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Goal-Oriented Client-Centered Psychotherapy of Psychosomatic Disorders

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This chapter serves to elucidate a specific client-centered psychotherapy (CCT) approach for those persons who suffer from so-called psychosomatic disorders. This therapy, called goal-oriented client-centered (psycho)therapy (GCCT), has proved to be very successful. It enables psychotherapy to be applied to clients who in the past were considered "very difficult" or hardly capable of being treated (Sachse, 1994b, 1995a, 1995b).

To clarify what this therapy is about, three aspects are dealt with in more detail after a brief introductory section: (1) the underlying theory of disturbances; (2) the specific form of GCCT applied; and (3) illustration of therapeutic principles by way of transcripts.

DEVELOPMENT OF A DISTURBANCE THEORY

For a well-aimed formulation of therapeutic strategies and interventions it is necessary to develop a psychologically founded theory of disturbances that is capable of mediating between the disorder and the therapy. Such a disturbance theory must verify the therapeutic goals that are considered reasonable for a given disorder, must reveal the central therapeutic starting points, and must provide information about the type of therapeutic that is suitable to reach the desired goal.

When dealing with psychosomatic disorders—in our case with psychosomatic gastrointestinal tract disturbances (PGTD): ulcerative colitis, Crohn's disease (or regional ileitis), and duodenal ulcers—up to now there has been no disturbance theory that could be used to mediate between the disorder, on the one hand, and the CCT approach, on the other. For that reason, the prime intention of our current research efforts is to develop the essentials of a psychological disturbance theory as a basis for a CCT of psychosomatic disorders.

The starting points for developing the present disturbance theory stem from observations and examinations of the therapy process itself:

1. Observations and examinations have confirmed that clients diagnosed as being afflicted with psychosomatic ailments showed a very low degree of self-exploration in the therapy process (not only in CCT but in psychoanalytic therapy as well). They almost exclusively describe external facts and do not pay attention to self-aspects or even their own feelings, and a search for new associations in themselves does not take place (Atrops & Sachse, 1994; Ahrens & Mergenthaler, 1982; Tress, 1979). Such clients also show a very low degree of readiness to struggle with their internal problems (Sachse, 1994a, 1995a; Sachse & Atrops, 1991; Sachse & Rudolph, 1992a, 1992b). Psychosomatic clients often avoid any clarification—or explication—as to what extent they themselves contribute to their problems. These clients show almost no response to relevant interventions made by therapists (Sachse, 1990).
2. A second starting point was research work on the so-called alexithymia concept, which assumes that psychosomatic clients show or experience little emotion. They do not engage in introspection and seem to systematically avoid grappling with their feelings (see Ahrens, 1983, 1985).
3. Linguistic investigations of psychotherapy transcripts from psychosomatic clients show that these persons furnish a lot of redundant information. They give situational descriptions in a stereotyped manner and hardly deal with themselves at all.

These findings obtained by different methods (ratings, text analyses, questionnaires) in a variety of settings can be summarized as follows: *Clients suffering from psychosomatic disturbances systematically avoid coping and being confronted with negative self-aspects* (Sachse, 1995a).

We have systematically looked into this aspect of the condition and have asked ourselves what this finding would mean if it is understood as being not a peripheral but a central aspect of the disorder; if it is viewed not as a "symptom" of the disorder but as a central processing aspect; and if it is assumed that this not only takes place in therapies but is a consistent processing feature. If this is so, the following questions may be posed: How does this tendency to avoid dealing with self-aspects emerge? What are the consequences of such a tendency? To be able to answer these questions we evalu-

ated several psychological theories that were likely to produce relevant information to this effect. Based on these theories a psychological function model of psychosomatic disturbances was formulated, as considered in the next section.

A PSYCHOLOGICAL FUNCTION MODEL OF PSYCHOSOMATIC DISTURBANCES: THE THEORY OF THE DISTURBANCE OF SELF-REGULATION

The Avoidance of Reflection

The first essential question is the following: What causes a systematic tendency to avoid grappling with relevant problematic self-aspects to develop? A theoretical answer to this can be derived from the theory of objective self-awareness (Duval & Wicklund, 1972; Buss, 1980; Carver & Scheier, 1981, 1985a, 1985b, 1987; Frey, Wicklund, & Scheier, 1984; also see Sachse, 1995a). According to theory such a systematic avoidance may emerge if the following prerequisites are fulfilled:

- There is a distinct discrepancy between what is desired and what is actually achieved in certain domains. For example, someone may have high professional ambitions but in fact may be far from reaching these specific goals.
- A person assesses his/her competence negatively. He/she has doubts as to whether he/she is capable of eliminating the above discrepancy, whether he/she can reach his/her objectives with reasonable efforts.
- A person is constantly confronted with these targets, the discrepancy, lack of competence, etc.
- The desired goals are of vital importance to this person. This may be the case, for instance, if "identity targets" are involved (Gollwitzer, 1986, 1987a, 1987b; Gollwitzer & Wicklund, 1985), that is, targets serving to define a person's identity.

In this case the person will be unable to give up or even to seriously question his/her objectives.

For such a situation the theory of objective self-awareness predicts a constant attitude of avoidance (Carver, 1979; Carver, Blaney, & Scheier, 1979): The person will uphold his/her goals and objectives as well as the pursuance of these goals, but avoids systematically any reflection upon objectives, the desire/fact discrepancy, or insufficient competence. Such reflection would be highly aversive and is therefore circumvented. However, as the person is again and again confronted with these relevant aspects (as he/she is still attempting to pursue his/her goals!) the avoidance process must constantly be reinitiated: He/she is unable to fundamentally solve the problem, cannot really evade it, but only succeeds in "escaping" from acute in-

ternal conflicts so that finally reflection processes are systematically avoided (see Merz, 1984).

The avoidance of reflection primarily causes one's own attentiveness to be "withdrawn" from problematic or potentially problematic self-aspects. This can be accomplished quite effectively by changing over from an internal to an external perspective: The person no longer regards his/her own feelings, thoughts, actions, etc., but instead focuses on external situations, the behavior of other people, and the like. The avoidance of reflection thus leads to the *observation perspective becoming externalized.*

Assuming an internal perspective is, however, essential for reflection and representation of relevant self-aspects (Sachse, 1992a, 1992b). Therefore, a restriction of private self-awareness leads to an inadequate representation of one's motives, goals, and the like (Kuhl, 1994a, 1994b; Kuhl & Beckmann, 1994; Kuhl & Eisenbeisser, 1986). An insufficient internal perspective, furthermore, impedes the *current* accessibility of the motive system. The person avoids updating, focalizing, and representing his/her relevant goals, motives, values, etc. because any self-awareness of such personally problematic schemata would almost *force* him/her to deal with his/her imperfections.

Accessibility of the Motive System and Alienation

Thus, a direct consequence of reflection avoidance is alienation (Kuhl, 1994a; Kuhl & Beckmann, 1994), a state of estrangement from one's own motive system. The person is uncertain as to what he/she actually wants, what is important to him/her. He/she regards "borrowed" goals as his/her own motives and is no longer capable of verifying the appropriateness of goals (Kuhl, 1994a, 1994b; Kuhl & Beckmann, 1994). Affective processing is reduced, since evaluation processes as well as the activation of affective schemata are impaired due to an inadequate access to motives (Sachse, 1992a, 1992b, 1995a). These effects will then bring up the typical "alexithymic" behavioral patterns (Sachse, 1991, 1993).

