02:09 newsletter

IFP international federation for psychotherapy

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EDITORIAL

Dear colleagues,

quite a lot of activity has been done during this summer preparing our next World Congress in Lucerne, Switzerland. Read more about it in the president's message and be captured by the enthusiasm which stands behind of its organisation. We do hope that this leads to an active participation of our members, so that it becomes again a platform of exchange between our organisations.

As usual we bring some papers of interest to our readers. First is an obituary of Lester Luborsky, who died at the end of October. Crits-Cristoph from the University of Pennsylvania, where Lester Luborsky worked until his retirement, gave us this insightful acknowledgement of Lester.
Mechthild Neises gives us again the chance to read about her work and rich experience in the psychosomatic treatment of women with breast cancer and their specific needs.
Since my period as vice president of IFP comes to an end with the next Newsletter I wanted to give a good-bye note with a paper of mine. The description of the "Existential Fundamental Motivations" brings an important part of my personal contribution for a phenomenological psychotherapy.
Finally Prof. Peseschkian gives a glimpse in his reflections about the importance of the cultural background in psychotherapy, focused upon the influence of reading.

In our last board meeting we discussed the importance of indicating the IFP-membership in the publication organs of all our members. We therefore attach to the e-mail the IFP logo for your convenience to make free and frequent use of it in your journals, congress announcements, flyers and any other material of publication. This is of value for both sides – for your society and members to be aware of forming a part of this (let me say so:) prestigious worldwide society, as for IFP itself to gain more presence and to be better known.

Again I want to invite you to submit papers or any information of interest for our members to this journal. Our next edition is planned for May 2010.

Best wishes and greetings for the season from Vienna and Zurich

Alfried Längle

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President's Message

Dear friends and colleagues

Lester Luborsky has passed away. Born in 1920, he was one of the great, leading figures in the field of academic psychotherapy for half a century. Those among us who did not have a chance to get to know him in person will remember him not only as the author of the highly cited review of comparative studies of psychotherapies in which he applied the Dodo bird verdict „Everyone has won and all must have prizes“ to the effectiveness of various psychotherapies. Lester Luborsky also developed the concept of the „Core Conflictual Relationship Theme“ (CCRT), and made countless other valuable contributions to our field. An obituary will appear in the forthcoming IFP Newsletter which will be downloadable fromt he IFP Website by end of November, 2009.

The upcoming **20th IFP World Congress of Psychotherapy** in Lucerne, Switzerland, 16.-19.6.2010 is certainly the major focus of our current activities. Both the IFP Board and the scientific program committee are getting increasingly excited about what promises to become a truly memorable conference! Just to give you an idea of the program, there will be a total of six plenary lectures:

- „Culture and psychotherapy: Clinical, theoretical, and philosophical explorations from a worldwide perspective“, by Wen-Shing Tseng, Hawaii, President of the World Association of Cultural Psychiatry
- „Hearing God: an anthropologist looks at American evangelicals“, by anthropologist Tanya Luhrmann, Stanford, USA
- „Psychotherapy: a perspective from Africa“, by Merle Friedman, Johannesburg, South Africa
- „The neurobiology of psychotherapy“, by Lutz Jäncke, Zurich, Switzerland
- „Can attachment theory help us understand better what we're doing as psychotherapists?“, by Jeremy Holmes, Exeter, UK
- „Japanese culture and its influence on children and their family“, by Nana Hosogane, Tokyo, Japan

In addition, the program will feature three debates:

- "The management of recurrent depression: is drug treatment necessary?", chaired by Jules Angst, Zurich, Switzerland, with Giovanni Fava (Italy) and Hans-Jürgen Möller (Germany)
- "Cultural sensitivity - an eastern and a western perspective?", chaired by Bernhard Strauss, Jena, Germany, with Marvin Goldfried (USA) and Sudhir Kakar (India)
- "The development of the psychotherapeutic professions worldwide", chaired by Norman Sartorius, Geneva, Switzerland, with Gerhard Grobler (South Africa), Philippe Grosbois (France), Fritz Hohagen (Germany), Douglas Kong (Singapore), and Alfred Pritz (Austria)

The Congress website, including the online abstract submission and registration system, is operational as of now, informing you on the progress of our planning: please visit the Congress website at www.ifp-fmpp2010.com, and submit your abstracts! Please also note that the deadline for „Early Bird“ registration at a reduced rate is February 28th, 2010.

Our World Congress will be organized by the Foederatio Medicorum Psychiatricorum et Psychotherapeuticorum FMPP (http://www.psychiatrie.ch), which is an umbrella organisation that unites the Swiss Societies for Psychiatry and Psychotherapy, both for Adults as well as for Children and Adolescents. The conference is also co-sponsored by the World Psychiatric Association WPA. The venue will be the „KKL Luzern“, the Culture and Convention Centre Lucerne (http://www.kkl-luzern.ch): This magnificent building was designed by French architect Jean Nouvel. Built between 1995 and 2000, the KKL ranks today as one of the most spectacular modern buildings in Switzerland. The KKL Luzern is centrally located in the town of Lucerne, directly on Lake Lucerne and right next to the railway station. The old town centre is only a few hundred yards from the KKL Luzern, as is Lucerne's distinctive landmark, the Chapel Bridge.

Under the guidance of Dr. Sylvia Detri Elvira, a member of the IFP Council, the Indonesian Psychiatric Association Section on Psychotherapy will hold their **3rd National Conference on Psychotherapy** in Indonesia on May 1-2, 2010. The theme of the conference will be „The healing power of understanding: its strength and its limitation“. Please feel free to contact Dr. Sylvia Detri Elvira (sylvia.d.elvira@gmail.com) for more information!

The Asian Pacific Association of Psychotherapists APAP keeps being active as well: The Philippine Psychiatric Association will host the **6th APAP conference in Manila, Philippines**, in January 2011. Dr. Alma Jimenez and Dr. Maria Imelda Batar, President of the Philippine Psychiatric Association, will be jointly instrumental in organizing this conference.

The **Secretarial Office in Zurich** is running smoothly under the watchful guidance of Cornelia Erpenbeck. She is responsible for all administrative matters concerning the IFP and may be contacted at her office should there be any queries. To further optimize the visibility of the IFP, I would like to encourage all our members to introduce a link to the IFP website (http://www.ifp.name) on your respective homepages. We would be happy to do so vice-versa: please feel free to approach Cornelia Erpenbeck in case you need a hand!

IFP-sponsored master classes, workshops and seminars: The aim of these events is threefold, namely to help disseminate novel, evidence-based psychotherapeutic approaches, to raise the international profile and recognition of the IFP, and to recruit individual IFP members, thus generating income for the IFP. In 2009, successful workshops were held on Positive Psychotherapy with Professor Nossrat Peseschkian (Germany), and on CBT for Eating Disorders with Professor Chris Fairburn (UK). Another workshop on Positive Psychotherapy with Professor Nossrat Peseschkian (Germany), will be held in Zurich on February 12-13, 2010. More IFP-sponsored master classes, workshops and seminars to follow! For further information, please visit our website at http://www.ifp.name.

Collaboration with other international societies: There is an ongoing collaboration with the European Psychiatric Association EPA: Professor Möller, EPA President, and Professor Sartorius, a member of the IFP Council, invited me to be one of the speakers in the Presidential Symposium on ethical issues in psychiatric treatment organized during the forthcoming European Congress of Psychiatry in Munich, 27 February – 2 March 2010. The Presidential Symposium has now become a tradition, regularly dealing with ethical issues related to the theme of the congress. I will be giving a talk on „Ethical problems related to the use of psychotherapy".

