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Treating Anxiety with Strategic Brief Therapy

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

Keywords: security regulation; primary and secondary emotions; cognitive-affective schemata; personal values

Preliminary considerations:

Anxiety patients experience insufficient subjective security
Fear of real danger is a thoroughly healthy response pattern. It ensures survival and belongs to the basic configuration of human existence. This quite reasonable behavioral pattern may lead to a maladaptive cycle, however, when it occurs frequently and intensely and is accompanied by an experience of the underlying threat as an overwhelming existential danger, i.e., as a dramatic loss of subjective security.
A large part of our lifelong endeavors aim at gratifying our basic needs for security. As we know, security may spring from the most different sources and may be based on the most diverse foundations. Thus, we seek security within our families, partnerships, friendships, employment; we buy insurance and build financial equity, engage in preventive healthcare, etc. Finally, we look for security in a multitude of communities of the religious, spiritual, or political kind or, more generally speaking, in common worldviews and perspectives.
Consequently, many very different efforts are directed toward one aim, namely the generation of security. How may the psychology of motivation understand this phenomenon? The Zurich
Model of social motivation (Bischof, 1993; 1998) convincingly answers this question within a system-theoretical framework (Figure 1).

![Diagram of security regulation](image)

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

At the center of the author's considerations is a security reservoir, which optimally should neither be empty nor overfilled. The optimal level represents the subjective security reference value, which varies from person to person. Emptying the reservoir evokes insecurity, anxiety, and a search for affiliation. Weariness and boredom result from overfilling the reservoir. It is fed by several wellsprings: Externally, by the proximity of familiar persons who communicate protection and shelter; internally, (1) by the individual's self-confidence that is supported by a demand for autonomy, and (2) by the memory of reliably experienced past external security, internalized as basic trust. A high demand for autonomy curtails dependence and increases motivation. In itself, it constitutes a source of security because it generates self-confidence internally and thus decreases the need for external security from familiar individuals. Basic trust rep-
resents an individual’s early learning history and internally, analogue to the demand for autonomy, buffers the security gauge against fluctuations in situational environmental influences. The learning history is shaped by the experience of secure attachment on the one hand, and on the other hand by self-efficacy that has been encouraged and affirmed at an early date.

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

<table>
<thead>
<tr>
<th>Security</th>
<th>Autonomy</th>
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<tbody>
<tr>
<td>o Experiencing dependability</td>
<td>o Wanting influence, leadership</td>
</tr>
<tr>
<td>o Having a vis-à-vis, an ideal</td>
<td>o Distinguishing oneself</td>
</tr>
<tr>
<td>o Being challenged and nurtured</td>
<td>o Overcoming barriers</td>
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<tr>
<td>o Receiving love and affection</td>
<td>o Performance</td>
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<tr>
<td>o Experiencing empathy and understanding</td>
<td>o Distinction</td>
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<tr>
<td>o Being given respect and praise</td>
<td>o Competition</td>
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<td>o Receiving set boundaries</td>
<td>o Assertiveness</td>
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<td>o Being welcome</td>
<td>o Status and esteem</td>
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<tr>
<td>o Harmony</td>
<td>o Scope for development</td>
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<td>o Protection</td>
<td>o Doing oneself, being able</td>
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<td>o Shelter</td>
<td>o Determining one’s path</td>
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<td>o Warmth</td>
<td>o Risk-taking, experimentation</td>
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<td>o Playful experimenting</td>
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The relevant motivational significance of a demand for security or a deficit of security, as seen in anxiety patients, suggests a close examination of the special aspects of security regulation. Attachment theory offers a thematic fit.