Such a motivational "alienation effect" has a strong influence on decision making and verifying whether certain alternatives are compatible with one's own motive system. If there is no current access to one's own motive system and no reasonable representation, it can no longer be determined whether one's *own* intentions have initiated a given action. One's decision-making basis (i.e., the motivational foundation on which the selection of an action has been based) can thus neither be retrieved from memory (since there is no "entry" for this) nor is it possible to actually reconstruct the decision making basis ("Why did I choose X?") via one's own motive system (Kuhl, 1983a, 1983b). Even the selection of a given action may, to some extent, be governed by chance; that is, even when this selection is made, inadequate consideration is given to one's own motive system. In this case *there is no difference* at all, post hoc, between self-initiated and externally initiated actions. Action control is impeded.

Reflection Avoidance Impairs the Establishment of One's Own Identity

Insufficient access to one's own goals and insufficient representation also impair one's *personal identity*: If I do not know what I want, what is important to me, I do not know anything about myself that defines me. I also start to doubt my own competences and capabilities. These reduce my self-definition, lead to self-insecurity (who am I, what governs me?), erode my self-confidence, and in this manner impede my self-worth and self-acceptance.

A significant feature of a self-concept or self-schema (see Markus, 1977) is the organized representation of self-aspects. Experience gained "from oneself," what one does, what one is capable of doing, etc., is compressed into a schema representing one's own person, the "self." If a person resorts to a systematic avoidance of reflections, as outlined above, he/she in fact systematically does *not* deal with certain self-aspects: All self-aspects that are (or may be) problematic are included in the avoidance process, are faded out of attentiveness and thus also excluded from representation. As a result of this, an incomplete, fragmentary self-concept develops a deficient representation of one's self.

Reflection Avoidance Impairs the Sense of Self-Worth

The access to one's motive system also impacts the functioning of a *self-reinforcement system*. Self-reinforcement, the feeling of pride if something important has been accomplished, the feeling of competence, are indispensable for the development of self-worth (see Heckhausen, 1969, 1977, 1980; Meyer, 1972, 1973). However, these effects are only achievable if one has access to one's goals and motives. The feeling of pride, the experiencing of competence, the feeling of having accomplished an objective completely on one's own resources necessitates that one's own actions be adapted to one's own motive system.

Building a well-functioning self-assertion system and thus developing self-worth depend on the degree to which a person has accessibility to his/her own motive system. It thus follows that persons who have little access to their own motive system will not be able to develop a satisfactory self-reinforcement system.

Lack of Self-Worth Strengthens Avoidance

Insufficient self-worth and a low degree of self-acceptance will lead a person to view his/her competence as being inadequate and maintain it at this low level. This will contribute to upholding the system itself because a low competence assessment promotes the tendency toward reflection avoidance and the like. In this case the system shows a *significant self-devaluation loop: It stabilizes itself.*

Social Uncertainty and Anxiety

The factors hitherto described often entails uncertainty about how to act. The pursuance of one's goals even *against* the will of other people, the fighting out of social conflicts, etc. initially requires knowledge of what one wishes to do. To be able to pursue and defend one's own interests, one must first determine what one's interests are. For this purpose one must have access to one's own motive system, which also needs to be represented. Without access and representation the pursuit of goals and the development of social competence is hardly feasible. *Reflection avoidance* in conjunction with insufficient *representation* should therefore promote anxiety and uncertainty about how to act.

External Orientation

Insufficient representation of one's motives as well as lack of access to one's motive system promote a norm orientation (Snyder, 1974, 1979; Kuhl, 1983b): People who cannot rely on their own norms of behavior, who cannot by themselves determine what they want to do, must necessarily be guided by external norms, by the expectations of others, or by social standards. In this way, these people become highly *externally oriented*. They are no longer guided by their own intentions (their "organismic valuing tendency" in the sense of Rogers, 1959) but focus on and adapt themselves to the demands of others.

This external orientation is strongly backed by feelings of social uncertainty and anxiety, as mentioned above. So one's inclination increases to direct one's attention to issues of whether one "is doing things right," "does not give offense to anybody," "is liked by people," and so on. This leads to the loss of social control; since one is unable to strive for things one needs against the opposition of others for fear of losing their approbation and is unable to resolve conflicts or fight for one's goals (which ones are right?), one feels controlled and at the mercy of others. The result is the feeling of being a "pawn"—a pawn on a chessboard being pushed around by others and having almost no control of one's life.

Inability to Say No: Stresses from Social Demands That Cannot Be Curbed

Everybody is confronted at times with the need to respond to certain demands. A person must react to various situations, adapt to social settings, and the like.

A demand in itself need not be stressful. A person may decide to accept it or not. People are thus in a position to examine demands to determine whether they should be accepted and obligations taken on or whether they should be rejected.

Examining obligations can act as a method of stress regulation: If a person is already under great stress, one step toward stress regulation might certainly be to *reject* taking on further stressful commitments.

Self-obligation may, however, become even stronger due to a number of variables described in the model. If a person is highly *externally oriented*, that is, tends to abide by the expectation of others, conform to norms, etc. and attaches great significance to external recognition, he/she may find it hard to reject demands. A person anxious about being rejected for "nonconformist" behavior will often be unable to turn down a demand (see Froming & Carver, 1981; Carver & Scheier, 1981; Froming, Walker, & Lopyan, 1982; Cheek & Briggs, 1982). A high degree of external orientation impairs flexible self-regulation in the event of stresses.

Furthermore, a person's ability to access his/her own motive system is of great importance. When I am confronted with a request to perform a task, it is mandatory for me to examine this request with regard to not only whether it may involve a social commitment but also whether it is compatible with my own motive system: Is this what I really want? Does it fit with my own objectives? Should it turn out that it does not, this must be duly considered when I decide whether this self-obligation should nonetheless be assumed.

Persons subject to a high degree of reflection avoidance are generally unable in such a situation to "mediate" between and balance their own goals and external demands. They are prone to primarily abide by external demands and allow their own goals to pale into insignificance. In doing so they abandon the self-regulation processes that control their actions in conformity with their *own* goals, values, etc. and surrender to "external regulation."

Unfavorable Strategies for Stress Control: Avoidance Instead of Confrontation

A distinction can be made between functional and dysfunctional stress control strategies (cf. Obrist, 1976; Obrist et al., 1978). Functional stress control strategies are those that bring about an actual change of the stress load: A modification of the stress source proper, experiencing the pressure as a positive challenge (i.e., as something from which positive feedback or support can be obtained). Dysfunctional stress control strategies are those that impede any active coping with stress sources and stress reactions. Although they may have a stress-reducing effect for a brief period, they are entirely unsuited to change the constellation of stress factors in the long run (Florin, Gerhards, Knispel, & Koch, 1985).