Finally, as always, all our members, meaning individual members of the IFP as well as individual members of associations who have membership status with the IFP, are offered the IFP's official journal, **"Psychotherapy and Psychosomatics"**, at a substantially reduced subscription rate. For details, please contact S. Karger directly at:

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Best regards

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Obituary by Crits-Christoph

Lester Luborsky

Lester Luborsky, a leading researcher on psychotherapy, died after a long illness on October 22nd, 2009. Lester Luborsky was born in 1920 and grew up in Philadelphia. His family originated from eastern Europe. After graduating from high school Lester took a job at Pennsylvania State University to pursue his passion: botany. But while at Pennsylvania State University he came across some of the works of Freud in his landlady's bookcase, and these books – together with a desire to work with people rather than plants – set in motion the course of his future career. Lester then attended college at Temple University and then proceeded to Duke University in North Carolina for his Masters and PhD degrees in psychology. After completing his Ph.D. in 1945, Lester obtained a research position in 1946 at the world-renowned Menninger Foundation. There were many influential psychoanalytic thinkers and researchers at the time at the Menninger Foundation, including David Rapaport, Karl Menninger, George Klein, Roy Schafer, Philip Holzman, Herbert Schlesinger, Howard Shevrin, Merton Gill, Otto Kernberg, Robert Holt, and Robert Wallerstein. These individuals had an enormous influence on Lester's clinical training and research ideas. In 1959, Lester was then offered, and accepted, a faculty position at the University of Pennsylvania where he stayed until his retirement in 2006. Throughout most of his years at Penn, he was not only a researcher but actively involved as a clinical psychotherapist and a teacher of psychotherapy.

Lester Luborsky contributed in a variety of ways to many aspects of current psychotherapy research, but his most notable contributions were the following:

Articulation of a Theory of Symptom Formation. A major theme in Lester's research was a focus on understanding the onset conditions for the appearance of both psychological and somatic symptoms during psychotherapy sessions. His method, which he called the 'symptom-context method,' involved the comparison of the clinical material that had preceded the appearance of symptoms to sections of a session preceding a "control" event (i.e., a randomly selected event that was not describing the appearance of symptom). This work is summarized in his book "Symptom-Context Method -- Symptoms as opportunities in psychotherapy" published in 1996.

Studies of Central Relationship Patterns. Perhaps Lester's most influential contribution later in his career was the quantitative study of relationship patterns in psychotherapy. The method Lester developed – the core conflictual relationship theme (CCRT) method – was a breakthrough in the operationalization of the clinical psychodynamic concept of transference.

Studies of the Patient-Therapist Relationship. Lester developed one of the first scales to measure the therapeutic alliance in psychotherapy. This area of research went on to become perhaps the most highly researched aspect of the process of psychotherapy.

Development of a Treatment Manual for Brief Psychodynamic Therapy. Lester published one of the first psychodynamic treatment manuals. This contribution set the stage for the evaluation of the efficacy of this form of psychotherapy.

Studies of predictors of therapeutic outcome. Many of Lester's publications dealt with attempts to predict treatment outcome from patient, therapist, or process variables. The Penn Psychotherapy Project was a large scale study conducted by Lester and colleagues designed to broadly assess the full range of potential predictors of outcome.

Studies of the Efficacy of Supportive-Expressive Psychotherapy. Lester collaborated on two studies of the efficacy of supportive-expressive psychotherapy for opiate addiction. This work led to additional studies of Lester and his colleagues looking at supportive-expressive therapy for major depressive disorder, generalized anxiety disorder, personality disorders, and cocaine dependence.

An Influential Review of the Literature on the Comparative Efficacy of Different Psychotherapies. In a widely cited paper reviewing about a hundred studies comparing different forms of psychotherapy, Lester concluded that all active treatments were equally effective. This finding convinced Lester of the importance of common factors across different psychotherapy.

In contrast to Freud, Lester was determined to show that empirical studies of psychoanalytic concepts and therapy were useful and could more rigorously validate such constructs. To the extent that he succeeded in this agenda in multiple ways, the practice of psychotherapy, and the scientific study of psychotherapy, has benefited enormously from Lester's career.

ADAPTED FROM:

LESTER LUBORSKY: A TRAILBLAZER IN EMPIRICAL RESEARCH ON PSYCHOANALYTIC THERAPY

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Mission Statement

1. The IFP is a worldwide umbrella organisation for psychotherapy. The Federation is open to professional societies, institutions and individual members.
2. The IFP aims to promote, endorse and maintain high professional and ethical standards of psychotherapy in practice, research, and training.
3. The IFP fosters a worldwide intercultural, interdisciplinary dialogue and mutual learning among psychotherapists, psychotherapy researchers, psychotherapeutic orientations, traditions, and related sciences.
4. The IFP provides a platform for the development of theories, methods and treatment approaches, and promotes the integration of psychotherapeutic thinking in clinical and non-clinical fields.

The IFP realizes its aims by means of

- World congresses (every four years)
- Regional congresses
- Supporting and co-chairing the organization of scientific congresses of their members and/or national umbrella organisations (and under certain conditions supporting them also logistically and financially)
- Supporting scientific activities in research, practice, and training, particularly activities of intercultural relevance
- Information transfer by constantly updated homepage and newsletters

Psychooncologic Aspects of Breast Cancer

Mechthild Neises

Breast Care

Review Article · Übersichtsarbeit

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Psychooncologic Aspects of Breast Cancer

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Key Words
Breast cancer · Psychooncology · Psychosocial interventions

Summary
Around one third of all patients reveal signs of stress disorder and adaptation difficulties following breast cancer or during the course of the illness, often manifested clinically as fear and depression. Supportive treatment should be made available to all patients in the form of psycho-educative group sessions introducing information and assistance to help overcome the illness. The indication for extensive treatment, e.g. psychotherapy, can be deduced from the somatopsychic disorders presented. Individual or group therapy will be offered to the patient corresponding to her diagnostics and motivation. The aim of therapy should be discussed openly with the patient, that is, an improvement in the quality of life and the possibility to overcome the situation. In general, the various intervention programmes have proved to be beneficial for patients with cancer. These include relaxation therapy and stress management as well as behavioural therapy and supportive psychotherapy. Patients have high expectations of the therapy offered and this should be taken into careful consideration by all physicians, psychologists and others responsible for administering treatment. The aim of this work is mainly to present the clinical experience gained in a breast centre.

Schlüsselwörter
Brustkrebs · Psychoonkologie · Psychosoziale Intervention

Zusammenfassung
Nach einer Brustkrebserkrankung sowie im Krankheitsverlauf zeigen sich bei einem Drittel der Patientinnen Belastungsreaktionen und Anpassungsstörungen, die sich mit dem klinischen Bild von Angst und Depressivität äußern. Eine Unterstützung im Sinne psychoedukativer Gruppenangebote zur Informationsvermittlung und Unterstützung der Krankheitsbewältigung sollte allen Patientinnen zugänglich gemacht werden. Die Indikation zu einer umfangreichen Behandlung, z.B. einer Psychotherapie, ergibt sich aus den somatopsychischen Störungen. Dabei wird die Indikation zur Einzel- oder Gruppenpsychotherapie entsprechend der individuellen Diagnostik und der Motivation der Patientin gestellt. Die Therapieziele sollten mit der Patientin auf einer realistischen Grundlage gemeinsam abgeklärt werden; diese sind eine Verbesserung der Lebensqualität und des Bewältigungsverhaltens. Insgesamt haben sich verschiedene Interventionsprogramme als nachweislich hilfreich für Tumorpatientinnen erwiesen. Dazu gehören neben Entspannungsverfahren und Stressmanagement die Verhaltenstherapie und die supportive Psychotherapie. Die Hoffnung gebende Funktion aller Behandelnden wird vonseiten der Patientin immer erwartet, und dem sollte von Ärzten, Psychologen und weiteren Behandelnden sensibel begegnet werden. Ziel dieses Beitrags ist in erster Linie die Darstellung der klinischen Erfahrung aus der Arbeit in einem Brustzentrum.

