Engaging in improved role play with feedback
6. Consenting to a behavioral contract: I will engage in the target behavior on ________________. As a reward, I will __________________________.

Exercise 14

Until the next session:

1. On a daily basis, visualize mastery of the situation.
2. Outline the details of the practice situation.
3. Practice the situation.
4. Document the practice.
5. Execute the contract: I have engaged in the target behavior on __________________. As a reward, I now ____________________.

b) Communication training

Open communicative exchanges may be prevented by an avoidance of one's own unpleasant feelings or the other person's reactions.

- Learning to speak (use the "I"-format, be concrete, stay in the present)
- Learning to listen (promote verbalization, ask, repeat)
- Learning to engage in conflict (feelings, wishes, willingness)
- Addressing all important themes with the significant person (practice difficult conversations in role plays)
- Engaging in conversation until communication avoidance turns into communication enjoyment.

The practical steps are adopted from Schindler et al. (1998).

Exercise 15:

Learning to speak:

1. Start sentences with "I"
2. Speak only about me and my issues
3. Speak only about present events
4. Speak only about specific behaviors of others
5. Speak only about my feelings

   Because: "You"-sentences are accusations. Speaking about another person does not solve problems. Past events distract from current issues. Other people's general characteristics are not subject to debate. Opinions and beliefs only prompt objections.

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Exercise 16

Learning to listen:

1. Let others finish their sentences
2. Signal attention by holding eye contact, uttering affirmations (such as "uh-huh," and "yeah")
3. Promote the speaker's continued engagement by asking open-ended questions and probing for details or circumstances ("And what happened then?" How did you feel?" "What did you make of that?")
4. Give feedback by repeating what you have heard in your own words

Exercise 17

Learning to engage in conflict:

A. Both persons agree on the topic of conversation
B. Person 1 describes his or her feelings
Person 2 describes his or her feelings evoked by Person 1's description
C. Person 1 describes his or her needs
Person 2 describes his or her needs
D. Person 1 states his or her demands
Person 2 states his or her demands
E. Person 1 describes the compromise he or she would be willing to make
Person 2 describes the compromise he or she would be willing to make
F. Both persons formulate a precise agreement

c) Autonomy training

Those who avoid anger often fear the loss of affection. Those who avoid grief often fear loneliness. Those who avoid mediocrity fear emptiness.

- Practicing a life without pursuing achievement or perfection in all areas (e.g., partnership, job, parenting, status, success) to reduce dependence on others' approval
- Establishing friendships without a partner
- Engaging in a hobby without a partner
- Refining one's own preferences
- Doing things that others might accept only with difficulty
- Having an opinion that is not shared by others
- Being mediocre in areas where I had to be the best

Exercise 18

Practicing a life without pursuing achievement and perfection in all areas (e.g., partnership, job, parenting, status, success) to reduce the dependence on others' approval
Was there an unbearable loss that made me depressive?
When push comes to shove, what do I have to learn to live without?
What kind of independence do I have to learn?
I have to become independent of
How can I practice this?
What would be an easy exercise?
When could I practice? _______________ Result:
What would be the most difficult exercise, the goal?

Exercise 19

Establishing friendships without the partner
Do I have old friends of my own with whom I (almost) lost contact in past years? . . . . . .
. . . .
Who used to be my best friend? . . . .
With whom could I reestablish contact without much effort? . . . .
When will I call to set up a meeting? . . . .
When will I have the second meeting? . . . .
How can I go about arranging regular meetings? . . . .

Exercise 20

Engaging in a hobby without the partner
What are my hobbies? . . . .
What would I like to try most? . . . .
What hobbies would I have liked to have? . . . .
Precisely what will I do to discover my hobby? . . . .
When? . . . . Result: . . . .

Exercise 21

Refining one's own preferences
What area of my life is characterized by my unique preferences? . . . .
How can I better express my preferences? . . . .
What exactly could I do, change, or purchase? . . . .

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Who has tastes similar to mine? . . . .
When will I invite this person to talk about our preferences? . . . .
Result: . . . .

Exercise 22

Doing things that others might approve of only with difficulty
What would I do, or what would I do more frequently, if I had the courage? . . . .
Something that I think is okay but others do not approve of: . . . .
What will I do first to stand up for myself? . . . .
How will I announce this? . . . .
When will I do it? . . . . Result: . . . .

Exercise 23

Having an opinion that is not shared by others
What opinion do I keep to myself as I lack the courage to express it? . . . .
Something that I interpret in a way that others oppose: . . . .
What context would allow me to voice my opinion and stand up for myself? . . . .
I am going to try it in a role play:
Result: . . . .
When will I do it? . . . .
Result: . . . .

Exercise 24

Learning to be mediocre in areas where I had to be the best
In what areas do I have to excel? . . . .
What would happen if I performed a little worse than others? . . . .
What context would allow me to try that? . . . .
When will I do it? . . . .
Result: . . . .

d) Want-replaces-must training

If the fulfillment of one's duties and obligations has been the only source of reinforcement so far, it is now time to learn to forget about "musts."

- Complete a daily activity diary
- For each activity, ask: "Did I perform this task because I had to?" (= D – duty)
- For each activity, ask: "Was this task fun, did I want to engage in it?" (= W – want)

- Plan the next day's activities such that duty-related activities occur as frequently as wanting-related activities. Cross the remaining duties off the schedule
- As often as possible, replace "feeling forced by a sense of duty" with "wanting out of a sense of responsibility"
- Decide: "Do I want to do this now?"

Exercise 25

Daily activity diary

	Activity	Duty?	Want?	Cross off?
1.	....	Yes/no	Yes/no	Yes/no
2.	....	Yes/no	Yes/no	Yes/no
3.	....	Yes/no	Yes/no	Yes/no
4.	....	Yes/no	Yes/no	Yes/no
5.	....	Yes/no	Yes/no	Yes/no
6.	....	Yes/no	Yes/no	Yes/no
7.	....	Yes/no	Yes/no	Yes/no

Therapy for depression = Anger replaces dysphoria

Exposure to anger*

a) Detecting anger and rage
b) Accepting intense anger and intense rage
c) Discriminating between emotion and behavior, fantasy and reality
d) Expressing anger and rage
e) Testing the appropriateness of anger and rage
f) Constructively negotiating

*Learning to manage anger and not to avoid it

a) Detecting anger and rage

- Compiling a list of situations that provoke one's own or others' anger or rage.
- Being present with these anger-provoking situations
- Feeling anger
- Noticing the process of emotional or cognitive escape from anger
- Trying to recover the anger

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Exercise 26

Detecting: A situation that provokes my anger/rage: ....
The most annoying thing is for me: ....
I feel my anger (how?): ....
I notice the process of escaping from my anger: ....
I feel my anger again by consciously focusing on what annoys me the most: ....
....

b) Accepting intense anger and intense rage

This constitutes the actual anger exposure component.

- Choosing the most anger-provoking current situation involving a significant person
- Being present with the anger-provoking, infuriating properties of the other person's behavior
- Imagining the situation and feeling the anger with closed eyes
- Imagining even more infuriating behavior by the other person
- Imagining that the other person does not let up
- Feeling the rising anger and accepting it
- Imagining defending oneself in anger, acting out of anger, until the anger has waned

Exercise 27

Accepting: The most anger-provoking situation with a significant person: ....
The other person's anger-provoking, infuriating behavior: ....
( ) Imagining the situation with closed eyes and
( ) Feeling the anger
( ) Imagining even more infuriating behavior by the other person
( ) Imagining that the other person does not let up
( ) Feeling the rising anger and accepting it
( ) Imagining defending oneself in anger, acting out of anger, until the anger has gone up in smoke.

c) Discriminating between emotion and behavior, fantasy and reality

- Cognitively grasping that the intense feeling of anger is within me and will not materialize without my will
- Cognitively grasping that I can regulate my emotions and that my emotions will not automatically result in angry behavior
- Cognitively grasping that imaginary angry behavior does not hurt anybody and is harmless
- Affectively comprehending that a feeling of anger and fantasies of angry behavior do not constitute wrongdoing

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Exercise 28

Discriminating: While I imagine the situation and feel my anger,
( ) I know that the intense feeling of anger is within me and will not materialize without my will
( ) I know that I can regulate my emotions and that my emotions will not automatically result in angry behavior
( ) I know that imaginary angry behavior does not hurt anybody and is harmless
( ) I do not feel guilty for my angry feelings and fantasies of angry behavior

d) Expressing anger and rage

- Communicating feelings of anger is the first step towards resolving the situation.
- Compiling a list of situations that make me or others angry
- Examining others' behavior that provokes anger
- Understanding the significance of others' behavior in relation to me
- Engaging in role play to practice the communication of anger
- Contracting to prevent a copout
- Documenting the process and the result of the situation
- Debriefing, confirming or modifying the new behavior

Exercise 29

Expressing: The most anger-provoking situation with a significant person: ....
The other person's anger-provoking, infuriating behavior: ....
How do I voice my anger and its intensity: ....
I try it in a role play: ....
Result: .... When will I do it? ....
I have a contract with myself: I will do it and arrange the following reward:
....
Result of the exercise: ....

e) Testing the adequacy of anger/rage:

Only after having learned to detect, accept, and to voice my anger, I can judge its appropriateness.

- Compiling a list of anger-provoking situations
- Respecting and considering the intent of both parties
- Developing an understanding of myself and of the other person
- Recognizing the futility of my anger if the other person did not intentionally or negligently act to harm me
- Keeping my anger to myself

Exercise 30

Testing: The most anger-provoking situation with a significant person: ....
My intent in this situation is to ....
The other person intends to ....
His or her intent is justified because ....
My anger is disproportionately great because ....
I acknowledge the other person's intent and keep my anger to myself. I tell myself ....
....
And I approach the other person in a cooperative manner: ....

f) Constructively negotiating

If two individuals have had an argument and voiced their anger extensively, then a final comprise may be reached if not too many injuries have been sustained.

- Each person says what he or she wants
- Each person says what he or she does not want
- Each person describes the compromise he or she could make
- Each person states whether this initial compromise suffices
- Each person declares his or her commitment to the comprise
- Both individuals shake hands and announce that the argument is over

Exercise 31

Negotiating: The most anger-provoking situation with a significant person: ....
I voice my intent (my wish): ....
My conversational partner voices his or her intent (or wish): ....
I say what I do not want: ....
He or she says what he or she does not want: ....
I describe how I could compromise: ....
He or she describes how he/she could comprise: ....
We state whether this initial compromise suffices:
I: ....He/she: ....
We declare our commitment to the comprise:
I: Yes/no.
He/she: Yes/no.
We shake hands and announce that the argument is over:
I: Yes/no.
He/she: Yes/no.

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Therapy for depression = Grief replaces dysphoria

Exposure to grief*

a) Remembering the precious and beloved that was lost
b) Feeling my longing
c) Being present with the moment of loss
d) Detecting the pain, the despair, and the grief
e) Staying with the feeling until it wanes

*Letting go and saying goodbye to free myself for the present and the future

a) Remembering the precious and beloved that was lost

If the loss was the loss of a person:

- Remembering life with that person
- Remembering specific situations with that person
- Remembering my experiences of those situations
- Remembering the person's nature, his or her characteristics
- Remembering disturbances in the relationship
- Tracking down photo albums, diaries, films, places, mutual acquaintances to regenerate experiences

Exercise 32

Remembering. I lost a beloved person and, on a daily basis, I will

( ) Remember life with that person. What?
( ) Remember specific situations with that person. Which?
( ) Remember my experiences of those situations. How?
( ) Remember the person's nature, his or her characteristics. Which?
( ) Remember disturbances in the relationship.
( ) Track down photo albums, diaries, films, places, mutual acquaintances to regenerate experiences.
( ) Mount a photo.

b) Feeling my longing

I only feel the extent of my loss when I feel the extent of his or her significance while remembering.

- Remembering and feeling the good and the beloved
- Feeling my longing for it
- Remembering the contentment and fulfillment it gave me
- Missing it

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Exercise 33

Feeling: Daily exposure to the loss:
Remembering and feeling the good and the beloved. What is it? ....
Feeling my longing for it. I need ....
Remembering the contentment and fulfillment it gave me: ....
It was so nice, beneficial, fulfilling, ...
Missing it. I miss it so much ....
Staying with the emerging feelings of grief until they fade ....

c) Being present with the moment of loss

The moment of loss is the shattering of my self, is an incision into my body and my soul.

- Remembering the days before the loss
- Remembering the day of the loss
- Feeling the moment of loss
- Capturing the significance of that moment

Exercise 34

Being present: My daily exposure to the moment of loss
Remembering the days before the loss ....
Remembering the day of the loss ....
Feeling the moment of loss ....
Capturing the significance of that moment ....
*You may speak or write

d) Detecting the pain, the despair, and the grief

The acceptance of pain is the responsibility of those left behind.

- Consciously feeling the pain
- Consciously feeling the despair
- Having all feelings that might arise
- Returning over and over to the significance of the loss
- Returning again and again to the pain
- And feeling the grief

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Exercise 35

Detection: My daily grief exposure:
Consciously feeling the pain: . . . .
Consciously feeling the despair: . . . .
Having all feelings that might arise: . . . .
Returning over and over to the significance of the loss: . . . .
Returning again and again to the pain
And feeling the grief: . . . .
Staying with the feeling of grief until it wanes.
*Talk about it, then write it down.

e) Staying with the feeling until it wanes

Grief needs time and space. It is the soul's natural healing process. Each pang, each feeling of grief is a sign of a healing soul.

- Feeling grief
- Letting grief be present
- Letting grief increase
- Letting grief completely fill one's consciousness
- Letting go off grief when it wants to leave
- Letting grief return when it wants to return

Relapse prevention … is a part of the therapeutic process.

Criteria:

The symptoms are evoked by

- A pathogenic lifestyle
- A pathogenic relationship style
- A problematic life situation

Relapse prevention considers all three situational aspects!

Strategies:

Establishing

- An effective lifestyle
- An effective relationship style
- The ability to cope with problematic life situations

Conclusion:

If one conceptualizes vitality as affective-cognitive-behavioral experiencing and responding, and if one understands depression as the suppression of all vital functioning, then the therapy for depression presents

vitality and emotions as strategies
for a health-maintaining homeostasis.

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Therapy for depression = From need-oriented to value-oriented behavior

HAYES, STROSAHL, & WILSON (2004) and HAUKE (2001) suggest that people who align their future behavior with their personal values benefit from behavioral flexibility by making previous dependencies and unsolved conflicts things of the past.

Thus, we do not allow ourselves to be governed by our gut feelings alone, which in turn are determined by our needs. Positive feelings signal the fulfillment of needs while negative feelings signal need frustration. Moreover, through deliberate experience and decision-making, we maintain contact with what is most important in our lives; what we want to achieve one day; or what we cannot live without and are not able to let go; but also, what kind of human being we would like to be, to become, or to remain. Often, our personal values hide a central, fundamental need whose fulfillment is so important that we attend to it on two levels: first, via an unconscious emotional-motivational control loop that governs our behavior automatically; and, secondly, on the level of conscious reflection, evaluation, and decision-making. A conscious value orientation helps me to forego the fulfillment of needs in concrete situations, e.g., not to take a second helping when others have not finished their first one yet. These values emerge from the inside; they are deeply connected to my identity and have to be clearly distinguished from external prescriptions and prohibitions that I heed out of a fear of social rejection, loss, or punishment. Values also do not have to aspire to ethical or moral heights. Striving to be a noble human being is not at issue. Rather, values are about what I have defined as important for my life or for myself. I will emit behavior patterns that are in the service of my values more readily than behavior patterns with a short-term advantage that generate distance from my values in the medium or long run. I should also check whether the inner structure of my value orientation is balanced, or whether important domains are missing from my life plan and my self concept. Then I should incorporate and balance these domains with my values so far. Sulz (2001) described a study showing that depressed individuals, compared with non-depressed, did not list "happiness" among their ten most important values; instead, they listed "dependability."

Practically, the important things in life as well as the pleasure derived from behaving with respect to them and being effective can be made present every day, e.g., with a mindfulness exercise. Then one has to commit to engage in the behavior today. The situational and interpersonal contexts and the timing of the behavior are planned in detail. Subsequently, one is again mindful of how one's behavior has served one's values and of the pleasure derived from value-oriented behavior.

The following practical exercises can be recommended to establish value-orientation as a new guideline for behavior:

Exercises to establish value-oriented behavior

- The patient has completed a value questionnaire (VDS 33) at home; the therapist has retained a copy.

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- Practicing *mindfulness*
- *Elaborating* and *deepening* the personal significance of important values
- *Accepting* my values to-date and my behavior with respect to them
- *Imagining* value-oriented behavior. Perceiving the somatic markers accompanying this behavior. Continuing the imagination until the behavior meets the values within a short or medium timeframe. Concluding with the initial imagination of fulfillment of important values. Perceiving and remembering the associated *somatic markers*.
- *Behavior plan*. What will I do to serve my values, and when?
- Imagining value-oriented behavior, including associated somatic markers, on a daily basis (mental training)
- Daily mindfulness exercises with monitoring of one's own behavior patterns
- Daily *recollection* of that day's value-oriented behavior. Imagining its contribution to value fulfillment. Completing the workbook SKT34 (SULZ, 2002b)
- Perceiving the satisfactory feeling, including somatic markers

Exercises to balance values

- Practicing *mindfulness*
- Noting one's personal values in the Cycle of Values (see Figure 5 in Sulz's article *Strategic Brief Therapy in practice: Effective steps toward symptom reduction, personality development, and enhancement of interpersonal relationships*, this issue)
- Which areas within a landscape of values are well represented? How do they affect my life and my relationships?
- Which areas within my value-scape are underrepresented? How does their absence affect my life and my relationships?
- *Accepting* my value orientation to date
- *Exploring* the still uncharted continents of my values. What attracts me, what scares me, what leaves me unaffected?
- *Imagining*. If I had a magic wand and these values could be met without generating additional fear, …. Perceiving the associated *positive somatic markers*.
- Is there an opportunity for safely broaching these novel value domains (concrete situations)? Am I tempted to the point of trying it?
- *Behavioral plan*: What will I do to serve my values?
- Imagining value-oriented behavior, including associated somatic markers, on a daily basis (mental training)
- Engaging in new value-oriented behavioral patterns
- Evaluation of behavior change and self-reinforcement

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Summary

Major depressive disorder requires psychiatric intervention, typically rendered in the form of pharmacotherapy. Here, an integration of behavior therapy with the psychiatric treatment plan is presented. The more severe the depression and the somatic presenting problems, the earlier should behaviorally oriented procedures, such as behavioral activation, social skills training, relaxation training, sports (SULZ, 1998a; 1998b; 2001), or emotion-activating procedures as found in SULZ'S strategic-functional approach (2002b) be implemented. This implementation should occur carefully and gradually, possibly in the smallest steps, to avoid overwhelming the patient. In cases of mild to moderate depression, cognitive therapy according to Beck (WRIGHT & BECK, 1986) or to Rehm's self-control approach (ROTH & REHM, 1986; SULZ, 1986a; SULZ, 1986b) provides a good working basis.