If one does not closely examine the sources or one's own reactions to stresses but instead avoids such a confrontation by assuming an attitude of evasion or running away, this will have a negative effect on the perception and processing of stresses. The person neither sufficiently perceives (poten-

tial or actual) strenuous effects caused by external demands nor adequately responds to the consequent internal demands. This leads to long-lasting stress effects that cannot be reduced.

Various stress theories (Selye, 1946, 1981; Henry & Stephens, 1977; Martin & Pihl, 1985, 1986) assume that a stress condition of "system overexertion" occurs if there are long-lasting and/or highly burdensome factors of external or internal nature that are not modified (or cannot be modified) by the person and whose oppressive effects can neither be compensated nor "cushioned" by coping measures. Such a system overexertion results in various physiological processes (depending on the type of process) leading to organic symptoms. Stringent demands in conjunction with a high loss of control will massively influence the immune system and in this way assist the development of chronic inflammatory bowel diseases.

In everyday life stress is normally self-regulated, based to some extent on conscious control mechanisms and on automatic processing and action schemata. The latter will take effect in a stress-alleviating manner without conscious control or initiation of actions. For example, one may briefly stop reading, lean back, and look out of the window without even being aware of it.

It is further assumed that a form of cognitive avoidance, termed reflection avoidance, can contribute to a dysfunctional processing of stress, as it implies that discrepant aspects are *not* reflected on, or grappled with, and are *not* examined, discussed, or analyzed.

The Disturbance of Self-Regulation

As has already been pointed out, psychosomatic diseases of the gastrointestinal tract may theoretically be said, on a psychological level, to be a severe disorder of self-regulation:

- Avoidance of reflection, caused by a chronic desire–fact discrepancy, leads to effects that strengthen the avoidance tendency and prevent a thorough reflection on dysfunctional goals. The system "preserves" its disorder.
- Reflection avoidance has as a consequence self-alienation, a loss of self-worth, identity, social autonomy, and social control. The person will experience an extreme loss in quality of life.
- The inability to say no, external orientation, and social uncertainty will cause stresses to increase.
- Dysfunctional processing of stress will prevent constructive coping with stress factors.

The person is "stuck" in a very unfavorable processing system that he/she is unable to abandon; effective self-regulation is no longer possible.

A SPECIFIC CLIENT-CENTERED APPROACH: THERAPEUTIC WORK ON THE PROCESSING LEVEL

Therapy Must be Adapted to the Client: A Client-Centered Method for Dealing with "Difficult" Clients

As can be seen from the foregoing discussion of the theory of the disturbance of self-regulation, the concept of reflection avoidance plays a vital role in the "functioning" of the disturbance. This has two major consequences for the formulation of an approach to therapy:

1. If reflection avoidance is linked with such massive dysfunctional effects that cause and maintain a disturbance of self-regulation, then such avoidance constitutes a central therapeutic point of approach. Reducing or eliminating reflection avoidance should result in largely constructive effects in the processing system and restore the functionality of the self-regulation system. So there is obviously an indication for a therapy aimed at promoting self-reflection, in particular, affective, emotional, and motivational self-reflection. This is what CCT is about (see Rogers, 1942, 1951; Gendlin, 1978; Finke, 1994; Sachse, 1992a, 1996).
2. On the other hand, a high degree of reflection avoidance, insufficient access to the motive system, and the like often lead to behavioral patterns of clients in therapy that make these clients "difficult," as noted earlier.

Therefore, female and male clients suffering from psychosomatic disorders have been considered "difficult" for a long time, especially for clarification-oriented forms of psychotherapy such as psychoanalysis or client-centered psychotherapy. These clients usually have not the prerequisite characteristics considered essential for these therapy forms, that is, a capability for introspection, self-exploration, etc., and for that reason are viewed as "unsuited" for these types of therapy. Therefore, by prior selection, these clients have been deemed no longer within the "reach" of these therapies. Such an attitude was strongly advocated by supporters of the so-called alexithymia concept, who suggested that, due to alexithymic characteristics, psychosomatic clients did not meet the prerequisites for effective therapy (see Kirmeyer, 1987; Shands, 1977; Franke, 1980).

If one were to follow this view, it would obviously be better for clients not to have these characteristics and preferably adapt to the rules prescribed by the therapy because then, and only then, could they expect help.

This problem—that a therapy form is basically indicated but clients do not meet certain prerequisites for its application—can logically be resolved only by means of a strategy of *adaptive indication* (Bastine, 1981): If there is a basic indication of a therapy form for group of clients and if this therapy

form prescribes something that the clients cannot fulfill, this therapy must be modified such that it "agrees" with the starting conditions of the clients. It must meet the clients where they are situated, must make a "suitable" adjustment. (There are no "unsuited clients" but only ill-fitting forms of therapy!)

From a client-centered viewpoint the client need not adapt her-/himself to the particular therapy, but the therapist must adjust his/her approach to the client's needs. The therapist must tailor his/her efforts in such a way that the client is met where she or he is. In such a case, "alexithymic" features will no longer be seen as a interfering with the therapy or of the therapist but as *aspects of the disorder* that are of significance and must be taken into account in theory and practice. In other words, instead of being irritated by the client's behavior, one should attempt to understand it and utilize this understanding therapeutically (see Martin & Pihl, 1985, 1986).

The Central Aspect of the Therapeutic Approach: Work on the Processing Level

Such an adjustment has been provided for in GCCT (Sachse, 1995a). It has been derived from the three-level model proposed by Sachse and Maus (1991) and Sachse (1992a). According to this model three levels of perception or analysis can be distinguished with respect to the psychotherapeutic process, as follows:

- The *content level*, encompassing questions such as "What are the client's problems and difficulties?" and "What are the central topics in the therapy?"
- The *processing level*, encompassing questions such as "How does the client cope with these problems?" and "Does she/he refrain from scrutinizing her/his problems?" On the processing level questions do not aim at the contents itself but are intended to find out how the client deals with content aspects.
- The *relationship level*, encompassing questions such as "How does the client arrange his relationship with the therapist?" and "Does the client enter into a trusting relationship with the therapist?"

A therapist may view the therapy process primarily on the content level. However, he/she may also attempt to ascertain how a client deals with her/his problems or how a client sets up the relationship with the therapist (see Grawe, 1988, 1992; Grawe & Caspar, 1984; Grawe, Donati, & Bernauer (1994); Caspar, 1989, 1996). These levels may not exclusively be regarded merely as levels of perception but also as levels of action. A therapist may make interventions chiefly directed toward the content level (e.g., to promote explication processes); but he/she may also make interventions aimed at the

processing level (e.g., by making transparent how the client deals with her/his problems); the same applies to the relationship level (see Sachse, 1995a).

A therapist may lay emphasis on the processing level. In this case he/she intends to find out whether and in which way the client dysfunctionally deals with her/his problems. If the therapist finds the client uses a dysfunctional way of processing, he/she may propose more constructive processing modes, may draw the client's attention to the dysfunctional way of processing, work on the reasons for avoidance, and so on.

