

*Section: Theoretical reviews and research***THE THERAPEUTIC PROCESS IN POSITIVE PSYCHOSOMATICS: 'FIVE FINGERS' FORMING A THERAPEUTIC RELATIONSHIP IN PSYCHOSOMATIC MEDICINE****Arno Remmers**

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Abstract

Medical doctors and therapists are challenged to focus on forming a fruitful therapeutic relationship with patients experiencing physical symptoms without clear medical causes. In positive psychosomatic medicine a five-step concept of therapy, represented by 'the Five Fingers' process of treatment involves empathic listening, understanding the patient's specific expressions for the symptoms, uncovering subconscious meanings and the functions of the symptom in the patients' life, exploring inner conflicts causing body reactions, and discovering the hidden language of the symptoms for the client and the social environment. Therapeutic interaction through phases of sensitive perception of feelings, understanding and naming contents, finding potentials and self-help resources, verbalizing value conflicts, and preparing the patient for self-help and change are described as a manual for the interview with the client and treatment planning. This interactive process aims to identify and address the triggers and root causes of symptom development, empowering patients to utilize their strengths, and ultimately to achieve changes and goal expansion for a successful therapeutic outcome, symptom reduction, and life balance.

Keywords: therapeutic process, positive psychosomatics, Positive Psychotherapy, therapeutic alliance, five fingers of therapy

Introduction*The development of a therapeutic relationship in psychosomatic medicine*

One of the most common difficulties in counseling, psychotherapy, and medical treatment is to form a **helpful therapeutic alliance** with patients suffering from body ailments when medically no physical reason has been found. As a therapist I perceive all body complaints as they are experienced by the patient. I am interested and ask exactly **how the**

client experiences the symptoms. I write down the words or expressions the patient uses and try to understand them as a **language of the patient's body**. Accepting all kinds of descriptions and **linguistic images** opens the door to a healing process in cooperation when my clients reflect back to me that my description resonates with their experience. As a therapist, I want to **clarify the qualities of the symptoms and their function in everyday life** until the patient gives feedback that I have really understood the individual experience. The way

in which symptoms are expressed, often with unconscious meanings and values. The linguistic expressions depend on the environmental culture. In all languages body expressions are hidden, like the hands (lat. manus) in 'to manage'. Emotional expressions are like expressions of body sensations, as in 'It's hard to bear', 'it hurts me', 'it itches', 'I cannot stand it', 'it sounds cold', 'it is like a stone', 'it burns'.

As a therapist, I try to discover the narratives in interaction with the client, try to find images, symbols, or proverbs that fit the experienced situation. This lets us understand the way the patient suffers, "to find together images fitting the experience" (G. Rudolf 2004). In everyday language, the connections between inner conflicts and symptoms often seem obvious: 'my back is breaking' - when the responsibility is too heavy for a person; 'it makes me want to vomit' - when aggression is suppressed; 'it itches' - when something touches me in a figurative sense; 'this is like a stone in my stomach' - in the conflict between adaptation, submission and one's own needs; 'this gets under my skin' - in unconscious closeness-distance conflicts; 'this makes my stomach ache' - like a primary school pupil who no longer wants to go to school with a stomach ache.

In psycho-somatic disorders, the **subjective meaning and the interactive function of the disease** work as a key to the second step of understanding the symptom function and psychodynamic significance. There is a useful, simple structure for questions which are understood by both the patient and the specialist. Using the four areas of life - body, achievement, contact, and future/fantasy - from Nossrat Peseschkian's balance model (1991), the question: "What changes have you noticed in these four areas of life as a result of the symptoms?", can reveal alterations in bodily experiences, influencing activity levels, social relationship patterns, and future perspectives.