If problematic life circumstances presyndromally affected a patient's functioning and substantially contributed to pathogenesis, then interpersonal psychotherapy (IPT) or the more recently developed strategic-functional behavior therapy should be considered. Depressive tendencies, personality disorders, and massive deficits in social functioning require a longer term behavior therapy (40 to 60 sessions) with a focus on self-control and the acquisition of social interaction and relationship patterns. In these cases an interval intervention might be appropriate, for it allows periods in which the learned material can be anchored to daily living. Interval interventions mesh well with the self-control and the more recent strategic-functional approach. A qualified behavior therapy education is necessary to be able to effectively apply the now very large and differentiated behavior therapeutic repertoire required by this therapy for depression. In addition to the relevant behavioral techniques, interventions targeting relationships and process have come to the fore and are also calling for more differentiated therapist behavior. These calls are generating relatively new demands for the psychiatric specialty education.

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Regina Thierbach

Strategic Brief Therapy of Posttraumatic Stress Disorder A Value-directed Approach

Abstract

The current paper will outline *Strategic Trauma Therapy* of posttraumatic stress disorder Type I (acute, brief, single traumatic event). Effective therapeutic interventions are adopted from *Strategic Brief Therapy, Acceptance and Commitment Therapy,* and the *dialectical approach.* According to the state of the art, the therapy progresses through phases of stabilization and exposure to the integration of the traumatic event. After detailing the presenting problems, we will suggest ways to break out of the stress cycle generated by the hot system, which usually perpetuates emergency responding in form of a survival strategy. Then therapeutic opportunities for promoting growth after traumatic evens are shown. Work on the shattered value system receives special consideration, for it explores the directive as well as the identity-building function of values. Terms associated with themes of post-traumatic growth, such as “wisdom,” “resilience,” “maturation,” and “language” are also considered. Finally, mindfulness and self-regulation are emphasized in the integrative phase as components of an effective therapy that has a scope beyond symptom reduction.

Keywords: Strategic Trauma Therapy, Strategic Short term Therapy, Acceptance and Commitment Therapy, Self regulation, Values, Posttraumatic Growth, Resilience.

1. Introduction

The quest for therapeutic approaches that prove to be effective in the treatment of posttraumatic stress disorder (PTSD) resembles the feverish search for novel alternatives in the management of severe infectious diseases: The affected person suffers dreadfully, and the call for action is urgent.

Trauma patients are interesting, for they would never access therapy were it not for the crucial traumatic event. Many cases do not present with instantly recognizable pre-morbid difficulties. However, often the assessment will reveal historical emotional equivalents that qualitatively resemble the traumatic event.

Not all novel therapeutic approaches promise as much benefit as does Strategic Brief Therapy (SBT), which briefly and concisely initiates treatment at the level of the current presenting problem. Based on its conceptualization of symptom development and maintenance, SBT subsequently focuses on a redefinition of life goals; some goals may even have to be abandoned due to their incompatibility with the current life situation. A train conductor whose train became the means for suicide on the train tracks, for example, may have to leave his or her dream job entirely or for a period of time and may have to apply for early retirement or a transfer.
While PTSD is not always preceded by pre-morbid dysfunction, other disorders, such as depression, anxiety, etc., favor the development of the presenting problem. For this reason, beyond the thorough intake assessment (e.g., SCL-90, DEROGATIS (1986), IES-R (German version: MAERCKER & SCHÜTZWOHL (1998), dissociation scales (e.g. BRUNNER, RESCH, PARZER, KOCH. (1999): Heidelberger Dissoziations Inventar HDI) and the symptom-reducing intervention, a concentration on the person's survival strategy (SULZ, 1994) and his or her pathological life and relationship style is warranted as well. Traumatic and thus extremely stressful situations may activate old and rigid behavior patterns that may serve to facilitate functioning in the moment. In the long-term, however, they do not contribute to symptom reduction and the recovery of an internal homeostasis. Therefore, discovering, understanding, and dismantling the mechanisms by which the symptom helps to avoid aversive consequences are important milestones in trauma therapy, reached by exposure-directed work involving feared emotions, cognitions, physical sensations, and external stimuli. Exposure constitutes an important – perhaps the most important – learning experience: Being able to tolerate stressful emotions, cognitions, physical sensations, and external stimuli without coming undone.
Usually, the pre-traumatic self-image and worldview cannot be maintained anyway: The world has ceased to be a safe and good place and has shown itself to be a threatening, destructive location where everything previously believed to be constant may rapidly change. The trauma virtually calls for an accommodation of affective-cognitive meaning, so that a concordant self-image and worldview become possible (SULZ, 1994): "I am vulnerable in an unsafe world."

The following case vignettes illustrate the different kinds of traumatic events upon which patients may seek treatment. Patients frequently articulate a desire to regain their "normal lives." The often expressed wish to return to pre-traumatic functioning already implies the dramatic steps that must be undertaken in therapy:

- Understanding the disorder and its effects
- Improving management of the symptoms
- Conducting an analysis of goals that match the new reality
- Deciding not to avoid emotions, thoughts, and situations
- Exposure to feared emotions, moods, and memories
- Grieving for the lost and unrecoverable, also concerning one's person
- Staying with this process

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- Experiencing progress and regress as typical recovery and coping patterns
- Changing relationships
- Integrating the experience with one's personality via
  - ◊ Development of a modified self-image and worldview
  - ◊ Development of self; integration as a lifelong learning process

Case Vignette 1:

A patient, Mr. M., enters therapy and reports having experienced and been unable to recover from distress at sea. He and his friends had floated on a life raft in the North Sea for hours. They had contemplated their deaths. The experienced fear, especially the fear of death, has passed, yet the experience itself is still present for Mr. M. He is a kind of patient for whom therapy would be unthinkable, were it not for such a life-altering event.

Mr. M. suffers the symptoms of a traumatic event "Type I" (singular event). In general and as shown later, this presenting problem has a good prognosis. After the trauma-typical symptoms have subsided, Mr. M. decides to terminate therapy and continue his journey alone.

Case Vignette 2:

For years, Ms. C. had been abused by one of her uncles. The family cloaked these events in silence. Years later, the patient is permitted to verbalize her experiences and to break through the wall of silence built around her. Years of careful therapeutic work follow. They focus on the repetitive traumata and their far-reaching consequences that also affect the patient's entire personality. She is not able to enter fulfilling interpersonal relationships or to have gratifying sexual experiences.

Ms. C.'s is a much more complicated case of "Type II" traumatization (repeated, long-lasting traumatization), more frequently found in therapeutic practice. This disorder is also treatable, but a broadly conceptualized approach to remedy impaired emotion regulation is required.

Case Vignette 3:

Hiking in the woods, Ms. S. discovered a corpse. She suffers traumatization because this current event fits into an entire succession of critical events throughout her life history. The current event – even if it seems rather "harmless" compared to other, earlier events – breaks the proverbial camel's back. Ms. S. experiences somewhat of a life crisis, and therapeutically the following questions concerning meaning must be urgently addressed: What is my purpose in this world; what does the finitude of being mean to me; why do I live even when I'm not successful; I am death's witness; how do I attain vitality?

Finding meaning and shifting earlier values require long-term therapeutic support as a kind of catalyst, which only initiates processes and then accompanies Ms. S. departure from the struggle with fundamental philosophical questions of life. The endeavor is successful, and Ms. S. finds her way to more success and gratification through professional development. As she

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emerges from the crisis stronger than before, one may speak of personal growth.
This case illustrates the complexity of a mixed Type I and II trauma, which may be most frequently presented in practice. Here, the most recent and thus current trauma provides the starting point of treatment.

In this paper, we will examine Type I traumatization exclusively. This area offers a challenge to practitioners for the following reasons:
• What may disrupt an otherwise well-functioning human homeostatic system to such a degree that even typical life functions may be thrown off balance?
• Which resources, strategies, abilities and skills help people to reestablish their completely disrupted mental homeostasis?

Of course, practitioners may be most interested in the following questions: How may therapeutic support facilitate
• Reducing the trauma-related symptoms?
• Rather than simply overcoming the traumatic event, integrating it within the personality?
• Promoting growth and development related to the experienced events?

Currently, PTSD is among the most frequently diagnosed disorders in the USA. Cultural preferences and the Zeitgeist not only affect the frequency of diagnoses and treatments but also what clients might define as therapy-appropriate. Through mass media, we contact potentially traumatic events every day: the tsunami of December 2005; the flood in New Orleans in 2005; or a student's attack on a teacher in 2004.
We have learned to view these events from the perspective of the victim, who needs more than the recovery of financial losses or basic psychological functioning. All efforts in this area target the prevention of victim status, which reduces people to their lost opportunities. When one considers its connotations, even the term "victim" is problematic: One is a victim of someone or something, and thus questions of causality arise. Someone or something is to blame. Being a victim is definitely more benign than being a perpetrator, but even the word "victim" implies negative content, such as "Prevention or avoidance was impossible; one was too weak, couldn't defend oneself, was helpless."
The following sections present a therapeutic approach that combines a multi-phase treatment, as it is currently practiced by different therapeutic schools, with procedures from Acceptance and Commitment Therapy and mindfulness-based therapies. This approach also takes into account the advantages and disadvantages of verbally learned evaluations of cognitions (HAYES, STROSAHL, & WILSON, 1999). In effect, not the cognitions *per se* cause dysfunction, but the evaluations accompanying these cognitions. Consequently, no reader will protest that becoming a victim is a bad thing; or that it is even more tragic to remain a victim; and that victims require a treatment different from that of perpetrators or non-victims. "I am a victim" forms the basis

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of a response set that contacts the environment in a specific way: as a demand for restitution, damages, or lifelong care, for example. It also establishes the basis for contacting oneself after a stroke of fate or a traumatic event. Self-pity is permissible in victims; self-focus *per se* is among the typical responses to a critical event. However, this state of extreme self-focus concurrently bears the risk to get stuck in one's own responses and one's own fate. A mindful and accepting stance toward oneself and one's often unsettled ideas of life, its values and the frequently confusing emotional states, may point a way out of this cul-de-sac.

2. Epidemiological data

The following data are based on KESSLER ET AL.'S (1995) well-known prevalence study. The hyperbolic use of "trauma" ("Help, my friend has left me.") and the adulteration of "traumatization" (reference to the strict "A"-criterion characterizing the preceding event (APA: DSM-IV) otherwise, every adversity is a trauma) indicate that a diagnosis of PTSD as an illness is currently en vogue.

Almost everybody is exposed to at least one violent or life-threatening event throughout his or her lifetime (OZER, BEST, LIPSEY, & WEISS, 2003).

- More than 50% of all people encounter situations in their lives that are sufficiently stressful to warrant the development of PTSD. The lifetime prevalence of meeting diagnostic criteria for PTSD is between 1 and 7%.
- Men and women usually differentially report the type of preceding traumatic event. Women experience violent transgressions (sexual abuse) more frequently, while men encounter war-related combat or traffic accidents. The risk of developing PTSD after a traumatic event is approximately 8% for men and 20% for females (KESSLER ET AL., 1995). The overall probability of PTSD development is 8% (5% for men and 10% for women). The overrepresentation of women in these statistics (women have twice the risk of men and disorders of longer duration) may be due to different factors: Women might encounter severely aversive events more frequently (e.g., sexual abuse); and women might be more likely to admit having difficulties and seek out professional help. Thus, the higher rates may present a statistical artifact.
- Children, adolescents, and older adults are more affected.
- The highest prevalence rates are associated with rape.
    - ◊ 65% of male and 46% of female rape victims developed PTSD (KESSLER ET AL., 1995).
- Lower prevalence rates (fewer than 10%) are associated with natural catastrophes.
- Higher prevalence rates correlate with catastrophes caused by humans.
- The type of traumatic event is decisive. Example: More than 50% of refugees/asylum-seeking individuals; every third rape victim; 20% of accident victims; 15% after the death of next-of-kin; PTSD after combat, torture, or sexual trauma shows a lifetime prevalence (the probability to meet diagnostic criteria at any point throughout one's lifetime) of 30 to 50% (LANGKAFEL, 2000).

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This statistical overview is in no way intended to minimize the extent of the suffering and anguish experienced by the individual. Rather, we would like to point out that we may naively and too frequently assume the "safety" and continuity of our existence, instead of contemplating the "what ifs." On the other hand, this circumstance demonstrates the essential human ability to hold on to the positive within the flow of life and to take for granted the appropriateness of living in the moment without continuously questioning its permanence. Perhaps we would all be better prepared for the inconceivable if we pondered the illusion of this assumed permanence at least once in a while.
The course of PTSD:
- The symptoms of PTSD most frequently emerge directly after exposure to the trauma.
- Delayed symptoms only develop in maximally 11% of all cases.
- Good news: Approximately 50% of the cases remit within the first year after the traumatic event. This occurs automatically, i.e., without professional assistance.
- Approximately 1/3 of all individuals who develop PTSD after a traumatic event meet criteria for chronic progression.
- The risk of chronicity positively correlates with the severity of initial symptoms.

3. Phenomenology and description of the presenting problems

The symptomatic triad consists of re-experiencing, avoidance, and arousal. The traumata and their effects are distinguished by natural versus human-caused catastrophes. The variables that predict whether a stressor may have traumatic effects are the event's duration and severity, the individual's history, vulnerability, and protective factors. Inherent in the course of traumatization is the risk of chronicity and even personality changes.
The four main diagnostic criteria for PTSD are
- Recurrent recollection
- Physiological hyperarousal
- Avoidance
- Emotional numbness

Depending on time course, diagnoses of PTSD or acute stress disorder are available. HAYES (2004) questions the general utility of diagnostic systems. Only a fine line separates individual and social acceptance of the diagnosis (evidenced by corporate fiduciary duties to sufferers, for example) from its still prevailing detraction in the form of self and social stigma.
The treatment approach presented here attempts to turn away from a strictly symptom-based and toward a behavioral analytic conceptualization that arranges for the restoration or change of the obliterated value system (BUTOLLO, KRÜSMANN, & HAGL, 2002). A pragmatic perspective that seeks to identify change processes as well as useful treatment approaches considers the current syndromal classification system of little help (HAYES, WILSON, GIFFORD, FOLLETTE, &

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STROSAHL, 1996). In contrast, a contextual approach to the presenting problem involves not only the trauma per se but also relevant stressors, the therapeutic relationship (FOLLETTE, PALM, & RASMUSSEN HALL, 2004) as well as work on values (HAUKE, 2001).

4. Interventions for PTSD

While modern effective interventions for PTSD have an integrative nature, they avoid theoretical eclecticism (FOLLETTE, PALM, & RASMUSSEN HALL, 2004). Expandable approaches to trauma therapy occur on the basis of scientific testability. State-of-the-art therapies are influenced by techniques adopted from behavior therapy, such as exposure under certain conditions and limiting factors, as well as LINEHAN'S dialectical behavioral approach (1993). Presented here is the integration of elements from Acceptance and Commitment Therapy (ACT) (HAYES, STROSAHL, & WILSON, 1999), mindfulness, and self-regulation and value integration (HAUKE, 2005). Before the integration into a theory-transcending model is attempted, the possibilities and the limitations of the respective therapeutic approaches are outlined.

a) The behavior therapeutic approach (SORC model)

The characteristics of a situation (S) meet criterion A of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, p. 467) or they represent an event of an "exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone," according to the *International Classification of Diseases: Classification of Mental and Behavioural Disorders* (ICD-10, p. 169). The organism variable (O) is not a determinant in the etiology of the presenting problem, as the disorder may develop without an idiosyncratic vulnerability factor. For this reason, the situation factor is the causal factor. However, this does not imply that any premorbid dysfunction would not affect the emergence of the disorder.
The response (R) comprises the symptom triad described earlier. The maintaining consequences (C) mainly involve avoidance behavior as well as dysfunctional behavioral patterns and cognitive processing styles, as detailed in EHLERS AND CLARK'S (2000) model of chronic PTSD, which proposes a system of interactions between trauma memory, i.e., psychobiological processing or appraisal of the trauma and/or its consequences, and dysfunctional behavior and cognitive strategies. The cognitive response during the traumatic event, the inability to maintain a self-referential perspective, and dissociation may predict the severity of later traumatization. The more weakened a person's sense of self or the stronger the dissociation, the more severe the degree of traumatization in the long-term (FISCHER & RIEDESSER, 1999).

b) Critical element: The trauma memory

Although the traumatic event occurred in the past, the individual's anxiety concerns the future. EHLERS AND CLARK (2000) point to the specific trauma memory and the appraisal of the trauma to explain this circumstance.