Such therapeutic "work on the processing level" is needed if a client effectively avoids reflection because content work in this case is not the main objective of the therapy; rather, the focus is on avoidance processes that significantly impair any effective content work. This means that if clients avoid reflection to a considerable extent, there is a therapeutic indication for a well-aimed "processing of the processing work."

What Does Therapeutic Work on the Processing Level Mean?

If a therapist focuses attention on the processing level, he/she handles information that differs from that encountered on the content level and processes this information in a different way. The therapist does not so much take notice of what the client says and what it means in regard to its contents but rather attributes importance to how the client deals with, follows, and views a given content aspect. A therapist who works on the processing level addresses other types of questions and in doing so keeps track of other issues than those that concern a therapist who is working on the content level. Working on the processing level a therapist may, for example, address questions of the following nature:

- Is the client's representation concrete, conceivable, and conclusive?
- If not, is any inconcreteness linked with certain subjects or contents aspects?
- Does the client block the processing of certain subjects?
- Does the client systematically exclude her/his own share of the problem?

The interventions a therapist makes on the processing level serve therapeutic purposes:

- The therapist wishes to impart other, more constructive processing modes to the client; the client is meant to learn how to cope with problem aspects in a different manner so as to enable problems to be clarified.
- The therapist wants the client to produce a representation of her/his dysfunctional way of processing. The client is expected to gain knowl-

edge about how to handle problems and how these strategies prevent her-/himself from clarifying and resolving her/his problems.
- The therapist wants the client to recognize the reasons why certain processing strategies should be adopted. The client is expected to understand that she/he evades certain self-aspects and should also understand why she/he evades them.

These three therapeutic goals constitute the "processing of processing work": The way in which the client processes her/his problem itself becomes the subject matter of the therapy.

A Central Aspect of Processing the Processing Work: The Therapeutic Approach to Avoidance Strategies

As explained earlier, the therapy process with psychosomatic clients is marked by the phenomenon that the clients avoid being confronted with self-aspects and refuse the reflection, clarification, and thus processing of relevant schemata, which is at least the case in the initial phase of the therapy.

In their avoidance efforts clients very frequently use a "standard form"; that is, they follow simple strategies that can be easily described. Nevertheless, therapists who are not familiar with these strategies and their functions may well have some difficulty in handling them. Therapists are often "checkmated" by these client actions and do not know how to react constructively. Therefore, some of the most frequently employed strategies and ways to take therapeutic action that straightforwardly illustrate what in fact is meant by "processing the processing work" are described in the following subsections.

Normalization

Description of the Client Action. The client names a problem. She/he may even see her/his own determinants of the problem. However, she/he speaks of this problem and/or the relevant determinants as if they were normal. The problem is said not to deviate from (mostly social) norms; it is an *average* problem.

Such an effort at normalization may in fact take place in various ways. A psychosomatic client may say, for example, "Well, isn't it the accepted thing to have gastric ulcers? In our company you are expected to." A client suffering from alcoholism says, "I don't drink more than what's normal. If you think me to be an alcoholic, 60 million people in Germany must also be." The message to the therapist is clear: "Either there is no problem at all [because it is unimportant] or it is a problem that most people have. If there is no problem, there is no need to deal with it. If it is a problem that most people have, then it is *not specifically* mine. If this is so, there no need for me to look at it. On the contrary, looking at it would mean for me to take on a responsibility others should accept. Of course, I'm not willing to do so."

In this case the client creates a pattern of argumentation either explicitly or implicitly insinuating that (1) there is no reason for her/him to clarify her/his problematic aspects, and (2) such a course of action would be an outright impertinence or intrusion. The client thus insulates her-/himself against interventions offered by the therapist. All approaches aimed at internalizing the perspective and inducing the client to process her/his internal aspects are thus defined as impermissible.

Possible Therapeutic Interventions. A strategy such as normalization serves to eliminate one's own share of the problem. If something is deemed "normal" or considered to be "general" it has nothing to do with me specifically. The message sent to the therapist thus is as follows:

I have a problem *X*.
This is a normal/widespread problem.
It must therefore be due to general factors (my company, society).
Obviously, I have nothing to do with it.
Since this is so, there is no need for me to look at it.
So let's stop talking about it.

With this chain of conclusions the client (explicitly or implicitly) has terminated therapeutic work and said goodbye. Were this accepted by the therapist, a clarifying psychotherapy would practically come to an end (checkmate in six moves). Therapists often sense such a development but allow themselves to be bluffed by the argumentation pattern since they are not familiar with it.

Basically, the therapeutic counterstrategy is quite simple. It is based on the "basic postulate of explicating psychotherapy" (Sachse, 1992b). The chain of reasoning the therapist follows in this case is straightforward:

The client has a problem *X*.
Problem *X* is that the client reacts to situation *Y* by response *Z*.
This response is not mandatory.
Even if many people react to *Y* by *Z*, there may be others who react completely differently.
If there are people who react in a different way, then *Z* is not an inevitable reaction.
But if the client's reaction is not inevitable, *Z* must have something to do with the client.
If *Z* has something to do with the client, the specific idiosyncratic internal determinants of the client have to be scrutinized.
Therefore, the focus of the therapy must be on the client.

The argumentation presented by the therapist thus produces quite a different result. While the client concludes that her/his person should not be ex-

amined any further, the therapist draws the conclusion that precisely this has to be done. The decisive difference between the two lines of argumentation is that in the second the reaction is *not* thought of as being inevitable: Even if 8 million people react similarly this need not necessarily be due to an external incentive. These people may have similar goals and schemata according to which they react in this and in no other way. Now if this involves the people, it is the people who must be examined more closely because this is where the underlying cause will be found.

For that reason, the therapist should never permit himself to be bluffed by normalization or generalization arguments. If, for example, the client says, "Gastric ulcers are normal in our company," the therapist might reply, "I believe that work in the company is quite stressful. But we still know that people react differently to stress. And what we don't know is how *you* react to stress. Until we have found that out, we are unable to help you. So we must take a closer look at it now." Here, the therapist strictly avoids any argumentation with the client. He/she accepts the client's assumption that the company causes stress but draws different conclusions from it and points out to the client that this course of action is mandatory if she/he wants to bring about a change.

The therapist should follow these rules: (1) whether the problem is normal, widespread, esoteric, or whatever does not make any difference at all; (2) what is important is how the client reacts, what the client does, what the client's processing is; (3) if the client does not make any mention of these aspects, the therapist directs the focus on them.

Downplaying

Description of the Client Action. Another way of impeding the processing of a problem and preventing explicating work is by playing it down. The client describes a problem, certain symptoms of it, and so on. The therapist then asks relevant questions (e.g., "What makes this problem so serious to you?"). It would now be appropriate for the client to start explicating work. But to avoid this she/he may underplay the issue, stating that the problem was not that acute, need not be dealt with, and in fact was not worth looking into any more. If the therapist accepts this, the problem has vanished; it is out of focus and thus has escaped processing.

If a client uses this downplaying strategy excessively, it may well develop that problems are no longer visible at all. This was the case with one of our female psychosomatic clients at the beginning of therapy. She had her bodily ailments, but beyond that all problems immediately ran through the therapist's fingers like water; allegedly, there was really nothing so important or burdensome that it needed to be discussed.