**Attachment theory.**

The theory of attachment was originally formulated by John Bowlby (1988) and substantially developed by Mary Ainsworth and colleagues (1978). The theory builds on the assumption that human beings, like other primates, are innately motivated to engage in social behavior. This innate motivation, viewed as a continuously present human characteristic that exerts its influence from birth to death, also comprises the ability to form strong emotional bonds with other special individuals. The purpose of the attachment system is to maintain and guarantee protection and security by establishing contact to appropriate attachment figures. These figures may be persons but also – especially in the case of adults – symbols or representations of the
respective security-relevant objects or events. The attachment system is activated mostly when
the person – scared, stressed, tired, or sick – feels the urge to seek out protection, coziness,
or support with a primary attachment figure who seems appropriate. Obviously, attachment
theory is suited to explain the special kind of relationship that forms between a parent and his
or her child. Bowlby himself pointed out, however, that attachment theory does not only per-
tain to children. Indeed, attachment is clearly observable in adults, particularly when some form
of stress is experienced. Adults seek the proximity of significant attachment figures, usually the
respective partner, in the case of illness, pain, anxiety in the presence of novel situations, feel-
ings of rejection or affront, problems at the workplace, personal loss, etc. In these situations
attachment-related behavior and the associated desire for protection are rather typical, even if
adults have a higher threshold for activation of the attachment system than children.

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

Today, there is hardly any doubt that the quality of childhood relationships with significant oth-
ers is internalized and maintained into adulthood as an “internal working model of relation-
ships.” Therefore, interview schedules were developed to assess such attachment representa-
tions in adults. MAIN AND GOLDWIN’S (1994) Adult Attachment Interview (AAI) is the most pop-
ular instrument. Adult attachment styles may also be described by self-report measures using
two continuous dimensions, i.e., avoidance and anxiety (RHOLES & SIMPSON, 2004). In this con-
text, avoidance characterizes an adult’s discomfort with psychological proximity and his or her
desire to maintain emotional independence even in intimate relationships. Insecure attach-
ment, associated with anxiety as the core emotion, refers to the strong need for receiving care
and attention from attachment figures and to a deeply pervading insecurity concerning the abil-
ity or readiness of attachment figures to gratify the respective need.
These three attachment styles were validated by the AAI; we relate them to the “precocial” versus “altricial” anxiety styles:

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

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

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

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

3. Secure
   a. Strong optimism concerning security and protection within intimate relationships; basic trust.
   b. A sense of personal autonomy and the ability to view past and current attachments without denial or entanglement, unresolved feelings or thoughts.
   c. Ability to switch relatively well between dependence and independence.
The secure attachment style implies the critical ability to buffer the mental effects of external threats with internal security.

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

1. Representation of self-in-relationships: Pleasant, security-promoting interactions constitute an important source of positive information about the self. When effectively coping with the threat situation that originally activated the attachment system, the person may experience him or herself as active, strong, and competent. In this context, the presence of a “stronger,” “smarter,” and “wiser” other additionally contributes to feeling calm and safe. The respect and acceptance put forth by the attachment figure not only leads to the development of appreciation for oneself but also to the conviction that one is capable of mobilizing close, satisfying relationships with others and their support. These representations are stored in semantic memory and probably reach from relationship-specific to more abstract and generalized concepts.

2. Self-care: The security-based self-representation comprises the internalized characteristics of particular, supportive attachment figures. The respective interactions are not only important sources of information about the attachment figure’s intentions and responses, but also an important foundation for our perception of other people. Positive interactions let the attachment figure seem available, sensitive, empathic, caring, and warm. The assumption that our self-representations could resemble the representations of significant attachment figures originates in psychodynamic and object relations theories. Important regulatory functions provided by external attachment figures are first internalized via mechanisms of incorporation, introjection, and identification and then gradually transformed into internal regulatory mechanisms that progressively increase their autonomous functioning: People treat themselves in the same manner as they used to be treated by significant attachment figures. In this context, the authors MIKULINCER AND SHAVER (2004) speak of “expansion of the self.” Accordingly, close relationships prompt the integration of characteristics and resources of the attachment figure into the self-concept.
When working with personal values in the context of anxiety disorders, the following finding may also be of interest: In a carefully controlled study with adult participants, Mikulincer and colleagues (2003) showed that priming attachment security, i.e., lower scores along the dimension of attachment avoidance, correlated with a significantly higher endorsement of self-transcendent values.