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Introduction

Over the past 20 years psychooncology has established itself as a specialist field of medicine. In Germany, this development has evolved from the field of psychosomatics as well as from medical psychology. Increasing interest towards the psychic aspects of cancer contributed to the changes brought about in medicine and influenced also the attitude of the physician towards the patient presenting with a grave and often chronic illness. Furthermore, the patients, in particular the self-help groups, have called for more involvement when drawing up a decision together with extensive measures corresponding to their psychic situation [1]. Medical treatment has become a challenging and often an overtaxing assignment. Especially the approach to a principally life-threatening illness which demands the necessity of intervening therapeutic measures, sometimes offering only a minimal chance of success, can bring about psychic instability [2]. Psychooncologic treatment has become an integrated feature in the concepts of breast centres and disease management programmes (DMPs). Despite the fact that this job is often taken up by qualified colleagues such as physicians, psychotherapists, psychologists and social workers, it must be emphasised that the diagnostics of psychic stress as well as the psychosomatic fundamental treatment remains primarily the task of the gynaecologists specialising in oncology.

Stress Experienced by Women with Breast Cancer

The diagnosis of cancer leads to intense emotional stress as well as physical changes. The life of those affected by this condition becomes a turmoil of confusion. The patient has to come to terms with the uncertainty brought about by a potentially life-threatening illness, even if the prognosis holds some hope for recovery [3]. The breasts play a significant role for a woman both in an emotional and a sexual way and present a feature of attractiveness for the woman herself as well as for others. The impairments associated with the intervening cancer treatment are brought about by surgery, radiotherapy, antihormonal therapy and/or chemotherapy. There is also the external clinical picture of the impairments; this includes loss of the breast or, more frequently, prosthesis, scarring or reconstructions. The sensitivity of the skin changes as a result of radiotherapy and the patient often suffers from loss of hair under chemotherapy. Persistent disruption of ovarian function during and following chemotherapy is another stress factor together with the loss of self-confidence, diminished participation in social activities as well as the psychic impairments regarding the future. All these factors greatly affect the close contact person or the entire family.

A psychic morbidity as a result of these stress factors has been recorded as 50% in cancer patients. Following cancer, the most frequent psychic disorders have been registered as depression and anxiety disorders (table 1). The prevalence data show marked differences according to the investigation group and depending on the setting and the diagnostic methods; these findings have been documented in detail in the literature [4, 5]. A number of reviews assessing the occurrence of co-morbid depression in cancer patients found that the incidence of depression ranged from as high as 58% to as low as 4.5% [6]. In the German-speaking countries there are to date only few investigations featuring this topic. The prevalence figures also vary in a broad range between 5% depression, 20% anxiety and 37% symptoms of distress [7]. About 10% of all patients suffer from severe depression during the first years after diagnosis [8]. Inconstant prevalence figures for meta-analyses in breast cancer patients have also been revealed. In a number of studies, the clinical symptoms have been recorded as significantly high; for example, depressive symptoms at 42% and anxiety symptoms at 30% [9]. Peak prevalence for depression, anxiety, or both was 33% in the year of diagnosis and falling to 15% after 1 year [10]. There are some groups of women who demonstrate an exceptional vulnerability to psychic disorders. These include women without a partner, younger women and women with more severe gynaecological symptoms. Those women living together with a partner presented with fewer complaints depending on the length of the relationship.

Table 1. Psychological co-morbidity following diagnosis of breast cancer stadium I and II [4]

Criteria of depression	36.6%
	9.6% major depression
	27.1% minor depression
	24.7% adjustment disorder and depressed mood
	2.3% dysthymic disorder
Criteria of anxiety disorder	10.6%
	5.9% adjustment disorder and anxious mood
	1.6% generalised anxiety disorder
	1.3% panic disorder
	1.6% post-traumatic disorder

Needs for Assistance

Only few studies have reported on the needs for psychosocial assistance by cancer patients [11, 12]. Although the desire for assistance was generally high, both on the side of the patients [13] and on those persons administering the therapy, the investigation carried out by Söllner et al. [14] showed that there was only a moderate concurrence recorded between the requirement of the patient and the estimation of the requirement by the referring physician. The oncologists acknowledged in this investigation the presence of grave psychic problems in only 11 of the 30 affected patients. The recommenda-

Table 2. Influence of clarification on the patient and her relationship to the physician

- Attention and interest of physician is of great support to patient.
- Information diminishes fear of the unknown and excessive feelings of panic.
- Clarification enables the patient to trust in the competence of the physician. The patient learns that one can talk about the illness, one can treat the illness and one can learn to cope with the illness.
- The process of learning to overcome the illness creates a counter-balance towards passivity and regression.
- The collaboration of physician and patient is brought about by clarification by the physician and cooperation of the patient.

tion of the oncologists to undertake supportive counselling did not correlate with the problems of the patients. These results underline the requirement of further training for the oncologists in order to improve their knowledge when diagnosing patients with psychosocial stress.
Even fewer data are available referring to the consent to psychosocial therapy. One German study reported that 28% consented to participate in a group programme. This featured mainly women with breast cancer. This corresponds approximately to the figures presented by the working groups of Brusis and Plass [15, 16].
Particularly low are the figures at 2–8% in a US American investigation relating to a random sample of insured patients. Consent is low, despite extensive knowledge covering the various assistance possibilities. At the same time, it can be said that consent to psychosocial assistance as regards the needs of the patients is estimated to be higher by the professionals [17, 18].

Assistance through the Various Stages of Illness

Diagnosis Report

The determination of a diagnosis and the ensuing treatment constitute the most difficult phase during the course of cancer. During this phase, the physicians are often the most important contact persons of the patients, together with other cancer patients, family and close friends. From the perspective of the patient, the physician-patient interaction presents a particularly stressful situation: with often inappropriate setting, lack of empathy, sometimes findings related over the telephone and inconsistent information [19]. In the last decade, a positive outcome for the physician-patient relationship was achieved concerning the clarification and information obligation using the catch phrases 'patient autonomy' and 'joint decisive factor'. There are a number of significant aspects associated with the disclosure of bad news, since for the patient this situation is always connected with shock and there are certain ways of helping the patient to deal with this. Firstly, it is important to make sure that the environment is suitable for an undisturbed discussion, also that enough time is given to impart the necessary information and that close contact persons are in the vicinity. The next step is to clarify for the patient her position as it stands and, according to the requirements of the patient, the extent and details of the information to be imparted. For the disclosure of the diagnosis, it is of great help to the patient if the referring physician shows some element of empathy, e.g. 'I am so sorry to have to inform you of the following diagnosis.' The emotional reaction of the patient must meet with empathy and be allowed to be freely expressed. Depending on the condition of the patient, further offers of assistance must be made. In each case, the counselling should conform to the wishes of the patient [20]. The process of clarification always greatly influences the relationship between the patient and the physician (table 2).
On disclosure of the diagnosis, it is important to divulge to the patient only the details she needs to know referring to the therapeutic possibilities. The reactions at the time of disclosing the diagnosis show a broad spectrum of shock reactions, ranging from a spontaneous expression of intense despair to a distant acknowledgement of the diagnosis revealing hardly any noticeable reaction. Independently of how the information is imparted, it will come as unexpected for many patients, resulting in shock and, for some, like a sentence of death. Since in this phase several important decisions will have to be made regarding further treatment, many women continue to function without exactly perceiving what is happening. The frequent reaction of denial may represent a safety mechanism, in particular when feelings appear to be unbearable. This may be expressed in such a way that the patient, despite detailed clarification and her knowledge of the illness, refuses to acknowledge a tumour or cancer. This denial should be respected and in no way confronted or denounced. Confrontation with the illness may be resumed once the primary treatment has been finalised and the transition to private and professional day-to-day routine has been achieved.