Possible Therapeutic Interventions. Downplaying is a strategy enabling the client to block the processing of a content aspect: If there is not anything really that bad happening, it is hardly worthwhile talking about it in detail.

I think a therapist should not let him-/herself be impressed by this. Especially at the beginning of therapy (when this strategy is most frequently encountered) the processing of vital problem aspects is not so decisive. Rather, it is essential for the client to learn how to work in the course of the therapy. However, this cannot be taught by the therapist giving lectures; instead the client will learn from appropriate interventions that the therapist offers with a view to elucidating important issues. Moreover, from a therapeutic angle it is not important where a client starts. *A stringently working therapist will arrive at central content aspects with clients who show cooperation no matter where the client starts in therapy.*

For that reason, the client's statement that something is "not so bad," "not so important," and the like is to be regarded as highly irrelevant. There is absolutely no reason not to start with therapeutic work at that point. In fact, the main thing at the beginning of therapy and at the beginning of every new therapeutic subject is *just to start*. Therefore, the therapist replies, "You say it's not that bad. But it's bad enough. What's so bad about it?" or "You say it's not bad, just a little bit unpleasant. I'm not quite sure what "unpleasant" means to you. Can you be a bit more specific?"

"I Don't Know"

Description of the Client Action. A particularly favored blockage of processing is at the same time a very simple one: If clients are asked to look into an aspect a bit more closely, or if they are asked what in fact they want, they often answer, "I don't know." This reaction has an absolutely paralyzing effect on inexperienced therapists as a rule. They are perplexed and do not know how to proceed.

The reply "I don't know" is mostly resorted to when therapists direct clients' perspective inwardly and request them to deal with their own relevant motives, values, or convictions with respect to certain problems. It is a standard reply to questions such as the following:

What of *X* is important to you?
What crosses your mind in this situation?
What do you want to achieve by it?
What makes this situation so hard for you?

Now it is important to understand that the reply "I don't know" may mean that either the client does not have a "good" answer or the client wants to block the process. Let us consider each of these possibilities in turn.

The Client Does Not Have a Good Answer. Sometimes clients answer a deepening (or concretizing) question by "I don't know" because they think the therapist wants a "good" and detailed answer that they do not have. In such a case the reply actually means, "I'm not so sure about it, and I

don't dare to express what I know." Here, the client does not intend to block the process but rather cannot go on as the result of unfavorable circumstances.

The Client Wants to Block the Process. However, quite a different intention may be linked with the answer "I don't know": By that reply, clients may be refusing to follow a certain aspect. Processing a specific content may be an unpleasant experience, too "hot" to handle. In this case they may say that they don't know what they feel or what has crossed their minds. In this way, they succeed in hiding information from the therapist that is needed to address further unpleasant issues. Thus the process is halted at this point, and such clients are in a position to prevent any aversive aspects from being looked into.

So an "I don't know" is often more than just an indication of the client's difficulties; it may be an *active blockage of the process.*

Possible Therapeutic Actions. How the client's "I don't know" reply ought to be responded to depends on whether the therapist is under the impression that the client wishes to continue the process but does not know how to do this or is blocked by her/his own excessively high expectations, on the one hand, or whether the therapist feels that the client wants to prevent any further processing of the subject, on the other.

In the first case, if the therapist thinks the client's "I don't know" reply is due to the client's inability to provide a "good" and elaborate answer, the therapist should put the client at ease. The therapist may say, for example, "I know you don't have a perfect answer yet. After all, these are aspects that are still indistinct and, obviously, that's why we are working on them. So I don't want a perfect answer from you. All we need now is a hint, some traces on which we can base our further work. Therefore, I would like you to stay on this point [or this situation] and take a closer look: What's crossing your mind? What do you feel?" Here, the client is expected to learn that therapy is in fact meant to deal with aspects that are *still* unclear. Consequently, any piece of information furnished must be taken seriously and any traces, vague though they may be, must be followed.

Clients impeding themselves in the process in the above manner usually make every effort to achieve clarification. They *endeavor* to answer the questions the therapist poses, but in doing so they experience difficulties. On the other hand, clients that actively block processing do not *attempt at all* to answer the therapist's questions. Rather than even trying to do what the therapist has proposed, without having looked into a situation and their own feelings in that particular situation, they simply reply, "I don't know." For a valid assessment of whether a client is circumventing contents, some other aspects need to be taken into account, however: lack of explication, missing "work order," and the like.

If a therapist comes to the conclusion that the client is using "I don't know" in an effort to actively block processing work, the therapist must adhere to the "contrary" principle. In this case, the client's message to the therapist is "I don't want to look into this content aspect any further (or more closely) and prefer to leave it right away." However, the therapist's intervention signifies to the client that "On the contrary, let us take a very close look at these content aspects." The mere fact that the client prefers to circumvent an aspect is evidence that it not only has relevance to the client but has not yet been clarified and integrated. This again is indicative of the fact that it *needs to be processed.*

Accordingly, the therapist might say, "I know it is hard for you to stay here and take a closer look. That's quite understandable. If you could tell me about it, everything would soon be cleared up and nothing would be left to look into. Therefore, I would ask you to continue with this point and tell me exactly what you are feeling or what is crossing your mind. . . . " In this way, the therapist at first exerts considerable "pressure." But if the client maintains her/his "I don't know" attitude, the therapist then *increases* the pressure: "I know it's difficult for you, but please continue with it. There is always something at the back of one's mind: You always feel or think about something, no matter how diffuse it is." In this way, the therapist establishes a "counternorm"; that is, he/she assumes that from a psychological perspective a person must have data of some nature available, which undoubtedly is true. By this course of action the client's obligation to continue with the particular issue at hand becomes stronger and being evasive has been made more difficult.

If the client insists that she/he has no idea the therapist will change over to the meta-processing level and make the client's behavior itself the subject matter: "I would like to talk with you about why it is so difficult for you to stay with it and take a closer look." On the other hand, the therapist may also resort to confrontation, saying for instance, "When I ask you a question you immediately say, 'I don't know.' You don't even take time to look and see if there is something else happening. Why not try to further clarify the subject at this point?" Here, the therapist offers a *processing the processing work* approach: The avoidance attitude itself becomes the subject matter of the therapy.

If a therapist carries out interventions in this manner it will be of decisive significance that these are integrated into a durable therapeutic relationship. The therapist must point out to the client that it is the sole aim of the approach to direct the client's attention to her/his own processes so that she/he will finally be in a position to recognize them and reflect upon them. There should be no doubt whatsoever that the aim is not to criticize the client or "forbid" anything. The basic idea that the therapist should impart to the client is that a client can only tackle a problem if she/he is aware of it; and if the problem is situated on the processing level, the client must recognize her/his

way of problem processing and its dysfunctional consequences. Only then can she/he restore her/his capability to act and decide.