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

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

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

Solomon, Greenberg, and Pyszczynski (2004) report some findings of interest to our discussion: The cognitive salience of one’s own mortality (e.g., contemplating one’s death; being in proximity to a cemetery; subliminal priming, etc.) leads to a defense of one’s cultural worldview, particularly increased affiliation with and acceptance of persons who share one’s worldview and increased antipathy, aggression, and rejection of persons who question or do not share one’s worldview.
As indicated earlier, self-esteem serves to buffer potentially debilitating existential anxiety. Correspondingly, experimentally induced or dispositionally high self-esteem reduces the level of defensiveness. In turn, the cognitive salience of one’s mortality increases the tendency to maintain or increase self-esteem. Mortality salience may, for example, increase one’s readiness to engage in risky driving practices if one’s driving abilities impinge upon self-esteem; or it may emphasize a focus on one’s physical appearance if the body is relevant to self-esteem. One may suggest that, due to a particular worldview and/or lack of self-esteem, people manage their existential anxiety more ineffectively and therefore are generally more susceptible to anxiety of different kinds and associated mental disorders. This suggestion has already received some converging support in the context of anxiety disorders (Arndt, Routledge, Cox, & Goldenberg, 2005).

Anxiety from an SBT perspective

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

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

**Survival strategy.** Anxious persons struggle to gratify their need for security. They have learned to produce minimal security even in difficult situations. To attain this goal even under aversive conditions, a time-tested program or a procedural rule is executed. We term this part of the response process “rule-governed,” for it runs its course on the “program level” of hierarchical self-regulation (Hauke, 2004), where the procedural organization of goal-directed behavior is controlled. In contrast to the sensory-motor regulatory level, cognitive effort and directed attention are relatively important at this level. More recently, this distinction has also been accepted in the development of clinical behavior therapy. In this context, conditioned behavior to be accounted for by a theory of learning is differentiated from rule-governed behavior (Hayes, Brownstein, Haas, & Greenway, 1996; Sulz, 1994). Here, the extensively documented human ability to process complex information is taken into account by acknowledging that not only dichotomous information (such as reinforced/non-reinforced, or punished/non-
Figure 2. The development and maintenance of mental disorders from SBT’s point of view.

punished) regulates human behavior, but the mind integrates this learning history, e.g., in the form of general assumptions about self and world (Beck & Wright, 1986), and derives situation-specific behavioral plans (Grawe, 1998). The hierarchical self-regulatory model would locate these processes squarely at the rule-governed level. Especially important for clinical work are the so-called “survival strategies” (Sulz, 1994). Considering anxiety disorders, the survival strategy could be explicitly stated as, “Only if I manage to maintain complete accessibility to my protective person through active-cooperative conformity, then I will be able to survive with his or her protection. If I fail, then I will be alone and helpless in facing the dangers of a threatening world.” As a result of an early learning history described as attachment experiences in the
preceding section, survival strategies always contain “instructions” detailing in a context-specific manner which behavior must be activated or avoided, so the responses required to guarantee emotional survival may be obtained from the social environment.

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

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

Primary and secondary emotions and responses. Most researchers who study emotion acknowledge the extraordinarily nuanced richness of emotional experience encountered by the practitioner in everyday work. In particular, the significance of higher order cognitions and the
appraisal of emotional components are more recognized. Indeed, psychological models are emphasizing the role of the person’s responses to his or her own inner or emotional experience (e.g., CHAMBLESS & GOLDSTEIN, 1981; GREENBERG & SAFRAN, 1987; HAYES, WILSON, GIFFORD, FOLLETTE, & STROSAHL, 1996). GREENBERG AND SAFRAN (1987) proposed the distinction of primary and secondary emotions.