Postoperative Care

The transition from inpatient therapy to postoperative care and thus back into the daily routine of life is always an extremely stressful time for the cancer patient. Despite all impairments while being an inpatient, the patient feels reassured that she is in the hands of competent physicians and nurses. She is released from the burdens of day-to-day life; as one patient described it: 'She feels she is inside a bell jar.' With the return to familiar surroundings, she is now responsible for her own health and well-being. It is at this particular point in time that the cancer patient becomes fully aware of the extent of her illness and what effect this will have on her life style in the future. She feels uncertain of how her illness will progress; hence the term Damocles Syndrome. This refers to the latent stress and fear of a relapse of the illness which will accompany the patient for the rest of her life, especially prior to the post-

operative follow-ups. This fear may result in sleep disturbances and nightmares. One patient reported that she dreamt constantly of her own funeral although she had been cured for over 5 years. The fact that the patient feels she is not fully recovered despite reassurance by the physicians can lead to an ambivalent conflict between physician and patient. On the one hand, the patient may experience subjugation and wariness towards the supposedly patronising manner of the physicians; on the other hand, she may surrender completely to them. This psychic alarm reaction often leads to behavioural patterns that diminish all feelings of fear and strengthen the hope of recovery. In the positive sense, the need for information to compensate for feelings of helplessness may indeed constitute to regaining control over life once more [21]. This may result in changes in nutrition and to general well-being. During this phase, many patients express the wish to join self-help groups so that they can share their experiences. Besides, they gain a feeling of self-assurance to be able to transmit their experiences to others. Often during this phase, the patients wish for additional therapy, be it nutrition supplements or established treatment by natural remedies or alternative medicine. All these factors serve to ensure that the outcome of therapy is successful for the patient. It is important for the physician-patient relationship to discuss all these methods, and even if the physician is not in full accordance with the patient's wishes and decisions, these must not in any way be denounced or rebuked.

Postoperative follow-ups often place the patients under psychic strain: on the one hand, fear that the illness could recur and, on the other hand, hope that the follow-up is not associated with early detection but purely a routine medical check-up. In the case that recovery is confirmed, this at least offers the patient hope for the future and appeases the fear of any relapse. Seen from this angle, the follow-up must be viewed as a medical and humane pact of mutual professionalism and assistance. The cancer patient will only be able to overcome her fear once she is aware that denial of the condition will not serve to alleviate the situation. Far more helpful are distraction, projection, optimism and other, similar strategies. It is the task of the physician to accept and to respect the defensive reaction of the patient and, at the same time, to allow the patient to speak of her fears. One patient reported: 'I wish I had a physician with whom I could discuss my fears and that he would be prepared to give me an ultrasound even if he considered this unnecessary.'

Stage of Progress

In this phase, the patient must be informed of her chance of recovery, and the limitations of her life must be explained clearly. This may lead again to feelings of isolation, fear of separation or loss, and to mistrust in the treatment received so far. This phase places new demands on the physician-patient relationship. It is the responsibility of the physician to relate frankly and truthfully to the patient in order to maintain a sound basis for the physician-patient relationship. The patient may show signs of disinterest concerning certain details. This defensive mechanism should be tolerated and respected by the physician. It would, however, be counterproductive on the part of the physician to refrain from imparting these details. It could well lead to a breakdown in the relations should medical assistance be refused even if the situation does become extremely distressing and difficult. Fear and despair would result if the patient was no longer able to discuss her problems with her physician. At the stage of the formation of metastases, the patient becomes more dependent on the physician since it is imperative for her to seek support and assistance. This dependence brings about several differing expectations: on the one hand, that the physician shows an interest in the patient's condition and imparts positive information, on the other hand, the fear of receiving bad news and then withdrawal from the situation. The physician should show sympathy towards this behaviour and should be available for the patient throughout the course of the illness. During this phase, it is imperative to convey to the patient a realistic approach towards the hope of recovery.

Table 3. Spectrum of conditions of group counselling corresponding to treatment programme

- Compliance with the individual psychosocial situation of the patient
- Determining the requirement of a psychotherapeutic diagnostics/treatment
- In the case of a discrepancy in the mammography findings, the patient is assured of a second opinion
- Determining the requirement of pain therapy
- Counselling should – if possible – be carried out together with partner/family members/close contact person
- The patient should be given the possibility of writing down the important points of counselling
- The patient should be permitted at any time to peruse her documents
- Consideration of information status of patient
- Advice on the certain specifications of the individual health services, if known

Palliative Care

Assistance and moral support from the nursing and medical staff is of utmost priority for the gravely ill and dying patients. They are engaged in an area that is mostly ignored and considered as taboo in our society. An increase of publications based on the individual experiences of illness and deaths, both biographically and scientifically, has been documented and demonstrates to the society that this is a subject to be faced and not denied. A significant pioneer in this area was Kübler-Ross [22]. During this phase, it is of immense support and help for the patients to know that there are people around who are available for them and who offer a reliable source of assis-

tance. For those no longer in the position to carry out day-to-day functions, it is necessary to rely on others for assistance. It is also important to enquire after the needs of the patients since they are often no longer able to express their complaints or problems. In this phase, contact with family members is of great importance. The physician-patient relationship is always determined by the fears and wishes of both parties. Details on the progressive illness can offer an impetus regarding the current position of the patient and physician. During this phase, the relationship with the physician should be one in which the patient can be assured that she will not suffer a premature or communal death.

Table 4. Dimensions of psychotherapy for those with organ diseases [27]

- The case history of a patient with her specific experiences, that is, her inner thoughts and memories of her childhood
- The configuration of the basic outlook and values in the life history prior to illness
- The aims in life and the question as to how close one is to achieving these aims
- The current social situation of the patient regarding her professional, domestic and especially her personal life
- The discontinuation of day-to-day life as a result of illness
- The significance of the commencement and progress of the illness in connection with the patient's own life history
- Further possible theoretical concepts formed by the patient, as perceived subjectively, relating to commencement and progress of her illness
- The perspectives as perceived by the patient in her present condition pertaining to the future and whether or not they are viewed with hope or resignation