Answering Questions That Are Not Asked

Description of the Client Action. Another especially elusive strategy, one often difficult for the therapist to recognize, seeks to change the subject and bring something new into focus by answering questions that have not been asked. The therapist asks a question to which the client replies at some length. If one now attempts to conclude from the answer just what the question to this answer might have been, it turns out that the question so reconstructed has very little to do with the original question. In the course of answering, the client has implicitly modified the question in such a way that she/he in fact has replied to quite another question. But the answer, and this is of significance, still has a slight association with the contents of the original question. Therefore, the strategy can be viewed as a pseudocommunicative approach. Apparently and seen cursorily, the client has continued the communication process, but what she/he has actually done is to "stifle the contents."

And this is what bothers the therapist: He/she is under the impression that the client has responded "somehow," yet knows there is something wrong with that answer without being immediately able to pinpoint the mistake. To find out what is wrong he/she is particularly attentive to what the client says—and so he/she follows the newly laid track.

Possible Therapeutic Actions. When coming across this avoidance strategy in therapy, the therapist acts according to the principle: "OK, let's start over."

If the therapist notices that the client does not answer a relevant (e.g., concretizing or deepening) question, he/she poses the question again. In doing so, he/she may take the responsibility for the problem by saying, for example, "I think I've not made myself clear enough. My question was . . . " The therapist may also attempt to formulate a clearer, shorter, more concrete question than before to rule out any misunderstanding. If the client still fails to answer the question, the therapist may elect to put the question again, saying, "There is still an aspect I'm not sure about . . ." So, the therapist does not allow him-/herself to be deceived but instead always focuses the client's attention on central aspects.

Should the client again proffer an evasive reply, the therapist may change over to a meta-level of processing by pointing out to the client that the question in fact *has not been answered*, in which case the therapist makes this the subject of the therapy; for example, "I would like you to note what you are actually doing in the therapy. I've asked you twice about *X*, but you twice have answered *Y*. So, please, let us discuss why it is so difficult for you to answer this question." If the therapist has already drawn the client's attention to such aspects several times, confrontation may even become more direct; for instance, "I've frequently noted that you evaded my questions by

giving answers that did not fit—and I've often told you about it. I would urgently prefer to talk about what makes it so difficult for you to address my questions."

When dealing with this (and also other) avoidance strategies it is essential that a therapist takes a stringent approach. In the process, he/she must remind the client of these aspects again and again. This is vital, because a single intervention of the therapist will not be sufficient to enable a client to recognize her/his own strategies and their underlying intentions and motives.

ILLUSTRATION OF THERAPEUTIC PRINCIPLES BY MEANS OF TRANSCRIPTS WITH COMMENTS

Objective

Excerpts from two transcripts of therapies are given below to illustrate some of the relevant therapeutic principles. Obviously, since only short transcripts can be analyzed here, the number of principles illustrated is quite limited; nevertheless, transcripts are better suited than mere descriptions to elaborate the underlying principles.

Both transcripts are from the beginning of the third therapy session. They present some typical processing difficulties experienced by psychosomatic clients and indicate ways to handle these difficulties in therapy. To improve legibility and understanding the transcripts were slightly modified from spoken to written language but without any substantive changes having been made in the transcripts' contents.

Client S: "Clarifying Feelings Does Not Make Any Sense"

Mr. S came to the therapy project because of ulcerative colitis. From the start he appeared to be very stressed and under pressure but told the therapist everything was not that bad really and "nothing could be done about it anyway"; it would be best if the disturbing feelings could be eliminated by the therapy. It took Mr. S 16 sessions of "processing the way of processing" before any noteworthy clarification work could start. The therapist had to tackle processing difficulties again and again and avoid getting too involved in the client's arguments. The therapy turned out to be a success, and Mr. S was very satisfied with what had been achieved.

Transcript

T1: (1) What do you want to talk about today?

C1: (1) Don't know.

T2: (1) Isn't there anything that bothers you at the moment? (2) Do you have a subject you want to discuss?

C2: (1) It's always the same. (2) Every day looks the same. (3) So what shall I tell you?

T3: (1) That sounds as if you were bored to death.

C3: (1) Bored? (2) No. (3) Only, nothing happens.

T4: (1) Do you find it difficult in this setting, with me, to name a subject you can or want to talk about?

C4: (1) There is not anything to tell, really. (2) It's always the same.

T5: (1) Last session you named three subjects. (2) Three fields that irritate you occasionally: your work, the relationship with your wife, and the way you manage your financial affairs. (3) Do you want to talk about one of these topics now?

C5: (1) I have already commented on all of these. (2) Mind you, I'm not feeling irritated all the time. (3) Such is everyday life, you know.

T6: (1) Yes, that's how your everyday life is. (2) But I'm not yet sure what in particular is eating you. (3) And, likewise, I don't know exactly what's happening with you when you feel irritated. (4) For example, if you are annoyed about your foreman, what do you feel?

C6: (1) I feel upset about him all the time. (2) Everybody does. (3) Actually, he is absolutely crazy. (4) Everybody in the workshop thinks he is.

T7: (1) OK, everybody knows the foreman is a difficult guy. (2) But I still don't know what upsets *you*. (3) May I ask you to think it over again and tell me what about the foreman annoys *you*?

C7: (1) Yesterday again there was such an incident. (2) I was told to paint a door. (3) He expects that we work overtime to do the job. (4) But you won't be paid for this. (5) If you say no, you are possibly bullied into doing it.

T8: (1) What exactly irritates you about this?

C8: (1) You certainly feel annoyed. (2) Well, of course, you can't help it. [Client stays completely cool and at ease; his anger is not noticeable at all.]

T9: (1) When you are talking about it now, do you still feel angry?

C9: (1) No. (2) There is no point in being angry. (3) It's useless. (4) It wouldn't change the foreman, would it?

T10: (1) You prefer not to feel angry. (2) What you are saying is—Feelings are useless. (3) It would be better to have no feelings at all.

C10: (1) Yes, that's right.

T11: (1) But you feel annoyed day after day. (2) Being angry shows you there is something wrong. (3) Your anger is like a lit oil pilot lamp. (4) But what you do, in fact, is disregard it.

C11: (1) But what shall I do? (2) I can't go and kill the foreman, can I? (*laughs*)

T12: (1) (*laughing*) You'd better not. (2) But I would like to understand what you are doing with yourself. (3) You say to yourself: I can't change anything. (4) And being unable to make changes, I would rather leave my feelings alone. (5) Is that correct?

C12: (1) Of course it is. (2) No point in being angry. (3) Won't help me in any way.

T13: (1) Yes, you are right. (2) The way you have handled your anger in the past won't help you at all.

C13: (1) What do you mean?

T14: (1) Well, I think the anger does exist. (2) It is real. (3) You feel irritated frequently, day after day. (4) But you say you can't do anything about it. (5) So there is no need for you to look at your anger more closely. (6) So you are not doing anything. (7) And that is why nothing changes.

C14: (1) And what am I supposed to do?

T15: (1) What can I say? (2) I'm convinced it would be very good if you come to a clear understanding—with my help—of what the anger tells you. (4) We will then understand what's going on. (5) We will then, and only then, understand what the problem is. (6) And understanding the problem is mandatory to arrive at a solution.

C15: (1) But I've tried everything.

T16: (1) Is that so? (2) Have you ever tried before to analyze your anger with me?