Primary emotions are affective responses that may be conceptualized as a bundle of sensory and perceptual information, i.e., communicated via physical experience. “Primary” indicates that these emotions are temporally first and immediately result from the transaction of person and environment. Primary emotions such as fear or grief are triggered rapidly, for example by stimulus constellations relating to a physical threat or the loss of a loved one, respectively. Their level of cognitive processing is comparatively shallow, occurs subcortically and non-consciously, and facilitates quick responding. Secondary emotions are responses to primary emotions and are also well-established by neuroscience (GREENBERG, 2000; LE DOUX, 1996). Here, learned emotional responses are at issue. Often, anger – a primary emotion – is followed by massive anxiety: “If I express my anger, then she will leave me,” or “if I express my anger, then I will produce counter-responses that I won’t be able to handle.” The more frustrated or dramatic the situation, the stronger is the primary emotion and the more intense the primary impulse for action. As the anticipated consequences seem unbearable, they may not be risked under any circumstances. Everything must be tried to avoid executing the primary impulse. The mind manages this situation by replacing the primary with the secondary emotion (GREENBERG, RICE, & ELLIOTT, 1993). Consequently, the transaction of person and environment has been altered, as demonstrated by a change in self perception shifting the balance of power in the other person’s favor, for example. Therefore, the primary action impulse ceases to be the optimal response and the primary action intention is suppressed. It is not the original situation anymore in which the other person has displayed highly irritating frustration or provocation. Instead, the individual finds him or herself in a situation of helplessness and takes the blame for the sequence of events. Rather than the other person, “fate” will be identified as the cause. At this point, the secondary evaluation and the associated secondary emotion result in observable behavior that aims at conflict avoidance and the prevention of any possibly negative consequences of assertion. Viewed from a different theoretical perspective, the behavior has a self-protective function and refills the security reservoir. Figure 1 points to the “external” source of security that may not be risked. The cognitive-affective survival strategy that corresponds to this stance could read, “Only if my cognitions, emotions, and behavior correspond to the wishes of significant attachment figures, if I never express needs that could be incompatible, then I will maintain the protection, the warmth, and security and I will avoid loss.” However, as frustration and threat levels increase further (i.e., the security reservoir is emptying to balance self and relationship interests or person and environment) a more effective measure must be found. If the survival strategy does not allow any other potentially effective behavior, then the symptom is the last resort. On the one hand, it maintains the survival strategy; on the other hand, it pro-
vides relief in the interpersonal realm by substantially changing the symptom-evoking situation. The transaction between the individual with the symptom and the environment has been altered completely. Everybody is alarmed, and the problem of an acute anxiety disorder is appearing within the relationship. Now the relationship is not jeopardized by the original problem, i.e., the intent to separate, anymore. The social system has been stabilized until further notice, and the self is protected from a loss of social support. From the perspective of self-regulatory efforts, yet another aspect is relevant. The attention is focused on the very concrete and direct level of cognition and behavior: The constant management of physical and emotional symptoms of anxiety and the constant preoccupation with details of avoidant coping in everyday life do not leave much room for a reflection on superordinate life contexts, for a contemplation of one’s understanding of self, goal setting, values, and future plans. This fixation of attention on the lower levels of behavior regulation leaves the hitherto existing self-concept untouched, protects the existing identity (BAUMEISTER, 1990). The consequence of the symptom is its maintaining function: The avoidance of a loss of affiliation or relationships; the upkeep of self-protective gratification (e.g., protection, affiliation) or a minimum of independence and autonomy are the saving result of symptom development. The affirmation of self-image and worldview as a cognitive representation of the self and the social environment is as important a consequence. The transitory discrepancy has been removed; for the time being, the mind has managed to clear the conflict zone.

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

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

Pathogenic lifestyle. The patient had devoted her life to her relationship. During the day, her work was easy and not particularly challenging. She had neglected her hobbies and interests and had limited her social contacts to colleagues. Otherwise, she neither nurtured friendships nor acquaintanceships, excluding some occasional telephone contacts. She had abandoned a non-traditional college-level education when her partner reacted irritably to her frequent absences and complained that she was not dedicating enough time to the relationship.
Pathogenic relationship style. The patient nurtured her partner with great devotion and attempted to pamper him with homemade meals, small favors, and care. She felt successful if he was able to shed bleakness, irritability, and weariness in her presence and to display good spirits and optimism. As time passed, she noticed that he increasingly sought this kind of interaction. If he met with his peers at the pub or if he went to ballgames, she stayed home and longingly waited for his return.