Psychosocial Intervention Possibilities

Counselling and Group Discussions

At present there are several different methods of intervention offered to the patients following cancer diagnosis, such as possibilities to seek advice in order to come to terms with the illness and also for information concerning the illness. Emotional support is also imparted in self-help groups. In the postoperative phase, psycho-educative group sessions have been established and, in addition, also individual and group psychotherapy. These different methods of intervention serve to reassure the patients and help them to overcome their fears, despair, depression and stress. Several studies have reported on brief interventions lasting a few hours, and also on long-term interventions with a duration of up to 1 year. A meta-analysis covering different investigations concerning psychosocial interventions with cancer patients came to the conclusion that positive changes could be observed in conjunction with the emotional and functional adaptability as well as with the treatment and symptoms associated with the illness. The results suggested that there is sufficient evidence to conclude that cognitive-behavioural interventions are effective in reducing and managing psychological distress in cancer patients and are accepted by these patients [23]. Since the success of psychosocial intervention lies mainly in the motivation of the patients themselves, participation in such interventions can only be recommended but not prescribed as obligatory. It is therefore of great importance to provide a low-threshold service of group therapy in which the patient can participate after inpatient treatment. Significant topics and information include questions concerning the disease, therapy and further diagnostic procedures, and also the psychic effects of the illness. In view of this point, it must be emphasised that relevant and detailed information must be given in answer to the questions that are repeatedly asked. In a more physical approach, the women were able to learn relaxation therapies. Information about rehabilitation was communicated and, additionally, the women received information about dietetic aspects and physical exercise. An investigation by Fallowfield et al. [24] revealed that the patients who did not receive adequate clarification as to the serious side effects of an oncological treatment showed more insecure and anxious tendencies and were of the opinion that their allocated therapy was ineffective due to the side effects experienced. In order to avoid the development of such insecurities, it was aimed to establish a modest choice of limited and constructed intervention programmes [25]. The contents of the discussions were based on the structured treatment programme (DMP) (table 3).
Besides the group discussions, individual counselling sessions were also established. These are supportive and are geared to suit the individual needs. The contents are focused on the frequent problems and stress situations at the start of the illness and take into account the needs of several patients according to concrete orientation guidelines and specifications. All the listed programmes cover the positive aspects of social activities, the psychic well-being, and physical functions such as fear and depression, and also the strategies to overcome the drawbacks [3]. Development of serious psychic disorders can be avoided with the help of psychosocial discussions. Focusing on the psychosocial dimension of the progress of the illness can offer emotional relief to the cancer patient. Moreover, in some cases, early introduction to an alternative form of psychotherapeutic treatment can be recommended. The patient's involvement in her treatment for cancer will thus be restored and the quality of her life greatly improved.

Individual and Group Psychotherapy

Psychotherapeutic interventions in an individual or group setting are reserved for risk patient groups. This refers especially to the psychic co-morbidity of an illness-related disorder. Around 10–30% of all cancer patients suffer from this disorder during the course of the illness. The impairments present as stress reactions and adaptation difficulties, which manifest

themselves clinically as fear and depression. Evaluation of both individual and group therapy shows that the patients generally benefit from this therapy, independently of the tumour localisation, their age and gender. The effect was also independent of the procedure, in general, expressive-supportive or cognitive-behavioural. In most of the cases, fear and depression were alleviated, and the patients were better able to cope with their illness and therefore improved their psychic well-being and social relations [3, 26]. The more specific the problems of a patient, the more likely is the success of an intervention geared to the individual situation. The constructed methods of intervention have the advantage of being more easily evaluated; however, they may not always be suited to the individual needs of the patients. It is still to be investigated in the future which patients benefit more and which patients less from the various forms of psychotherapeutic intervention offered. It is important to receive as much information as possible on those patients who decide against the intervention method of therapy.

The objectives of psychotherapy include the stabilisation of self-esteem, help in the orientation in life as well as restoration of social competence and perseverance. Psychotherapeutic measures can be referred to as crisis intervention, that is, a short-term assistance to overcome the acute stressful situation triggered off by the illness. Moreover, there are supportive therapies aimed to consistently assist the patient over a longer period of time. Psychotherapy with patients following a grave physical illness is oriented according to the dimensions listed in table 4. This refers to the so-called discontinuation of normal life experienced by the patient as a result of her illness and the way the patient views her illness from a subjective point of view, her objectives in life and how she is able to continue her life according to her objectives.

Outlook

To date there are still no routine psychooncologic services offered in many of the acute clinics. Deficits exist also in the research of the influence of such services on the quality of life and the battle to overcome the illness. At present there is, however, a broad spectrum of psycho-educative group therapy and counselling sessions, in particular in the established breast centres. It should be made possible for all patients to participate in these sessions. The identification of risk patients still presents a challenge, e.g. genetic counselling for patients following breast cancer. More specific forms of therapy should be offered to this particular group of patients since they require a longer motivation phase before they can be allocated further treatment. It should be stressed that the importance of the impartment of hope to the patients by the medical or the psychological-psychotherapeutic staff should never be underestimated.

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Existential Fundamental Motivations

Alfried Längle

The motivation of people as autonomous and responsible subjects takes place within a characteristic existential framework, which is constituted from certain prerequisites. These consist in an emotionally free (decided) stand towards the world, towards one's own life, toward one's own identity (authenticity) and towards one's own greater context in which one sees one's activities and from which one derives their sense. –
Existence can be seen as a continuous dialogue (preoccupation) with these themes which form the foundation of a fulfilled life. Hence people are always motivated to gain, improve or protect these supporting and fulfilling elements. Therefor the striving for these contents represents the fundamental existential motivations
These four existential motivations have many implications. They form in a clinical context a matrix of psychopathological disorders and provide a practical background for clinical interventions. They represent the structure model for modern Existential Analytical Psychotherapy.

1. Introduction

Some introductory remarks may be helpful at the beginning to ease the entering into this field of psychotherapeutic thinking. The existential-phenomenological approach is in my experience very unusual for those scientists and practitioners who are accostomed to work with datas, figures and statistics and who therefore look more at manuals, questionaires and empirically prooved techniques.

The greatest difficulty of this approach seems to arise for most people from its use of a *paradigm* contrary to the actual mainstream of teaching and thinking: the phenomenological approach. – What is so unusual with phenomenology[1] ? - For many people the most unusual of this paradigm lies at a first glimpse in its procedure of "verifying the datas" which does not seem as being "scientific" since it is not "objective". In fact, phenomenology tries to ensure its findings by using the subjective intelligence, feeling and sensing, which the old Greek called "nous". This is the individual capacity of understanding and for evidence and needs dialogical exchange. To come along with this it implies a trained viewing of the facts as they are and as they show themselves to be. Phenomena ("things") are "speaking to us" and they "speak themselves" (Heidegger). If we don't give way to that we are already manipulating them, trying to control or to possess them. This phenomenological attitude implies to let aside all judgements, theories and knowledge (this activity is called "epoché"). To ascertain the findings it is not tried to objectivate the results by measures – this can be done in addition but does not relate to its proper objective – but by the dialogical proof of having understood well.

In short we could say: *phenomenology results in understanding the subjective, individual, unique* – the "essence" and its specific way to be related and to appear in the world. It may be applied in our context to a person, to a situation or to a sentence, to a gesture. *Natural science* on the other hand results *in measuring the objective (as opposite to subjective), common, general, statistical* – the laws that lay behind the reality and which can be thought as binding together the single facts.

What I am going to present here are phenomenological findings and as such they are related to the subjective, to one's own experience. Moreover these findings are presented in a phenomenological way: just giving directions through which we can look to our existential reality. By the way this is in our opinion the best way for what Jeffrey Binder was concluding today in his keynote adress as being the essential for an effective psychotherapeutic work: to develop and train one's *intuition*.

Our approach being phenomenological has as a consequence the central theme of existential psychotherapy being the essence of the person: his free will. The human potential to decide represents the basic tool for a fulfilling existence. So existential psychotherapy is focussed in mobilizing and implying the person's decisiveness and is working mainly with this tool and preparing its prerequisites.