C16: (1) No, I haven't, of course. (2) But what's the point in doing so?

T17: (1) An analysis is meant to clarify what exactly happens inside you. (2) What do you think, shall we give it a try? (3) Is there anything against the two of us trying this out together?

C17: (1) No, not at all.

Comments

In the case of this client the main processing problem involved normalizing, relativization, and downplaying combined with resignation, which however did not lead to depression but rather to externally oriented brooding, as is customary with psychosomatic clients.

The client thinks it useless to take his feelings seriously and accept them as a basis for analyzing the problem because "You can't do anything about it anyway" and therefore there is no point in having feelings. Of course,

this doesn't prevent his feelings from causing constant trouble and a consistent state of stress accompanied by permanent feelings of discontent.

This attitude is evident from statement C2: It doesn't pay to work in therapy since nothing can be done. When the client said this he by no means made a depressive impression but appeared to be very tense and "under pressure."

In C3 it is quite clear that the client has assumed a highly external perspective and is experiencing extreme difficulties in directing his attention inward. Therefore, this sets a significant process target for the therapist: Internalize the perspective!

In T5 the therapist makes an effort to "process the processing work." He wishes to induce the client to direct his focus on own aspects, address questions, activate affective schemata. Therefore, the therapist deliberately *refrains* from dealing with the content aspects in C4; the therapist also views the therapeutic alliance between himself and the client as intact and for that reason does *not* refer to the relationship level. Rather, his process target is to familiarize the client with another way of dealing with problems.

In C5 the client responds to this by relativizing and normalizing: Everything is quite all right and, thinking about it, completely normal.

In T6 the therapist does not question the normality (1) but proceeds by asking a clarifying question: What happens to *you* (2–4)? As a pretext the therapist claims his *own lack* of understanding as being the reason, the "motive," for this question: He, the therapist, would like to have more clarity! This should help the client to accept this approach.

But in C6 the client again responds in a normalizing and generalizing way. He does not see the problem as being specific to him; everybody has this kind of problem. This, again, is not contested by the therapist; rather, he uses the same processing approach, saying in T7, "I would like to know what annoys *you*."

C7 again shows that the client "normally" assumes an external perspective and not an internal one. He has no intention of finding out what is happening to him but he reports events and concludes by accepting the inevitable: That's the way it is.

T8 illustrates something of the greatest significance for our access to processing: The therapist does not allow himself to be led astray. He wants the client to take a close look at his feelings, to focalize and clarify them.

If the client does not follow this prompting the therapist tries again and again (T9), or he investigates with the client the reason why the client does not internalize and clarify the perspective (T10). In this way the therapist consistently pursues a "processing of the processing work" and does not let himself be diverted!

In T10 the therapist puts the client's assumption to the test that it is better not to have feelings. Again, it is the therapist's goal that the client should internalize, focalize, and clarify his feelings. If there are obstacles impeding this for the client, these obstacles must be processed in the course of the therapy process.

In T11 the therapist uses a metaphor that he thinks the client, who works in an automotive paint shop, will understand: the red oil pilot lamp that the client disregards.

Following this, in C11, the client himself gives some elucidation about his construction that "There isn't anything to be done" and for that reason there is no point in understanding the problem. The therapist in T12 makes this construction transparent and offers a proposal (T15, T16, T17) after he has pointed out to the client the consequences of such a construction (T13, T14). The therapist tells the client (in T13) very pointedly that he considers the client's previous strategies as dysfunctional and is not at all surprised at the client's inability to solve his problem in this way. Such clear-cut remarks are often necessary to attack a client's attitude that may be plausible to him though hardly helpful. They are also necessary to restart the clarification process.

The Perfect Millionaire

Mr. T came to the therapy project because he had suffered from severe recurrent and chronic gastric and duodenal ulcers for 16 years. Medical measures that included treatment to attack *Helicobacter* bacteria did not result in recovery. Therefore, Mr. T was completely frustrated and strongly opposed to further medical treatment. To attend a therapy session he had to travel 120 kilometers and so must be viewed as having been highly motivated.

Mr. T. was co-owner of a large construction company and very affluent. Nevertheless, he was under the impression that he could not do anything enjoyable with his money because he was either working or experiencing severe pain or both.

In comparison with other psychosomatic clients, Mr. T was found to perform a comparably high degree of intrapersonal exploration that resulted in beneficial clarification work starting after only 8 hours of "processing the processing work." The therapy was altogether extremely successful. Mr. T was highly satisfied with the therapy and as of this writing, some 1½ years later, has not suffered any relapse. (In 35 sessions psychotherapy alone had achieved what medical treatment could not do in 16 years.)

Although Mr. T was a "good" client, he showed typical processing difficulties. However, the therapist was able to counteract them effectively, as reported below.

Transcript

T1: (1) Last session we started to talk about your work, (2) especially about your impression that you must be very thorough all the time. (3) Where do you want to continue, today?

C1: (1) I think I told you everything that is important here. (2) Come to think of it, I can't tell you any more about this. (3) At the moment, there is nothing I consider important.

T2: (1) It's difficult for you to start over at that point. (2) But I would still ask you to go back to the subject. (3) Perhaps, you should look again at aspects that make you angry, that strike you as remarkable. (4) Take your time, don't feel rushed.

C2: (1) You know, I keep forgetting everything we discussed here very quickly. (2) At the moment I'm not sure what else I can tell you about the whole affair.

T3: (1) I understand quite well that it's difficult for you to talk again about the subject of "work." (2) But last time I felt that you mentioned many things that gave you a great deal of trouble. (3) I know it's hard and maybe even unpleasant for you to get that out again. (4) But if we want to clarify what is putting a strain on you, this is a real must. (*pausing briefly*) (5) Now, if you look at the whole work situation again what is it that bothers you most?

C3: (1) Well, bothering is perhaps not the right expression. (2) Sometimes I just feel annoyed. (3) On the one hand, I'm very correct, very pedantic. (4) But as a self-employed person you have to be, don't you think? (5) But if I see how my partner is handling matters, too fast, not in the least less effective . . .

T4: (1) Then you would wish you could sometimes "stretch a point," make concessions now and then?

C4: (1) Yes, maybe that wouldn't be bad sometimes.

T5: (1) And what stops you? (2) What gives you trouble if you try to be more permissive?

C5: (1) I don't know. (2) Come to think of it, there isn't very much that could go wrong. (3) Operations in the company are checked over several times. (4) No need for me to do everything myself. (5) But still . . . (*pausing briefly*) (6) Of course, it would be a disaster if anything turned out badly because . . .

T6: [Interrupts the client] (1) Now, keep looking at yourself! (2) What keeps you, personally, from being more relaxed or permissive.

C6: (1) I don't know.

T7: (1) Please, do not turn away from this question—think about it. (2) Take your time.

C7: (1) I really don't know (*pausing*) (2) I'm a guy who must have everything functioning well. (*emphatically*) (3) That's simply the way it must be! (4) Of course, I know that it's not that serious to make a mistake

now and then! (5) No doubt I've made quite a number of mistakes myself in the past!