What personality characteristics did she bring into this life situation?

Historical disposition. The patient’s learning history may be understood as a transaction with her familial environment. She described her father, an officer in the German army, as strong, protective, yet hardly available. She always enjoyed his proximity and was able to influence her relationship with him, particularly their level of closeness, by poking fun and being in good spirits. Nevertheless, she rarely managed to establish a complete emotional connection with him. She constantly had the feeling that he was not fully present; that she could never really live up to his standards. The patient reported that her mother had talked about herself exclusively; that she had appeared generally overwhelmed, anxious, and moody; and that she had demanded strict obedience. As a child, the patient had been gregarious and bright, an excellent student. The patient’s self-image and worldview: “I need protection, security, and dependability, which my father will provide only if I am a bright daughter, and my mother will provide only if I am a compassionate listener to remain under her supervision and avoid threats and challenges.”

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

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

The patient’s responses. Her responses in the symptom-evoking situation may be explored via the response chain illustrated by Figure 2. Her primary emotion was feeling hurt and angry when the partner threatened to terminate the relationship. Her primary behavioral impulse was battering and choking him. The consequences anticipated by her were the complete loss of the relationship and subsequent loneliness, which she had reliably avoided in the past. In other
words, her primary behavioral impulse would have jeopardized her survival strategy and resulted in the loss of protection, security, and dependability. The counter-regulating emotion of fear as an emotional stopper came into play. For some patients, this is already the first panic attack. The emotion targeted the suppression and avoidance of the originally intended behavior. The further development of symptoms could have been prevented if fear had caused the patient to completely abandon all tendencies for autonomy. However, anxiety flared up repeatedly, its intensity was maintained, and it served as a reminder of the survival strategy. The patient was not able to continue living as before, but she also could not change her life. This unbearable conflict had to be resolved. Phobia, as a symptom, provided the necessary relief. Certain areas, such as elevators, subways, or a heavily frequented department store, are as anxiety-provoking as unfamiliar surroundings and wide open spaces, in which any individual human being seems small and lost, without immediate access to help. Anxiety occurred especially when transitioning from the home to the outside. The possibility of a professional change with frequent travel challenged autonomy-related behavior patterns and so produced a peak in panic. The patient strictly avoided all phobic stimuli and attempted to leave home only with her partner. The consequences of the symptom maintain the anxiety disorder. The anxiety disorder persists for it prevents challenges to the survival strategy on the one hand and therefore an unprotected and lonely existence in a threatening world on the other. Particularly from an operant perspective, the patient received affection from the partner as well as never before experienced concern from her family of origin. The downward regulation of the patient’s demand for autonomy reduced her anxiety. Therefore, the anxiety disorder maintained and strengthened relationships that guaranteed protection, security, and reliable access to the attachment figures.

The therapy
Strategic Brief Therapy (SBT) conceptualizes the development and maintenance of disorders from a cognitive-behavioral point of view (Table 2).
This kind of therapy shows similarities but also differences in comparison to other cognitive-behavioral interventions for anxiety (e.g., Barlow & Allen, 2004; Eifert & Forsyth, 2005; Grant, Young, & deRubeis, 2005):
- A superordinate target of therapy for anxiety is the facilitation of a life change. Patients learn to flexibly manage the core conflict between needs for autonomy and attachment, i.e., they learn to take care of both needs concurrently.
- The therapy views the therapeutic relationship as instrumental in the processing of the patients’ interpersonal problems.
- The therapy is resource-oriented. Usually patients have established a plethora of resources over a lifetime, some of which may have to be reactivated, some rediscovered and made accessible.
Table 2. Outline: The course of anxiety treatment in Strategic Brief Therapy.