After these introductory remarks let me now give

[1] One should be aware that the term „phenomenology" is nowadays often used in not a quite correct way for dennominating pure description. This can be taken as a beginning of phenomenology but not as its essence.

you a short overview on the task of existential analytical psychotherapy and than move on to the structure of existence as a basic understanding for psychopathology and practical work. This model is usefull for all different approaches of psychotherapies and is finally that what lies behind our statistical datas and ultimately gives them their life.

2. Existential analytical approach

For Viktor Frankl (1973, 62), the founder of existential analysis (and moreover of logotherapy), the general clue to existence is laying in a specific attitude towards the world. It is the *attitude* that life is asking us questions, every day, every hour, every minute – and we are to give our answer to these questions of the situation. We are "questioned, questioned by life", questioned by the facts asking us: "What are you going to do with it? – How will you relate to them?" The essential of our life is depending on our answers to the demands and questions the single situations are bringing up.

This attitude is in fact a *phenomenological* attitude, a pure *openness* of the mind without any personal interest, pure looking for the need or essence of the situation, letting one reached or even captured by it.

Frankl's clue to meaning is a more *philosophical* approach, elaborating the appropriate attitude and subsequently providing the necessary substance or "grain" for a fulfilling existence.

Seen more from the inside, i.e. seen more from a *psychological* point of view, we can describe the clue for a fulfilling existence in finding a way of living with ***inner consent*** to what we do, to what we commit or omit.

In other words: to live with inner consent means that there is a continuous activity. It consists in a *double dialogue*: the one directed towards the *outside* with the question: What appeals me? What attracts or challenges me? Where am I needed, what do I want to do in this situation? E.g. here – is what I hear interesting for me, challenging me, talking to me in a way so that I see what I can do with it? – If this is not the case I would say I am probably not in the outer dialogue.

The other side of the dialogue runs *inwardly*. Whatever I decide to do – I cannot leave myself aside, if I want to experience my existence (and find meaning). We therefore always live with the question if we do agree with our decision. To put it more concretely, this inner agreement is a process of contacting the deepest feelings which are arising in any situation. We have to take them seriously. I am not speaking about anxiety, mood, delight or the like, they, too, have their meaning, but about the most inward movement. If these deepest and freest emotions correspond to our intentions and plans then we live with inner consent, our inwardly felt or spoken "yes". With such an agreement with what we do, we stand by ourselves and realize ourselves by fulfilling the corresponding demand of the situation, the demand of the other or ourselves.

This process can be taken as the *shortest description of Existential Analysis* and possibly of existential psychotherapy in general: to help man to find a way of living where he can give his inner consent to his own actions.

A *processual* definition of Existential Analysis describes it as aphenomenological-personal psychotherapy with the aim of enabling a person to experience his/her life *freely* at the spiritual and emotional levels, to arrive at *authentic* decisions and to come to a *responsible* way of dealing with him/herself and the world around. (Längle 1993, 1995, 1999a).

3. The four fundamental conditions for fulfilled existence

If we scrutinize phenomenologically the themes we are concerned with throughout our entire life they turn out to be an offspring of *four fundamental realities*. This was the main empirical and theoretical result of our phenomenological psychotherapeutic work of the last 20 years. As persons with a bright spirit and a need of understanding we are essentially and inevitably confronted with four facts which engender our existence: with

- the ***world*** in its factuality and potentiality
- ***life*** with its network of relationships and its feelings
- ***being oneself*** as a unique, autonomous ***person***
- the ***future*** shaped by oneself = development through one's activities

Human existence is based on these fundamental realities – they can be considered as the four ***"cornerstones of existence"*** according to the modern existential analytical theory.

They are called "existential" for one central reason: they claim our own inner position towards

them. They ask for our decision on how we want to relate to them, thus challenging our activity and our response to change and work on our reality until we can give our inner consent – a consent which we give no longer merely to what we do but also to what we live. There is, of course, always the possibility to fail, to founder and to fall into groundlessness, emotional death, loneliness and the feeling of absurdity. The tragedy pertains to human existence. But these cornerstones offer on the other hand a chance to relate to and to entrust ourselves to their structures and contents which in their depth lead to spiritual layers lying behind, underneath or above all human reality (Längle 2001).

As the structure of human existence these realities are basically involved in every motivation and can therefore also be called the **"fundamental existential motivations"** (Längle 1992, 1993, 1994a, 1997, 1998a,b,c, 1999a,b, 2002b). Any motivation implicates inner consent and agreement, besides cognition, feeling values and meaning (Längle 2002b).

As existential basics they are important in all relations where the person stands in the center: education, pastoral counselling, management trainings, prevention of diseases, coaching, organisational structures etc. – They are described in the following in form of the first person as to make them more applicable to one's own experience and life practice, such trying to come to an individual proof by the reader him/herself.

4. The *first* fundamental condition for a fulfilled existence

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

But I am here, which puts the fundamental question of existence before me: **I am - *can I* be**? Can I claim my place in this world under the conditions and with the *possibilities* I have? This demands three things: *protection, space and support*. - Do I enjoy protection, acceptance, do I feel at home somewhere? - Do I have enough *space* for being there? – Where do I find support in my life? - If this is not the case, the result will be *restlessness, insecurity and fear*. But if I *do* have these three things, I will be able to feel *trust* in the world and *confidence* in myself, maybe even *faith* in God. The sum of these experiences of trust is the fundamental trust, the trust in whatever I feel as being the last support in my life.

But, in order to be there, it is not enough to find protection, space and support – I also have to *seize* these conditions, to make a decision in their favour, to *accept* them. My *active* part in this fundamental condition of being there is to accept the positive sides and to endure the negative ones. To *accept* means to be ready to occupy the space, to rely on the support and to trust the protection; in short "to be there" and not to flee. To *endure* means the force to let be whatever is difficult, menacing or unalterable and to "tolerate" what cannot be changed. Life imposes certain conditions on me, and the world has its laws, to which I must bend myself. This idea is expressed in the word "subject" in the sense of "not independent". On the other hand, these conditions are reliable, solid and steady. To let them be, to accept them as given is only possible, if I can be at the same time. Therefore, to *accept means to let each other be*, because there is still enough space for me, and the circumstances do not menace me anymore. Man procures himself the space he needs with his ability to endure and to accept conditions. – If this is not the case, psychodynamics take over the guidance in the form of coping reactions, which are to secure life (Längle 1998a).

Each fundamental motivation has four types of *coping reactions*: the *basic reaction type* – here this would be avoidance or flight; the *paradoxical reaction type or activism* – here this would be overactivity like fighting bacteria by compulsive washing; the third type of coping reaction is a specific aggression

(Längle 1998b) – here it would be a destructive aggression such as hate; the last type of coping reaction is a *reflex of freezing*, of death imitation with paralyzation – here denial or pretending to be non-existent. If these coping reactions do not suffice fear and anxiety arise.

5. The second fundamental condition for a fulfilled existence

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

Therefore I am confronted with the *fundamental question of life*: **I am alive – do I *like* this fact?** Is it good to be there? It is not only strain and suffering that can take away the joy of life. It may as well be the shallowness of daily life and the negligence in one's life style that make life stale. In order to seize my life, to love it, I need three things: *relationship, time and closeness*. Do I have *relationships*, in which I feel closeness, for which I spend time and in which I experience community? – What do I take *time* for? Do I take time for valuable things, worthy to spend my time for? To take time for something means to give away a part of one's life while spending it with someone or something. - Can I feel close and maintain *closeness* to things, plants, animals and people? Can I admit the closeness of someone else? – If relationships, closeness and time are lacking, *longing* will arise, then *coldness* and finally *depression*. But if these three conditions are fulfilled, I experience myself as being in *harmony with the world and with myself* and I can sense the depth of life. These experiences form the *fundamental value*, the most profound *feeling for the value* of life. In each experience of value this fundamental value is touched upon, it colours the emotions and affects and represents our yardstick for anything we might feel to be of worth. To this correlation relates our theory of emotion as well as the theory of values.