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Modern theory assumes a specific trauma memory with differential functions compared to other "normal" memory. Traumatic experiences are not stored in a context-specific manner as are other events, but they are available as "raw data." Imagine your birthday a year ago, your company and your mood. Remembering these is probably relatively easy. This is not the case with a traumatic memory, which appears unintentionally and abruptly and is accompanied by a range of emotional responses.
Individuals with PTSD often have difficulty when asked to voluntarily and precisely recall the traumatic event. Frequently, memories consist of unordered fragments (FISCHER & RIEDESSER, 1999).
Characteristics of the trauma memory:
• Sensory memory: Sensory impressions rather than thoughts are remembered.
• The memory is experienced as a present rather than a past event.
• Strong emotions occur without a specific memory, i.e., emotions or physiological states that accompanied the event emerge without conscious thought of the event.

The suddenness of the traumatic event prohibits its contextualization in time and place (EHLERS & CLARK, 2000). Because of its intense and unexpected nature, the event is stored in a virtually "raw" format in memory. The usual categorization, as demonstrated by recalling the context of last year's birthday, is lacking.
Moreover, a strong stimulus-response association is present (priming): Stimuli perceived shortly before the trauma become strongly associated with the experience and may prompt re-experiencing the trauma (e.g., Lisa may remember being mugged upon seeing a baseball cap). Therefore, similar stimuli not directly linked to the traumatic event may evoke memories as well. Finally, technical properties of memory may play a role in traumatic re-experiencing as well, as the frequency with which something has been remembered increases the ease with which it will be remembered ("kindling") (EHLERS, 1999).
The effects of self-regulation of traumatic events involve the shutdown of the so-called "cold system" (the hippocampal processing of normal cognitions) and an increase in activity of the "hot system" of limbic regulation (METCALFE & JACOBS, 1996). These effects are also maintained by dysfunctional behavioral strategies and cognitive styles, which may provide relief in the short-term but result in persistence of the symptoms in the long-term (e.g., thought suppression, ibid).
Exposure therapy is effective, especially with patients who had one or two concrete and bounded traumatic experiences but, as recent studies have shown (e.g., MCFARLANE & YEHUDA, 2000), it does not constitute the "be-all and end-all" for the dissolution of the traumatic symptom complex. The more frequent case encountered in practice is one with a broad range of difficulties and a complicated life history overall. (FOA ET AL., 1999) noted that Stress Inoculation Therapy (SIT) was more effective at posttreatment than exposure. Furthermore, she and her colleagues did not find significant differences among cognitive behavioral therapy (CBT), SIT, and supportive counseling.

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Dysfunctional behavioral patterns and cognitive processing styles maintain and reinforce the symptoms. Also, interpersonal style may play a large role in the processing of the traumatic event: Sometimes withdrawal occurs; sometimes others are excessively exposed to the experience. Talking about the traumatic event may be interpreted as an individual avoidance strategy, not having to feel certain emotions, which would present a point of intervention for ACT.

c) Linehan's (1993) dialectical behavioral approach

LINEHAN'S approach was initially developed for the treatment of borderline personality disorder, particularly suicidal and parasuicidal behavior. Many of the borderline patients' histories also suggest a causal role of traumatic events (abuse). They point to symptoms that are similar to those of trauma patients, such as intensive negative emotions, rapid switches to negative emotions, and chaotic life situations (FOLLETTE, 2004).
The treatment concept derives from Far-Eastern religions and aims at building tolerance to negative emotions rather than escape from them. Here too, emphasis is placed on contextual variables, such as the dysfunctional environment in which interactions and transactions occur. The historical environment exerted an invalidating influence on a particular biological predisposition. "Mindfulness" exercises that guide attention to the "here and now" are the central components of this approach. In addition, goal setting focuses on self-acceptance and validation.

d) Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999)

Already the name of this therapeutic approach suggests a strong connection to language as a health-maintaining as well as a disease-causing factor. The evaluation of our thoughts, which occurs when direct experiences merge with cognition, makes us sick. This approach is based on Relational Frame Theory (RFT) (HAYES, BARNES-HOLMES, & ROCHE, 2001). There is a difference between a trauma patient's mere statement that he or she is going crazy and life is uncontrollable and his or her actual belief in these thoughts as unalterable reality.
The core piece of ACT is experiential avoidance, as seen with certain mental disorders (e.g., alcohol abuse disorder) and especially with anxiety disorders. This piece is strongly reminiscent of EHLERS AND CLARK'S (2000) conceptualization of avoidance as dysfunctional behavioral pattern and cognitive style. However, the pragmatism of the ACT approach is captivating: Experiential avoidance develops when a person prevents contact with certain private events (memories, physiological states, emotions, thoughts) and attempts to change the nature, the frequency, or the context of their occurrence. These patterns are not to be confused with effective distraction, which may provide a useful relief strategy for trauma patients as well. Avoidance is only considered a problem when it competes with important tasks (e.g., driving a car) or with behaviors that are deemed important by the person (e.g., devoting time to family).
The actual target of ACT is defusion, i.e., the disentanglement of the self from language processes. It is achieved through mindfulness meditation, work with metaphors, and other experiential exercises, which enable patients to conform to their values and goals again.

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Based on Far-Eastern religions, the salutary principle of mindfulness is taught within therapy (HAUKE, 2005) and understood as an ongoing process to arrange an antipole to suffering from the connotations of language. Mindfulness means

- Directly experiencing the present moment without identifying with thoughts or emotions
- Assuming an accepting and non-evaluative stance with regard to one's difficulties and mistakes, patience and openness in relation to self and others
- Accepting and maintaining contact with experience rather than struggling with painful and unpleasant emotions
- The direct acknowledgement of steadily changing thoughts, emotions, and sensations and their transient nature

Returning to interventions for PTSD: Neither the memories nor the emotional responses evoked by the trauma are pathological *per se*, for they are also found in "normal" versus "pathological" processing of traumatic events (HOROWITZ, 1997). The persistence of traumatic responding is usually a function of attempts to avoid and of efforts to circumvent certain experiences. In therapy, the normalization of symptoms to facilitate their management is an extremely essential and helpful intervention. For example, the therapist might say, "This is a typical response to atypical stimuli and does not mean that you are going crazy." The natural tendency to avoid certain emotional responses becomes a theme in therapy and thus amenable to processing. Therapist and patient move together into the direction of the fear and away from impulses to escape.

The literature on thought suppression specifically and on attempts to control mood in general (SALKOVSKIS & CAMPBELL, 1994; WEGNER, ERBER, & ZANAKOS, 1993) confirms the paradoxical effect of suppression-induced long-term persistence of undesired states. Nevertheless, this does not mean that avoidance should be avoided at all cost. Avoidance has its place, but a decision favoring avoidance should precede the behavior.

e) Strategic Brief Therapy

The previous references to interventions based on mindfulness and acceptance should not conceal that especially trauma patients might benefit from a very structured and stringent regimen, such as offered by Strategic Brief Therapy (SBT). The course of SBT may be grossly divided into three phases of stabilization, exposure, and integration. If necessary, some phases have to be repeated; thus, the therapy is not characterized by a linear progression but resembles a waltz dancing two steps forward and one back. During the initial phase of therapy, the time course of assessment and diagnosis has to be individually determined. Usually, the primary goal of therapy at its outset is stabilization. The first session provides support but also contains psychoeducational components, such as the illustration of typical responding to atypical events. Trauma patients also benefit from a thorough diagnostic process that calls a spade a spade. Undertones of malingering or accusations of lacking distress tolerance may still accompany a

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layperson's conception of PTSD and place an unwarranted burden of proof upon patients. The diagnosis of a serious clinical problem should override the common assumption that the problem could be solved if one could only pull oneself together. Contrary to other presenting problems, assessment is appropriate at a later time as it does not induce immediate relief and is only of secondary importance for the intervention's initial steps. Nevertheless, it is important to explore other possibly traumatic experiences to assess the degree of pre-exposure.

Breaking out of the memory loops within the hot system's circuitry (i.e., trauma memory; storage of traumatic memories in the limbic system and amygdala as raw data) and all disorder-specific responses (hyperarousal, avoidance, intrusions) and establishing connections with the cold system (hippocampus as library of memory) are the focus as therapy progresses. Thus, the escalating loop during stress cycles is disrupted, and experiences that are incompatible with the symptom become possible. The generation of an affective-cognitive connection effects the classification and labeling of incomprehensible events, which then can be viewed as temporally bounded (cf. EHLERS AND CLARK'S (2000) model of trauma memory). In this context, the therapist assumes a strong motivational role to ensure the patient's persistence regarding work with the stressful experiential content and further exposure to fairly recent events. The patient must actively choose to commit to this gainful, albeit challenging, step in therapy.

f) The "hot/cold" system

According to the hot/cold-system model (METCALFE & MISCHEL, 1999; MISCHEL & AYDUK, 2004), the affective loop dominates while the cold system is shut off during this quasi-emergency regulation. Within the last years, these hypothetical self-regulatory processes have been supported by neurobiological evidence (ibid.). Behavior is the result of an interaction of two systems, the "hot" and "cold" systems. The cold system, evidently linked to the functions of hippocampus and frontal lobes, interacts with the hot system that is mediated by the amygdala. Both systems reciprocally influence each other. The cold system is an emotionally neutral knowledge sytem that contains well-integrated biographical events and their respective spatio-temporal context, for example. It works relatively slowly and generates rather intentional, reflected, and strategic behavior. This broad and flexible perspective is in stark contrast to the hot system's modus operandi. The hot system comprises need and motivational templates and works directly, rapidly, highly affectively, and inflexibly and is strongly stimulus-bound. The lower regulatory levels of our regulatory hierarchy may thus be classified within the hot, the superordinate regulatory levels, i.e., identity and values, within the cold system. Behavior is a product of the interaction of both systems, where the contribution of each system depends on the personal and situational conditions. When stress builds, both systems initially increase their activity. In this context, the affect-related ("hot") characteristics as well as the contextual narrative properties ("cold") of a situation are more intensively processed. All regulatory levels are more strongly involved in the regulatory task. However, this involvement changes as stress increases further. Upon reaching a certain threshold, the activity of the cold system rapidly decreases while the

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activity of the hot system quickly increases. Aspects of superordinate reference values, such as identity, self-concept, or values, hardly exert any influence on self-regulation anymore, i.e., given a certain stress level, self-regulation is performed by the lower regulatory levels only and is thus progressively determined by the hot system. Attention becomes very narrow and selective; in the case of traumatic stress levels, the situation's fear-producing characteristics are the sole focus of attention.

For this reason, in the long term conformity between experiences (e.g., the world is not a safe place; it is unsafe) and particular system concepts fails to be established. The reference value "return to baseline" does not make sense either as the reference parameters of "baseline" cannot be recovered. The system "human being" notices that a "return to baseline" is impossible and, in the case of experience that is traumatic, existential and permeates all life areas, replacement reference values are also unavailable. Usually, goals have moved out of reach; only the "now" exists and therefore goals are lacking. The system is caught within a foreshortened loop of responding and situation.

This circumstance would be less disastrous if the person were able to allocate perceptual processes to the evaluation of discrepancies and rely on an identity that used to exist at one point in time. But just this identity has been questioned by the query, "Given this event, who am I? I am not the same person anymore," which cannot be answered. Thus, the identity suffered damage with the shattered integrity of the heretofore intact system. Attention is now excessively directed to the self; attention is literally drawn away from the environment, yet a solution is not possible. HAUKE (2005) says: "The system is stuck like a car in the mud whose motor – running at full speed – and its spinning wheels are exhausting the fuel reserves." Only with time, after the hot system has quieted, the frequency of neuron firing has subsided in the limbic system, and the experience has been stored in the hippocampus and classified as incomprehensible event in one's life history, the path clears for a restructuring of the value system. In a best-case scenario, a strengthened identity is the result, possibly even stronger than before if posttraumatic growth occurs. During mere recovery from stressful symptoms, without gradual growth, the previous values may be readjusted at best and endowed with significance for one's life.

Based on the work of DUVAL AND WICKLUND (1972), CARVER AND SCHEIER (in HAUKE, 2005) suggest that the direction of attention may quickly switch back and forth from the self to the respective environment. Usually, attention is self-directed to the degree that enables successful self-regulation regarding self-relevant goals.

If a discrepancy between reference and actual values is perceived, as in the extraordinary case of traumatic events, then the person requires additional attentional resources to take on the problem area. Often, the trauma absorbs the entire person. Therefore, an intensification of self-directed focusing occurs, which in turn motivates appropriate efforts and facilitates the removal of the perceived discrepancy (HAUKE, 2005). Depending on whether these efforts succeed or fail, positive or negative emotions result, respectively.

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The trauma, with its massive perturbation of even basic needs (e.g., for security), also jeopardizes the individual's survival strategy (SULZ, 1994), which according to SULZ (2004) should guarantee the minimal satisfaction of needs and maintain internal equilibrium.

Categorization and processing of the traumatic event also requires a consideration of the maintaining conditions, particularly the persistence of dysfunctional behavior patterns that emerge from the patient's adherence to his or her survival strategy, even when these patterns have proven to be ineffective. Economically speaking, they only generate costs and do not lead to personal gain. This may be the case, for example, when a traumatic event virtually legitimizes withdrawal tendencies and becomes an acceptable reason for isolating from the social context. Once the symptoms have abated and the trauma patient is able to categorically deal with the experience rather than feeling completely at its mercy, then work on the integration of the experience becomes possible. Usually, this work directly leads to the value system, which sometimes must be reconstructed and sometimes considerably changed to enable compatibility of the self and the world; and of the shattered ideas about life and the experienced reality. This step is the most difficult and perhaps the most exciting one in therapy, a time when everything or nothing is possible. "Nothing" would characterize the patient's inability to appraise the crisis as an opportunity for the initiation of progressive self development. Often, however, such an appraisal more closely corresponds to wishes of the therapist who may have a humanist view of the world and expect continuous growth. Therapists function as catalysts and impulse generators for possible personal growth by sustaining the process and openness for the manner in which the individual patient shows up, becomes creative or productive, or develops a spiritual or somehow different perspective on matters and the world, for example. Even so, therapists neither direct nor force this path.

5. Therapeutic influence on personal growth following traumatic events

a) "I am more vulnerable, yet stronger."

The practitioner interprets outcomes of trauma therapy as most favorable when, in addition to symptom reduction, clients step into a stream of novel perspectives concerning themselves and the world and thereby enter a long-term development process. In this context, it may be possible to speak of lifelong coping and learning. Usually, neither trauma symptom reduction nor personal growth occurs exclusively, but both coexist (TEDESCHI & CALHOUN, 2004). Posttraumatic growth may occur following different types of traumata.

Remarkable progress has been made after the traumatic event when clients perceive new tasks in their life, have new concerns, or want to communicate a message. Nevertheless, the extent to which such processes may be initiated – or let alone forced – by therapy is limited. Given this autonomous developmental process, at most the therapist may function as a catalyst or partner in a dialogue in BUBER'S (1983) sense of the term. This phase of therapy therefore has

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entered the philosophical realm. European history, with its atrocities of the 19th and 20th centuries and two world wars, demanded a positive approach to trauma, for which examples may be found in the rich tradition of philosophy and literature. Especially the term "wisdom" contains theoretical references to HEGEL (1931) and the Berlin Wisdom Paradigm (BALTES, 2000). Different theoretical interpretations of "need" view self actualization, even following a traumatic event, as a fundamental human need that transcends the basic needs of life. Subsequent to a traumatic event, basic needs might not be met. However, adaptive coping with traumatic experiences surpasses a mere recovery of functionality and requires an abstraction from experience that goes beyond the facts. ROGERS (1961) speaks of an "actualization tendency" that drives all people; MASLOW (1954) also proposes self-actualization. This abstraction might particularly benefit chronic PTSD patients who experience the devastation of fundamental beliefs and ideas about life (EHLERS & CLARK, 2000): The world as a predictable place is lost.

DOSTOEVSKY'S works (e.g. The Brothers Karamazow, 1995), motivated by the traumatic experience of a mock execution and subsequent imprisonment, must be mentioned here as well as FRANKL'S (1962) conception of logotherapy. Frankl's search for and discovery of meaning contributed to his survival in Nazi concentration camps. He thus demonstrated that focusing upon a purpose or meaning of life may constitute a factor for survival.

ANTONOVSKY'S (1987) salutogenic approach and his concept of "sense of coherence" were inspired by the study of Jewish women who not only had survived the holocaust but had also grown from this experience. CSIKSZENTMIHALYI'S (1975) personal experiences in Italy were also a determining factor for his study of the psychology of optimal human functioning. With the themes of positive coping with trauma and growth following trauma we enter an idiosyncratic realm colored by personal history, with its opportunities and also limitations.

Different concepts will be introduced and compared in the following section. Each contributes to an understanding of adaptation of traumatic experiences and their positive processing. Each could also contain a point of intervention for integrative work within trauma therapy.

b) Resilience versus maturation

As much as there is no single trauma therapy, there is more than one path to resilience. BONANNO (2004) lists four different paths:

(1) Hardiness
(2) Self-enhancement
(3) Repressive coping
(4) Humor and laughter

A certain robustness or hardiness suggests individuals who believe in themselves and in their opportunities and who are able to learn from the most negative experiences (STEELE & KUBAN, 2005). Self-enhancement refers to individuals who hold themselves in high esteem; are indeed better able to cope with mishaps; are less prone to negative stress; and recover faster,

even if they seem conceited, arrogant, or even narcissistic. Repressive coping denotes the avoidance of emotions, cognitions, or verbalizations regarding the negative event (ibid.), adopting the motto "Ignorance is bliss." There is only a seeming contradiction to the healing effects of narratives or the telling of stories (STEELE & RAIDER, 2001), for healing requires story-telling with an outcome that accepts the events or handles them appropriately. Then the story does not have to be retold repeatedly and without apparent progress. Thus, even in this context an accepting approach comes to bear, with the individual's liberty to engage in avoidance once in a while, if so needed. Regarding the relationship of humor and resilience, the work with cancer patients has extensively demonstrated the importance of laughter. More recent studies show that not laughing *per se* is of issue, but the patients' ability to have positive emotions (love, interest in others, wanting to continue) (LINLEY, 2003). Posttraumatic growth, in contrast to resilience, means to abstract the positive from one's experience by confronting all aspects of that experience.