Qualities of suffering and also the functions of the actual symptoms can be the basis for a 'positive interpretation' of the symptom as a language of the body to find out the "function of dysfunctionality" (Stavros Mentzos, 2010). A physical complaint can be seen as an expression of organs, in a language that the patient does not yet understand, as a readiness to react, as an organic function answering when the voice cannot express something. The **somatoform disorder** and the body's reactions to conflicts can

be seen as a **physiological side reaction of suppressed action** patterns. In a continuing, emotionally-loaded context they can increasingly become chronic symptoms, a "mute" pathophysiological fixation according to Franz Alexander (1950).

Listening closely to the patient's speech reveals the hidden subconscious meaning of the symptom. Linguistic images and sayings or proverbs sometimes open the door to the patient's own imagination.

Methodology

The psychodynamic interview in psychosomatics

After this first phase of empathic listening and changing the point of view, the second phase of therapeutic interaction starts with questions concerning the subjects involved: 'What is it about? When did it start? Who is around you? How did your life change?' so as to find out the content of the problem or the subconscious conflict, the inner dilemma to which the body reacts 'honestly as a true friend'. From multicultural therapeutic interviews N. Peseschkian (1987) found a list of values called "actual capacities" because of their importance in the current situation. "**Primary capacities**" represent **emotional needs** in a relationship - such as time, trust, or tenderness. "**Secondary abilities**" such as order, justice, achievement, or reliability embody **social norms** that govern the organization of interactions and relationships.

The **ambivalence** between **needs** and **expectations** leads to an inner tension, that can be expressed consciously verbally, or preconsciously by the body. Simple, understandable terms for the involved capacities and values become the basis for discovering the inner value conflicts that finally cause the psycho-somatic symptoms in a bio-psycho-social-existential understanding.

Five stages of initial consultation and therapy

The **five-step concept** of positive individual, family, and group therapy resembles a **natural process of interaction**. J. L. Moreno described five phases in psychodrama, Raymond Battagay in group psychotherapy, Frederick K. Kanffer in self-management, Alfred Adler in a therapeutic growth process, Nossrat Peseschkian published a five-stage therapy. The five fingers of the hand

symbolize the therapeutic process in positive psychosomatic treatment in order to find an individually appropriate way to self-help and treatment. It is used in each session, in the initial interview, in counseling, and in family therapy.

The five phases of interaction provide a structure for the communication process within a session and during the entire therapeutic process. It accompanies the patient in the process of

1. feeling,
2. understanding,
3. finding potentials,
4. conflict solution, development and self-help,
5. preparing the time after therapy.

To provide an 'anchor' for therapists linked with a body memory in the session, the 'five finger model' was introduced for the therapeutic process - based on the five phases in psychosomatic treatment:

- Thumb: Listening and feeling with empathy and finding different points of view
- 2nd finger: To ask for clarification of the life

situation, areas of life, conflicts, and capacities

- 3rd finger: To find out the coping and potentials of the client, support, and mobilization of capacities, involvement of the social environment – encouragement in the situation
- 4th finger: To verbalize difficulties and conflict contents, understanding and accompanying inner conflicts of values and interpersonal conflicts
- 5th finger: To see the future after therapy by expanding goals, future orientation; looking at the future after conflict resolution

The better we can handle difficult situations within the therapeutic encounter, the more we interactively work out the differences in each one's perception and feelings, reflecting them in the therapeutic relationship, the better the result of therapy will be. The following overview shows the steps of changing the therapeutic attitude, the client's perspective, and exemplary questions for each phase.

1. Phase: Observation and changing the point of view – establishing contact, looking at symptoms and their function in the first interview

Therapeutic approach: As a therapist, I perceive my counterpart and myself, listen with empathy, put into words how I understand my counterpart's suffering, and the effect of the symptoms on everyday life until the patient feels understood. We can find linguistic images and look at the patient's experience and situation from different angles (transcultural view, narrative description, function of the symptom in life, developing therapeutic connectedness)

Questions: How do you feel and experience your complaints or symptoms? What explanation do you yourself have for the disorder? When did the symptoms begin, what was your life situation then? Are there moments that trigger symptoms? What did help you? When did you feel better? How have you been treated so far? How can we find words, narratives, or pictures for what you suffer from?