Still, it is not enough to have relationships, time and closeness. My own *consent*, my active participation is asked for. I seize life, engage in it, when I *turn* to other people, to things, animals, intellectual work or to myself, when I go towards it, get close, get into touch or pull it towards me. If I turn to a loss, *grief* arises. This "to turn to" will make life vibrate within me. If life is to make me move freely, my consent to being touched is necessary.

The basic *coping reaction* on this level is *regression*. The activism here is *overprotection* or achievement, typical forms of combating evil; the typical aggression is *fury*, rage which does not lead to destruction, but wants to agitate the other person with the impulse to obtain or to improuve the relationship. *Resignation* reaction of feigned death paralyzed half-way. If these reactions cannot neutralize the problem or the loss, depression arises.

6. The third fundamental condition for a fulfilled existence

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

In the midst of this world, I discover myself unmistakably, I am with myself and I am *given to* myself. This puts before me the *fundamental question of being a person*: **I am myself – *may* I be like this?** *Do I feel* ***free*** *to be like that?* Do I have the **right** to be what I am and to behave as I do? – This is the plane of identity, of knowing oneself and of ethics. In order to succeed here, it is necessary to have experienced three things: *attention, justice and appreciation.* – By whom am I *seen*? Who considers my uniqueness and respects my *boundaries*? – Do people *justice* to me? - For what am I appreciated – for what can I appreciate myself? – If these experiences are missing, *solitude* will be the result, *hysteria* as well as a need to

hide behind the *shame*. If, on the contrary, these experiences have been made, I will find myself, find my authenticity, my relief and my self-respect. The sum of these experiences builds *one's own worth*, the profoundest worth of what identifies my own self at its core: the *self-esteem*.

In order to be able to be oneself, it is not enough to simply experience attention, justice and appreciation. I also have to say "yes to myself". This requires again my active participation: to *look* at other people, to *encounter* them and, at the same time, to *delimitate* myself and to stand by my own, but to *refuse* whatever does not correspond to myself. *Encounter and regret* are the two means by which we can live our authenticity without ending up in solitude. Encounter represents the necessary bridge to the other, brings me out of the possible isolation, makes me find his essence as well as my own "I" in the "you". Thus I create for myself the appreciation requisite for feeling entitled to be what I am.

The *coping reactions* of this motivation are: *distancing* oneself as the basic reaction, *stubborn insistence* and leading a *functional* life as form of activism. The typical aggressive reaction consists in indignation, *annoyance* – anger, reproach. The freezing types of reaction at this level are *dissociation* of the bodily integrity, dividing and splitting of emotion and cognition. If these reactions don't suffice to neutralize the hurt, histrionic symptoms and/or personality disorders arise.

7. The *fourth* fundamental condition for a fulfilled existence

If I can be there, love life and find myself therein, the conditions are fulfilled for the fourth fundamental condition of existence: the recognition of what my life is all about. It does not suffice to simply be there and to have found oneself. In a sense, we have to transcend ourselves, if we want to find fulfillment and to be fruitful. Otherwise we would live as if in a house where nobody ever visits.

Thus the transience of life puts before us *the question of meaning of our existence*: **I am there – *for what* is it good?** For this three things are needed: *a field of activity, a structural context and a value to be realized in the future.* – Is there a place where I feel *needed*, where I can be productive? – Do I see and experience myself in a *larger context* that provides structure and orientation to my life? Where I want to be integrated? – Is there anything that *should still be realized* in my life?

If this is not the case, the result will be a feeling of *emptiness, frustration, even despair* and frequently *addiction*. If, on the contrary, these conditions are met, I will be capable of *dedication and action* and, finally, of my own form of *religious belief*. The sum of these experiences adds up to the meaning of life and leads to a sense of fulfillment.

If man fails systematically to reach meaning, his *coping reactions* will be a *provisional attitude* towards life as basic reaction, together with a *"planless, day-to-day attitude* toward life" and *"collective thinking"* (Frankl 1973, XVI), idealisation and fanaticism as main forms of activism, *aggressive games* and cynicism. Fatalism (Frankl 1973, XVI), *loss of interest*, *apathy* and probably *nihilism* can be seen as forms of freezing reactions. Disorders at this level mainly lead to addictions.

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

We define meaning as "the most valuable, realistic possibility of the given situation, for which I feel I should decide myself". *Existential meaning* is therefore what is possible here and now, on the basis of facts and reality. It is reduced to what is actually possible for the single person. The object may be anything I *need*, or whatever is the *most pressing, valuable or interesting* now. To define and redefine this continually is an extremely complex task for which

we possess an inner organ of perception capable of reducing this complexity to livable proportions: our sensitivity as well as the moral conscience.

Besides this existential meaning there is an *ontological* meaning. This is the *overall meaning* in which I find myself and which does not depend on me. It is the philosophical and religious meaning, the meaning the creator of the world must have had in mind. I can perceive it in devination and in faith (cf. Längle 1994b for the differentiation between the two forms of meaning).

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Literary Concepts in Psychotherapy and Psychosomatics: Who is your favourite author?

Nossrath Peseschkian

Those who do not help others need doctors to help them.

Oriental wisdom

Abstract

The literature on family and psychotherapy would give the impression that ultimately concrete personal relationships determine the milieu for a person's upbringing. But alongside these personal relationships we are connected in a network of concepts that are associated with individual persons, of course, but go far beyond them. There are concepts of imaginary people, and these concepts branch into one's own concept system and either strengthen it or call it into question.

For this reason literature is of special importance. It is the medium by which a society gathers a considerable part of its concepts and ideologies. It thus fills a representational role: literature reflects what the reader himself thinks and feels. Literary concepts thus become an object of psychotherapy. They give clues to the cognitive structures and the conflict-laden concepts of the individual. He/she does not find himself solely in the concrete family group, the peer group, et cetera, but also, by means of his concepts, in an imaginary group that is linked by a philosophically transmitted "sense of we." Insight into this collective mythology is provided by the questions of which collective mythologies one adheres to and with which world views, philosophers, religious leaders, ideologies, writers, or scientific approaches one at least partially identifies. This question is of therapeutic significance, because the preferred concept program is not unchangeable. Rather it needs constant reaffirmation, if one leans towards experiences that support the concept and relies on other concepts that call the other ones into questions (Peseschkian 2007).

Introduction

In psychotherapeutic practice, we actually observe a conspicuous relationship between relational problems and the personality structures and a preference for individual writers. I found, for example, that a number of patients undergoing a serious identity crisis selected Nietzsche and Hermann Hesse as their favourite writers. Included in this group were patients with generation conflicts, alcoholics, schizophrenics, and people suffering from depression. These concepts accompany a person throughout his life or seem typical for the crises of growing up. Interwoven with his life story, they become characteristic features that help us sketch a "psychogram." When we establish such a connection for an individual patient or a group of people, the preference for one writer or for a particular type of literary concept is not an absolute diagnostic clue. The real purpose for isolating literary concepts is not primarily a diagnostic investigation, but an aid for better understanding.

Material and Method:

Aids for Changing One's Perspective

One way of mobilizing the patients' resources instead of constantly rehashing old, familiar problems is for the therapist to provide stories and proverbs as counter concepts.