T8: (1) You said you *know* that mistakes are not that bad. (2) But your *feelings* tell you something different. (3) Your feelings tell you that mistakes are in fact horrible!

C8: (1) Yes, that's true! (2) It just must not happen! (3) And, what is more, you are under an obligation to your customers to perform excellently.

T9: (1) The customers, OK. (2) But actually I think it is a horrible situation for you personally to make a mistake! (3) Can you tell me the reason for that?

Comments

Although Mr. T was a comparatively willing exploratory client he also faced the difficulties characteristic of psychosomatic persons.

The problem starts with the client thinking that the problem list prepared by him and the therapist can be checked off in one session and that will be all that needs to be said about it: "In fact, everything is quite normal; in fact, I don't have any problems; and, in fact, there is little sense in getting involved in personal issues." This is a message quite frequently received from psychosomatic persons, and it is important for therapists not to allow themselves to be deterred by this.

The therapist accepts here that the client faces problems with processing his personal difficulties (T2/1), but nevertheless she induces the client to stick to his task (T2/2–4): Look for personally relevant subjects and focus your attention on these!

The same is repeated in C2 and T3 when the therapist explains why she asks the client not to turn away from this task (T3/4) and then tells him to cope with the task again.

Now the client attempts to provide something like the definition of a problem (C3/C4) actively supported by the therapist (T4), who then (maybe a little bit too early) asks a deepening question (T5).

From C5 it is evident that the client is not yet ready to access this level of processing, but he nevertheless sticks to the subject until he clearly "takes off" (in C6): Whereas he at first showed an internal perspective and directed his attention to *himself* and his norms, he now starts focusing again on external aspects and tells the therapist something about professional constraints. [Listening to the transcript we notice here that the client says sentence 6 faster than the previous sentences; we say the client "goes into higher gear" and thus again abandons the clarification process.]

The therapist, obviously noticing this change in processing mode, interrupts the client and explicitly requests that he should maintain the internal perspective and should stick to the question already addressed (T6). In this

way she is very process-directive and induces the client not to disregard his clarification task.

Moreover, she does not allow herself to be irritated by an "I don't know" (C6) but again requests that he fulfill his task (T7). The client complies and resumes his internal perspective and again addresses the question, "What makes it so difficult for me to be permissive" (C7).

In T8 the therapist carries out an intervention we call "separating a cognition–emotion bond": The client "in fact knows" that he can react differently (cognitive constituent), but he still feels that way (emotional constituent). The client is now expected to explicitly disregard and remove from his focus the cognitive constituent accepted by the therapist and concentrate solely on the emotional aspect and the clarification *of this aspect.*

As C8 shows, the client experiences difficulties in reacting in this way (otherwise, there would probably not be a need for therapy). But the therapist proceeds by persistently requesting that the client try again (T9).

Having presented the theory, practice, and a case example of a GCCT approach to the treatment of psychosomatic disorders, a research study of this treatment is summarized below.

A THERAPY STUDY

Based on the principles and approaches of a processing-oriented CCT as outlined here a therapy study was conducted involving 87 male and female clients suffering from psychosomatic gastrointestinal diseases.

Phases of the Therapy

In the first phase of the therapy the therapists were instructed to lay emphasis on "processing of the processing work." The content aspects of the relevant client problem would be dealt with in later therapy phases.

The following phases of therapeutic work can be distinguished:

Phase 1. Establishing Contact (1 to 2 sessions)

The clients furnish information about their somatic symptoms, their previous symptom history, etc. Together with each client the therapist prepares a *psychological problem list.* For this purpose clients report all the difficulties (as trifling as they may appear) they face in everyday life (during work, in relationships etc.)

The somatic symptoms are *not* included in the list of problems. The client is requested to address one of these psychological problems.

Phase 2. Processing the Processing Work (10 to 15 sessions)

During this phase the therapist makes major efforts in a process-directive manner to draw the client's attention to dysfunctional types of problem processing and offers constructive problem-processing alternatives to the client.

At this time the focus is not yet on clarifying or changing the contents. Therefore, it is not essential that clients address central problems at this stage. Rather, it is important that clients, for example, assume an internal perspective, perceive their own feelings as an important source of information, respond to questions by the therapist, and notice and reduce avoidance strategies.

Phase 3. Clarifying and Changing Content Aspects (10 to 20 sessions)

If the client's way of processing changes, the amount of clarification work increases and the transition is fluid.

During this phase clients endeavor to understand their experiencing and to understand and represent their motives, targets, and values. For example, clients may want to find out whether it is actually important to them to be always "functioning" individuals or whether they have other goals and motives they want to realize by actions. Clients may find that they do not want to be at the disposal of others all the time but instead have their own needs and wishes they would like to have by other people.

At this point clarification and change of (affective) schemata is desirable, contributing to a change of self-worth, increased access to clients' own motives, and diminished anxiety and fear.

Phase 4. Transfer (5 to 8 sessions)

During this final phase the therapist can help clients to actively apply the knowledge they have gained about everyday life, which they may already have started to do on their own.

Together with the therapist clients draw up a plan as to what they actually want to change, for example, how to say no, or making a response where they can try out their self-awareness.

Therapy Outcome

The empirical results show that, when compared to control groups, the clients achieved major significant improvements, some examples of which were the following:

- Self-acceptance increases.
- The conviction that one is controlled externally lessens.

- "State orientation" (Kuhl, 1994a) decreases, indicating a diminution of alienation.
- The ability to be successful and conduct oneself in society improves.
- Active coping with stresses improves and passive coping diminishes.
- Due to the resultant stress reduction and improved coping with stresses, the psychosomatic gastrointestinal symptom complex often significantly improves as well.

GCCT: A Successful Psychotherapy for Psychosomatic Diseases

The results show that a specially adapted GCCT can effectively help clients suffering from psychosomatic gastrointestinal diseases (duodenal ulcers, ulcerative colitis, and Crohn's disease). It is not true that only a behavioral therapeutic approach is helpful for so-called alexithymic clients (Tönnies, 1986; Tönnies, Gades, & Pieper-Raether, 1987). The therapeutic improvements are numerous. They cover improvement of self-acceptance, the capability to act, improved social authority, adoption of active stress-coping strategies, as well as marked improvements of the physical symptoms. The duration of the therapy is rather short, and thus the effects can be achieved quite economically. Two things are evident from the results:

- CCT appears to be an indicated form of therapy for PGTD clients.
- To provide effective help CCT must, however, be adapted to the particular starting conditions and capabilities of each client.

Furthermore, the results show that it is essential for PGTD clients to systematically improve existing dysfunctional problem processing patterns. For that reason, it takes a considerable time in the therapy to "process the processing work." This type of therapeutic approach seems to be particularly expedient for clients suffering from psychosomatic disturbances, and it may even be specifically expedient for PGTD clients. On the other hand, the approach does not appear to be expedient for clients with "neurotic disorders" who have different prerequisites with respect to contents processing at the beginning of therapy. Moreover, it may not be expedient for clients with personality disorders (see Fiedler, 1994) who exhibit special interaction patterns when starting therapy; in this case, it is expedient to conduct therapeutic work on the relationship level.

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