2. Phase: Inventory - life situation, concepts, and conflict contents

Therapeutic approach: Clarification through interactive questions, visualization of areas of life, life events, and conflict processing in the balance model, skills (DAI), recognizing family concepts and microtrauma, first assumptions about the emergence of the symptom history (inner conflict, basic conflict, trigger, family dynamics), resources, helpful experiences.

Questions: Which life events have come up for you in the last 5-10 years, how could you deal with them? What influence did these events have on your general well-being, your job, your partnership, your family, and other interpersonal relationships? How do you react to problems and conflicts (microtrauma)? What is it all about? What skills do you and your partner value? Where do you get these skills from (role model dimensions)? What do you remember in your family? How was your own development?

3. Phase: Situational encouragement - strengths, resources, and potentials

Therapeutic attitude: Naming and encouraging the strengths and coping strategies of the patients, if necessary, supporting psychoeducation for persons to develop coping skills, promoting social support, relaxation training, medication, and stimulating counseling.

Questions: What has helped you until now? What did you experience as good for yourself? Who supports you? What makes you feel better? What has been neglected so far? How could you solve such symptoms or conflicts in the past? Where did you develop these skills?

4. Phase: Verbalization – inner conflicts, thresholds, and changes

Therapeutic approach: The therapist as a counterpart for verbalizing the conflict and ambivalences, addressing politeness-openness conflicts, naming the conflict dynamic (trigger and inner conflict, unilateral abilities), feeling and discovering basic conflicts and concepts (countertransference, transference), preparing communication with the social environment, accompanying the client in changes and challenges.

Questions: What do you see as difficult? Which are the two sides between which you stand? What did the symptoms change? What does the feeling you have to remind you of? What is it you are not satisfied with? What for do you need the therapy now, what can no longer be done alone? How do others see your situation? What have you already tried in order to change?

5. Phase: Goal expansion – the time after therapy

Therapeutic attitude: Keeping an eye on the patient's own activity and independence, having in mind the future after consultation; clarifying requests for a consultation or therapy, keeping an eye on the social environment, and including it in the therapy process.

Questions: Which of the problems that have arisen do you want to tackle first? What are your and your family's long-term goals? What would be different if the current problems were solved? How did you experience our encounter today, what thoughts do you take with you? Which subjects do you want to work out for yourself?

Source: Remmers, A. (2021)

In such a **five-step process**, positive psychosomatic therapy and self-help are developed, reflected upon, and individually designed. Thereby, qualities of the therapeutic conversation, such as empathy, change of the point of view, differentiation of conflict contents, encouragement to self-help, conflict counseling, and goal expansion complement each other and are tailored to the individual relationship.

Discussion

In the first step, the actual life situation and type of suffering as well as the function of the dysfunctionality of the symptoms can be discovered. Using the balance model, the influence of the symptoms on everyday life can be looked at and understood as a function of the symptoms. Understanding the patient's values and value conflicts, biographic background and potentials is the task of the second step. Finding out the client's resources and actual coping strategies in the third step becomes the basis for the fourth step of conflict resolution, clarification, or new patterns of interaction. These are trained with the therapist as a person in the fourth step, i.e. understanding the inner conflict and the fundamental conflicts that cause the symptoms also within the therapeutic

relation. In the fifth phase, special attention is given to the time after therapy, after possible changes, and the independence of the patient, reflecting the therapy results.

Conclusions

In a therapeutic alliance it is possible to create a new perspective within a five-step process. Reference persons can be included in this process for social support. Hope that lies in the patient can first be considered by looking at capacities and the function of the symptoms as the language of the body. Later we can reach an understanding of the situation, in which the symptom came up as a reaction to conflicts. The differentiation of conflict content and subconscious concepts and styles, expressed as abilities, can enable constructive change based on existing potentials. The final step of therapy prepares the future with a question like 'What will life look like after the conflicts and symptoms have improved?'

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