By using stories, one can avoid the old one-way communication between therapist and patient. The therapist is no longer the one who, simply by virtue of his position, has all the answers and interpretations. Instead, there is a real exchange of concepts and counter concepts. This requires a change of perspective on the part of the therapist and the patient so that both can learn from one another. When the gap between them is breached, the transition from psychotherapy to self-help becomes possible.

Many stories, parables, allegories, and proverbs make it easier to adopt an intellectual and emotional change of perspective. They accomplish this through their image-laden language, which stimulates not just logical thought, but also fantasy, intuition, and creativity. Furthermore, they serve as models and thus enable the listener to identify with the "hero" and thereby try out new solutions in his imagination. In child rearing, self-help and "folk therapy" stories have always occupied an important place. But even in the framework of critical self-help and modern psychotherapy they can provide the individual with important stimuli (Peseschkian, 1974, 1979, 2002, 2009)

Case Study 1

A fifty-two-year-old woman experienced great anxieties when she had to be separated from her adult son. She complained that she had lost the ground under her feet: "Sometimes I'm overcome by the feeling that I've lived in vain. This happens when I think about my current situation. What have I accomplished in my life, and what do I really mean to my son? He hardly ever shows his face around here." At this point, the concept of the woman clearly emerged: "Since I don't have my son (children) around here anymore, my life is meaningless. I am worthless."

To counter this idea, I told the patient a parable:

The secret of the seed

A seed offers itself for the tree that grows from it. Seen externally, the seed is lost, but the same seed that is sacrificed is embodied in the tree, its branches, blossoms and fruits. If the continued existence of that seed had not been sacrificed for the tree, no branches, blossoms or fruits could have developed.

The patient accepted this mythology as flattery, as an honour bestowed on her for her conduct. She was the one who had sacrificed herself, renounced her own interests, and finally achieved her son's being able to lead an independent and happy life. It did the patient good that her achievement was recognized. Only after her personal accomplishment was confirmed and she could feel secure in this recognition was she finally in a position to give up, step by step, her fixation with her singular and dominant reason for living - namely her son.

This dissolution was no longer just a negative process for her, a contradiction of the maternal role. It was a step on the way to new interests and new goals.

Case Study 2

A fifty-six-year-old engineer came to my office because of a retirement process. He appeared to be very depressed. He sat stiffly in his armchair and hardly showed any facial expression as he described his problems in short, choppy sentences. He seemed to wear a wrinkled mask that reflected depression and pessimism. He was not very talkative. The little he said was simply information in catchwords: "Heart attack two years ago, difficulty with concentrating. My doctor says I should retire." Aside from these complaints and a brief summary of his life, there was not much to discover. He was, as one calls such people in psychotherapy, an unproductive patient, one who mainly uses language for silence. Since I didn't get much more through direct questions, I tried to determine how he reacted to conflict. I was particularly struck by his affective repudiation of social contact:

Patient: "When I come home, I want my peace and quiet. "
Therapist: "Do you do much with your wife and kids? "
Patient: "I can't, and I wouldn't want to either. "
Therapist: "Let's assume you'll live another twenty years. Do you want to continue living so isolated and lonely? "
Patient: "I´ve lived like this for fifty-six years, so I can do it for another twenty years. You can't do anything about your fate. You are what you are. You can't simply do an about-face. "
Therapist: "What do you do instead of that? "
Patient: "I read books. "
Therapist: "What kind, if I may ask? Who's your favourite author? "
Patient: "Schopenhauer! "
Therapist: "What do you particularly remember about him? "
Patient: "Well, there's a saying of his that means a lot to me: Fate shuffles the deck, and we play. "
Therapist: "What does this saying say to you?"
Patient: "That it is all a matter of fate and that we can´t do much about it. I´ve always been a quiet, withdrawn person, and you can't change that!"
Therapist: "I know a similar saying from the Persian poet Saadi: 'Even though everyone is fated to die, don't put your head in the mouth of the lion!' "
Patient (after a period of silence): I never heard this version before." (He again becomes silent and, deep in thought, is obviously interested).
Therapist: "Who is your favourite writer besides Schopenhauer?"
Patient: "Gottfried Benn. He wasn't successful in dealing with his fate either.... He became melancholy.... But he regained his equilibrium through his writing."
Therapist: "What is it that you like about him so much?"

Patient: "For one thing, that one experiences his sorrows. And then there's a sentence of his that means a lot to me: 'Silence is more than truth.'"
Therapist: "How has this saying affected your life?"
Patient: "I can be happy by myself, too. Why should I quarrel with my wife? Everybody should know for himself what he can do and what he should leave alone."
Therapist: "What other author comes to mind?"
Patient: "Well, there's Goethe. In his conversations with Eckermann he said, 'Regardless of what happens, life is good.' But I have trouble with this sentence. It's exactly the opposite of what I think."

I noticed that the patient spoke much more freely and openly when he wasn't the goal of the investigation, but when he could talk about his literary interests and the concepts contained in them. It was easier for him to present Schopenhauer's or Benn's ideas than to describe his own being. In the patient's statements, he outlined a number of conflicts that could have been worked through in ensuing psychotherapy. The openness that he exhibited was especially surprising in view of the background of his generally closed and withdrawn personality, his reserve, and his silence about matters concerning his inner life. At this discussion, it was not yet determined whether there would actually be psychotherapy. But the patient seemed very open: "My work is really the focal point of my life, and I don't know if it's such a good idea for me to retire already."

When he left, he asked me to write down Saadi's saying for him, "because I'd like to think about it some more." This form of self-depiction, of course, does not provide an exact description of biographical data, but does present important qualities about one's perceptions and aspects that, on the one hand, come from a definite psychic development, but, on the other hand, introduce this development (in the form of the parents' basic concepts) and intensify them (as one's own attitudinal and behavioural concepts). The literary tradition is filled with such concepts, which arose from a particular situation and now serve as a model, as an aid to understanding, and as an outline for the interpretation of analogous life situations. Perhaps this relationship is one reason why literature and art speak to us so powerfully. They reflect situations and problems that are also important for us and reveal connections that we can use for our own guidelines. Literary concepts offer an almost unending reservoir of counter concepts and concepts that can expand one's horizons. They provide alternatives to the interpretational scenarios from which conflicts originate. In this sense, we can draw on the sayings of other writers and poets or on the sayings of the same poet in order to look at a literary concept in a new light.

Result and Conclusion

It is precisely this case depiction that shows that a cultural system of relationships contains well-formulated concepts that can help a person learn to understand himself. Of course, which concepts are chosen depends on the developmental conditions in question. And part of these conditions are the family backgrounds embedded in the social processes.

Questionnaire and Self-experience

Concepts, like many other things, we have also learned our relationships to stories, fables and fairy tales. We have learned to love or reject them, or to react indifferently. There are some questions that can help us understand the sources of our attitudes toward stories:

- ➢ Who read or told stories to you (father, mother, siblings, grandparents, aunt, kindergarten teacher, and so forth)?
- ➢ Can you remember situations when concepts, wisdom and stories were told to you?
- ➢ How did you feel?
- ➢ What do you think of concepts, fairy tales and stories?
- ➢ Which wisdom, story, narrative, or fairy tale comes to your mind automatically?
- ➢ Who is your favourite author?
- ➢ Which proverbs or concepts have the greatest significance for you?

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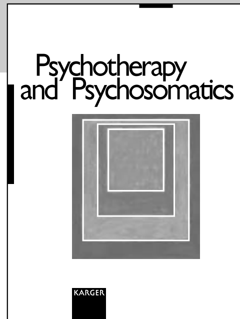

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