One does not have to preclude the other: With regard to the client's situational and actual needs, approach and avoidance do not have to be exclusive but may be complementary. In this context, mindfulness is the prerequisite for noticing the significance of each present moment. Avoidance per se is not bad, but avoidance that is not recognized as such. In fact, if a client actively decides not to do, feel, or think something (which by itself is paradoxical already) this decision does not constitute proper avoidance in the pathological sense (cf. HAYES, 2005).

What determines personal maturation?

Positive life changes subsequent to traumatic experiences may include a realization of individual strength, increased closeness to friends and family, and a joy of life greater than before (FRAZIER, 2005). Fifty to 60% report such positive changes categorized as follows (ibid.):

1. Concerning the self
2. Concerning relationships
3. Concerning one's worldview
4. Concerning one's perspective-taking ability

TEDESCHI & CALHOUN (1995) describe five characteristics of posttraumatic maturation:

- *Changed philosophy of life – a greater appreciation for life:* "I honor each day."
- *Increased knowledge of human nature and improved relationships:* "I have more empathy."
- *Greater self-confidence and personal strength:* "I discovered that I was stronger than I thought."
- *New possibilities:* "I developed new interests."
- *Religious and spiritual development:* "I have a greater understanding for religious and spiritual matters."

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c) Maturation versus posttraumatic growth

According to evidence to date, the human mental health apparatus would not have to respond to traumatic events with maturation: A connection between posttraumatic maturation and mental health has not yet been unambiguously established.

- Many studies have not found any correlation with mental health (e.g., MAERCKER ET AL., 1999; PARK, COHEN, & MURCH, 1996).
- Some studies have found negative correlations with mental health (e.g., MOHR ET AL., 1999, cited in MAERCKER, 1999).
- Other studies have found positive correlations with mental health (e.g, AFFLECK & TENNEN, 1996; MCMILLEN, FISHER, & SMITH, 1997).

Despite these findings, most clinicians and researchers in the field assume the adaptive value of posttraumatic maturation.

Coping with trauma is a multidimensional and complex process, as illustrated by Maercker's (1997) heuristic model. Moreover, the process is not linear but iterative, such that some phases (usually constituting a pyramid of safety planning, emergency stabilization, exposure, and integration; see also Butollo, 1998) must be transitioned. Therapy vacillates between forward-motion from milestone to milestone within each particular phase and the processing of setbacks, which give information about areas that have not been mastered or sufficiently internalized by the client.

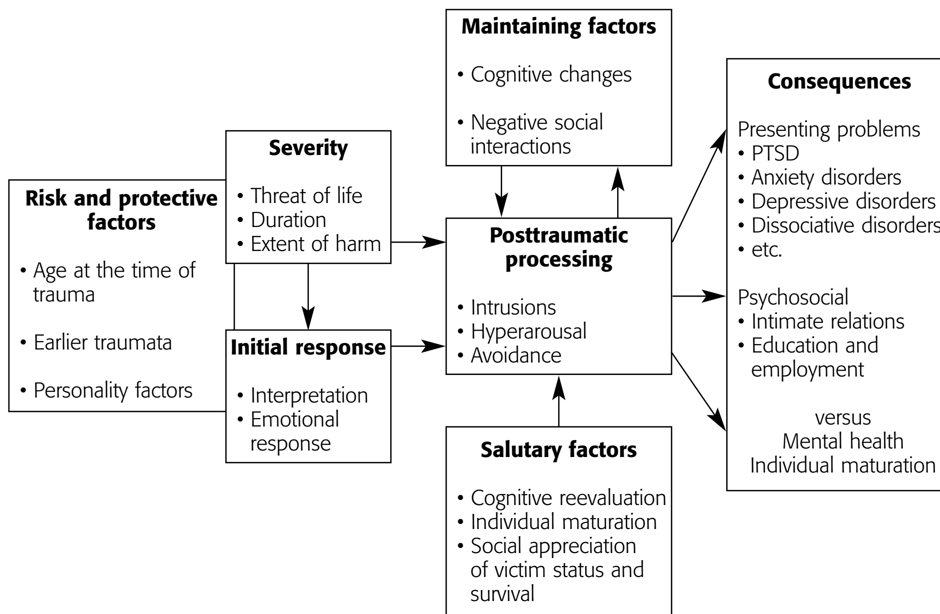

Figure 1. A heuristic model of trauma processing (Maercker, 1997)

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Timing is particularly important in trauma therapy and usually dictated by the client's respective internal state. In the meantime, the therapist assumes a "container" function for the client's needs and difficulties (i.e., receipt of content and storage for later use; see also FISCHER & RIEDESSER, 1999). The therapist supports without being forceful. He or she provides structure and concrete interventions without disregarding the client's comments.

In acute crisis interventions, crisis counselors initially provide non-directive support and advise mindful caring for oneself. Clients are sensitized to possible changes. Early interventions may relieve some of the stress of the immediate situation (for a review, see GRAY & LITZ, 2005). But these interventions are not always indicated: NEIMAYER (2000) found that 38% of individuals who received grief counseling had a worse outcome than those who did not. Meanwhile, critical incident stress debriefing (DYREGROV, 1998) has become as controversial and may even impede recovery (MAYOU, EHLERS, & HOBBS, 2000), especially in the case of individuals with pre-traumatic risk factors.

Therapeutic interventions are delivered well after the trauma has been experienced. For this reason, variables external to the therapeutic situation play an important role for processing, such as the social or institutional acknowledgment of victimization, or the client's social support system, for example. Clients may be empowered to manage prospective interactions with self-relevant systems, as illustrated by the case of a teacher who fought for a new job after the school's principal had been murdered.

d) Language

Associations evoked by the word "victim" also are important in therapy. If a victim remains a mere victim, then later changes directed at becoming a perpetrator may not be far-fetched (HUBER, 2003). If behavioral patterns that are associated with victimization (e.g., helplessness) are disrupted, then the word "victim" bears a continuing acknowledgment of the current, frequently unintentionally encountered state. The sweeping and difficult topic of guilt, its implications and relationship to the value system are also important for a successful trauma therapy.

Developing an acceptable narrative of the trauma involves the integration of the traumatic event into the changed value system and understanding of life as a whole. This requires intensive work on the value system and the higher levels of self-organization. From a therapeutic perspective, cognitive reevaluation and behavioral change are necessary. In a qualitative study, TURNER AND COX (2004) conducted interviews with thirteen accident victims who identified willpower and altered perspectives as the main factors facilitating their posttraumatic growth. Willpower was understood as stubbornness, determination, planning one's own recovery, and the rejection of dependence on others. Altered perspectives included the interviewees' taking responsibility for their journey to recovery, which was associated with greater empathy and appreciation for others. This finding also reflects the rediscovery of volition in psychology (HAUKE, 2005).

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Thus, trauma therapy is affected by historical and current client variables. Those clients who have not yet accessed resilience or posttraumatic growth, are in need of rather trauma-specific interventions; others only require support and brief crisis interventions.

e) Wisdom

Many authors and researchers consider wisdom an important component of positive adjustment (CALHOUN & TEDESCHI, 1998; BALTES & STAUDINGER, 2000). Of course, traumatic experiences are not necessary for wisdom. BALTES AND STAUDINGER (2000) list the following five aspects of wisdom: (1) Rich factual knowledge and (2) rich procedural knowledge about the fundamental pragmatics of life; (3) lifespan contextualism, i.e., context-relative knowledge about different areas of life, such as family, education, etc.; (4) the distinction of belief and values, and tolerance of value differences; and (5) management of uncertainty. Wisdom is outcome and process at once.

When apparent contradictions are resolved, synthesis may emerge from thesis and antithesis (HEGEL, 1931), such as "Bad things happen to good people."

Alternative theories of adjustment (e.g., sense of coherence, ANTONOVSKY, 1987; self-efficacy, BANDURA, 1982; dispositional optimism, CARVER & SCHEIER, 1999; hardiness, KOBASA, 1979; internal locus of control, ROTTER, 1966) shall not be detailed here.

What then is wisdom, and how does one attain it?

Wisdom is indeed a clearly defined construct that correlates with life experience. A wise person learns from his or her own and other people's mistakes. Non-normative experiences also contribute to the development of wisdom, but at this point myths must be debunked: Wisdom is neither reserved for special groups nor for the elderly. Young people may develop wisdom, too. The three basic dimensions of wisdom are:

1. the recognition and management of uncertainty (see also the shattered value structure described earlier);
2. the integration of affect and cognition through acceptance and mindfulness
3. the recognition and acceptance of human limitations

Here, the possibilities of therapeutic influence are obvious:

ad 1. "Everything flows."

According to KITCHENER AND BRENNER (1990), this observation is at the heart of the concept of wisdom. JANOFF-BULMAN (1992) speaks of shattered fundamental assumptions about the world. The therapeutic targets would be nonresistance and openness toward change (see also TENNEN & AFFLECK, 1998).

ad 2. "I am not my trauma."

Neither cognition nor affect has privileged status. The task in therapy is to promote the perception of sensations and cognitions without fusion (cf. HAYES, 2004: "defusion"). The elimi-

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nation of the fragmentation of memories and the mergence of affect and cognition are essential. Therapeutically, only the dialectical process involving affect and cognitions may accomplish this task.

ad. 3. "conditio sine qua non"

Accepting one's limitations as well as the finitude of human existence may enhance the value of the "here and now." HEIDEGGER'S (1931) note that "thinking is thanking" also may be able to alter one's conceptualization of life and to increase altruistic behavior.

Another characteristic of wisdom is high moral valence, which may provide the foundation for building a meaningful life. A bit clearer and less dramatic is the reference to a clear-cut conceptualization of life by respecting and maintaining one's own and others' boundaries.

6. The therapeutic reconstruction of the shattered value system through self-regulation, values, and mindfulness

"People who have a strong enough why can bear almost any how.'" (NIETZSCHE, 1939)

Surely, practitioners agree that traumatic experiences are accompanied by shattered assumptions and beliefs. Individuals with traumatic experiences, and even their therapists after a certain point, spend more time than before on existential questions about death or the meaning of life. An interruption in the experience of a coherent flow of life increases the probability of these questions (HAUKE, 2001). Therapeutically, these are the interesting, yes even fascinating, phases for they may involve clients switching their life tracks. They are comparable to the rebuilding of a house after an earthquake: Now completely different building standards apply. One has to say "farewell" to the old fixtures; and at the same time, knowing the old, one can start reconstructing with new considerations.

a) Values

As illustrated in Figure 2 (HAUKE, 2005), the regulatory system attempts to achieve conformity with the person's *identity*. A particular identity is bound to particular *personal values* (HAUKE, 2001; SCHWARTZ, 1999, cited in HAUKE, 2005), which function as the reference values of the next respective regulatory level.

The removal of discrepancies between reference and actual values and possible value conflicts may occur at different levels, each of which presents points of interventions of importance to trauma therapy. Based on the fundamental works of POWERS (1973), CARVER AND SCHEIER (1999) distinguish four hierarchical levels:

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- *System concepts* form the top of the hierarchy, e.g., the ideal self "good person."
- *Principles* are defined by reference values that determine how to be the ideal self ("be" goals), such as "be honest." Like a meta-script, they specify characteristics. Such guiding principles may be preset by personal values.
- *Programs* set a general course of action ("do" goals), e.g., "opening the door." As details are unspecified at this level, there is room for decision-making and adjustment to situation-specific circumstances.
- *Sequences* are determined by the goals of motor control processes. Here, the course of action is fixed.

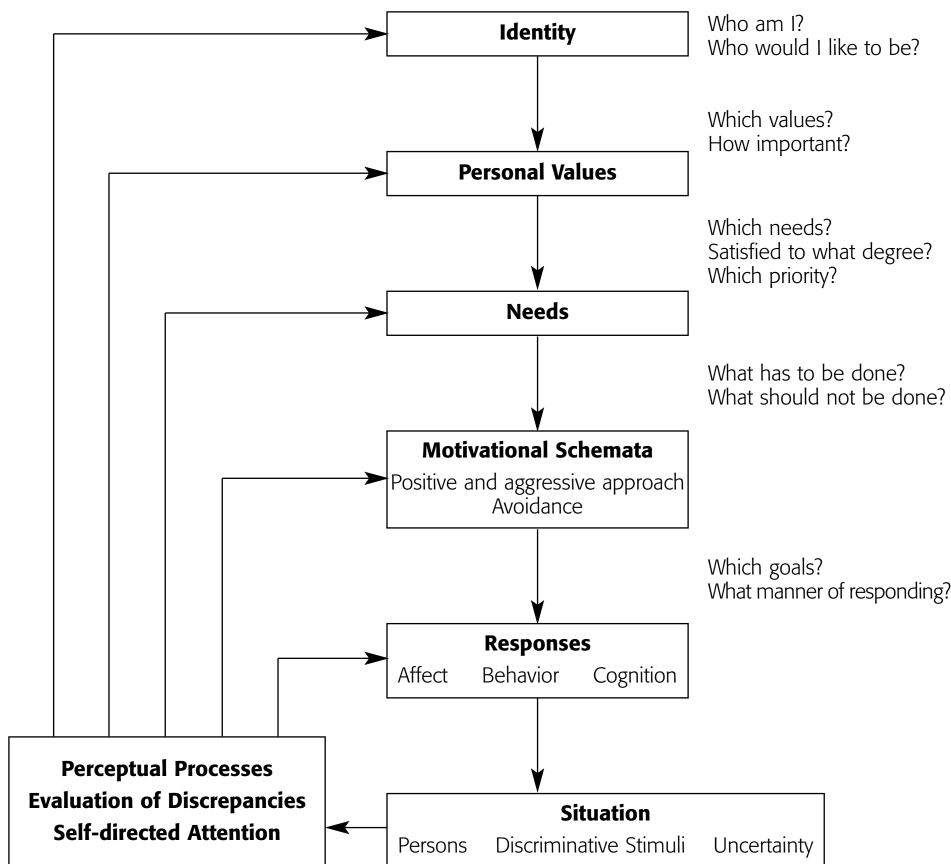

Figure 2. Clinical questions emerging from a broadly conceptualized regulatory hierarchy (Hauke, 2005)

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A person's behavior is directed toward reference values and any encountered event is evaluated in relation to these standards. The characteristically permanent self-directed attention of trauma patients does not lead to conformity and is a function of the discrepancy caused by the traumatic event.

A self-directed focus serves to register the discrepancy and should be directed to the self-regulatory level that is incurring the most difficulty with conformity to reference values. Unfortunately, the behavior that used to be effective in terminating discrepancies between reference and actual values is not able to achieve conformity, because access to the higher levels of the regulatory hierarchy is barred and earlier goals are contradicted by the trauma (HAUKE, 2005).

A traumatic event is to be understood as a massive perturbation in the feedback loop regulating compensatory behavior with respect to actual and reference values. Within the hierarchy of goals (see Figure 2), the system concept of the "safe and sound human" has been destroyed; likewise, the principles have ceased to be applicable in the case of trauma. Typically, people are able to access coping strategies for dealing with stress (LAZARUS, 1984) if the demands of the current situation do not by far exceed the available coping strategies. In the latter case, the regulatory loop would be unable to produce conformity.

The question as to values is essential for regaining a sense of gratification in life: "In a world where you could choose to have your life be about something, what would you choose" (WILSON & MURRELL, 2004, p. 135). Values are not forced or suggested; instead, after the therapist has drawn attention to them, the client is free to focus and to generate relevant themes. To prevent a limitation to the cognitive level, exposure to a stressful and avoidance-producing situation may be arranged (e.g., anxiety in a situation that resembles the original trauma). Following exposure, the client is asked to write about his or her emotions, thoughts, and memories, which are then jointly processed in session (cf. PENNEBAKER, 2001, cited in WILSON & MURRELL, 2004). Value-related activities may be able to motivate the client to work on his or her anxiety. For example, on the journey toward a meaningful life, comprised of fulfilling social exchanges, one may encounter a panic attack in public along the way. However, the path of value-directed behavior does not always have to be actionable; instead, it may require pausing for a brief moment, tolerating, and observing.

b) Personal growth, coping, and the role of mindfulness

Positive coping with trauma seems to depend on the choice of the coping strategy (avoidant versus active coping) and perceived control or self-efficacy. Perceived control over past events, the current recovery process, or future events must be distinguished. As expected (TEDESCHI & CALHOUN, 1995), FRAZIER (2005) also found the following changes: Greater empathy, an altered self or greater assertiveness, a changed spirituality or philosophy of life as well as a greater appreciation for life. In this context, the time that had passed since the trauma was not a determinant, for such changes occurred very quickly. As a decrease in posttraumatic stress

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correlated with these positive changes, avoidance could be ruled out as a mechanism of action. The active or "approach" coping strategy corresponds to the strategies of acceptance and mindfulness-based therapies. Perceiving control over the recovery process seems to be more important than perceived control over past events. This result lends additional support to therapeutic approaches that focus on the "here and now" and mobilize individual coping resources. Timing is a critical factor for the delivery of interventions to promote posttraumatic growth: The most extensive changes are expected to occur two weeks to two months after the traumatic event. Consequently, this finding is of major significance for theoretical conceptualization of crisis interventions, as people are especially receptive to external influences during this period of time. In a best case scenario, these influences should take into account the individual's value system as well as his or her current circumstances and personality structure.

8. Conclusion

First, the presentation of PTSD was detailed and illustrated with case vignettes. A description of PTSD's epidemiology and course was followed by an outline of various promising therapeutic approaches to treatment. Strategic Brief Therapy is able to integrate these diverse approaches. The treatment of PTSD does not only require symptom reduction, but it also poses the question how mindfulness-based processes and work on the shattered value system may lead to an incorporation of the experience within the personality and an abstraction of the positive. In this context, it is assumed that traumata affect and concern the personality as a whole. Individuals' self-actualization tendency, the lifelong desire to self-actualize, or the wish to transcend human existence and move beyond the experienced events to a new personal realm of experience and behavior, enable growth from crises in a philosophical sense. An overview of relevant findings demonstrated empirical support for this philosophical assumption and this wellspring of literary work, and at this point it was shown how this process might be externally supported and promoted by therapeutic means.