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

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

Building relationships. The preliminary considerations of motivational processes as well as the case vignette pointed to the extent to which interpersonal factors influence the development of symptoms and the course of the disorder. Relatively recent behavior-therapeutic approaches, such as the "Third Wave" behavior therapies, incorporate such factors by requiring the therapist to respond contingently when a certain patient (target) behavior occurs, for example (Kohlenberg et al., 2004; Kohlenberg & Tsai, 1991). SBT also attends to the therapeutic
relationship, as particularly evidenced by its attachment-theoretical approach to the regulation of security. From an ideal-typological perspective, two types of relationships may be distinguished based on their balance of autonomy and attachment. “Altricial” individuals are encouraged to demand a minimum of attachment and, instead, to fuel their self-confidence with self-efficacy in the context of autonomous behavioral patterns. The autonomous behavioral patterns of “precocial” individuals, on the other hand, are validated and appreciated; at the same time, “precocial” individuals are encouraged to experiment with different levels of attachment. Moreover, the therapeutic relationship is seen as a realm in which therapist and patient together may study the factors of crucial interpersonal influence and explore and test alternative interpersonal styles. Indeed, we hold that many problems in the life of the patient are also represented within therapy. In this context, the patient’s survival strategy is developed as a theme in therapy, carefully observed and later challenged by the therapist, albeit mildly at first. Together, a space of opportunity is created where the exploration of behavioral alternatives and their effect on the survival strategy may be explored via experientially oriented experiments. Accordingly, the patient described in the earlier case vignette formulated alternatives to her dependent survival strategy and tested them within the therapeutic relationship. The therapist’s feedback and validation generated much movement in the patient’s relationships outside of the therapy room. Exposure therapy very quickly prompted a first opportunity for bringing up the patient’s survival strategy as a theme in the therapeutic relationship: Difficult exposure work in rain and sleet for six to eight hours a day evoked rage and anger that were directed also at the therapist. The patient tried hard to suppress and hide her anger but did not fully succeed, which allowed for a discussion of the survival strategy in the “here and now” of the therapeutic session. Finally, alternatives could be developed and reinforced. Subsequently, other, similar everyday experiences in different life domains of the patient were compared and goals could be set accordingly.

Therapeutic process: The strategic nature of the symptom implies the strategy used in therapy.
Assessment phase. The therapy plan strictly develops from the core piece of SBT, i.e., the survival strategy. Of course, first the context in which the survival strategy is embedded must be assessed and understood. Intake, assessment, diagnosis as well as a behavioral and a contextual analysis of symptom development are routine steps. Initially, patients learn to develop systematic self-monitoring and directed attention (mindfulness) skills. Thus, the initial primary goal is to live with one’s symptoms and to carefully observe them using mindfulness skills. The patient’s need to get rid of his or her anxiety as soon as possible is gently but decisively denied. In the framework of a psychoeducational module, we explain that the effectiveness of our treatment for anxiety hinges on the patient’s ability to experience anxiety in the first place. Here, we describe experiences and findings from the literature on exposure. Thereby the effectiveness of this phase is clearly improved. Most patients consider mindfulness practice unfamiliar and
initially difficult. To explore their possibilities and limitations with regard to mindfulness, patients are asked to sit and to direct their attention to their breath for ten minutes a day; to notice upcoming thoughts and emotions in a non-evaluative manner; and to refocus on the breath immediately. Further, patients are asked to practice being completely present with an activity of daily living, i.e., to direct their attention fully to the respective execution of the task, such as eating, walking, etc. If one notices a preoccupation with thoughts, emotions, or internal images, then the attention is redirected toward the precise details of the performance, e.g., the motion of the chewing jaw, the meeting of feet and floor. Initially, it may be easier for patients to engage in the corresponding imaginal exercises described by Hayes, Strosahl, and Wilson (1999). During the first phase of therapy, organism factors are also assessed, including a person’s learning history but also relevant needs and resources. These data are organized according to Figure 2, and the target analysis and therapy plan directly emerge from the assessment summary. Both are preliminary and must be readjusted and refined in the course of treatment. In the following section, we will describe the required process modules. Their sequence characterizes the course of therapy, but often modules are applied in parallel.