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Martin Johannes Fegg

Strategic Therapy in Palliative Care

ABSTRACT

So far, only a few publications have addressed psychotherapy with palliative care patients. This article first describes the growing field of palliative medicine and its central paradigm, quality of life. Then an overview of frequent clinical symptoms is provided, and therapeutic approaches originating in the first (behavioral) and second (cognitive) waves of behavior therapy are outlined. However, the main foci of this present work are the approaches of the third wave behavior therapies: We will concentrate on their key concepts, such as mindfulness, acceptance, values, and meaning-in-life, and their intersection with existing psychotherapies for palliative care patients. We will also clarify the role of Strategic Brief Therapy in inpatient settings. The introduced concepts will be theoretically integrated into a "hot-cool" perspective. Finally, a case vignette will illustrate our approach.
Keywords: Palliative care, behavior therapy, acceptance, mindfulness, values, meaning in life

1. Introduction

Excepting some theoretical and preliminary clinical work, psychotherapeutic interventions for patients at the end of life rest on very scant conceptual and research bases. While the idea of hospice – providing shelter, food, and assistance to travelers, the poor, the sick, and the dying – has existed since Christianity's incipience, the modern hospice movement did not begin until Dame Cicely Saunders (1918-2005) opened St. Christopher's Hospice in London in 1967. From here, the idea of palliative care was disseminated within England and in other countries. In 1975, the first palliative care unit opened its doors at Montreal's Royal Victoria Hospital. In Germany, the first initiatives and associations that contributed to the promotion and acceptance of the hospice idea did not emerge until the 1980s. In 1985, the "Christophorus-Hospiz-Verein" [Christophorus-Hospice-Association] was founded in Munich and became the first association that contained the term "hospice" in its name. In 1992, the "Bundesarbeitsgemeinschaft Hospiz" [Federal Hospice Committee] organized, and in 1995 the "Deutsche Gesellschaft für Palliativmedizin" [German Association for Palliative Medicine] was founded, which unites physi-

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cians and other professional groups to jointly work toward development and progress in palliative medicine (RADBRUCH & ZECH, 2000). At present, the number of inpatient and outpatient caregiver services is increasing rapidly. Concurrently, there is a great need for evidence-based research concerning areas of pain and symptom management, ethical and legal issues, as well as the development and research of psychotherapeutic interventions.

In Germany, the term *hospice* denotes a care facility in charge of pain therapy and symptom management. Usually, hospices have an independent organizational structure and are managed by nursing professionals. Medical care is most often provided by local community rather than in-house physicians. Eligible care receivers are seriously ill individuals with terminal and progressive diseases who do not require inpatient treatment in a hospital, but for whom outpatient care at home is not an option. Care is provided for weeks or months, usually until the patient dies. In contrast, a *palliative care unit* is an independent, hospital-associated, or integrated facility that targets optimal symptom management with interdisciplinary or multi-professional teams supervised by a physician. The average duration of stay is approximately 14 days. The primary goal is the patient's discharge to home-based care. If such care is impossible, continued inpatient care, in a hospice for example, is arranged.

The World Health Organization *defines* palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (http://www.who.int/cancer/palliative/definition/en – URL accessed on March 28, 2006). Clearly, an increase in the quality of life of patients as well as their families is palliative medicine's central concern. Its task is not only the alleviation but also the prevention of suffering. The underlying view of human beings equally considers physical, psychosocial, and spiritual aspects of an individual's life.

2. Improvement of Quality of Life as the Task of Palliative Care

Quality of life has become an important concept in healthcare, especially in palliative care. The growing number of publications over the past 20 years reflects the research activities in the field. While "quality of life" is the topic of many studies and most health-related research includes quality of life measures, there is *no consensus of definitions* regarding quality of life. It is widely recognized that quality of life is a complex and idiographic construct that changes in response to illness (BAUSEWEIN, unpublished; CARR & HIGGINSON, 2003; RICHARDS & RAMIREZ, 1997). A variety of dimensions contribute to quality of life, such as pain and other symptoms, physical and cognitive functioning, psychological and social functioning, functioning in one's roles, and spiritual wellbeing (RICHARDS & RAMIREZ, 1997). The significance of attitudes and expectations is expressed in Calman's (1984) definition of quality of life termed "Calman Gap" (quality of life = patients' achievements minus patients' expectations).

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Several *concepts* and tools help to understand quality of life, e.g. health-related or subjective quality of life measures. Many instruments for measuring specific domains of quality of life have been developed and validated. However, the exact nature and composition of factors that influence quality of life and therefore must be considered in its measurement are still unclear. For example, we recognize that many patients obtain high quality of life scores when impaired physical functioning and serious illness are present (BAUSEWEIN, unpublished). We also do not know how quality of life changes over time, e.g., as a progressive disease advances. Most publications on quality of life take snapshot measures at only one point in time and do not show the course of quality of life across time.

However, in recent years a new construct termed *response shift* has emerged, which could provide a better means to understanding how people perceive their quality of life and how they cope with health-related or other life changes. Response shift is defined as "a change in the meaning of one's self evaluation of a target construct as a result of recalibration, change in values and reconceptualization" (SPRANGERS & SCHWARTZ, 1999, p. 1508).

The *Schedule for Meaning-in-Life Evaluation* (SMiLE, FEGG ET AL., submitted, http://www.meaninginlife.info) offers one way to measure response shift. The SMiLE is a respondent-generated measure of individual meaning-in-life and assesses three aspects. It asks subjects:

(1) To name three to seven domains that they judge to be important to their individual meaning-in-life.

(2) To rate their current level of satisfaction in each of these domains using a seven-point Likert scale (range, -3 to +3);

and

(3) To rate the importance of each of their chosen areas using a eight-point adjectival scale (range, 0 to 7).

To obtain a total individual meaning-in-life score (SMiLE Index, 0–100, with higher scores reflecting higher individual meaning in life), relative weight and current satisfaction are multiplied for each domain and the results are summed. For analysis, raw scores can be grouped into categories such as family, partner, leisure activities, health, finances, etc. Repeated measures within subject demonstrate that the SMiLE detects response shift, defined as the redefinition or re-conceptualization of some domains as a function of contextual changes in patients' lives (cf. case vignette).

3. Psychological Symptoms in Palliative Care Patients

The prevalence data characterizing the psychological difficulties encountered by seriously ill and dying individuals correlate with the patient population, the measurement methods, and the progression of the disease (BREITBART ET AL., 1995).

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Table 1. The prevalence of psychological symptoms as a function of disease progression (Pouget-Schors & Degner, 2002; Schwarz & Krauß, 2000).

	Curative	**Palliative**	**Final**
Depressive symptoms	25-50%	77%	
Anxiety disorders	1-44%	9-33%	
Generalized anxiety disorder		1.1%	
PTSD	5-22%		
Adjustment disorders		7.5%	
Fatigue		84%*	60-80%
Neuropsychological symptoms		19.8-44%	61%
Suicidality	0.2%		0.003%

* After radio or chemotherapy.

A construct of special significance in palliative care is the *fear of death*. On the one hand, this fear of death is determined by biological variables that serve self-preservation. On the other hand, it is a function of interpersonal experiences and social learning (e.g., models of coping with death and dying in the parental home, in the public sphere, and in the media). FLORIAN AND MIKULINCER (2004) proposed a theoretical model that identifies three dimensions of the fear of personal death. These dimensions refer to the intrapersonal, interpersonal, and transpersonal meanings that people may attach to their own death. The intrapersonal dimension specifies the consequences of death for one's own mind and body, such as failure to accomplish important life goals and decomposition of the body. The interpersonal dimension relates to the possible impact of death on one's interpersonal life, such as the termination of close relationships, the failure to care for loved ones, and the possibility of being forgotten. The transpersonal dimension includes a person's beliefs about the hereafter and the transcendental nature of his or her existence, such as uncertainty about what to expect in the hereafter or the possibility of punishment.

Terror management theory (TMT) assumes that humans cope with their fear of death via two cultural anxiety-buffering mechanisms: (1) the belief in a cultural worldview and (2) the esteem that is derived from meeting the standards of that worldview (GREENBERG ET AL., 1997, JOIREMAN & DUELL, 2005). All cultural worldviews provide their constituents with a sense of enduring meaning and a basis for perceiving oneself as a person of worth within the world of meaning to which one belongs. By meeting or exceeding individually internalized standards of value, norms, and social roles derived from the culture, people transcend their fear of death and hence maintain psychological equanimity despite their knowledge of their own mortality. Effective terror management thus requires (1) faith in a meaningful conception of reality (the cultural worldview) and (2) the belief that one is meeting the standards of value prescribed by that worldview (self-esteem). Self-esteem-related psychological resources, such as hardiness

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(Florian et al., 2001) and secure attachment styles (Mikulincer et al., 2003) have been found to reduce the effects of mortality salience manipulations. Also close relationships serve as a fundamental buffer of existential anxieties (Mikulincer et al., 2004).
Furthermore, Kissane et al. (1997) described *demoralization* in the terminally ill, which they characterized as a syndrome distinct from depression. It consists of the triad of hopelessness, loss of meaning, and existential distress. Patients with this syndrome are more likely to commit suicide or wish to hasten death (Kissane & Kelly, 2000).

When treating psychological disorders and their effects on patients' social environment in general and on partnership and family in particular, one must consider that the vital threat posed by the disease and its treatment may overshadow all other behavioral domains (*mental centralization*; Fegg & Frick, 2003).

4. Classical Behavior Therapeutic Approaches

According to Kanfer et al. (2000), assessment in behavior therapy consists of an analysis of the behavior patterns to be modified (target analysis), the conditions that generated and maintained these patterns (problem analysis), and the means by which the desired changes will be effected with a particular individual (therapy planning). Different interventions, outlined below, may be appropriate for the treatment of patients with serious physical illnesses.
Involving family members in the patients' treatment and, if necessary, providing family members with separate psychotherapeutic support is of special importance in this area of psychotherapy more than in any other. Especially in the USA, structured group intervention programs are available to cancer patients (Fawzy & Fawzy, 2000, Spiegel & Classen, 2000, Spiegel et al., 2000): psychotherapists cooperate with physicians, nurses, social workers, counselors, and self-help groups within a multi-layered psychosocial oncology network. In many cases, psychopharmacological interventions may be indicated as well. Recommendations and guidelines can be found in Bausewein et al. (2005).
From a behavioral therapeutic perspective, the following interventions may be considered (Härtl & Schreiner, 2005):
The term *exposure treatment* subsumes a heterogeneous group of behavioral therapeutic interventions that constitute first-line treatments for anxiety disorders. Systematic desensitization and exposure with response prevention are counted among them. In its original conception, systematic desensitization, applicable to surgery or before chemo and radiotherapy, consists of three components: (1) Relaxation training; (2) construction of an individualized fear hierarchy; (3) exposure to the individual items while relaxing. The latter may be practiced in sensu, in the patient's imagination, or in vivo, through the actual encounter with or presentation of fear-producing situations.

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Exposure techniques imply the presentation of the situation that is feared by the patient. The presentation of the fear-producing situation can occur in small steps (graduated exposure) or begin with the most feared item (flooding). Response prevention denotes the prevention of avoidance behavior to enable the patient's habituation to the fear-producing situation. Exposure usually lasts for at least 30 minutes; however, the patient's experience of fear reduction is critical. The classically conditioned, anticipatory gagging reflex that was elicited by the sight of the clinic in which chemotherapy had produced nausea and which therefore was avoided by the patient, provides an example of the applicability of exposure with response prevention to the care setting.
Operant methods serve to increase desired behavior or to decrease undesired or disruptive behavior. Shaping involves the systematic reinforcement of successive approximations to the target behavior. An example is a child with cancer whose ability to play alone should be increased to prepare him or her for a long inpatient hospital stay. First, independent play is reinforced by the therapist. Alternatively, opportunities for positive reinforcement of the child's behavior can be generated by prompting (support via verbal or physical assistance that directs attention to the target behavior), fading (the stepwise reduction of assistance) and backward chaining (the establishment of a complex behavioral chain by reinforcing the last link first). Before using positive reinforcement, reinforcers that are effective for the individual patient must be identified. These are then presented contingently by the therapist, family members, or by the patient him or herself (self-reinforcement). Behavioral activation and positive reinforcement are implemented especially with depressed patients. The patient's day is structured with an activity schedule; the frequency of activities is increased; and particularly those activities that may have self-reinforcing effects are targeted.

Effective communication by the patient with family members, physicians, and care staff may be promoted with the help of *role plays* focusing on posing questions, articulating needs, or expressing emotions, for example. The therapists and patients jointly plan the role plays, analyze their component parts, engage in debriefing with concrete suggestions, and practice generalization to everyday life. Video feedback is useful, for positive and problematic behavioral sequences may be replayed repeatedly and modified, if necessary. Role plays are also amenable to group settings. Role-play techniques are a basic component of self-assertiveness training. Modeled social situations are trained during role play with video feedback, and subsequently trained via in vivo exercises. Self-assertiveness training is particularly indicated for those patients who have a negative body or self-image following surgery or medical therapy.

JACOBSON'S (1996) Progressive Relaxation is suggested for *relaxation training*. Patients first learn to notice and to discriminate different degrees of tension in their striated (voluntary) musculature to be able to relax these muscle groups at a later time. Patients also receive detailed instructions about the interaction of physiological and mental tension or relaxation. In a prede-

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termined sequence, different muscle groups are contracted for 5 s and then relaxed for 10 s. Daily home practice, mostly assisted by audio tapes, is assumed. Progressive relaxation training may occur in individual as well as in group sessions. It has been shown to reduce nausea, vomiting, and other psycho-physiologically adverse effects of chemotherapy in cancer patients (MOLASSIOTIS ET AL., 2002). The procedure may also be applied to pain, depression, or anxiety. For this reason, Progressive Relaxation Training may be termed the "aspirin of psychotherapy", for it seems to be applicable in a plethora of areas where it produces non-specific effects.

Controlled breathing is probably the most versatile of all the relaxation techniques. It is easy to learn, may be used in almost any situation, and may be helpful for controlling all adverse symptoms. However, for patients with breathing difficulties this technique may be contraindicated (TURK & FELDMAN, 2000).

In *attentional training*, guided imagery may be used to enhance patients' ability to use all their sensory modalities (i.e., vision, audition, olfaction, gustation, and tactation) and thereby increase their engagement. The therapist may ask the patient to imagine scenes, such as a pleasant day at the beach. Such practice can be of assistance for patients by providing them with opportunities to try a range of different scenes in order to learn to use all their senses and to generate a set of images that is of particular use for them (TURK & FELDMAN, 2000). In attentional training, different methods are described (FERNANDEZ & TURK, 1989): (1) Those that focus on the environment rather than on the body; (2) neutral images; (3) dramatized images including the pain or discomfort component; (4) pleasant images; and (5) rhythmic activity.

A technique that must be viewed with caution given recent research results is *thought stopping*, a covert conditioning procedure. Patients learn to disrupt their ongoing negative thinking with a loud "Stop", further enhanced by noise from clapping their hands or hitting the table. Patients are also taught to engage in predetermined positive self-verbalization. However, research participants who were instructed to suppress a thought in this fashion showed an increase in the frequency of the suppressed thought compared to participants who did not receive such a suppression instruction (CLARK ET AL., 1991, GOLD & WEGNER, 1995).

Stress Inoculation Training (SIT) is a procedure that aims at general stress management. An initial didactic phase focuses on an analysis of the problem and a formulation of a plausible explanatory model. In the following practice phase, an alternative new behavior is tested under induced and controlled stress conditions. The application phase involves the implementation of the learned coping skills in everyday life. Especially with seriously ill patients who are hospitalized for longer durations, SIT may be used strategically. In this context, the elaboration and written formulation of an emergency plan is also helpful.

The different procedures of *cognitive therapy* require that the therapist and the patient work together to analyze the patient's dysfunctional, mostly automatic thought patterns. The identification of the patient's core assumptions is facilitated by extensive self-monitoring of automatic negative thoughts to illustrate the connection between these thoughts and the patient's emo-

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tions. A typical daily diary consists of a brief description of the problematic situation and of the accompanying emotions and thoughts. The dialog with the therapist challenges the patient's typical dysfunctional thoughts and replaces them with appropriate ones (cognitive restructuring). Typical cognitive errors are overgeneralization (e.g., "This nausea will never stop."), arbitrary inferences (e.g., "I lived wrong, that's why I am sick."), personalization ("Our friends are not calling anymore because I'm sick."), dichotomous thinking (e.g., "I'm a failure.") and selective minimization or maximization (e.g., "The nurse was unfriendly today; she does not like me."). Their modification can be prompted with different cognitive techniques. In the Socratic dialog, the therapist directs the patient's attention to heretofore neglected aspects of the situation, to earlier experiences that contradict the present situation, or to alternative interpretations. The patient may also be prompted to supply "rational" answers and alternative thoughts. For example, a patient with a dysfunctional, subjective theory of his or her disease may be asked to list all variables that could have possibly contributed to the cancer. The technique of hypothesis testing requires the patient to examine the accuracy, completeness, and logic of his or her thoughts by gathering experiential data, evaluating them, and drawing conclusions. Nevertheless, recent evidence suggests that some of the theoretical assumptions underlying this procedure may have to be revised (TEASDALE ET AL., 1995; TEASDALE, 1999).

Numerous clinical studies have investigated the efficacy of the interventions described in the preceding paragraphs. However, studies in the area of palliative medicine are few and far between. Results from psycho-oncological research to date have been promising (HOLLAND, 2002, KIDMAN & EDELMAN, 1997, SPIRITO ET AL., 1988).

5. "Third wave"-therapies and other modern psychotherapy methods

From the behavior analytic as well as the cognitive influences in behavior therapy, the third wave of behavior therapy – following the purely behavioral ("classical") and the cognitive phases – has emerged in recent years (HAYES, 2004; SONNTAG, 2005). It consists of Functional Analytic Psychotherapy (FAP; KOHLENBERG & TSAI, 1991), Dialectical Behavior Therapy (DBT; LINEHAN, 1996), Integrative Behavioral Couples Therapy (IBCT; JACOBSON & CHRISTENSEN, 1996), Integrative Family Therapy (IFT; GRECO & EIFERT, 2004), the Cognitive Behavior Analytic System of Psychotherapy (CBASP; MCCULLOUGH, 2000), Mindfulness-Based Cognitive Therapy (MBCT; SEGAL ET AL., 2002), Behavioral Activation according to the late Neil Jacobson (MARTELL ET AL., 2001) and Acceptance and Commitment Therapy (ACT; HAYES, STROSAHL, & WILSON, 2004).
The primary aspects of these therapeutic orientations (e.g., mindfulness, acceptance, values) are essential in the psychotherapeutic treatment of palliative care patients; on the one hand, the progression of the disease is inevitable; on the other hand, the time for a psychotherapeutic intervention targeting modification is often limited. Especially in this existentially signifi-

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cant life situation, questions as to the meaning in life and its values become increasingly important. So far, however, an integration of "third wave" therapies into psycho-oncology, palliative medicine and hospice work has not occurred. For this reason, the following section will detail the core concepts of these therapies and other related topics and thereby generate a first approximation to new therapy methods in the areas of psycho-oncology, palliative medicine, and hospice work.

Of course, foci must be selected: therefore, we will restrict our discussion to the following concepts: (a) mindfulness; (b) acceptance (with ACT as an example) and (c) values. Then we will broaden our approach to include as a theme (d) the meaning-in-life, which is of major significance for seriously ill patients.

Many of these constructs have a long historical tradition, e.g., the concept of mindfulness originated in Buddha's teachings. It is the core principle of the Buddhist "Theravada" tradition (i.e., the way of the elders; SCHMIDT, 2004). Other concepts were adopted from philosophy: It is important to further elaborate their foundations, as new impulses for present-day research may be gained from a thorough understanding of these concepts' long and extensive tradition.

(a) Mindfulness

Mindfulness has been described as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (KABAT-ZINN, 1984; KABAT-ZINN, 1990; TEASDALE ET AL., 1995). The essence of mindfulness is to be fully aware of one's experience in each moment, equally open to whatever the moment has to offer, and free of the domination of habitual, automatic, cognitive routines that are often goal-oriented and – in one form or another – related to wanting things to be different to what they are (TEASDALE, 1999). Mindfulness may include qualities like non-judging, non-striving, acceptance, patience, trust, openness, letting go, gentleness, generosity, empathy, gratitude, and loving-kindness (SHAPIRO ET AL., 2002). Unfortunately, the defining criteria and operationalization procedures for mindfulness have not yet been determined (BISHOP, 2002).

KABAT-ZINN (1990) developed a structured group intervention termed *Mindfulness-Based Stress Reduction* (MBSR). MBSR typically consists of 8 to 10 weekly group sessions, with one session being a full-day "retreat". In formal mindfulness practice, the participants sit quietly in an erect and dignified posture and attempt, non-strivingly, to maintain attention on a particular focus, commonly on their own breathing. When their attention wanders from the breath to the thoughts and feelings that inevitably arise, the participants acknowledge and accept these thoughts or feelings, let them go, and redirect their attention back to the breath. This procedure is repeated many times, whenever the participants notice that their attention has wandered. In informal practice, participants apply the same approach as often as possible during their typical day, bringing the attention back to the "here and now", using a focus on the breath as an "anchor" whenever they notice that attention has been diverted. These meditation techniques are used to develop a perspective on thoughts and feelings so that they are recognized

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as mental events rather than as aspects of the self or as necessarily accurate reflections of reality. BISHOP'S (2002) literature review summarizes the efficacy studies conducted so far and concludes that considerable methodological problems necessitate more methodologically precise studies of MBSR's effects.

Based on MBSR, TEASDALE ET AL. (1995) developed *Mindfulness-Based Cognitive Therapy* (MBCT) for the treatment of depression. MBCT is a theoretically driven group intervention program that combines the attentional control training and implicit modification of affect-related schematic mental models of MBSR with aspects of Beck's cognitive therapy for depression. It is explicitly designed to foster a decentered relationship to negative thoughts ("thoughts are not facts"). Techniques to change belief in specific negative thoughts or assumptions are not included (TEASDALE, 1999).

(b) Acceptance and Commitment Therapy (ACT)

ACT is based on an analysis of language from a functional contextual perspective (HAYES & WILSON, 1994, HAYES ET AL., 2004). This "analysis suggests that it is common for humans to regard some of their own private reactions (e.g., physiological sensations, affect, cognitive evaluations, and perceptions) as aversive and to make attempts to modify or eliminate these reactions. In general, however, attempts to control such aversive private events tend to be ineffective and paradoxically result in more of the same thoughts and emotions that the individual was trying to avoid in the first place. In many instances, the individual may manage to achieve some short-term relief from these noxious thoughts, feelings, or sensations; however, this short-term relief often is associated with additional long-term difficulties" (e.g., substance abuse, physically avoiding people, places, or things that evoke the emotion; CALLAGHAN ET AL., 2004, p. 196). ACT emphasizes acceptance as an essential skill that aids in moving clients toward their specified values. The goals of ACT are "to help the client recognize the ineffectiveness of experiential avoidance and to develop a new, more effective repertoire for experiencing painful thoughts and feelings. This new repertoire is always based on the client's personal set of values and goals for therapy." (CALLAGHAN ET AL., 2004, pp. 196-197)

The acronym *FEAR* describes ACT's explanatory model for human suffering:

- *Fusion.* The descriptors of private events are cognitively fused with the person. For example, the statement, "I *am* depressed," denotes a state of being and thus fuses the person with the descriptor ("depressed"). A statement such as, "I am a person who presently has a feeling that could be described as 'depression'," would be more precise.
- *Evaluation.* Evaluation may serve to label experiential avoidance. The goal, however, is to be present in the here and now.
- *Avoidance.* Avoidance of unpleasant private events: ACT encourages their acceptance.
- *Reasons.* Individuals constantly give reasons for private and public events. Experiential avoidance may result from the confusion of reasons with causes.

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The acronym ACT summarizes the ACT approach:

- *Accept your reactions and be present!* This means that actively accepting a situation, an emotion, etc., *as it is* presents an alternative to experiential avoidance. Feeling *better* is not at the heart of the matter, but becoming better at *feeling* is.
- *Choose a valued direction!* Giving one's life a value-oriented direction that is experienced as worthwhile.
- *Take action!* Denotes engaged behavior: Choosing a valued direction is the first step, actually moving one's feet into the direction is the second.

SONNTAG (2005) provides a concise overview of ACT. Its therapeutic process consists of the following phases:

1. In the *first* phase, clients are brought into contact with the reality that previous struggles to control their inner experiences have been unsuccessful (HAYES ET AL., 2004). "Creative hopelessness" is generated, which forms the starting point for a new beginning. A variety of metaphors, detailed in HAYES ET AL. (2004), are employed to initiate an experientially oriented therapeutic process.
2. In the *second* phase, clients are helped to see that not only their previous struggles to control private events have been unsuccessful but that these struggles have actually made matters worse.
3. The *third* phase of ACT further increases acceptance.
4. The *fourth* phase of ACT focuses on the "discovery of the self." HAYES ET AL. (2004) differentiate the conceptualized self, ongoing self-awareness, and the observing self.
   - *The conceptualized self:* "We humans do not merely live in the world, we live in the world as we interpret it, construct it, view it, or understand it. […] Clients have told stories, formulated their life histories, defined their dominant attributes, compared their attributes to those of others, constructed cause and effect relations between their histories and attributes, and so on. […] The conceptualized self can create severe problems." (HAYES ET AL., 2004, p. 192f)
   - *Ongoing self-awareness:* From a behavior analytic perspective, awareness is the continuously ongoing verbal responding prompted by one's own behavior. Rather than focusing on the specific content of self-knowledge, ACT promotes flexible and functional aspects of self-knowledge (HAYES ET AL., 2004).
   - *The observing self* is the location that remains after all content has been subtracted. "For example, notice what is consistent in answers to the questions 'What happened to you yesterday?' 'What did you see?' 'What did you eat?' […] The 'I' that is referred to is not just a physical organism, it is also a locus, place, or perspective." (HAYES ET AL., 2004, p.195f).

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The juxtaposition of conceptualized and observer selves and the promotion of self as a perspective serve to undermine the fusion with the conceptualized self.

5. Values come to the fore in the *fifth* phase: Clients learn to formulate their own values and begin to orient their lives toward them.
6. Finally, the *sixth* phase of ACT involves securing a commitment from the client and implementing behavior change strategies.

There are multiple studies reporting the effectiveness of ACT with a number of populations (Callaghan et al., 2004; Hayes et al., 2006). So far, clinical psychotherapy outcome studies with palliative care patients have not been conducted. Presumably, some aspects of the intervention would have to be modified.

(c) Values

SCHWARTZ AND BILSKY'S (1987) circumplex model of human values, empirically tested with more than 40,000 participants worldwide (SCHWARTZ & BILSKY, 1990; SCHWARTZ ET AL., 2001), has not received much attention in psychotherapy. Ten motivationally distinct domains were derived from sets deemed representative of universal human requirements and validated in cross-cultural research projects (SCHWARTZ & BILSKY, 1990). Each value domain was defined in terms of its central goal (that is, the desired end state to which it is directed).

Values are cognitive representations of goals or motivations that are important to people. They can be described as emotionally and cognitively relevant principles guiding people's lives

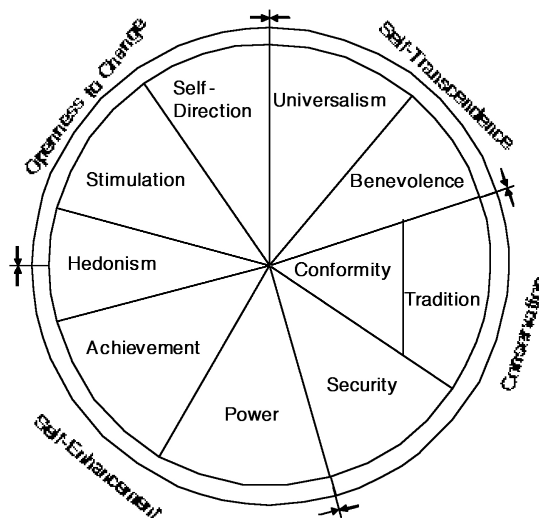

Figure 1. Theoretical model of structure of relations among 10 value constructs (Schwartz et al., 2001)

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(ROKEACH, 1973). Values are closely connected to needs. However, while needs are not evaluated as "good" or "bad," values always have a positive connotation. As a transsituational reference system, they offer orientation and influence behaviour (ROCCAS ET AL., 2002). Values are relatively stable and conceptually related to personality characteristics. However, they are different constructs: Traits refer to what people are like, values to what people consider important. There is some evidence that, while traits have stronger influence on behavior over which individuals have little cognitive control, values affect behavior under more voluntary control.

Following Schwartz's value theory, it has been demonstrated that patients with *self-transcendent* values (universalism, benevolence), who are concerned about global contexts ("macro worries"), are more likely to be satisfied in their subjective well-being than patients with "micro worries" who are concerned with *self-enhancement* values (power, achievement, hedonism; Boehnke et al., 1998). Another differentiation is between the value domains *openness to change* (self-direction, stimulation, hedonism) and *conservation* (security, conformity, tradition). Confirming Terror Management Theory, it has been shown that proselfs are more likely than prosocials to endorse self-transcendent values under mortality salience (GÄRLING, 1999, JOIREMAN & DUELL, 2005). In palliative care patients, there also is a shift towards self-transcendence (FEGG ET AL., 2005). Compared with healthy adults, palliative care patients scored significantly higher in benevolence and lower in self-enhancement values. Conservation values (security, conformity, tradition) were correlated with higher levels of individual quality of life.
Values present both resources and difficulties in psychotherapy. Reflecting on lived values or on opportunities and capacities for behavior in the service of one's values may create experiences that counter suffering and illness. However, values may become problematic (a) when they cannot be lived because of situational constraints or a lack of necessary skills, for example; and (b) when conflicts between core values and core needs arise.

(d) Meaning-in-Life

Many seriously ill patients question the meaning of their disease, the (remaining) meaning in their life and regarding their future. Questions as to how to maintain meaning in one's life or how to restore it gain in significance. For this reason, we extend the third wave therapies to include this component. The following paragraphs will outline a few positions on the topic "meaning-in-life".
Questioning the "meaning in one's life" must be distinguished from questioning the "meaning *of* life" (e.g., Leibniz' question: "Why is there something rather than nothing?"). For pragmatic reasons, psychotherapy focuses on the discovery of personal meaning *in* one's life. Questions as to the meaning of existence in general are more appropriately addressed by philosophy. However, one may assume that both kinds of meaning are required for effective coping with suffering, illness, and death (WONG & FRY, 1998).

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The construct "meaning-in-life" has only recently entered *clinical research*. MOADEL ET AL. (1999) surveyed cancer patients and assessed their most important needs: 40% of the patients needed help discovering meaning in their life. MEIER ET AL. (1998) found that 47% of the physicians who had granted at least one request for assisted suicide cited the patients' "loss of meaning in their lives" as a reason for the request. Furthermore, BRADY ET AL. (1999) showed that cancer patients who reported a high degree of meaning in their lives were able to better tolerate severe physical symptoms than patients who reported lower scores.
FRANKL'S (1976) achievement was to draw attention to the significance of existential questions for psychotherapy. His personal history as a survivor of the Nazi concentration camps led him to develop *logotherapy*, which subsequently underwent multiple extensions and modifications (LÄNGLE ET AL., 2005). Frankl defines "meaning" as the manifestation of values, which occurs via three main paths: Creativity (e.g., work, deeds, dedication to causes), experience (e.g., art, nature, humor, love, relationships, roles), and attitude (one's attitude toward suffering and existential problems). Some of Frankl's basic concepts include: "1. Meaning of life – life has meaning and never ceases to have meaning even up to the last moment of life, meaning may change in this context but it never ceases to exist. 2. Will to meaning – the desire to find meaning in human existence is a primary instinct and basic motivation for human behavior. 3. Freedom of will – we have freedom to find meaning in existence and to choose our attitude to suffering" (BREITBART, 2002, pp. 7-8).
WONG (1998b) summarized the criticisms raised against logotherapy: The main weakness of logotherapy is that its principles are stated in philosophical terms or in metaphor. This vagueness precludes scientific analysis. Another common critique of logotherapy is that it overemphasizes values and spirituality. The third criticism alleges that Frankl's writings are faithfully proclaimed by many of his disciples as if they were "the sacred scriptures". Within the logotherapy movement, there seems to be little evidence of critical self-examination and creative tension.

Contrary to Frankl's approach and to existential therapy, Maslow (1943) assumes that individuals' needs are organized hierarchically. His *hierarchy of needs* consists of five levels: physiological needs; needs for safety; needs for belonging/love; needs for esteem; and, finally, self-actualization.
The four lower levels are grouped together as "deficiency needs", while the top level is referred to as "being needs". While our deficiency needs must be met, our being needs are continually shaping our behavior. The basic concept is that the higher needs in this hierarchy only come into focus once all the needs that are lower down in the pyramid are mainly or entirely satisfied. GASIET'S (1981) approach, postulating a hierarchical organization of physiological core needs, fundamental interpersonal needs, and needs for social status and meaning, is similar. ALLPORT (1955) differentiates between deficiency and growth motives. Growth motives include long-range purposes and striving toward distance and goals.

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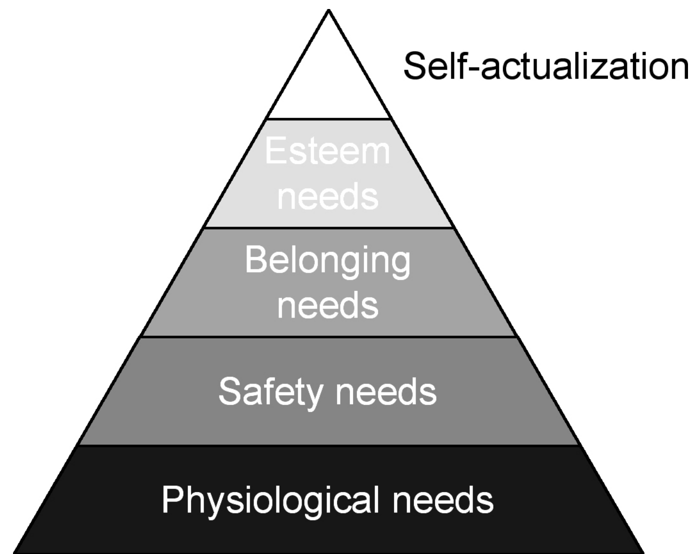

Figure 2. Maslow's (1943) Pyramid of Needs.

ANTONOVSKY'S (1997) salutogenesis focuses on what allows people to maintain or restore their health in the presence of persistent burdens and stressors. He coined the term *sense of coherence* to describe a global attitude that expresses the degree to which a generalized, lasting, and dynamic feeling of trust, composed of comprehensibility, manageability und meaningfulness, is present.

The *classical coping model* according to LAZARUS AND FOLKMAN (1984) was expanded to include a meaning component. FOLKMAN AND GREER (2000) speak of meaning-based coping, when unachievable goals are abandoned and new ones are formulated, which then seem to become worthwhile or achievable.