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

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

**Respecting the survival strategy: Discovering the good in the bad.** At this time, the patient experienced outrage and anger regarding her conformity and different interpersonal partners who readily enjoyed her “low maintenance” stance. Thus, it is necessary to emphasize the significance of the survival strategy as a cognitive-affective emergency tool that did not have any
alternatives within the historical context of its emergence. The notion of the survival strategy as a potentially useful resource regularly meets with surprise (Hauke, 2004), as again demonstrated in the context of the case vignette. Through lifelong adherence to the survival strategy,

• The patient had become highly emphatic and able to quickly grasp the situation of the interpersonal partner. This is an important competence. But here, an internalized “stop sign” had to be implemented that allowed room for her own goals, needs, and emotions. Self-neglect must be replaced with stronger self-referential behavior to enable a more precise evaluative process.

• Early detection of signs of conflict and negative emotions is advantageous when used for preparation. Behavioral processes thus may be regulated more effectively.

• Security is important and its provision is an essential part of self-care. However, too much security may be paralyzing and make life boring. Consequently, different degrees of autonomy are required.

• The avoidance of relationship loss also entails the thoroughly positive ability to develop and maintain close and committed relationships. Here also, the cost must always be calculated.

The patient was touched by this collaboratively formulated perspective. Repeatedly, memories of frequent internal struggle and fatigue were linked to her learning history.

Symptom reduction II. The process so far has emphasized insight into the necessity for a direct encounter with the anxiety symptoms. Willingness and commitment related to anxiety reduction through massive in vivo exposure represent an important keystone of therapy. In the meantime, sufficient skills have been developed to mindfully observe other emotions that may accompany anxiety.

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

Emotion therapy. The patient’s response chain clarified that her anxiety symptoms essentially functioned as a barrier for her primary emotions of frustration, anger, and rage. The patient’s survival strategy in particular assigned a “forbidden” status to such emotional qualities. An exclusive focus on symptom reduction would have surely helped the patient already. But it would not have taught her to manage those primary emotions that were functionally linked to anxiety. Being able to have, regulate, and modulate such emotions constitutes an especially
important competence in psychosocial contexts. For this reason, emotion therapy first teaches patients to notice and discriminate their primary emotions. Then permitting such emotions, letting them be, giving them space, comprehending their origin, understanding their meaning, and explaining their function is of issue. Subsequently, the patient learns which behavior patterns are prompted by respective emotions, and which aims a certain emotion sets out to achieve. Additionally, patients acquire the skill to clarify whether the emotion and its intensity are situationally appropriate and if the behavior that would be evoked by the primary emotion is situation-appropriate or promising. Thus, the development of a skill is achieved that produces a behavior corresponding to the emotion and appropriate to the situation. This gradual shaping process is supported within SBT by experimental learning through success. The content of our structured procedure focuses on primary emotions, thoughts in connection with emotions, and expression and communication of emotions and behavioral impulses that directly result from primary emotions (Sulz, 2000).

In this context, the patient had to confront anger and rage. She quickly realized that these emotions often arose when she allowed other people to interfere with problem-solving that would have been effective for her in certain situations. The resulting frustrated need gratification frequently evoked anger. Here, as a form of exposure to anger, the patient was asked to imagine different everyday situations that would elicit anger and rank them according to degree of difficulty. With role plays and experiential exercise, the generalization to everyday life was prepared. Catharsis is not our target. Our interventions occur in the mental realm, i.e., we exclusively condition covert responses. In the context of the case vignette, we prepared the conscious cognitive regulation of anger and constructive negotiation, so that the patient was able to represent her concerns early and competently. Now her consciously noticed anger became a reliable crutch, in some sense a measure that the gratification of her needs was still lacking.