Giving meaning to negative events in times of crisis may constitute a form of control. It may help the person to make sense of these negative events and bolster his or her self-worth (FEGG, 2004, HILBERT, 1984, SNYDER & PULVERS, 2001, TAYLOR, 1983). Several authors (e.g., DEVOGLER & EBERSOLE, 1981; EBERSOLE & DEPAOLA, 1987; EBERSOLE & DEPAOLA, 1989; ERIKSON, 2003; TAYLOR & EBERSOLE, 1993) propose a dependence between the questions for meaning and a person's developmental level or age cohort. JANOFF-BULMAN AND YOPYK (2004) describe two different concepts of meaning: one revolving around *comprehensibility*, the other around *significance*. In the aftermath of an extreme, negative life event questions arise about the comprehensibility of the event. There is a human need for a "comprehensible, meaningful and just world" (LERNER, 1980). Positive illusions of control or influence over one's own fate (TAYLOR, 1989) may constitute physically healthy individuals' basis for mental health. On the other hand,

a meaningless world, in the sense of a random, incomprehensible world, is one that induces intense anxiety and dread. Coping processes following a diagnosis of a serious illness involve moving from a blanket perception of randomness and uncontrollability to attempts to minimize these views. Importantly, the literature also points to a potentially positive impact of traumatic life events on meaningfulness. The term "posttraumatic growth" reflects this new attention to the "benefits" of victimization (CALHOUN & TEDESCHI, 2001; TEDESCHI ET AL., 1998). Between 75 and 90% of victims gain in strength through suffering and report a greater appreciation of life, particularly in life domains such as close relationships, nature, and spirituality (Tedeschi et al., 1998). Survivors reprioritize what is important to them: They make conscious choices about how to live their newly valued lives.

Although the importance of meaning has been repeatedly emphasized, there is no agreed-upon *definition of meaning*. Even the nature and the number of the domains that may comprise or influence meaning is unclear: BAUMEISTER (1991) lists four[1]; REKER AND WONG (1988) twelve[2] sources of meaning. One has the impression that other authors do not differentiate (a) meaning-of-life from meaning-in-life, (b) comprehensibility as meaning, (c) comprehensibility as a relation among events, and (d) meaning as a consequence of a value-directed life, etc.

Meaning-in-life probably occurs on different levels. Baumeister and Vohs (2002) distinguish lower and higher levels: *Low levels* involve concrete, immediate, and specific meanings, whereas high levels invoke long time spans and broad concepts. A shift upward to a *higher level* of meaning is typically experienced as a very positive event that brings satisfaction and pleasure. But a happy life and a meaningful life do not seem to be the same thing. BAUMEISTER (1991) reviewed evidence showing that having children reduces parents' happiness and life satisfaction, but that this loss of happiness may be compensated by an increase in meaningfulness. It would be excessive to conclude that happiness and meaningfulness are opposites. Rather, meaning may be necessary but not sufficient for happiness (BAUMEISTER & VOHS, 2002).

REKER ET AL (1987) view meaning-in-life structurally as an idiographic, *three-dimensional construct* composed of cognitive, motivational, and affective components. The cognitive component consists of the individually constructed value system within which people deem themselves and their environment meaningful. Motivationally, it implies the selection and the pursuit of activities and goals, which seem worthwhile within the individual's value system. Finally, the affective component encompasses feelings of contentment and fulfillment, evoked by the

[1] 1. Need for purpose, 2. values, 3. sense of efficacy, 4. self-worth.

[2] 1. Meeting basic needs (e.g. food, shelter, safety), 2. leisure activities or hobbies, 3. creative work, 4. personal relationships (familiy or friends), 5. personal achievement (education or career), 6. personal growth (wisdom or maturity), 7. social and political activism (e.g. peace movement, antipollution campaigns), 8. altruism, 9. enduring values and ideals (truth, goodness, beauty, justice), 10. traditions and culture (heritage, ethnocultural association), 11. legacy (leaving a mark for posterity), 12. religion.

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achievement of goals and by a positive attitude toward life. The cognitive component provides a basis for the motivational and affective components as well.

Meaning-in-life can be defined as an "individually constructed, culturally based cognitive system that influences an individual's choice of activities and goals, and endows life with a sense of purpose, personal worth, and fulfillment" (WONG & FRY, 1998, p. 406-407).

It is hypothesized that authentic personal meaning involves all three elements. The absence of any one element will undermine personal meaning. Subsequently, WONG (1998a) added additional components: social (comprising love, caring, relationship) and personal categories (comprising intelligence, education).

6. Psychotherapy in Palliative Care

A small but growing literature is developing on psychotherapeutic interventions for palliative care patients. We will limit our discussion to those interventions that are based on the principles described in the preceding sections.

CHOCHINOV (2003) defines *dignity* as a multifactorial construct which incorporates physical, pychological, spiritual, and social aspects of the illness experience. A factor analysis suggested six dimensions describing aspects of the dying patients' experience (HACK ET AL., 2004): Pain, intimate dependency, hopelessness/depression, informal support network, formal support network, quality of life. In a qualitative analysis (CHOCHINOV ET AL., 2002b), three major categories emerged: Illness-related concerns, a dignity conserving repertoire, and a social dignity inventory. Loss of dignity is associated with both psychological and symptom distress, heightened dependency needs, and loss of will to live (CHOCHINOV ET AL., 2002a).

In *Dignity Psychotherapy* (CHOCHINOV, 2002), patients are offered the opportunity to speak of issues they hold to be most important, such as recounting aspects of their life they feel most proud of, things they feel are or were most meaningful, the personal history they would most want remembered; or words they might provide in the service of helping to look after their family and friends, such as hopes, wishes, or directives for those they will soon leave behind. Dignity psychotherapy sessions are taped, transcribed, edited for clarity, and quickly returned to the patient. Dignity therapy is found to increase purpose, dignity, and the will to live. It reduces depressive symptoms and is helpful also for the family (CHOCHINOV ET AL., 2005).

Meaning-Centered Group Psychotherapy (MCGP) is designed to help patients with advanced cancer to sustain or enhance a sense of meaning, peace and purpose in their lives (BREITBART, 2002; BREITBART ET AL., 2004; GREENSTEIN, 2000; GREENSTEIN & BREITBART, 2000). The eight-week MCGP program (one one-and-a half hour session per week) includes the following sessions: 1. Summary of concepts of meaning and sources of meaning. 2. Cancer and meaning. 3 and 4. Meaning derived from the historical context of life. 5. Meaning derived from attitudinal values. 6. Meaning derived from creative values and responsibility. 7. Meaning derived through experiential values. 8. Termination and feedback.

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MCGP uses a mixture of didactics, discussion, and experiential exercises that focus on particular themes related to meaning and advanced cancer. With this manualized group intervention, patients are assigned readings and homework tailored to each session's theme, which is then discussed in the following session. Participants must be willing to help create meaning, both for themselves and for the other group members. The intervention aims to help expand possible sources of meaning by teaching the philosophy of meaning on which the intervention is based; by group exercises and homework for each individual participant; and by open-ended discussion, which may include interpretive comments from group leaders (Breitbart, 2002).

The following approaches are not limited to palliative patients: In *Meaning-Centered Counseling* MCC (WONG, 1998b), key concepts of existential psychology and logotherapy are translated into cognitive processes that can be operationalized and subjected to empirical research. MCC affirms that with proper counseling, all individuals can learn to live with dignity, meaning, and purpose even when they believe their lives are not worth living because of suffering or loss of dignity. MCC is "a hybrid from an unlikely marriage between existential psychotherapy and cognitive/behavior psychology" (p. 403). Specific therapeutic goals include: (a) Help clients to gain insight about their core values, deep-seated beliefs, existential concerns, and the inner workings of their minds; (b) help clients to clarify their values and have clearer ideas of what they really want in life; (c) equip clients with the necessary skills to cope effectively with life's many demands; (d) provide social validation and establish meaningful relationships.

KEYES AND COLLEAGUES (2002) distinguish subjective and psychological wellbeing. *Subjective wellbeing* encompasses a global evaluation of life in terms of contentment and balance of positive and negative affect. *Psychological wellbeing* concerns existential life questions and comprises six dimensions: Self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (RYFF & SINGER, 1996). The *Psychological Wellbeing Scales* measures these dimensions and shows differences regarding age, gender, and cultural factors (RYFF & KEYES, 1995, RYFF & SINGER, 1996), personality (SCHMUTTE & RYFF, 1997), aging (HEIDRICH & RYFF, 1993), life changes (KLING ET AL., 1997, KWAN ET AL., 2003) and difficult life events (RYFF ET AL., 1998).

Based on this multidimensional model FAVA ET AL. (1998) developed *Wellbeing Therapy,* which aims at enhancing the patient's mental wellbeing with techniques from cognitive behavioral therapy (FAVA & RUINI, 2003). This kind of therapy is used for affective disorders, among others (FAVA ET AL., 1998), for relapse prevention in depression (FAVA ET AL., 1998), and for psychosomatic problems (FAVA, 1999).

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7. Strategic Brief Therapy and Strategic Functional Family Therapy

Strategic Brief Therapy (SULZ, 1994) is of multifaceted interest in palliative care: first, the formulation of a survival strategy aids the patient in his or her individual relationship formation; moreover, Strategic Functional Family Therapy (SULZ & HEEKERENS, 2002) provides a valuable approach for addressing the often challenging relationship issues among family members in an inpatient context.

A core concept of the Strategic Brief Therapy is the *survival strategy* (SULZ, 2001) which contains the following logic:

"Only if I (observable behavior) … and as long as I never (avoidance of emotion) … may I preserve (fulfillment of core needs) … and may I prevent (avoidance of putative consequences of emotion) …"

Aspects related to approach and avoidance connect the survival strategy to motivational schemata. Survival strategies have the following characteristics (SULZ, 1994):

(a) Unjustified generalizations (mistaking particulars for the whole)
(b) Dichotomous thinking (either/or, "and" – as a third solution – does not exist)
(c) Flawed causal reasoning (e.g., my behavior will cause my dad to leave us)
(d) Mistaking thoughts and feelings for actual events (e.g., if I feel I hate him and I have the thought to kill him, this will happen)
(e) Overestimating other people's power (e.g., he does not need me; he is far superior to me)
(f) Underestimating one's own power (e.g., I won't be able to live without him or without his positive attention).

Survival strategies are mostly implicit, unarticulated and unconscious. While such a rule may have contributed to surviving and maintaining the homeostasis at an earlier childhood developmental level, it has become dysfunctional in adulthood. Difficult situations lead to symptom development, which prevents a revision of the survival strategy based upon actual experience. Therapy aims at an explicit formulation of the survival strategy and subsequent testing of the strategy against reality, in the sense of empirical hypothesis testing (WRIGHT & BECK, 1986) via action that deliberately counters the strategy.

When working with palliative care patients, it is important to know the implicit survival strategy as it concerns the building of reciprocal relationships (GRAWE, 1992). Upon conducting a vertical behavioral analysis (CASPAR & GRAWE, 1982), the more superordinate plans of the patient are identified and his or her identity goals are met in a complementary or alternative fashion. The following table gives a summary of self-concept, worldview, core motives, behavioral patterns, and survival strategy of some clinically frequent personality types. For a more comprehensive treatment, the reader is referred to SULZ (1994) and FYDRICH (2001). The complementary relationship formation is primarily focused on the core motives that underlie the respective personality style.

Table 2. Complementary relationship building: Outline of self-concept, worldview, core motives, behavioral patterns, and survival strategies of selected personality styles. Adapted from Fydrich (2001) and Sulz (1994).

Personality Style	Self-concept (Schemata)	Image of others (Schemata)	Core motives	Behavioral patterns	Survival strategy
Borderline	Instable, fickle, autonomous and yet dependent, spontaneous, vulnerable, complicated, worthless, unlovable	Unreliable, uncaring, exploiters, focused on their own advantages. Hurtful but also supportive. Absolutely necessary. Life-saving.	Avoid emptiness and emotional pain. Seek out absolute acknowledgment and unconditional acceptance.	Search for help, make demands, seek closeness, maintain distance, impulsivity (e.g., self-injurious and parasuicidal behavior, temper tantrums).	Only if I completely engage in good and emotionally intensive relationships, and as long as I never trust these relationships but take the smallest signs of hurt as a reason for separation, may I preserve the hope to find a thoroughly good relationship one day and may I prevent being alone and bereft, internally empty.
Histrionic	Dazzling, extraordinary, enchanting, impressive	Seducible, to be impressed, admirer, potentially affirming	Looking for affirmation, showing and spontaneously expressing distinctiveness, being the center, demonstrating one's worth	Theatrical, charming, clearly demonstrating emotions, avoiding "shadows"	Only if I exaggerate my emotions and my expressions and as long as I never convey an unvarnished reality, never leave the stage and initiative to others, may I maintain sufficient attention, attraction, and thereby control others, and I may I prevent disappointment, abuse, and dependence.
Narcissistic	Extraordinary, unique, self-confident, entitled to special privileges, superior	Subordinate, servant, admirer	Getting the admirationand the special treatment to which you are entitled	Boasting, competing, manipulating, using others, being the center of attention	Only if I am always magnificent and super and manage to gain the world's affirmation and admiration, and as long as I am never second class or mediocre, may I preserve attention, respect, and the hope for love and may I prevent becoming nothing and withering while being ignored.

Table 2. Complementary relationship building: Outline of self-concept, worldview, core motives, behavioral patterns, and survival strategies of selected personality styles. Adapted from Fydrich (2001) and Sulz (1994).

Personality Style	Self-concept (Schemata)	Image of others (Schemata)	Core motives	Behavioral patterns	Survival strategy
Insecure	Vulnerable, self-critical, socially awkward, inferior, incapable	Critical, humbling, superior, competent	Hiding one's flaws and weaknesses	Reservation, avoidance of social situations, silence, self-criticism	Only if I never say anything wrong, never express my own wishes, and as long as I never deny others' demands, provoke others' displeasure, rather if I am silent, may I preserve a chance to belong and may I prevent rejection.
Dependent	Devoted, loyal, faithful, weak, insecure in decision-making, alone, helpless	Strong, caring, helping, knowledgeable, competent	Must have others available; avoiding mistakes	Tying others to oneself; showering them with praise; subordinating oneself; being silent and self-critical	Only if my thoughts, feelings, and actions correspond to the wishes of my attachment figure, and as long as I never allow incompatible needs to emerge, may I preserve the protection, the warmth, and the closeness and may I prevent avoid loss.
Compulsive	Responsible, precise, careful, dutiful, competent	Careless, incapable, unrestrained, making mistakes	Perfectionism; maintaining control; others should be perfect as well	Following the rules to a tee; controlling; evaluating; criticizing and punishing; having great expectations (toward self and others)	Only if I check the effects of my behavior with regard to meeting a standard of perfection, and as long as I am never imprecise, untidy, unclean, careless, may I preserve control over the effects of my behavior and may I prevent irreparable damage through my aggressive impulses.
Passive-aggressive	Independent, autonomous, vulnerable, critical	Pushy, incompetent, controlling, demanding, domineering	Unwilling to surrender control; maintaining autonomy; protecting oneself from exploitation	Passive resistance; rule breaking; seeking approval; becoming unapproachable	Only if I am always internally opposing authority and as long as I am never openly aggressive, and if I only compromise as much as absolutely necessary, may I preserve my autonomy and also the opportunity for goodwill and may I prevent open conflict and rejection.

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Strategic functional family therapy (SULZ & HEEKERENS, 2002) is based on MINUCHIN'S (1981) structural approach, HALEY'S (1977) strategic view of family homeostasis, and ALEXANDER AND BARTON'S (1976) functional analysis of family patterns.
MINUCHIN (1981) categorized family structures with regard to their internal (intra-familial) and external boundaries (between family and environment) and identified four common forms of dysfunction:

1. Enmeshment (extreme closeness, diffuse boundaries between individuals),
2. Overinvolvement (as a form of excessive responsiveness and boundary transgression),
3. Rigidity (strong resistance to any form of change), and
4. Conflict avoidance (mostly by one member of the parental dyad).

The target of therapy is the restoration of clear boundaries and the hierarchy as well as the communication of effective problem-solving strategies.
While HALEY (1977) points to the stabilizing effects exerted by mental and psychosomatic symptoms on the family homeostasis, ALEXANDER AND BARTON (1976) investigate the instrumentality of the familial (i.e., problematic) behavioral patterns and focus individual therapy on discovering novel behavioral alternatives that might fulfill the same function as the dysfunctional behavior or the symptom. Similarly to the individual level, *family survival strategies* may also be formulated on the level of the family system, where they encompass the core family needs, the core family anger, the core family anxiety, and family behavioral patterns (SULZ & HEEKERENS, 2002):
"Only if the family always (behavioral patterns of use to the family) … and if the family never (avoidance of patterns harmful to the family) … the family can maintain (core family need) … and the family can avoid (avoidance of a core family threat) …."

The strategic functional family therapy focuses on the individual, on the family subsystems (e.g., parents-children, male-female, etc.), and on the family as a whole with regard to the functional and dysfunctional behavioral patterns that may appear on the intra-familial level on the one hand and in interaction with the environment on the other. Especially in an inpatient context, conflict-laden relationships are frequently experienced: Already protracted conflict situations as well as those partially exacerbated by the stress and the role strain connected with the life situation place a considerable burden on the therapeutic team. It is often helpful to understand these conflicts in the context of the family survival strategies as defined during team sessions and supervisions. Analogously to working with the survival strategy on the individual level, relationship building complementary to the survival strategy of the family may significantly reduce the problematic behavioral patterns.

In the case of *dysfunctional family communication*, i.e., ambiguous or self-contradictory messages or the avoidance of particular content or the erroneous decoding of unambiguous mes-

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sages, the promotion of open communication or specialized communication training is indicated. Often, family members assume to protect each other by disregarding or discounting the terminality of a family member's medical condition. In clinical practice, an open family conversation is almost always experienced as a relief, for the energy required for avoiding a particular situation does not have to be expended anymore. Specialized communication training may also be conducted to improve communication: This training consists of psychoeducational elements with concrete instructions and practical exercises (SCHULZ & VON THUN, 2001).