**Behavior therapy.** True behavior change is only possible in the context of new experiences. For this reason, this building block of the therapy process refers to the development and testing of behavioral plans, the content of which is implied by the survival strategy. This means that the patient was asked to develop behavioral plans that helped her to counter her survival strategy, initially in small steps. These behavioral plans are integrated into the construction of concrete projects that serve to gratify the most diverse current needs: Discussions with supervisors regarding professional change or vacation planning with a friend, both requiring the acknowledgement of own needs, interests, and boundaries; negotiations with parents regarding an estate, etc. Commitment and the prospect of success are considerably increased by detailing the intention for implementation (Gollwitzer, 1999), i.e., the what, when, where, and how of behavior that counters the survival strategy. The patient learned to gratify her need for security to a realistic degree and concurrently engaged in a self-regulated, successive increase of autonomous behavioral patterns.
Designing a future: Working with personal values. Personal values always have a positive connotation and thus virtually contain a constructive intention. This intention is an active directedness toward the generation of a most optimal future, i.e., to establish or build something, or to realize something that is understood as “good” or “true.” Once the patient had sufficient evidence that she could live relatively well without her avoidance strategies and could tolerate distress, primary emotions, and delayed gratification respect to her need for security, then a temporal perspective that extends beyond the immediate gratification of needs – the future – becomes accessible. The therapeutic process now focuses on the direction that life should take, influenced by directional goals that are determined by personal values stated as future intentions. They constitute the context in which goal-setting occurs. To avoid the usual difficulties in working with values (social desirability, absence of contingencies, illusions) the work is tied to concrete future projects (see Wilson & Murrell, 2004).

In our work, we are convinced of the credibility and potential of the patients’ personal projects if we are able to locate their origins and roots in the person’s self-concept. Referring to the case vignette, creative work with the self-concept and personal identity in the form of a collage generated two projects that were associated with corresponding values:
- Entering a partnership that allowed for self-actualization and mutual growth;
- Professional growth consisting of increased mobility, diversification of tasks, and increased contact with others.

Further processing of these projects (e.g., “Imagine you would meet the respective partner, how would that be? What would be important to you?”) produced additional guiding principles 70% of which could be categorized into the domains of security, conformity, and tradition. Here, a certain polarization of the patient’s value orientation emerged (cf., Values in Strategic Brief Therapy: From need to value-directed living, this issue). A more detailed examination of this finding reestablished an excessive need for security and risk aversion in the approach to these projects. The patient also recognized that the desired need-appropriate and constructive, sustainable changes were virtually blocked. This finding was further emphasized by a newly formulated survival strategy that was quite similar to the original one. The patient was amazed that an old topic could reemerge in a new guise. She noticed how rapidly stress incurred during change or simply habit may lead to “relapse” and to which degree preparation, planning, and commitment were required to produce real and sustainable change. In this context, our work with personal values offers an appropriate solution: Within the value spectrum and antagonistically located to the domains of “security,” “tradition,” and “conformity” are the value domains “stimulation” and “self-actualization” (i.e., essentially the qualities desired by the patient). These must be occupied by concrete behavioral targets. Thus, the value spectrum suggests a strategy for change that initially preserves a bit of the familiar ground but simultaneously and at controlled levels tolerates uncertainty, risk, etc., so that the new may emerge and be nourished (Hauke, 2004).
The careful dosing of antagonists resulted in the following: In the partner domain, the patient was able to meet several men at after-work parties. She was able to notice and resist her security-oriented guiding principles and became increasingly convinced of the necessity for a new orientation. Furthermore, she reestablished contact with an acquaintance who offered her a position in the context of self-employment. She introduced herself to the new team and utilized a severance pay period within her company to begin establishing the newly desired way of life. Formally, we utilized the “mental contrast” method as an intervention targeting the emergence of developmental goals. An action-oriented, proactive approach replaces freely fantasizing, basking in a desirable future, and also obstructively ruminating. Deliberate mental contrasting of positive fantasies about the desired long-term outcome (e.g., discussing differing life expectations or lifestyles with a partner, preparing the new work situation) with negative aspects of the impeding reality (e.g., low distress tolerance in conflict situations involving specific discrepancies, outdated learning style) should lead to the formulation of binding goals for action and the discovery and creation of opportunities for learning that results in coping with future challenges. Contrary to basking and ruminating, which only lead to moderate commitment regardless of the probability of success, mental contrasting activates the relevant chances for success (or expectations of success) and utilizes them for goal-setting. If the relevant expectations of success are low, people shy away from committing to binding goals, but if the expectations are high then people tend to bindingly commit to the realization of the desirable future (Oettingen, Hyeon-Ju, & Schnetter, 2001).

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