If a *disruption in the family homeostasis* has occurred, e.g., because a family member fell ill, the following therapeutic strategy is recommended: (a) after having analyzed the homeostasis of all individuals, subsystems, and family systems, the individual as well as the family survival strategies are formulated. (b) Through role-play or other scenic presentation, each family member is able to experience the effects of his or her effort to maintain the homeostasis on other members of the family. Special attention is given to the consequences of the changed role constellation due to a family member's illness. (c) The other's response attempting to restore or maintain his or her homeostasis may further displace the family homeostasis from equilibrium. (d) For this reason, alternatives for generating a new homeostasis are worked out. (e) These solutions are presented and jointly discussed. (f) Repeated role-plays or scenic presentations test the effects of the novel homeostatic effort. (g) Over time, the jointly achieved result is examined. Subsequent sessions work on further improvement.

8. Theoretical Foundation: A "hot-cool"-Perspective

SULZ (1994) views the *homeostatic effort* as the central principle governing humans. He differentiates a voluntary from an autonomous mentality: The voluntary mind is our conscious sensing, perceiving, feeling, thinking, and behaving. It is governed by the autonomous mind, which treats our conscious mental apparatus "as a puppeteer would treat a marionette" (SULZ, 2001). Analogous terms are experiential and rational systems (EPSTEIN, 1993) or implicit and explicit systems (GRAWE, 1998). Homeostasis is achieved through self-regulation, i.e., through organization without external directed control. This occurs through self-reinforcement (see automatic reinforcement, HAYES ET AL., 2004). Moment-to-moment positive (reinforcing) and negative (weakening) feedback processes generate a dynamic equilibrium. Concurrently, new order parameters emerge that in turn generate stable equilibrium states (SULZ, 2003).
METCALFE & JACOBS (1996) proposed a two-system framework for understanding the process of self-control or "willpower" in the delay of gratification paradigm (MISCHEL & EBESEN, 1970): an emotional, hot system and a cognitive, cool system. The amygdala-based emotional, *hot system* is largely under "stimulus control", characterized by direct rapid automatic triggering, conditioned responding, inflexibility, stereotyping, and affective primacy. In contrast, the hippocampus-based cognitive *cool system* is the locus of cognitive mediational processes, gener-

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ating thoughtful reflective reactions. It is narrative, recording autobiographical events, complete with their spatial-temporal context, giving knowledge about sensations and emotions, thoughts, actions, and context into an ongoing narrative that is coherent, goal sensitive, and strategic. It is argued that the evolutionary adaptive value of the hot system comes from allowing quick fight-or-flight responses under threat conditions without the need for time to think (METCALFE & JACOBS, 1996). Such an emergency system can become maladaptive, however, if activated indiscriminately in situations that require patience and reflective, strategic behavior.
Normally, encoding in the two systems is thought to operate in parallel, with the cool system encoding the contextual panorama and the hot system contributing a "highlighting" of the specifically fear-provoking (or emotional) aspects of the experience. Although at relatively low levels of stress, the two systems work together, hot-system processing begins to dominate the cool system as stress levels and negative arousal increase. The hot system and the cool system seem to respond differently to increasing stress. "The cool system shows a non-monotonic response to increasing stress, much like the classic Yerkes-Dodson-Law. At low levels of stress, mineralocorticoid receptors in the hippocampus produce an increase in responsivity, but at higher levels of stress the successive occupation of glucocorticoid receptors, in addition to the mineralocorticoid receptors, causes the hippocampus to become less responsive, and eventually, at extremely high levels, dysfunctional." (METCALFE & JACOBS, 1996 , p. 2). Exposure to chronic stress has been shown to be correlated with volume decreases in the hippocampus (SAPOLSKY, 1996). In contrast, the hot system shows a simple increase in responsivity to increasing stress (MCGAUGH, 1989).

The differential reactivity of these two systems in the presence of stress explains the necessity to activate problems within therapy, one of the change processes according to Grawe (1998): for only at a moderate arousal level is the cool-system sufficiently activated to develop novel problem-solving strategies or to allow a recoding of distressing material (e.g., in trauma therapy). A purely rational disputation in a completely relaxed state, in contrast, does not lead to any change. Clinical experience raises the question whether increasing stress actually prompts a completely linear increase in the activity of the hot-system, as postulated. Exposure with response prevention demonstrates a different experience: After having spent sufficient time in the stress or fear-producing situation, habituation occurs, i.e., the arousal level decreases. It would be helpful to empirically test Metcalfe & Jacobs' (1996) system in this regard.

"Thus, effective self-regulation hinges on being able to access cooling mechanisms to attenuate negative arousal and suppress hot system activation when needed" (MISCHEL & AYDUK, 2002, p. 115). For this reason, especially the frequently extremely stressful situations of palliative care patients require a sufficiently large arsenal of "*cooling strategies*": Among those are – as described above – directed attention techniques (RODRIGUEZ ET AL., 1989, LEVY ET AL., 2001), mindfulness, values work, meaning-in-life, and spirituality. The hot system comprises

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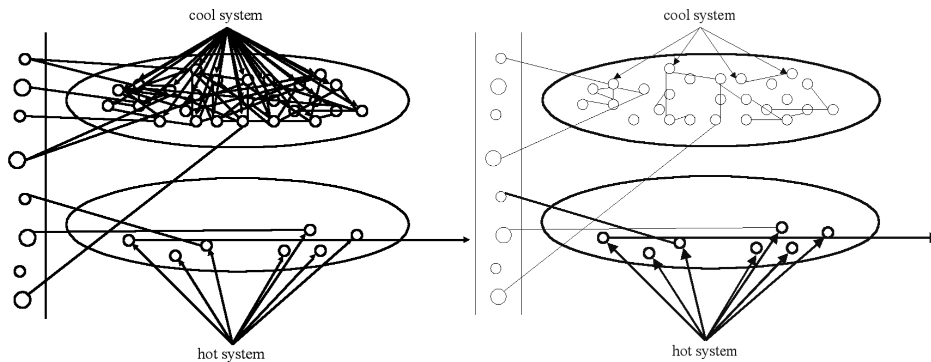

Figure 3: The cool and the hot systems during low and extreme stress (cf. Metcalfe & Mischel, 1999, p. 15).
The left panel shows the hot/cool systems under low levels of stress. The right panel shows the effects of extreme stress as seen with many palliative care patients: The hot system is hyperresponsive, whereas the cool system is becoming dysfunctional. Both systems show so-called "hot spots" (i.e., fragments of feeling unconnected to other hot spots) and cool representations (differentially intercorrelated).

survival strategies (SULZ, 1994) and motivational schemata (GRAWE, 1998). The findings of AYDUK ET AL. (2002) support the adaptive value of activating a cooling strategy under hot, arousing conditions that otherwise elicit automatic, hot-system responses.

In summary, many of the described techniques and interventions of "third-wave" therapies (e.g., mindfulness, acceptances, values work) as well as meaning-in-life, spirituality, and survival strategies can be categorized into the "hot-cool" perspective. Cooling strategies help palliative care patients to compensate for the hyperactivity of the hot system. In general, there is a considerable need for the development of psychotherapeutic interventions specialized for palliative care patients. Most of the treatment programs described in the preceding paragraphs are still in development, and the evidence for their use is too sparse to recommend any of these programs for daily clinical practice. Interventions for family members are also needed, for the impending death of their family member or partner may thrust them into a critical life situation.

9. Case Vignette

A 53-year-old patient approached me some time ago and said, "I need new ideas and strategies, so bad news won't affect me anymore." She had been diagnosed with a malignant lymphoma a few months ago and, according to the doctors, had only a few months to live. She said she would like to process the terminality of her illness and develop perspectives that

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allowed her to meaningfully live out her remaining time. For quite some time she had felt some pressure on her heart, but the results from a previous medical examination had been unremarkable.
During assessment of the patient's history, it was noteworthy that the patient always considered herself too small with regard to her physical size of 156 cm. She did not go to college ("That's not necessary for women"), unlike her brother who became an historian and whom she "always looked up to and admired." Her mother was emotionally withdrawn. The patient reported having had a positive and friendly relationship with her father.
Christine, as I choose to call this patient, showed the following *survival strategy*: "Only if I am consistently friendly, lively, in motion, and if I never show my anger unmasked or am at rest, then I can maintain sufficient attention and interest and can avoid loneliness and disappointment."
There were no known physiological or physical preexisting conditions. The functional pressure on Christine's heart had occurred previously, several years ago when her daughter entered a relationship with a man who abused alcohol and had lost his job in the course of his substance use disorder: Christine had feared that her daughter could "socially drift" or get pregnant by the man. As the relationship fell apart, Christine's problem also remitted.
During her *mental health assessment*, Christine reported discomfort and distressing thoughts of death and dying, feelings of loneliness and strong feelings of tension and arousal. In personal interactions, she was very friendly and attentive. *Diagnostically*, an adjustment disorder (F43.2) was warranted; the criteria for a somatization disorder were not met.
The patient identified as her current *resources*: her relationship with her husband, with whom she had had a very long loving relationship; generally her family, which included a son and his family in addition to the now adult daughter; the family home, where she felt safe; her creativity (pottery and painting) as well as her engagement in the Catholic Church.
A *SMiLE* was administered and repeated at three different points in time (in two-month intervals). The family domain (including the children in addition to the husband) was the most important area and even had increased by the time of the fourth assessment. Physically defined power (e.g., bicycling, gardening, etc.) was named only during the first two assessments and was then replaced by mental power (e.g., inner balance, gaining strength from religion). Employment was important only at the first assessment point, then leisure activities became increasingly importance. Health was only mentioned during the first three visits. Finally, cultural activity constituted an additional domain (especially reading and listening to music). Across visits, creativity (pottery and painting) constituted a consistently important domain for meaning in life.
This simple example illustrates that three of the initially named domains were replaced in the course of the repeated assessments (employment, health, and power). Domains that required activity and effort lost their importance as the tumor progressed. The importance of family clearly increased. If – as is the practice in numerous questionnaires – only the physical function had been assessed across time, one would conclude that the patient's quality of life had continually decreased as her illness progressed. However, a consideration of the patient's con-

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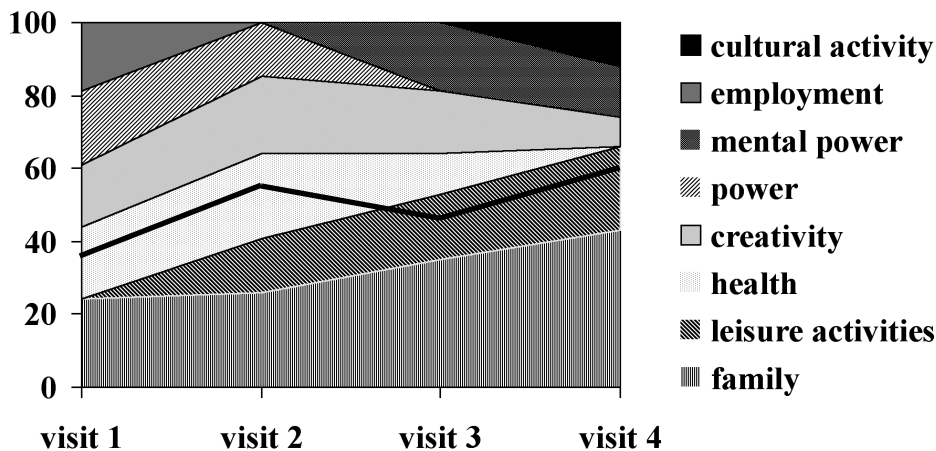

Figure 4. The patient's individual meaning in life as therapy progressed.
The diagram depicts the relative importance of five domains relevant to the patient's individual meaning in life, which sum to 100%. Furthermore, the global index of individual meaning in life is presented. The figure does not indicate the patient's contentment in any of these domains.

tentment with each domain even indicates a slight increase in the patient's overall meaning in life in the course of therapy (as shown by the thick line in Figure 4).

Similarly, the patient's *values* were formulated by using the exercise "What do you want your life to stand for" described in HAYES ET AL. (2004). Christine considered the question, "Who am I and who do I want to be", and how she wanted her family members to remember her: What she wished her husband to think of her after death, and what she wanted her children, relatives, and friends to remember about her. The "Schwartz Value Survey" was also completed. The following image emerged on her values disk (Figure 5).

Self-direction, as independence, autonomy, and personal control, was predominant, followed by universalism and benevolence. The survival strategy had already indicated Christine's striving for autonomy and her heightened activity level. This also related to her high level of creativity. *Benevolence* was also strongly pronounced and had been expressed for years with Christine's social engagement with diverse charities. In addition to other people's wellbeing, she was especially concerned with the wellbeing of the family members closest to her, for whom she greatly cared. Finally, *universalism* also showed a special emphasis: Christine's engagement in "fair trade" also encompassed an interest in equality and understanding of minority populations. Additionally, she worried about ecological nutrition and a careful treatment of nature.

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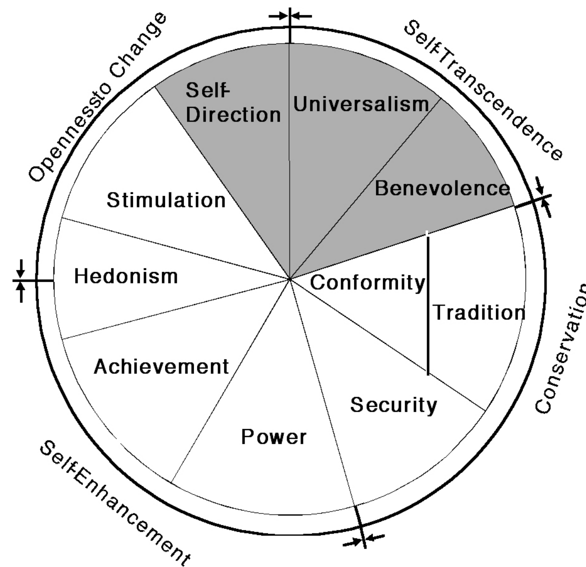

Figure 5. The patient's value domains

The strongly pronounced *self-transcendence* of the patient is demonstrated by many seriously ill patients close to death (FEGG ET AL., 2005) of by experimental participants during conditions of mortality salience (JOIREMAN & DUELL, 2005). However, a one-sided orientation of the value structure might become evident too: If the value disk would be thrown like a Frisbee, its flight would be extremely unsteady or it would even crash because of the displacement of its gravitational point. A stabile flight path requires a symmetric form and a balanced, even distribution of mass (cf. Hauke in this issue). Therefore, the therapeutic work determined which values could be found in the neglected domains of "self-enhancement" and "conservation" and could be strengthened.

It became evident that the patient neglected herself through her lively, consistently active behavior pattern. After empirical tests of the previously formulated and defined survival strategy had weakened the old patterns step-by-step, Christine was able to permit herself the domain "hedonism": Enjoying, pampering herself, and being pampered by others. Here, the "little school of taking pleasure" was combined with other exercises from "Euthymic Therapy" (LUTZ, 2000). Another domain that gained in importance was "safety". This domain is particularly important for seriously ill patients, for they often experience an extreme loss of control due to their illness. For the patient, religion and the unconditional support of her family provided the sources of security and stability.

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One further aspect of the patient's survival strategy was addressed in therapy: Her avoidance of anger and rage. Role-plays as well as repeated empirical hypothesis testing taught Christine to contact her avoided feelings and to express them appropriately, e.g., to her partner but also to her doctors. She began to ask for more emotionality from her husband: She reported feeling livelier and rediscovering her "sassy" side.

Immediately at the start of therapy, *mindfulness training* was initiated: Christine began to sit mindfully for ten minutes three times per day. She was instructed to focus on her breath and to observe her thoughts, feelings, physical reactions, memories, and internal images during this time. This practice was supported by audio-CDs. Moreover, Christine took regular lessons with a yoga teacher.
In a behavioral therapeutic context, it was rather unusual that the patient reported several *dreams*, which were discussed with her. In my opinion, one of these dreams is related to the patient's progression in mindfulness practice and demonstrates the increasing activity of the observing self:

Masses of snow fall
From a window I observe gigantic masses of snow that crash into unknown depths. The snow forms silent clouds, almost similar to the smoke columns of Aetna erupting at this time, only in the opposite direction. Then I turn to a window in a right angle to the left and see a huge roof avalanche plunging. I do not feel any fear in the presence of these events, but I have the feeling that I have been walking around in different rooms for a while. It is not cold, and I have food.

When anxiety emerged, the following thought helped her to manage her anxiety: "I view my illness as an adventure. My life is my adventure." She actively processed death and dying: She read the "Tibetan Book of Living and Dying", while she also began to consciously enjoy her last summer together with her husband and experienced phases of intense vitality: "I awoke this morning with an urgent thought: I want to live, live, LIVE, LIVE, live, live, LIVE LIVE LIVELIVELIVELIVELIVE …………!!!!!!!!!!!!!!!!!! The wish to let go with dignity is still present, still is there, but it is far away " (one of the patient's emails to the therapist).
When the fear of death grew stronger, she practiced *breathing techniques* that she learned in prenatal classes: She tried not to counter the fear, to breathe into it and not to engage in resistance. She commented this practice as follows: "I attempt to become a willow bending in the wind and not the pine that breaks."
Music became more important to her as well: "Since I peacefully have listened to Beethoven's piano sonata 'The Hunt', I tend to compare my mood to it. Although I still had a chemo day ahead of me, I was touched by the light and joyful flowing of the melody and I related it to all

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levels of my inner life. That is, I feel quite well and cheerful … and I find my path acceptable, even if it is a bit crazy."

Christine learned to pay more attention to self-care and to *reduce excessive responsibility*: For example, her sister-in-law took over caring for Christine's demented mother. Christine took more frequent breaks, which led to a clear reduction of her somatoform heart problems.

In addition to being able to express anger and to reduce her responsibilities, Christine deliberately implemented breaks for serenity and recovery. The value work produced increases in her ability to enjoy/hedonism (concerning her partnership as well as her experience of nature) and in security through her family's support and her spirituality. She developed several anxiety management strategies, did not avoid fear, and integrated mindfulness training into her everyday life.

When the disease progressed and Christine became physically weaker, the continuity of the psychotherapeutic work was maintained by conducting home visits. Christine passed away peacefully in the presence of her family.

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